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

**Consultation submissions**

**186 – 220**

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| **Submission 186** |

We held a workshop with our local Health of Older Persons Strategic steering group. There were some general themes that the group wanted to highlight:

* In general there are a number of good, aspirational ideas and there are good linkages to other strategies.
* An outcomes/measurement framework is vitally important as that will clarify objectives and help in the reprioritising of resources.
* Strongly agree with more intersectoral/cross-agency work – challenge is the different structures in Govt services and, consequently, where budget decisions are made.
* People need to be helped/encouraged/incentivised to value their health more
* We should make more use of older people and their networks to get messages through
* Need to model the changes in the Maori and PI population separately to show the potential impact of reducing the inequity in premature death rates for Maori
* There are opportunities for using technology and data in a much more useful way
* Matters of policy should be led nationally – we don’t have the resources individually to develop and trial separate responses.
* More promotion to shape expectations
* The integrated shared care record is expected to resolve a number of issues
* Need better ways to share each other’s successes and challenges
* Would like to see a nationally led piece of work around the different subsidies (eg. RSS and RCS) and the implications of means testing/not means testing. Should be consistent so as to prevent the incentive to use one or other for the wrong need.
* May need to prioritise a bit more strongly and cut down the number of specifics – or put the specifics in the “implementation addendum” so that the strategy stands alone.

Attached are the notes from that meeting to provide detail of some of the individual actions.



**Meeting: Health of Older Persons Strategic Forum**

**Date:** 24 August 2016

**Time: 10.30am**

**Venue:** Pohutukawa Meeting Room

**Present:**

Service Director, Older Persons Services; Chief Allied Health Professions Officer; Psychiatrist, Older Persons Mental Health; Consumer Advisor; Geriatrician; Strategic Services Manager; Regional Manager from Aged Residential Care provider.

**Apologies:**

Nurse Director, Older Persons Services; Clinical Quality Manager, ARC Provider; CEO of local PHO; Programme Manager, Maori Health Services; Medical Director, Older Persons Services

**Discussion**

|  | **Item** | | |
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| **Health of Older People Strategy = Consultation Draft** | | | |
|  | **Link** | Link: <http://www.health.govt.nz/publication/health-older-people-strategy-consultation-draft> |  |
|  | **Background** | Consultation draft out since May. Consultation until 7 September.  Detail in the action plan to reflect on – how this will affect us. |  |
| **1.** | **Build Social Connectedness and Wellbeing in Age Friendly Communications** | | |
| **D.** | * Promoting volunteering, networking and paid work among older people - very important and good to see in this document. * Links closely to local strategy component of older persons retiring still well and active and wanting to still be involved in volunteering etc. * Service for frail elderly (EngAGE) – looking at better consumer engagement, volunteer workforce to be considered. * Wider forum – intersectoral needs to keep comms open. | | |
| **2** | **Increase Resilience Through Local Initiatives** | | |
| **A.**  **B.** | * ACC issuing RFP on this soon – challenge will be getting individuals to value this enough to do it regardless of funding incentives or not. * Green prescriptions reviewed locally; shift to emphasis to young people. Lot of volume for older adults. * Some stats are not on radar for EngAGE – how do we change that? Need to improve demographic analysis. EngAGE aware not many Māori i but numbers in population quite small. * Model relies on referral from primary care – some coming directly through to ED and not through rapid response (Orbit). Need to work with NGOs around this. * Not looking at clinical reason for presentation – we don’t understand what is happening. * EngAGE committed to working with older Māori. | | |
| **3** | **Work Across Government to Prevent Harm, Illness and Disability and Improve People’s Safety and Independence** | | |
| **A.**  **D.** | * Orbit team picking up through primary care. Sharing information and coordination still need work. Consumer advisors (eg budgeting services) see vulnerability in the community across the board – not easy to access services if not well off * Opportunities for people to be active within the community. Prevention is best value. Need to look at units being made more dementia friendly. * Thresholds for health needs should be looked at. Problems with medical and MSD side – poorly structured. * Lots of older people don’t get help that they actually should be able to access. * Everyone in healthcare should know the system and how to access it. * Elderly feeling overwhelmed by information provided don’t follow up. Patients need to be walked through the process/navigate. * Consumer Advisor feels knowledge the source problem. More attention required on building knowledge/literacy | | |
| **4.** | **Improve Health Literacy and Communication Systems** | | |
| **A.**  **C.**  **E.** | * Accessibility and responsiveness; looking at needs of people and their families/agencies – those in front of client. * Key responsibilities of DHBs. * Patient portal, trial remote monitoring nationally, U-book. Good to have on the radar. * About older persons communicating with their health providers. Opportunities in remote monitoring for eg. | | |
| **5.** | **Improve Oral Health in all Community and Service Settings** | | |
|  | * Access to care via WINZ. | | |
| **7.** | **Improve Outcomes from Injury Prevention and Treatment** | | |
| **A.** | * Already have work on this within DHB. * ACC turned corner – moving towards prevention. * Better use of data very important | | |
| **8.** | **Reduce Acute Admissions** | | |
|  | * Need evidence and research based – national leadership to get it off the ground. * Inefficient to just have each area creating their own model which can’t be transferred to other areas so difficult to capture data. * Broader leadership, MOH, academic. * Barrier after hours – not resolved at local level. National policy needed. * Lots of models but lots of implications industrially and re resources. * National improvement coordinating function very important – our DHB needs to be support this. * We need to look globally at models and what is working. * Need to fix community to allow fix with DHB. | | |
| **9.** | **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** | | |
| **B.**  **C.** | * Lifting skill base of workforce. * Kaiāwhina CareerForce. Certificate or a training for all support workers. * Employees who are paid caregivers - providing training to these people and more carer respite * We get a lot of requests for people caring from family asking to up-skill. * Undergraduate education about conditions – not being taught. * Change healthcare details to workforce. Living and fair wage will make it more attractive to recruit to. * Taking RNs off the critical skills list has had a detrimental effect. Cannot get NZ based trained nurses in ARC. Barriers as less well paid to DHBs and harder work in terms of conditions and workload. * Not an area that encourages doctors, nursing and allied health. * Need to train workforce more specifically in some conditions. * Need to look at a different workforce. * Some ARC facilities provide third year student placement in rest home. * Life skills and societal attitudes. * Enrolled nurses versus care giver – phasing out enrolled nurses and providing structure programmes for care assistants. ARC are keener on (new) position of senior care assistant. * Need more workforce trained, valued and regulated. | | |
| **10.** | **Enhance Cross-Sector, Whole-of-System Ways of Working** | | |
|  | * Pharmacy action plan released – ensure alignment. * Medicine management; home-based and residential based care supports – better direction on meds management requried. * Need interventions and screens because of errors in prescribing when transitioning between sites. * Ability for all systems to talk to each other would reduce errors. | | |
| **11.** | **Expand and Sharpen the Delivery of Services to Tackle Long-Term Conditions** | | |
| **A.**  **E.**  **F.**  **G.** | * Very broad dementia framework. Dementia - 90% needs to be managed in the community. * Recognising cognitive impairment at front door – addressing undiagnosed cognitive impairment in the community. * Some development, better use of InterRAI required. * Connecting to what people will need in home care support areas. * Clinicians are not seeing InterRAI data info – not being sent to them. Focus on making sure more people are seeing the information. * InterRai needs long term care assessments done every six months (ARC – appropriate care level, looks at transition). * What are the utility and costs? What is the value of the information? * Needs broader national academic steer. Extremely difficult. Need direction rather than trying to do things in smaller areas. There are difficulties in standardising iwi information. Each iwi has different ideas. Kaiāwhina – provide tools to put services in place. * Stroke work going ahead. Encouraging. * Trying to get multiple organisations involved very difficult. * Put patient at the beginning then get agencies involved to provide care. | | |
| **13.** | **Use New Technologies to Assist Older People to Live Well with Long-Term Conditions** | | |
|  | * Still looking for identification tool. * A lot coming out of UK which we can utilise. * EngAGE to address some of these issues. * Can get DHBs that are ahead to share their methods/tools | | |
| **15.** | **With Service Users, Their Families and Whānau, Review the Quality of Home and Community Support Services and Residential Care in Supporting People with High and Complex Needs and Involving Family and Other Caregivers** | | |
| **A.**  **B.**  **C.** | * Should involve ARC providers. * Some of the smaller areas are involved and keen to share ideas. * Village style approaches where people share homes together and still cook and do activities together positive. * Needs national steer very complicated. * Contracting models are very black and white and not very flexible. Person is not at the centre of this. Criteria misses the person. | | |
| **16.** | **Integrate Funding and Service Delivery Around the Needs and Aspirations of Older People, to Improve Health Outcomes of Priority Populations** | | |
|  | * Seeing this in other population groups, like children. We are quite far off this type of approach. * Vision to aim towards this needed. * Aspirational. | | |
| **17.** | **Improve the Physical and Mental Health Outcomes of Older People with Long-Term Mental Illness and Addiction** | | |
|  | * Good to see this. * Policy way of approaching this is needed. * We could do this better. * Funding impairments. | | |
| **18.** | **Better Integrate Services for People Living in Aged Residential Care** | | |
| **A.**  **C.**  **D.** | * Discussion about failed yellow envelope trial. * We can do this better. Everyone is bad at this. Work to be done there. * You would hope this is happening. * Reporting on inappropriate admissions to hospital was previously provided and was useful in monitoring and keeping on top of this . * Some of the larger providers with villages are providing home based services around this. Proposed conflict of interest – Ministry to work on this. | | |
| **20.** | **Improve Medicines Management** | | |
|  | * Previously there was a Pharmacist Facilitator working ARC – Pharmacy did not adopt model. * We need to focus more on the community. * Our approach to Polypharmacy is good but medical management of short-term ARC admissions is not done well. | | |
| **22.** | **Ensure Widespread and Early Participation in Advance Care Planning** | | |
| **A.** | * Good to have in; also in the Central Region regional service plan. * But no national policy * Some funding nationally for ACP was removed and DHBs have had to fund – uncertain value and has been agreed on a limited time basis. * There are resources issues. * ARC provider had a presentation to residents and had good uptake. * We don’t always honour what is done as lost in clinical letters/ECA. i.e. patient management systems cannot cope with ACPs at the moment – inconsistent approaches across the country | | |
| **23.** | **Build a Greater Palliative Care Workforce Closer to Home** | | |
|  | * Wording around this is not about increasing specialist workforce but making more of a generalist workforce competence. Need to highlight that the need is really for more (general) workforce to have some competence in palliative care – as opposed to building a specialist workforce. * Implementation – need to tie into outcomes framework. Ie. Clarity about the objectives. | | |

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| **Submission 187** |

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| Organisation (if applicable): | ADHB |
| Position (if applicable): | Geriatrican |

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

x 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:

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  District health board

Education/training provider  Local government

x 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 background and preamble is not contestable .  With regard to healthy ageing the foundations of this come from a healthy pregnancy , childhood and good health in middle age. Management of cardiovascular risk factors in middle age are critical  Lifelong exercise is important .  It could be argued that healthy ageing priorities sit in all health strategies |

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 concept of age friendly communities needs a shared definition –otherwise too vague . Really means incorporating universal design principals into all builds , adequate accessable and affordable housing ESPECIALLY for those who will be renting ,-a looming crisis, being creative when giving building consents for retirement villages –eg insist that x %are for renting and adequate transport . Urban design needs to ensure new housing areas incorporate a mix of housing types  2a agree but need to ensure that ACC does not unilaterally pull out of programmes and funding as they did in the recent past , putting falls prevention strategies 10 years behind  3e what responsibilities do Housing NZ and local councils have here??  4 health literacy needs to be addressed well before old age . The desire to use more technology needs to take in the realities of dementia, sensory impairment like vison and hearing and cost otherwise this will further isolate older people.  5. these goals are meaningless without some investment . there are helpful guides for residential care and older people already –the issue is cost |

### 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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| This sections is extremely disappointing . It does not address the reality that acute hospital care has a real and valid place for many older people . There is nothing here to encourage hospitals to improve the care for frail people wherever they are in the hospital . This would reduce complications , LOS and readmissions . Similarly nothing is mentioned about improving the detection of cognitive impairment in acute hospitals in all areas to improve care despite section 11 . I note the Australians have just incorporated this into auditable standards for all hospitals .  All clinicians bar paediatricians and obstetricians . need training in the fundamental geriatric medicine –the concept of fraility and frailty syndromes and the impact on outcomes .Similarly for those with dementia and delirium  Suggest you add this goal  **Older people who are frail or have dementia are cared for safely in acute hospitals** |

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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| 7a agree  8 change this to reduce **inappropriate** admissions . The constant push to “reduce acute admissions in older people“ is a **form of institutional elder abuse** –made to feel unwelcome ,a burden etc and yet many with seemingly non specific subacute presentations turn out to have serious problems . There is already ageism in many areas –better than it was but still present |

### 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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| . Need to acknowledge that the reality for many people with long term conditions is a steady and inexorable decline –dementia , Parkinsons disease , interstitial lung disease, etc  The language here needs to include this reality . Need to add a goal for those that face ongoing deterioration - they are well supported to cope with changing health and support needs . If this is not included the real healthcare needs of this group are at risk of being overlooked in the focus to age well , be healthy etc . It becomes disrespectful  • *Health outcomes for vulnerable older populations with long-term conditions are equitable with outcomes for the (?older )population as a whole*. This is ambiguous and potentially unachievable |

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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| 9a and c agree but general literacy might need to be supported first . Regular work hours for this group would help this goal. They also need mentors and coaches to role model care rather than traditional classroom learning fraility , and frailty syndromes , dementia etc .  9b need to add basic training in the core components of gerontology. This is still not adequately embedded in undergraduate training programmes –suggest MOH audit time and content for key health professional training programmes  The model of primary care provision in residential care needs urgent attention. The costs have been rising faster than the aged care cost adjustments via contract . It is very difficult to retain GP services in many areas , Very difficult to get GP after hours care . The ARRC contract suggests monthly to three monthly visits yet 50 percent of GP contacts are for urgent assessments (data available on request). House bound older people also have major access issues yet few DHB primary care annual plans make any mention of these groups .  No strategy to use residential care in innovative ways to support older people will work without addressing this issue. Needs a working party to address this  11c –not sure this is the neediest group . Good recent international guidelines for this group . A key change would be to add references ranges for the HbA1C results according goals of care –currently reference range is for fit younger diabetics putting older people at risk of hypoglcemia  11e InterRai data –needs to be easier to access with more regular reports include benchmarking DHB data . Disappointing this is taking so long ‘  Not sure that the centralised model under TAS will be a step in the right direction or not  12a agree but need to address the silos of funding as well in this area  16a needs rewording  One might argue there are services already doing this and more focus and support would enable greater success evolution not revolution. Greater intergration might only come with better communication technology as one person might need a large team with individuals contributing more or less depending on the problem  The joint responsibility harks back to the separatist funding and responsibility of the past between Dept Health and DSW  Many of the suggestions are already in place , or are being developed . Hard to know how the strategy can be implemented well with few time frames , no costing or financial comments, and joint responsibilities between agencies . |

### 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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| 14a excellent  15 Residential care already has an intensive multiagency review programme going on and has just implemented interRai –a massive undertaking that is not yet fully embedded. Neither is there any evidence yet that this has improved quality care .The training required has certainly taken nurses away from the bedside .Suggest InterRai is embedded and utilised before considering any other form of residential care change  16a needs rewording  One might argue there are services already doing this and more focus and support would enable greater success evolution not revolution. Greater intergration might only come with better communication technology as one person might need a large team with individuals contributing more or less depending on the problem  The joint responsibility harks back to the separatist funding and responsibility of the past between Dept Health and DSW  Many of the suggestions are already in place , or are being developed . Hard to know how the strategy can be implemented well , with few time frames , no costing or financial comments, and joint responsibilities between agencies .  Strongly suggest New Zealand develops standard s for naming different support programmes in the community –extremely confusing array of community support programmes doing similar things with completely different names in adjoining DHBs . This would help with monitoring outcomes and expenditure |

### 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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| Need to ensure some equity of palliative care specialist support to age residential care cf hospices . NZ is a high user of ARRC for acute palliative care for older people . High pressure to discharge dying patients from acute hospitals and a large proportion go to ARRC for the first time . Considerable resourcing differences between facilities for this high needs group .Still considerable differences in the perception of the worth of hospice workers cf aged care workers doing the same support in many instances  Need to focus on “advance treatment plans “set up by health professionals in consultation with family for those who do not have the capacity to set up advanced directives |

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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| Timeframe for implementation is tight . What consultation will there be for this?  In terms of outcome measurement existing sources of information should be used to the maximum and efficiently before asking for new data to be collected |

### Other comments

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| **Submission 188** |

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**The Silver Line New Zealand**

***Supporting the***

***Health of Older People***

***Strategy***

**September 2016**

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Executive Summary

This document is a submission by Silver Line Charitable Trust New Zealand

(SLCT), an innovative body designed to offer services benefitting older people of all cultures, orientations and abilities in New Zealand. SLCT services are designed to mitigate the loneliness experienced by increasing numbers of older New Zealanders. SLCT will provide the first free, nationally available, full-time befriending, information and help line specifically for older people.

The role of SLCT will support the Ministry of Health’s vision and strategy for the care of older people in NZ. SLCT Trustees are mindful of the rapidly growing number of older people in New Zealand (over 650,000) and the significant levels of loneliness among them.

SLCT is, in large part, based on, and designed in collaboration with the highly successful UK Silver Line. The UK service, although in operation for less than three years, is experiencing extremely rapid growth and is on track to become the UK’s leading helpline service of any kind. The UK and NZ Silver Line organisations are working closely together, both to assist NZ’s Silver Line introduction and to assess potential for international roll out of the concept.

SLCT aspires to be a ‘welfare guardian’ and will:

* Include input from its target clientele to aid design, provision and review of services;
* Encourage volunteers from a broad spectrum of the population, including younger and older people;
* Be independent;
* Operate an evidence-based, outcome-led approach to service provision; and
* Seek to collaborate with other bodies and agencies caring for older people.

SLCT will also collaborate in research and evaluation with Auckland University of Technology (AUT) whose health and social services specialists have significant experience of issues concerning the wellbeing of older people. AUT is represented on the Board of Trustees of SLCT and will provide ethical and research expertise, as well as practical training in the care of older people.

Below we provide comments on how SLCT will support the various strands of the Ministry’s strategy. We also give a more detailed description of SLCT and its genesis.

# The New Strategic Focus for New Zealand’s Older Peoples’ Health

In July 2016, the Ministry of Health produced a revised draft strategy aimed at enhancing the health and wellbeing of older New Zealanders. Its discussion document highlights both a vision and a set of five priority areas for policy and service provision. All are directly served by the work of SLCT.

***The vision:***

## Older people live well, age well and have a respectful end of life in age‑friendly communities.

## Priority areas:

* prioritise **healthy aging** and resilience throughout peoples’ 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.

The Ministry recognises that to realise its vision, effective policies, funding, planning and service delivery must all be in place and must be well-co-ordinated. The Ministry also recognises increasing demands of an aging population both in terms of the growth of the older population and of increasing expectations among individuals, families and whanau. It also recognises the potentially overwhelming financial implications of meeting those increasing demands unless more innovative, cost-effective and volunteer assisted solutions can be found.

## How SLCT will help support the Ministry of Health’s Priorities

### The vision:

Part of the vision that older people live well, age well and have a respectful end of life in age‑friendly communities, requires that older people are recognised as individuals, who have earned respect and care, without being patronised or reduced to ‘cyphers’ or ‘problems.’

Aging well implies autonomy, recognition that ‘community’ means a variety of things to different people, not simply local areas or sheltered accommodation. It also follows that choice is a fundamental human right for older as well as young people.

SLCT will embody a strong ‘customer voice’. By reducing the extent of loneliness among older people it will encourage, and provide opportunities for, social engagement that is meaningful to, respectful of, and strongly influenced by older persons...

Part of the ethos of SLCT is encouraging younger people, including health and social work students, to both experience the benefits of volunteering and to gain hands on insight into working with older people. This inter-generational contact will, we believe, help ensure that the benefits of SLCT will be sustained into the future.

The information and database systems which underpin SLCT will foster the building of a national database of take-up, service demand and outcomes. This is likely to prove of great worth in targeting resources to where they are most effective and following-up individuals in need of particular care.

### Healthy aging and resilience

The ‘Medical Model’ is not the only determinant of healthy aging and resilience. There is considerable evidence that loneliness, neglect and lack of consultation, social involvement and choice can both reduce life span (e.g. through loss of motivation to live or a sense of belonging) and increase demands on already stretched emergency and primary health care services.

The Silver Line will provide a point of social contact that helps solve practical problems, with the added benefit of reducing demands in other areas. A ‘friendly voice and ear’ can create a sense of belonging, empowerment and wellbeing and so is an energising force in people’s lives. It can also help detect problems before they escalate.

### Enable high-quality acute and restorative care

SLCT will provide neither acute nor restorative care. Nevertheless, it will have a potentially key role in helping older persons to access acute care e.g. by ‘signposting’ to the Healthline or other services. SLCT will not provide a triage service, but we are aware of some potential users ‘not wanting to be a nuisance’ or calling on acute services simply because they have no one else with whom to interact. The Silver Line will also have a role in restorative care by being an aware and supportive friend at the end of the phone line, any time night or day throughout NZ.

SLCT (as with the UK’s Silver Line) will have built in flexibility in terms of working with population sub-groups, both to meet the particular needs and interests of those groups and to monitor and measure service effectiveness. Examples could include:

* People discharged from hospital.
* People contacting emergency services (111 calls) where immediate emergency help is not required.
* People referred by PHOs etc.

### Live well with long‑term conditions

Many older people are either unable or unwilling to leave their homes for even short periods. Often other people (even busy family members) begin to forget them. Contact becomes increasingly infrequent.

An older person, living anywhere in New Zealand can be sure that SLCT befrienders are always available for social interaction. This knowledge alone can help alleviate the misery of isolation and loneliness.

### Support people with high and complex needs

People with high and complex needs may fall through the gaps between caring services. A visit from a nurse or doctor is valuable. But such services are time limited and have restricted reach and availability. They often offer little chance for social interaction. SLCT people can help fill the gaps and, with permission, may act as a form of first responder when someone is in distress.

### Respectful end-of-life care

The end of life period can be one of the most lonely and isolated for anyone. Loved ones may be unavailable or unwilling to talk at a time when talking can provide an unrivalled source of comfort. A regular befriender may make this time easier to accept and even savour.

# Silver Line Charitable Trust – The Genesis

The concept for the Silver Line has been under consideration for some time. SLCT Trustees and their advisers have experience in operating a variety of helpline services in NZ and overseas. Personal contact with older people in lonely and distressing circumstances has highlighted the need for a service dedicated to older people. In addition, various research papers have highlighted the vulnerability of older people to shortened life spans (including suicide) that correlate with loneliness and isolation. In 2015, the Trustees began to build a working relationship with the UK’s Silver Line and SLCT has invested time and money in creating a collaborative relationship as set out in a formal Memorandum of Understanding (MOU). This has included one of SLCT’s people spending time in the UK at both the 24/7 helpline and the more personalised befriending service. The UK model is effective in alleviating loneliness and its attendant issues. The MoU between SLCT and the UK Silver Line will enable NZ to roll out a proven model in a short time, with limited software and operating modifications required. It will have access to the UK’s experience and expertise.

SLCT has also entered into a Heads of Agreement with AUT covering monitoring and evaluation, training and IT support. It is envisaged that Information sharing will increasingly be a two-way flow involving SLCT and AUT in NZ plus Silver Line UK and its academic partners. Longer term other countries are expected to join the process.

## Vision

The Silver Line’s goals will be:

* Being accessible to older people throughout NZ free on demand 24 hours per day 365 days per year.
* Reducing the sense of loneliness and despair experienced by older people and the powerlessness and invisibility that accompany it.
* Fostering a sense of belonging and value among older people.
* Providing links to other services for older people.
* Understanding and articulating the needs of older people and representing them to government, other policy makers and service providing agencies.
* Being able to segment service monitoring and outcome evaluation to help inform national health/wellbeing policies.

## Mission

SLCT’s mission is to provide innovative services which benefit older people of all cultures, orientations and abilities throughout New Zealand.

SLCT supports the Befrienders Worldwide philosophy by:

* Being a principal source of emotional support.
* Sharing research which can lead to innovative service practices, delivered by volunteers.
* Valuing the importance of being listened to, in confidence, anonymously, without prejudice.
* Providing support through a wide range of means e.g. via telephone helplines, SMS messaging, mail, the internet and social media.
* Recruiting, training and supporting volunteers.
* Striving for and developing international best practice, training, research, support and guidance for the benefit of users.
* Connecting the community.

Any collaborative partners for SLCT will also need to embrace this philosophy.

## Values and Success Factors

## SLCT will be based on a number of core values. These include:

* Valuing and respecting older people.
* Hearing and embodying the ‘Voice of the Customer’ (i.e. the older person).
* Delivering on promises.
* Not undermining the original concept of Silver Line (TSL in the UK).
* Seeking feedback and using it to enhance the services provided.

The Silver Line’s success will be gauged through both internal measures and through independent research. It will include:

* Feedback from service users and volunteers (and caregivers).
* Volumes of first time and repeat contacts.
* Numbers and varied profiles of volunteers.
* Service drop out by users and volunteers.
* Feedback from supporters.
* Objectively measured emotional/situational changes among users using bespoke measurement indices.
* Identification of new life opportunities.
* International relationships.
* Endorsement by Government and DHBs.
* Effective (comparative) budgetary and cost control.
* Collaboration with other agencies.

The more general social benefits of the Silver Line will be considered in terms of the sense of value older volunteers will enjoy, the engagement of younger volunteers (UK volunteers are as young as late teens) and the involvement of health/social work students as well feedback from Silver Line users.

## Governance and Operational Approach

The Trustees of SLCT have developed a Governance Framework covering ethics, roles and responsibilities. The Board has a Chairperson and Deputy Chairperson, as well as sub-committees responsible for financial management etc.

# The Government Is Concerned

The Government recognises that an aging population and an increase in people living alone mean that social isolation and loneliness are quickly emerging as major social issues which have particularly adverse impacts on the health and well-being of the rapidly growing population of older people.

Social isolation and loneliness have been found to be associated with a range of health issues, including increased mortality, depression, high blood pressure, and dementia. A recent study found that social isolation has negative health impacts equivalent to daily consumption of 15 cigarettes or six units of alcohol.

Social isolation and loneliness are negatively associated with well-being among New Zealand adults. Over 300,000 are estimated to experience loneliness, with perhaps 50,000+ experiencing it on a chronic basis. Only 59% of adult New Zealanders who felt lonely all of the time in the preceding four weeks were satisfied with their life compared with 91% who never felt lonely.

## Silver Line Is Needed

Addressing loneliness to improve people's well-being and health is an increasingly important policy goal. Reductions in social isolation and loneliness are targets for the Ministry of Health and District Health Boards.

Social isolation is also identified as a factor in the development of suicide behaviours in the NZ Suicide Prevention Strategy. In addition, it is recognised that there is a strong relationship between feeling lonely and a person’s self-assessed (poor) mental health status.

The Government is continuing to explore implications and options for responses to aging and loneliness.

The Silver Line Model in the UK has proved to be effective in reducing presentations to the NHS and reducing pressures on 999 services (the equivalent of 111 in New Zealand). These impacts are achieved at relatively small cost and are available. nationally. It is expected that similar results will accrue in New Zealand.

***Action Is Needed Now***

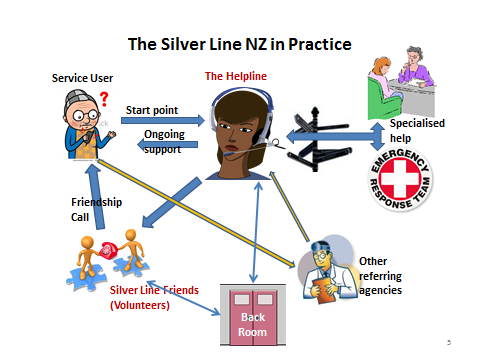
SLCT has encountered much enthusiasm for the Silver Line Model among other agencies/charitable bodies, DHBs and local government. Design and evaluation assistance has already been offered by a number of DHBs and local government. There is a danger that this enthusiasm will dissipate if the venture is not materially supported by Government. SLCT is offering a relatively low cost, readily available model which is proven to reduce loneliness and improve the sense of belonging/individual worth, which can be introduced throughout the country relatively quickly.

Government policy increasingly promotes private sector and self-help solutions rather than simply top-down public sector interventions. SLCT’s adaption of the Silver Line Model to New Zealand is consistent with this philosophy. SLCT’s version of the Silver Line Model represents welfare guardianship of older people, by older people, for older people.

SLCT should be seen as a basic national service with unparalleled reach but does not necessarily represent a final solution to the problem of loneliness among older people. Nevertheless, it will provide data not previously collected and so will point the way to new services more tailored to individual needs.

# How SLCT will work

## A Quick View



SLCT seeks to offer a nationally available, fully integrated helpline 24/7, plus a one-to-one befriending service with more restricted hours. The key element of the service adding value to people’s lives is likely to be the dedicated befriending service. Based on UK experience and SLCT expertise, the SLCT service is expected to have the following characteristics:

* A dedicated, well-publicised helpline freely available throughout NZ for older people, with open communication on a wide range of issues (health, financial, social, a place to chat – the initial elements of befriending). This will be a 24/7 operation in due course; timing will depend on both service demand and adequate funding.
* Using volunteers with professional supervision is expected to be more effective than paid call centre staff, from both financial and ‘engagement’ considerations. The UK Silver Line is increasingly focused on volunteers for its 24/7 helpline as well as one-to-one befrienders, as this approach is seen to increase the ongoing level of empathetic engagement.
* The key initial ‘tag line’ for the Silver Line will not over-emphasise the befriending element, as it is recognised that potential callers will not necessarily be encouraged to make contact if they have to effectively self-label as lonely.

But as part of a standard though flexible helpline approach, callers will be assessed for, and may quickly become open about, elements of isolation and loneliness. They will be offered regular contact with a vetted individual (not necessarily of the same age group) as a form of friendship.

* This befriending will initially be offered by telephone but, as with the UK, can be expected to expand e.g. into written communication (Silver Letters).
* SLCT will directly monitor and manage the ongoing befriending relationships as well as the operations of the 24/7 line through an operating contract with HelpCentre (2015) Ltd (HCL).
* Lessons on the approach and potential pitfalls have been, and will continue to be, learnt from The UK Silver Line. SLCT will also feedback its learnings to the central operation in the UK. It is expected that more countries will join the Silver Line ‘family’ and exchanges of learning will be important. NZ should be able to fulfil a key international role.

A mixture of effective software, careful operating design and responsible and responsive human judgement together with proactive quality control will be the keys to success. SLCT (including its retained consultants) has some experience of operating and controlling helplines and ancillary services. The UK Silver Line has developed considerable expertise in both software and human interactions and is open to developing arrangements for SLCT to draw on that experience and expertise and to contribute to ongoing development.

Policy and governance will be kept separate from day to day operations. Thus, SLCT will provide oversight and a ‘public face’ while HelpCentre 2015 (HCL) is contracted to manage the operation on a day-to-day basis. Exact boundaries and responsibilities will be codified from time-to-time in an agreement between the two organisations.

## Evidence-led, Thought Leadership

SLCT will adopt a comprehensive, collaborative, whole-of-sector approach to enhancing the welfare of older people. It will:

* Identify and seek to work collaboratively with others (e.g. charities, DHBs and PHOs) in support of older people.
* Instigate new joined-up services by brokering protocols for data sharing, remedies and interventions to counter elder abuse.
* Work closely with AUT, and others as appropriate, to identify the effectiveness, strengths and development opportunities of the Silver Line model; and to search out opportunities to further enhance it by improving the model’s effectiveness, efficacy and efficiency.
* Establishing relationships with telecommunications and internet service providers to foster learnings for both SLCT and companies in the IT sector will be important
* Seek input from appropriate government departments on the focus and direction of appropriate research, both short term and longitudinal.
* Develop audio-visual and other materials for access by users.
* Work with appropriate government departments and NGOs (e.g. Age Concern, CAB) to foster development of suitable services for older people.
* Develop (in collaboration with AUT) a Centre of Excellence and Think-tank on the care of older persons, and provide opportunities for students in direct experience in the needs and care older people.

## How SLCT will be different

There are many helplines and support services in New Zealand but none currently with the planned scope and dedicated reach of Silver Line. SLCT has learnt extensively from the highly successful UK equivalent and has entered into collaboration with that organisation. This will help ensure a successful and relatively speedy NZ-wide roll out for SLCT.

The ‘Voice of the Customer’ will be integral. There will be an advisory panel drawn from ethnic communities. Other providers of services to older people will be invited to contribute to a services operations committee. The general public will be invited to contribute to user panels and to meet with Trustees on a regular basis. This will ensure the focus of SLCT remains wedded to the real issues facing the growing population of older people.

## Possible Demand

New Zealand has a significant and growing population of older people. The following table indicates the breakdown of population based on government statistics in 2014 and shows the 65+ cohort as rapidly growing:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Age Group** | **Total**  **Population**  **2006** | **Total**  **Population**  **2013** | **Total**  **Population**  **2014** | **Annual % change 2006/13** | **Annual % change 2013/14** |
| **0-14** | **888,300** | **908,800** | **911,300** | **0.3** | **0.3** |
| **15-39** | **1,463,700** | **1,452,400** | **1,481,100** | **-0.1** | **2.0** |
| **40-64** | **1,321,000** | **1,455,000** | **1,467,100** | **1.4** | **0.8** |
| **65+** | **511,600** | **626,000** | **650,400** | **2.9** | **3.9** |
| **All** | **4,184,600** | **4,442,100** | **4,509,900** | **0.9** | **1.5** |

In the UK, the (original) Silver Line was established against a similar background to that of New Zealand. It commenced with a small pilot but was quickly swamped with calls and now normally receives well over 1,000 calls per day and will receive its 1 millionth call during 2016 (in under 3 years from commencement). It is on track to exceed the operations of the more established 24/7 services in the UK. In New Zealand terms that could be around 150-200 calls a day (55,000 to 75,000 per annum) to the helpline. Each of these can be expected to require considerable time. Thus, time inputs from helpline volunteers and staff in New Zealand could easily run to 50 hours per day and require approximately 12 FTEs including supervision and monitoring. In addition, there must be provision for outgoing befriending calls and letters.

# Environmental Operating Issues

## Possible partners and collaborators

SLCT is assessing potential collaborative partners in delivering the Silver Line services to New Zealanders. Discussions are likely to continue during the proposed pilot/trial period.

The Silver Line in the UK has discussed with its IT service providers how its systems and adaptations could be customised for NZ. A representative of SLCT has been introduced both to the UK’s systems and to the providers. Both these providers have already been thinking of NZ/Australia as potential markets and are interested in developing working relationships with SLCT.

Collaborating with The Silver Line UK and using its experience and willingness to work together could provide SLCT with accelerated learning and start up. SLCT has begun to define its requirements (and what the two parties can offer each other) and has opened dialogue with The Silver Line UK on a formal basis.

Collaboration with AUT will also bring benefits in terms of expertise in the care of older people and in objective, ongoing research and evaluation. The Silver Line UK has commissioned research in the UK and made its findings available to SLCT. AUT has set in progress a proposal to agree measures and research topics that can be set in place from the outset.

Other major issues to be addressed include:

* Government support is likely to be an important contributor to success.
* UK experience suggests recruitment, monitoring and motivation of befriending volunteers is not necessarily straightforward and may need to be carried out rapidly and flexibly as demand could build almost instantly.
* Privacy and data management issues will be important, both for clients, volunteers, and paid staff and university researchers.
* Volunteer wellbeing and standards will need to be closely monitored by effective software and experienced human intervention. It is particularly important that opportunities for exploitation of clients by befrienders (and vice versa) and others be prevented.
* Consideration will need to be given to what extent ethnicity and gender matching will be required.

## Software, Research and Data Collection

The Silver Line UK has extensive experience of a range of software approaches that have contributed to making their operation the success it has been to date. SLCT has access to that experience and expertise and has contact with the preferred suppliers. It is expected that some limited customisation will be required for the New Zealand environment.

As part of the research and evaluation process, SLCT will commission AUT to propose a suitable methodology to answer a range of questions and to estimate the costs of performing the research. It will be necessary to record and secure helpline conversations. It will also be necessary to store, process and analyse completed records in a secure environment under the supervision of AUT staff to ensure that ethical protocols are met.

Such data should be sufficient to provide a rigorous foundation for answers to questions about the extent and nature of demand for the service. However, they are unlikely to inform judgements about impacts and outcomes. For that, an additional follow-up study may be required. Callers may be asked if they are prepared to participate in follow-up interviews. This will be in addition to any befriending activities in which they become involved.

UK experience suggests that up to 12% of callers are likely to report some form of elder abuse. This will require the development of a reporting and intervention protocol so that collaborations with appropriate agencies can be harnessed. In the first instance, SLCT will discuss this issue with the Health and Disability Services Commissioner with a view to developing working protocols.

SLCT will be a service that is the voice, ears and support for older New Zealanders, fostering a sense of belonging and friendship. Policy and governance are the remit of the Board of Trustees. The Board has a range of experience and expertise in academic, health, business and charity fields.

## Governance and Management

Day-to-day operations are contracted to HelpCentre Ltd (HCL), which also provides secretarial services to SLCT.

HCL is a company established with the purpose of operating services and commercial activities for charitable bodies. It is a limited liability company, established for the purpose of managing and commercialising targeted social services such as SLCT.

HCL reports to the SLCT Board through the Board Chairperson and financial sub-committee as appropriate. HCL will also undertake research and development activities with a view to, for example, extending the service into other territories and/or identifying additional complementary service offerings.

Specialist advice will be taken from academic institutions, including AUT, with relevant expertise, from other organisations caring for older people and from The Silver Line UK. AUT will present detailed proposals for the monitoring and evaluation of the Silver Line as it progresses, together with recommendations on international research and information sharing e.g. through an international symposium.

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| **Submission 189** |

7 September 2016

Health of Older People Strategy Consultation Ministry of Health

P O Box 5013

Wellington

TAS submission on the consultation draft Health of Older People Strategy

TAS would like to thank you for the opportunity to provide feedback on the consultation draft of the Health of Older People Strategy. We would like to assure you that our feedback is intended to be helpful rather than critical and we trust that it will be received in this way.

Firstly, our congratulations on the very inclusive process that the Ministry has, and continues to run, to ensure the final strategy is representative of the views of all parties, particularly consumers who will be the beneficiaries.

TAS is a shared services organisation of the 20 District Health Boards undertaking work on behalf of its stakeholders both in the regional and national contexts. We look forward to the opportunity to work closely with our stakeholders, Ministry, Government and Social Agencies to help make the strategy a success. We currently deliver programmes on behalf of the 20 DHBs and Ministry across health of older people, interRAI, community pharmacy, primary care and employment relations and have a good sense of the challenges and opportunities that are covered throughout the strategy.

This submission is based on input from all the service programmes provided through TAS as mentioned above. There will be duplication to some extent in the feedback provided and we have purposefully presented it in this way so that it is clear to the reader that the impact or comments affect more than one service.

Again, thank you for the opportunity to provide this feedback. Yours sincerely



General Statement

As an organisation, we support the overall direction as outlined in the strategy, particularly the five outcomes identified. We do recommend however the inclusion of a sixth outcome and that is around workforce which we describe more fully under our “Workforce Submission”.

We note that the strategy takes a high-level systems view presenting a somewhat generic, non- specific outline of each of the outcomes sought and then presents the specific activity required to deliver on the outcomes under the “Action Plan” later in the document.

##### *Comment:*

We believe there would be value in having the actions specific to the outcomes included within their respective sections with an appendix that sets out all of the actions under the “action plan” for operational and implementation planning.

We found it somewhat difficult at times to align the high level statements in the strategy to any specific actions set out in the “Action Plan” due to the level at which the action plans are set. The stretch between the high level statements and related action plans appears extreme at times.

## *Policy Alignment*

The strategy points out that “the changing population has ***major policy***, funding and planning implications.”

Presenting further insight into areas of policy that will be impacted by this changing population (even at a high level) which may/will need to be considered if the strategy is to be successfully implemented would seem to be an important omission from the document. Direction and leadership in this regard would ensure clearer focus between strategy, policy and prioritised actions.

##### *Comment:*

We would recommend Ministry give more direction in this regard showing the interdependency between the 38 priority actions identified and their alignment to policy where it is appropriate.

## *Wider Integration Required*

Integrated services are something we talk a lot about particularly in the context of person-centred care. In the 2002 HOP Strategy there was a separate section devoted to integrated services headed “Key Factors in Successful Integration”.

In our view, close integration between services at all levels will be critical and fundamental to delivering on the strategy and the prioritised actions should reflect the importance of this.

Integration also includes issues related to housing and MSD and there is a big policy element here that has to be elucidated by Government.

##### *Comment:*

In our view integration is a priority action that needs to be progressed over the next 24months. We would recommend a priority action specific to integration be included in the action plan. We believe there should also be clearer alignment between the integration objective and the actions to reinforce the importance of integration to the strategy and give a higher level of confidence to a successful integration outcome.

## *Inequity and Inequality*

These issues are discussed on pages 8 and 9 of the draft in a very broad context. Inequity and inequality are as applicable to the older population and the intent of the HOP Strategy as to the general population, yet there appear to be few actions that are specifically directed to addressing issues of inequity and inequality for older people.

##### *Comment:*

We would like to see some actions that recognise these issues for older people and propose some pathways to resolving, at least to some extent, the inequality and inequity that exists in respect to access to health services for older people.

## *Models of Care that Meet Needs and Expectations*

There are numerous models of care intended to service the needs of older people. An action to undertake a stocktake as to whether the models are meeting the needs and expectations of older people would be useful. This might provide some insights in to whether some models exist that are champions of support for the strategy and would deliver benefits if emulated elsewhere throughout the system. We do not seem to be successful at coordinating on a national basis the sharing of successful models across our health services. The degree of inconsistency in access to care and the type of care received across the country is a common complaint that the strategy should be looking to address.

##### *Comment:*

A prioritised action to stocktake the plethora of models of care operating across the older people spectrum to identify champions of support for the strategy with a view to copying and pasting where gains/benefits can be made is recommended. An overall objective of reducing the level of inconsistency across the country should be a priority action in our view.

## *Growing demand*

The document recognises the significant growth in demand from older people over the next 10 years and beyond. This significant growth is likely to be within an environment of increasing funding pressures and constraints. It would be useful to identify and align actions in the strategy with the reality of the future environment and talk about how such actions are intended to support the higher level objectives. Perhaps extending the discussion on page 10 around social investment approaches that will deliver savings to the sector to ensure expenditure does not blow out to the 50% referred to in the paragraph above might give the reader more confidence that funding implications are in fact an important consideration for the strategy. The document passes over these important issues and leaves the reader with a sense that the challenging aspects of the strategy have not really been considered to any great extent.

##### *Comment:*

Closing the gap between the sometimes brief and high level statements and some of the very operational and detailed actions would assist. We would encourage the writers to add more to the strategy document around the important high level statements so that the connection with the actions is clearer.

## *Tension of Social Investment vs Expectation on DHBs to Make Savings*

Picking up on the theme above, in the current environment there is a real tension between this social investment approach and the expectation on DHBs to make savings (often as a consequence of deficits). The document should recognise such tensions and have some actions that are intended to consider ways to resolve such tensions in support of the strategy’s objectives.

##### *Comment:*

Actions that recognise and set in place methodology to address tensions as exampled above would assist.

## *Technology Solutions/Support*

The concept of smart systems as espoused in both the NZ Health Strategy and the draft HOP Strategy has the potential to deliver significant gains for older people if approached in a partnered way. It would be useful if the strategy provided some leadership thinking not only around information and the value of that information to measure performance and assist with planning and decision-making but also talk about the technology direction (e.g. robotics being trialled at Selwyn Care in Auckland) and the benefits that could accrue to older people overall.

##### *Comment:*

In view of the Director-General’s statements around the importance of technology to both the NZ Health Strategy and the Health of Older People Strategy we would encourage an action that looks more to the future around emerging technologies and potential investment options in this space, that can assist older people at all stages of the their health and social continuum.

## *Earlier Intervention for High Risk*

We strongly support the drive for earlier intervention for potential high risk clients. This will require the incentives or perverse incentives and some of the cultures that currently exist to be reviewed and addressed as necessary to ensure this objective is achievable.

##### *Comment:*

A priority action that specifically supports this direction is encouraged.

## *Workforce and Qualifications Linked to Needs*

There is a separate section following on workforce and qualifications but as a general statement we believe this should be a separate theme in itself for older peoples’ health. Older people are extremely reliant (and will become even more so) on having a workforce that is trained, qualified, remunerated appropriately and available to meet their assessed needs. There should be specific actions aligned to this important part of older people’s health.

# Action Plan

## *General*

It is our view, that to ensure success the actions identified should be set out under the SMART framework in the document at least for the 38 priority actions set down for the first 24 months.

We note the intention of the Ministry to develop an implementation plan with the major partners, setting out the timing, sequencing, responsibilities and resourcing required for achieving the actions however we would suggest that in respect to the 38 priorities the strategy would benefit from some forward thinking in this regard and to have that proactive thinking included in the document. There is much to be achieved within the 24months and the priorities identified run the risk of becoming bogged down in discussions about primary leadership, policy matters that may be instrumental to success, funding implications and timing.

## *The 38 Priorities*

It is unclear in the document how the 38 priorities were selected. A brief statement explaining the prioritisation process and advising the reader of the criteria used for identifying the priorities would assist.

In our view, one such criterion should be that the priorities chosen deliver the best return for the older population in the shortest time possible i.e. where the greatest gain can be achieved within the shortest timeframe.

This would then inform the resource planning that providers will need to direct/redirect to the priorities identified over the next 2 years. The strategy should be clear that the 24month period for the prioritised actions will commence from the date of implementation of the strategy. This needs to be clear and accepted by all parties for inclusion in their annual planning timelines.

## *Multiple Leads*

We are strongly of the view that assigning multiple leads to priorities (e.g. action 2a assigns the lead responsibility to ACC, HQSC, Ministry of Health and DHBs) is a recipe for failure. There should be one agency assigned lead responsibility for any one priority to ensure success. This should be attempted upfront rather than leaving it to go through a further process of debating which agency should have primary responsibility. We would recommend a straw model be developed that sets out for discussion (if necessary) the lead responsibilities and the rationale for the assignment of such responsibilities.

## *Funding of Priorities*

Statements about funding impacts are always difficult however there should be at least some acknowledgement that there will likely be a cost to implementing the strategy which government will need to consider particularly in respect to the prioritised actions for the next 24 months. There is little point in identifying what needs to be achieved within that timeframe without also considering and addressing the fiscal impact. Such considerations might well highlight that current funding allocations will need to be reprioritised i.e. agencies may have to stop some things they are currently doing and reinvest in the identified priorities. It would be useful to set the mind-set early that funding considerations, such as reallocation relative to priorities and highest gain, need to be a key part of the strategic thinking.

# Health of Older People Strategy – interRAI feedback

## *General comments*

While it is noted that a number of agencies are expected to take the lead on various aspects of the strategy, it is not clear which agency will be taking the overarching responsibility for ensuring the strategy is implemented. Clarity is sought on which agency will be driving the strategy and ensuring it is actioned.

While we are not seeking detailed and specific milestone expectations, it would be useful to see greater clarification of the reasoning behind parts of the strategy that could impact on interRAI, which as currently stands are open to interpretation.

The strategy writers appear to have an understanding of interRAI as an assessment tool, but have not grasped the potential for interRAI data to inform service development and delivery. There are a number of areas in the strategy that interRAI would be able to provide useful, accurate information, but it is not mentioned.

It is felt that interRAI was noticeably absent from several areas where it could be applied to implement the strategy – especially considering the investment already made and the desire to see a return on that investment.

# The following comments are based on the Action Plan section of the strategy

## *Section 11*

### *Expand and sharpen the delivery of services to tackle long-term conditions.*

Page 36 – 11e:

*‘Use interRAI assessment data to identify quality indicators and service development opportunities including with health providers.’*

We agree with the action as noted, which gives interRAI New Zealand the mandate for future work that was already planned for.

The 2016/17 business plan for interRAI includes expected outcomes that align with this action.

interRAI data should be considered a key component of service development – it has been developed not only as a means of assessing, but to capture all relevant information at client and aggregated level, at the point of care delivery.

interRAI was developed with the specific intention of gathering information once, but making it available for use across many different applications and care settings.

It was always expected that the data could be used to inform local, regional and national health policy for the care of older people.

We seek clarification on the timing – when does the two years commence that this work is intended to be completed within?

## *Section 14*

### *Reduce frailty in the community.*

Page 37 – 14a:

*‘Explore possibilities for a frailty identification tool to enable primary and other health professionals to identify frail older people earlier.’*

While the definition of ‘frailty’ is not consistent across care settings, interRAI does gather information across multiple considerations of a person’s condition to provide an holistic view. interRAI data can usefully contribute to a definition in the care of older people in certain settings.

## *Section 15*

#### With service users, their families and whanau, review the quality of home and community support services and residential care in supporting people with high and complex needs and involving family and other caregivers.

Page 37 – 15a:

*‘Identify models that are person-centred and needs-based and provide a choice of care that maximises independence and sustainability.’*

This essentially spells out the key aspects of what interRAI already delivers, yet it is not mentioned.

We seek clarification on what aspects of quality the point is focusing on – is it the older people’s perspective (the experience), or the quality of the services being delivered for that person?

There is potential for interRAI NZ to add more questions into the assessment process that would gather more detailed perspectives of the clients being assessed and their families in terms of their experience.

A new Quality of Life interRAI tool is now also available that could be implemented, which could assist with gathering this information.

## *Section 19*

#### Improve integration of information from assessment and care planning with acute care services, and with those responsible for advance care planning.

Page 39 – 19a & 19b

*‘Develop systems that collate relevant information and make it readily available at the point of care, as well as for planning at all levels.’*

*‘Develop tools and resources for health professionals and providers to support the integration of long-term care management, acute care services and advance care planning.’*

interRAI is a comprehensive clinical assessment that gathers all relevant information in one place, at the point of care, to inform care delivery.

However, more could be done to better integrate the interRAI platform into other existing systems used by care providers. interRAI data could be used more effectively and matched with other systems (e.g. pharmacy) to provide greater and more cohesive support for care provision.It is also noteworthy that there are a suite of interRAI tools already developed, which can support the care of other members of the community (i.e. not just older people). These could be used more widely across the health sector to gather information using a consistent and high quality assessment process leading to improved care planning and delivery.

## *Section 20*

#### Improve medicines management

Page 39 – 20a:

*‘Develop education partnerships between pharmacists and other health professionals to increase medication adherence and make better use of pharmacists’ expertise.’*

As above, interRAI can be used to support other systems related to medications. While not specifically a medication tool, interRAI does have the capacity to monitor medicines adherence in clients.

## *Section 21*

#### Build the resilience and capability of family and whanau, volunteer and other community groups supporting people with high and complex needs, and those with end-of-life care needs.

Page 39 – 21a

*‘Review and improve the support for informal carers in alignment with the New Zealand Carers’ Strategy Action Plan 2014 – 2018, including in terms of respite care, guidance and information, and training.’*

interRAI has a Carers tool that is being piloted in Auckland in conjunction with the University of Auckland.

The interRAI Palliative Care tool is also currently being piloted at three DHBs, with the potential for roll out nationally from later in 2016.

Using interRAI data from these tools could help implement this aspect of the strategy.

## *Section 23*

#### Build a greater palliative care workforce closer to home

As above – the interRAI Palliative Care tool is currently being piloted by three DHBs, with the potential for roll out nationally from later in 2016.

## *Section 27*

#### Establish an outcomes and measurement framework and planning and review processes

Page 42 – 27b

*‘As part of the measurement and evaluation system, include an outcomes framework and indicators to assess. Support and improve the health outcomes for older people. These indicators will form contributory measures that district alliances can monitor to help them improve on the overall health system level measures.’*

Aggregated interRAI data is able to contribute to this action.

# Feedback on HOP Strategy – Workforce Focus

### *Workforce as a Priority Outcome Area*

A critical factor that will impact on the delivery of the proposed Health of the Older People (HOP) strategy; is having access to a workforce that is able to effectively meet the health needs of older people. This involves having the right number of people with the right skills in the right place at the right time, to provide the right services to the right people. Workforce planning and development is a critical and complex area which underpins the entire strategy by ensuring there is sufficient trained staff to meet demand and develop the service. Therefore, it is recommended that this be recognised and prioritised as a separate outcome area within the HOP strategy.

Currently the draft HOP strategy proposes the following five outcome areas to achieve its vision:

* 1. prioritise **healthy ageing** and resilience throughout people’s older years
  2. enable high-quality **acute and restorative care**, for effective rehabilitation, recovery and restoration after acute events
  3. ensure people can **live well with long-term conditions**

#### better support people with high and complex needs

* 1. provide **respectful end-of-life** care that caters to personal, cultural and spiritual needs.

*Recommendation:*

It is recommended that an additional outcome area relating to workforce be included in the HOP strategy, with wording to the effect of:

I. Prioritise attracting, retaining, developing and making best use of the skills of all in the health workforce to meet the needs of an older population.

### *Analysis of Proposed Actions vs Identified Key Issues*

The draft strategy identifies the following **key workforce issues** on pages 10 and 11:

1. The ageing workforce is an issue.
2. Difficulty recruiting some key workforce groups.
3. Potential supply issues to meet the increasing need over the long term, particularly maintaining the necessary number of geriatricians and some other medical specialties, as well as registered and enrolled nurses in aged care.
4. There is an Increasing need to support and develop the skills of our nursing, allied and kaiāwhina workforces; as people live longer with long-term conditions and complex needs.
5. The are some initiatives to sustain and grow the workforce underway, including incentives for graduate nurses to come into the sector and programmes to support teams working together across all settings. However, these are not yet achieving significant gains.
6. Need to be smarter in terms of the way we make use of different parts of the workforce.
7. Need to prioritise attracting, retaining and making best use of the skills of all in the health workforce to meet the needs of an older population.
8. We will be better able to manage the growing need for integrated, collaborative and innovative models of care, when the entire HOP workforce is appropriately trained and working to their full scope.

#### Appendix A includes analysis of the goals and proposed action against the key issues identified in the earlier parts of the paper, and indicates:

* There is a lack of clear alignment between the identified workforce related issues (pages 10

& 11) and the action plan goals and proposed actions.

* While there are a number of workforce related actions, they are dispersed through the action plan and appear disconnected. This looks like a lot of action across multiple fronts and could run the risk of getting bogged down and achieving little.
* Many of the actions actually underpin and apply to most of the focus areas, but have been placed within a specific focus area and worded such that they appear exclusive to that focus area.
* Prioritisation needs to be carried out in terms of identifying which actions need to happen soonest.
* Would be good to see a road map of what to happen in first two years, next two etc.
* Health Workforce NZ does not feature prominently given the range of workforce actions. What leadership role would they have in this space?
* Some of the actions, e.g. 26 look a little vague and not quite clear what problem they are trying to achieve.

### *Workforce Capability Development Focus Areas/Considerations:*

1. Implement a workforce stream of the strategy to help ensure that an appropriately skilled and well-qualified workforce is available to support the health and care of older New Zealanders.
2. Ensure workforce training addresses skills gaps and the diverse needs of the aged care sector.
3. Make aged care a bigger part of health workforce training. Do healthcare professionals have adequate knowledge of the healthcare needs of older people? Geriatric care has traditionally been under developed as a speciality and there may be skill gaps.
4. Support targeted workforce planning to address changes in an ageing health workforce, identify needs in high-growth regions, increase aged care expertise in the health system workforce and generally support the long-term sustainability of the aged care workforce.
5. Cross sector collaboration to ensure a strong focus on addressing workforce pressures in regional, rural and remote areas, including action to improve the recruitment and retention and overall geographical distribution of aged care workers and lead to improvements in services for older New Zealanders.

### *Workforce Data / Information Perspective:*

1. What is known about the HOP workforce?
   * The draft HOP strategy document refers to ‘workforce’ in some sections of the strategy but does a very light once over and does not actually raise the issue of the lack of visible workforce information in the primary/community sector. There is only one reference to the collection of workforce data (P42) – “Implement a system to collect a minimum dataset on Kaiawhina workforce”, and this represents only one area/group that works in the aged care sector.
     + There is very limited information available about the HOP workforce. To be able to deliver on this strategy there is a need to understand the current workforce, and to then be able to consider what the future workforce requirements are likely to be in order to care for our ageing population. This is something that should be added to the strategy as a key, underlying requirement. This will provide important information which can be used to enable an evidence based approach to workforce planning.
     + It will also provide important information to enable better planning of models of care, resource and funding needs. Additionally, it will provide greater understanding of the contribution of the workforce outside of the hospital setting.
2. Capturing data on this workforce:
   * The HWIP (Health Workforce Information Programme) captures a centralised comprehensive dataset of DHB employed workforce information. HWIP is managed by the Strategic Workforce Services Team within TAS. This is a well established and trusted source of standardised, consistent DHB information, which is used for planning and decision making. At present there is no centralised collection of workforce data for the primary/community sector, which is, much larger than the DHB workforce. There are other pockets of workforce information captured, e.g. NZACA member profiling survey, AUT - the New Zealand aged care workforce survey, and the InterRAI system. Understanding and linking these existing channels of information would be a good starting point, along with capturing the primary/community workforce information through the DHB/primary care provider contracts. Bringing this and the HWIP, DHB employed workforce data together would build a whole of sector view and provide a platform to enable a richer picture of future workforce needs.

### *Additional feedback:*

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| **Page** |  | **Reference** | **Comment** |
| Page 4 |  | We currently spend 42 percent of the  $11,000 million health budget on people aged 65 years and older, who make up 15 percent of population. Based on population growth alone,  this could rise to 50 percent of DHB expenditure by 2025/26. | 1. The format of the financial figures would be more easily read if presented in billions, which is also consistent with the way The Treasury presents such figures. 2. It is unclear where these figures originated from and the source should be checked. According to   The Treasury website:  *The* [*Budget Economic and Fiscal Update*](http://www.treasury.govt.nz/budget/forecasts/befu2016)  [*2016*](http://www.treasury.govt.nz/budget/forecasts/befu2016) *(BEFU) published on 26 May 2016 forecast that core Crown spending on health for the 2016/17 year will be $16.2 billion.*  [*http://www.treasury.govt.nz/government/expe*](http://www.treasury.govt.nz/government/expenditure/health) [*nditure/health*](http://www.treasury.govt.nz/government/expenditure/health)  *The three largest areas of total Crown expenditure for the 2014/15 financial year were:*  *Social security and welfare: $28.2 billion* |

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| **Page** | **Reference** | **Comment** | | |
|  |  |  | *Health: $14.7 billion* |  |
| *Education: $13.5 billion*  *These figures are taken from the Analysis of Expenses by Functional Classification Total Crown in the Financial Statements of the Government of New Zealand for the Year Ended 30 June 2015.*  [http://www.treasury.govt.nz/government/expe](http://www.treasury.govt.nz/government/expenditure)  [nditure](http://www.treasury.govt.nz/government/expenditure)  3. Given the questions around the figures provided for the health budget, the 42 percent expenditure on people aged 65 years and older, should also be confirmed. | | |
| Page 4 | We currently spend 42 percent of the $11,000 million health budget on people aged 65 years and older, who make up 15 percent of population. Based on population growth alone, this could rise to 50 percent of DHB expenditure by 2025/26. | 1. There are issues with the information in this paragraph, which make it confusing. 2. The first statement refers to the percentage spend of the overall health budget on people 65 years and older. However, while the second statement references the percentage spend in the previous statement it then describes about it as a percentage of DHB expenditure. 3. In other words:   42% of the overall health budget could rise to 50% of DHB expenditure by 2025/26. | | |
| Page 8 | The Maori population of people aged 65 years and older is projected to increase by 115 percent in the 15 years to 2026. The older Pacific population is expected to grow in number by  110 percent, and older Asian population by 203 percent in this same period. | 1. This should read either:  “in the 10 years to 2026” **or** ”in the 15 years to 2031”. | | |

# Feedback on Draft HOP Strategy – Community Pharmacy

## *Purpose*

To provide a Community Pharmacy Services perspective on the Health of Older People Strategy Consultation Draft on behalf of the 20 DHB collective.

## *Feedback Summary*

### *Introduction*

This feedback is based on the perspective of a DHB contracting with community pharmacists. As such it focuses on specific areas of pertinence for Community Pharmacy. It does not present feedback on the entire Health of Older People (HOP) Strategy.

Feedback is initially provided as overarching thoughts with further detail presented in the structure requested for the consultation feedback.

### *Overarching Thoughts*

1. The Strategy covers a broad remit and can at times read both all-encompassing and non- specific. More tightly defined and prioritised goals with specific, measurable, attainable, realistic and timely (SMART) measures would provide clearer guidance to the health sector.
2. The addition of a glossary would be valuable. This should include:
   1. **Primary Care**: clearly stating the intention to include pharmacists, rather than seeing the pharmacist as an optional or occasional add on.
   2. **Allied Health:** similarly this general term used throughout the document has unclear boundaries from a pharmacist perspective. Often the pharmacist perspective needs including here but it is in no way explicit in the document.
   3. **Long Term Conditions:** one definition across primary care
   4. **Frailty :** a workable definition is need for this term to create a shared language between professionals
3. Alignment with terminology used in other strategies e.g. Pharmacy Action Plan 2016 - 2020
4. Easy and accurate exchange of information is critical to the success of a primary care “one team” approach. Key to this from a pharmacist perspective are:
   1. A shared Electronic Health Record (EHR) for exchange of information across primary care and at points of transition between primary to secondary care. Pharmacists need access to this information

#### b. Consistent uptake of NZ ePrescription Service (NZePS) by GP practices

c. Removing inter-professional **barriers to the sharing of information:** Addressing the “privacy” issues that are often used as an excuse for professionals not sharing information. A centralised lead on the protocols for sharing information is essential to minimise inconsistencies of approach across localities and between professionals.

1. There are clear links with the Pharmacy Action Plan 2016 to 2020 which details actions essential to building capacity in community pharmacists for patient centric, cognitive services. These are an essential precursor to freeing up time for pharmacist to spend with older people. Therefore the success of the Pharmacy Action Plan precedes many of the pharmacist related action in the HOP strategy.
2. The frail and elderly in the community often see the pharmacist at critical points in the pathway of care; or as an initiator of care. The Strategy could better promote the place a pharmacist can have as a frequently seen health practitioner that has an open door such as:-
   1. The pharmacist already plays a role in health care as they Triage Treat and Refer ailments presented. A Minor Ailments service should be an add-on not a replacement to this.
   2. The role of the pharmacist as a referrer could be better recognised through a referral pathway directly to GPs and other health providers rather than mediated through the patient.
   3. Optimising medications through synchronising and clinical overview should be recognised as a routine service by community pharmacist not specialist services.
   4. Pharmacists are often the health professional older people see the most often therefore the strategy needs to ensure that pharmacists are linked to the rest of the health care team to fulfil their potential value.
   5. Consistent uptake of NZEPS and access to a Shared Electronic Health Record will help pharmacists fulfil their potential in the primary care team. It will enable enhanced professional oversight of medicines safety for synchronisation, reconciliation, and mitigation of adverse events such as falls and other events causing hospital admission.
   6. Access to discharge summaries for elderly people at all transitions of care would support the optimisation of pharmacist specialist support for the patient’s benefit.

# Feedback in the submission document format

### *Healthy Ageing*

No Specific pharmacy related comments in here, see overarching thoughts. Action 4: “Improve health literacy and communication systems”

* Point a. Include the perspective of the PHO pharmacist facilitator enhancing medicine related literacy within the PHO organisation.
* The community pharmacist has a key role in enhancing health literacy in general and potential to enhance specific targeted initiatives through community pharmacy.

### *Acute and Restorative Care*

*Vision*

See comment about Pharmacists as allied health professionals.

Community pharmacists too have an important role to play in acute and restorative care.

* The pharmacist already plays a role in health care as the Triage Treat and Refer professional in the community.
* The role of the pharmacist as a referrer could be better recognised through a referral pathway directly to GPs and other health providers rather than mediated through the patient.
* Roles for pharmacists supporting rehabilitation could be referred to through GP or ACC.
* NZePS and access to a Shared Electronic Health Record are essential enablers for pharmacists’ action.

*Actions*

**Action 6:** *“Support effective rehabilitation closer to home”* Actions that support this from a pharmacist perspective include:-

* Referral pathways for pharmacists and from pharmacists.
* Systemic solutions to the inclusion of pharmacists in the care of house bound individuals will need to be implemented as the workforce is not mobile enough to cover home visits extensively, although some programmes of care may be able to facilitate this intensive level of pharmacist care.
* Consistent national implementation of NZePS and Shared Electronic Health Record is a key enabler.
* Sharing of discharge summaries across primary care would enable coordinated restorative care in the community (essential to include pharmacists in sharing of discharge summaries).

**Action 7:** *“Improve outcomes from injury prevention and treatment.”*

* Pharmacist inclusion in ACC funded treatments for rehabilitation.
* Promoting the role pharmacists have in minimizing the contribution of poly-pharmacy to falls risk, through medicine rationalisation and optimisation.

**Action 8:** *“Reduce acute admissions”*

* Promote the pharmacist’s role in optimising medicine usage and minimizing medicine related harm, an important role in preventing admissions due to poorly utilized medicine regimens untreated illness or adverse effects e.g. falls.

### *Living Well with Long-term Conditions*

*Vision*

There was some concern raised that the goal of “Health outcomes for vulnerable older populations with long-term conditions are equitable with outcomes for the population as a whole.” is an unrealistic and unachievable goal. The goal maybe better framed by focusing on Quality of Life with long-term conditions.

## *Actions*

Ensure the definition of Long-term conditions is agreed and shared across health sector.

**Action 9.** *“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”*

* Pharmacists have significant potential to enhance quality of life for people with long term conditions; through medicine review and optimisation, synchronization; adherence support, enhancing health literacy.
* “Allied workforce” should include pharmacy.
* Goals would benefit from being described as SMART measures.

**Action 10.** *“Enhance cross-sector, whole-of-system ways of working”*

* Agree, NZePS and Shared Electronic Health record are key enablers for pharmacists in the community.

**Action 11:** “Expand and sharpen the delivery of services to tackle long-term conditions.”

* Pharmacists are an under-utilised part of the workforce. They are able to pick up disease specific programmes of care e.g. enhancing care in diabetes and gout, and early intervention for musculoskeletal problems.

**Action 12:** *“Use new technologies to assist older people to live well with long-term conditions”*

* Consistent uptake of NZePS across GPs
* Shared Electronic Health Record a key enabler to supporting “one team” in community care.

### *Support for People with High and Complex Needs*

*Vision*

Co-ordinating integrated care and simplifying health services across “one team” requires that the pharmacist is specifically included as part of the team and is connected through a Shared Electronic Health Record.

## *Actions*

**Action 14:** *“Reduce frailty in the community”*

* A shared definition of “frailty” for identification and communication across health professionals is needed. Recognised referral capacity for pharmacists to refer on when a “frail” person is identified.

**Action 16: “***Integrate funding and service delivery around the needs and aspirations of older people, to improve health outcomes of priority population groups.”*

* Introduce better links for Work and Income to fund prescriptions directly (ie direct to the pharmacy rather than through the patient), this need to be consistently available nationallyand is a priority as Work and Income is closing offices enhancing risks to the vulnerable elderly who are less mobile and more easily confused by complex and inconsistent processes. ( reference [Subjective wellbeing in New Zealand: Some recent evidence](http://www.productivity.govt.nz/sites/default/files/nzpc-rn-2016-3-subjective-wellbeing-1.pdf) Productivity Commission May 2016 )

**Action 18:** “*Better integrate services for people living in aged residential care.”*

* Integrate and align pharmacist services contracted to Aged Related Residential Care facilities.
* Ensure discharge summaries from hospital and ARRC facilities are accessible to community pharmacists.
* Shared Electronic Health Record is a key enabler.

**Action 20:** *“Improve medicines management”*

* Agree with these goals.
* This needs to be seen as standard professional service provided by community pharmacists, not a specialised career pathway with gate keeper qualifications.

### *Respectful End of Life*

No pharmacist specific commentary, see overarching thoughts.

### *Implementation Measurement and Review*

*Vision*

As noted in the overarching thoughts; the document covers a broad remit and can at times read both all-encompassing and non-specific. Terms like scatter gun and woolly were used in response to the first reading. A clear steer on selected achievable priorities with SMART measures would provide clearer guidance to the health sector, and enhance probability of successful implementation.

## *Action*

Action 26: “Include older people in service design, development and review and other decision- making processes”

* Agree that consumer involvement is important at all levels from strategic direction and service development through to personal engagement with individual care plans.
* Point f: *“As part of the Pharmacy Action Plan 2016–2020 implementation, co-design a service model with consumers to support the development and implementation of a minor ailments and referral service*”.
* This doesn’t align with the goals in the Pharmacy Action Plan 2016 to 2020, it sets a tighter time frame for implementation and as such sets an un achievable target.

We suggest that other actions which promote the pharmacist as a key member of the primary care “one team” should take priority as this is where care of the elderly can be best enhanced by pharmacists. Actions should include:

* Enabling shared input by pharmacists through access to a Shared Electronic Health record
* Enabling referrals by and to pharmacists

### *Other*

No Specific pharmacy related comments in here, see overarching thoughts.

# Additional observations

Page iv column 2 first paragraph – should the words “and a future-oriented around healthy ageing,” be “and ***are*** future oriented around healthy ageing”?

Perhaps it is a consequence of the high level at which statements are made in the document however we question the following statement and the parallel drawn between the health of older people and expensive health services. Page 4 column 2, first paragraph reads: “Recently, the percentage of older people requiring some of the most expensive health services, such as acute care and aged residential care, has decreased. This indicates that older people are increasingly health and better supported to live well at home.”

**Action 11c –** suggest this should relate to “avoidable complications” rather than any complications. Older people with diabetes are likely to develop complications as their disease progresses. Reducing the incidence of any complications may not be realistic.

**Action 14a** – suggest a national tool be developed rather than having multiple frailty tools developing around the country. See our feedback under interRAI for additional comment.

Dementia – there is a view that the issues related to dementia have not been covered as fully as they might require in the document and this is something you might like to consider.

# Definitions Section Recommended

As this document has a very wide and diverse audience it would be helpful to have some of the more important terms defined so that readers of the strategy have a common base for understanding the strategy. Terms such as “long term conditions”, “long-term chronic health conditions” and “high and complex needs” are all referred to in the document and some readers may not understand the distinctions between the terms.

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| **Submission 190** |

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**RE: Health of Older People Strategy Consultation**

Thank you for the opportunity to provide feedback on the above consultation.

The Pharmacy Guild of New Zealand (Inc.) (the Guild) is a national membership organisation representing the majority of community pharmacy owners. We provide leadership on all issues affecting the sector and advocate for the business and professional interests of community pharmacy.

**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 Pharmacy Guild and its members look forward to contributing to achieving the vision. Older people must be enabled to take charge of their own health care management, and resources must be put in place to support them. The most cost effective support is provided to the patient while they continue to live in their own home.

Community Pharmacist’s are the health care professionals seen most often, they are the first point of contact into the primary healthcare system for the majority of health consumers. This is because community pharmacy is the most accessible source of health advice including information on healthy aging, and health and social services. Every day pharmacists triage, treat or refer patients. They play an active role in helping older people to be health smart and take responsibility for managing their own health. Community pharmacists are medicines management experts and provide all patients including older persons with medicine information personalised for their specific needs and abilities.

Pharmacists enable older persons to take responsibility for managing their own health by providing advice, support and targeted public health messaging conveniently in their own communities. The Community Pharmacy sector is keen to provide additional funded services to support older persons to live long healthy lives in their own communities including:

* targeted high quality information on a range of health and lifestyle issues;
* interventions to help older people with chronic long term conditions ;
* screening services for conditions related to ageing; and
* actively supporting health promotion initiatives to address the physical, social and environmental risks to healthy aging.

The Guild will advocate strongly for more funded community pharmacy services to expand the important role pharmacists play in these key result areas.

**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?**

Yes. These actions are a good starting point. Community pharmacy, in cooperation with DHBs, NGOs and community support groups, can make a positive contribution in increasing resilience through providing a range of services targeted at older people. This may include in-home medicines reviews and therapy assessments in cooperation with other community based healthcare providers. Our members look forward to working with the DHB collective to develop a more flexible contracting framework to encourage new and innovative ways of delivering services when and where they ae needed. We would be keen for some national oversight by the ministry to ensure that these important services will be funded for all older persons, no matter which DHB they reside in.

**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 Guild strongly supports this vision.

The key measure of success will be the health sectors’ ability to co-ordinate and integrate healthcare services across a range of primary, secondary and tertiary health care providers. The Guild believes closer integration will not only benefit the primary health sector, it will also result in fewer presentations to overstressed A&E Departments and reduce the reliance on tertiary care and in particular reduce hospital readmission rates.

Many older persons present with mild to moderate symptoms and a variety of conditions that can be appropriately treated with over the counter, pharmacy and pharmacist only medicines and/or pharmacist’s advice and counselling. Most of these patients could be managed in the community pharmacy which is the ideal place to triage, treat or refer minor ailments. We are pleased to note the Auckland DHBs have recognised the critical role community pharmacy already plays, and are actively promoting “pharmacy first” directly to patients who would otherwise access primary care through A&E services. Without funding for a triage, treat, and refer service the option of ‘pharmacy first’ is only open to people who can afford to purchase the medicines when it is appropriated to self treat.

Transitions in care, especially at hospital discharge, can be stressful experiences for hospitalised patients, particularly for older people when complex medication and therapy regimens are often changed. While hospitalised, patients have their medication management needs handled by nurses and pharmacists; upon discharge, many patients and their caregivers are left unprepared for self-directed medication management. At discharge, patients and caregivers often receive a significant amount of information that is confusing or incomplete and they have little time (or may not be in a proper state of mind) to ask questions or seek clarification.

Being unable to cope with their medicines is a prime reason that older persons are initially admitted into rest home care.

A community pharmacy based discharge service would help ensure all patients receive complete medication counselling and education with the medication in hand. This has been shown to improve medicines adherence, leading to a reduction in readmission rates.

The effectiveness of this type of pharmacist-led medication reconciliation programme on discharge is borne out by research reported in the British Medical Journal which found that **pharmacist intervention decreases:**

* adverse drug event related hospital revisits
* all-cause readmissions and
* ED visits (Mekonnen et al 2016).

**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?**

We agree the targeted actions are a good starting point.

**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?**

We support the vision as set out in the consultation document. As noted above, community pharmacy is the first point of entry into the primary health sector for many older patients. Community pharmacy is ideally placed to provide guidance, information and access to technology to help patients’ mange their long term conditions in partnership with other members of the multidisciplinary healthcare team. We see the need for a greater investment in funding for the management of long term conditions – particularly where mental health and addiction issues are involved. This may include an amalgamation of the Care Plus (GP) and LTC (Pharmacy) schemes so that GPs and community pharmacists work in partnership on the same targeted group of patients to ensure they are better able to manage their conditions and improve medicines adherence. The successful implementation of the Community Pharmacy Anti-Coagulation Monitoring Service (CPAMS) programme is an example of how a comprehensive community pharmacy led service can reap significant benefits for targeted patient groups (Harper et al 2014).

Community pharmacy can also provide patient consultation and other funded services on a no appointment basis thus increasing access to diagnostic and treatment services for conditions such as diabetes, heart disease and obesity while reducing the burden on GP clinics, primary health care centres and accident and emergency departments.

**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 actions are a good starting point. As we have noted earlier in this submission, community pharmacy can play an integral role in reducing hospital admissions, and as the healthcare provider seen most often they are best placed to provide an early detection and prevention service. Pharmacists triage, treat and refer patients every day, thus ensuring that patients receive the right treatment, in the right place at the right time.

**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?**

A well resourced community pharmacy sector, fully integrated into the multidisciplinary healthcare team and with full access to the shared care record can take a leading role in helping patients with high and complex needs manage their conditions and reduce avoidable visits to GP surgeries and A&Es.

The relationship between the patient and their community pharmacist is different to many of the other patient-clinician relationships across the health sector. The community pharmacist sees their clients regularly when they are well, relatively well (and can self treat) and when they are unwell. Pharmacists assist patients to actively managing their disease and also provide preventative wellness advice often over many years. They are therefore held in special trust by the patients who will often share important health information with the pharmacist that would not be shared with other providers.

Older people with high and complex needs are often best treated in a community pharmacy setting. They see their community pharmacist as a trusted health professional who provides helpful advice and counselling in an accessible and comfortable environment. This is a less formal setting and therefore often results in more open communication compared with visits to GPs or hospital specialists.

**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?**

We fully support the actions set out here and are pleased to note that integrated funding and service delivery is seen as an important element in improving health outcomes for older people and priority population groups.

We are also pleased to see it acknowledged that pharmacist led medicine reviews for older people with high needs is linked to improved medicines management. A significant number of hospital admissions are due to medicines not being taken correctly. Approximately 125,000 deaths per year in the United States are due to medication nonadherence, and 33% to 69% of medication-related hospital admissions are due to poor adherence (Osterberg & Blaschke, 2005). A funded medicines usage review service will ensure that pharmacists can use their expertise as medicine management experts to enable patients to obtain the maximum benefit from their medication and reduce the incidence of hospital admission and readmission.

**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?**

The Guild fully supports the vision for a respectful end of life.

Community pharmacists see their clients through all phases of their life when they are well, relatively well, and completely unwell. They are intimately involved with patients, their whanau and caregivers on the healthcare journey through to end of life. Palliative care support is already provided by community pharmacists through, aged care facilities, hospice and increasingly in peoples homes. We hope that funding is provided in the next community pharmacy services agreement (CPSA) to ensure palliative care services provided through community pharmacy can be extended and enhanced to ensure the highest level of care for people at this important time.

**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?**

As has been noted earlier in this submission, the Guild fully supports closer integration amongst the multidisciplinary healthcare team. Closer integration and access to the shared care record is essential if the vision of building a high performing palliative healthcare team closer to home is to be achieved.

**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?**

The Guild supports the development and implementation of a funded minor ailments and referrals service. Community pharmacy has been providing these services for many years to those people who can afford to self fund. As in 2a there is potential for pharmacy to play a greater role in reducing emergency department presentations if there was funding for pharmacy to provide a triage, treat, refer service with funded medicines able to be supplied when it is appropriate to self treat.

It is absolutely essential that the patient voice is heard as part of service planning as well as being part of the measure and review process

Taking responsibility for managing our own healthcare starts with taking responsibility for engaging in the planning process to ensure services are efficient, effective and targeted to local need.

**Other comments:**

The Guild and its members are pleased to support the vision for the health of older people set out in this consultation document. We look forward to working with the Ministry, DHBs and other sector stakeholders to play our part in achieving the vision through;

* extending the range of clinical pharmacy services offered to our communities from community pharmacists;
* a national approach to funding targeted medicines management input
* utilising the already developed service network of community pharmacies to enable DHBs to deliver on the Ministry’s intent of care closer to home;
* systemised delivery of health promotion and personal health messages. The widely distributed Community pharmacy network is well placed to deliver public health initiatives, not only to the users of health services but also those who are currently well and not accessing health services from anyone;
* developing acute demand management services within community pharmacy. There is value in making this service available with public funding for the most vulnerable in our communities, who are currently electing to access free services through the emergency department; and
* providing more services to enable patients to optimise the benefit they receive from their treatments, for example hospital discharge counselling, new to therapy consultations and medicine usage reviews provided to appropriate patients by their community pharmacist. Medicines are a very cost effective health intervention but only when used appropriately.

**Bibliography**

Harper, P., Harper, J., & Hill, C. (2014, September 2). *An audit of anticoagulant management to assess anticoagulant control using decision support software.* Retrieved August 29, 2016, from BMJ Open: http://bmjopen.bmj.com/content/4/9/e005864

Mekonnen, A. B., McLachlan A, J., & Brien, J. E. (2016, February 23). *Effectiveness of pharmacist-led medication reconciliation programmes on clinical outcomes at hospital transitions: a systematic review and meta-analysis.* Retrieved August 17, 2016, from BMJ Open: http://bmjopen.bmj.com/content/6/2/e010003.full

Osterberg, L., & Blaschke, T. (2005). Adherence to medication. *New England Journel of Medicine*, (353) 487-497.

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| **Submission 191** |

About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 47,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO’s vision is Freed to care, Proud to nurse.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the draft Health of Older People Strategy (“the Strategy”).
2. NZNO has consulted its members and staff in the preparation of this submission, in particular members of Gerontology Section, College of Primary Health Care Nurses, and Aged Care Sector Group, the Board Te Rūnanga o Aotearoa, and professional nursing, policy, legal, and research advisers.
3. NZNO would like to extend our thanks to the Ministry for its comprehensive and inclusive consultation on the Strategy, and the empathy and perception of the team developing it. We have been impressed and gratified by their respect, careful investigation and grasp of the issues.
4. This is certainly reflected in the first part of the document which clearly articulates the current context of aging in Aotearoa New Zealand (on an individual and population health level) and a rational, primary health care (PHC) based strategic direction for government to support the health and wellbeing of older people for the next 10 years.
5. We particularly welcome the Strategy’s focus on equity, prevention, diversity, changing acuity and a life course approach to aging and disability. This is consistent with the key priorities for health identified in our 2014 manifesto *Nursing Matters* (New Zealand Nurses Organisation, 2014) ie a primary health approach to population health; investment in public health; and empowering all New Zealanders to reach their health potential. We particularly welcome the following statement from the Strategy.

**Staying healthy and (inter) dependent in older age**

*We have an opportunity to reinforce and accelerate the positive trends we have seen in recent years. By focusing on preventing illness and by making it easier to choose healthy options (like eating healthy food, not drinking alcohol or only drinking at low-risk levels, and undertaking regular physical activity), we can help people to avoid developing long-term health conditions or slow the development of those conditions. Most importantly, we can do this by providing universal health services and public health initiatives that cover the whole population, and having services in place to intervene early, help people to return to good health and remain independent. As part of this, we need tailored approaches for some individuals and population groups, to help them access the same level of service and enjoy the same outcomes as others.*

*Draft Health of Older People Strategy (p10)*

1. On the advice of Te Rūnanga and members from other cultures and ethnicities, including Pasifika and Asian members, we note that the concept of individual independence for older people is inappropriate, even offensive, to some. We suggest that the term **valued interdependence** is a more useful and accurate descriptor of normative social relationships and would be a more realistic objective.
2. Despite the comprehensive approach and clear identification of the main spheres of action ie:

* Healthy Aging;
* Acute and Restorative care;
* Living well with Long Term Conditions;
* Support for People with High and Complex needs;
* Respectful End of Life; and
* Implementation Measurement and Review),

we are less sanguine about the *specific* actions, some of which lack precision and coherent prioritisation.

1. Though the spheres of action present a coordinated and comprehensive strategy, many of the listed ‘actions’ are couched in such overly broad terms without identified specific outcome(s) or commitment to resourcing, that it is only possible to agree or disagree, in an equally vague way, with the stated *intention* regardless of its likely implementation. That is a concern. NZNO has seen a plethora of ‘high level’ documents espousing honourable intentions, but the reality has been quite different and usually involves some variation on doing more with less.
2. The priorities are not always consistent with a coherent or progressive plan to implement the strategy; many are general ‘feel good’ initiatives which are already underway eg “establish age-friendly communities” (*how?*), or “participate in cross government group on family violence” (*with what aim, and is this not stating the obvious?)*
3. We suggest the Strategy needs to be grounded in actual actions that are costed.
4. While there are no ‘extraneous’ priorities which we would not support, we note that few concern the professional workforce, safety or employment and care standards.
5. In particular we are very disappointed to see that the most consistent and important recommendation NZNO has made over the past decade ie to update and enforce the New Zealand Standard *Indicators of Safe staffing for aged-care and dementia-care Consumers in New Zealand* to ensure minimum safe staffing levels in aged care facilities, is not part of the Strategy.
6. This is a ‘bottom line’ for NZNO. It is unconscionable that significant taxpayer funds are invested in support of older people in private residential facilities, that eye-watering profits are made by aged care providers, many owned by transnational corporations, and yet there are no still no minimum standards, let alone mandatory ones, for safe staffing levels or skill mix, to protect older people or workers in aged care.
7. Indeed, while the Strategy quite rightly identifies the need to utilise, retain and coordinate workforce resources, including kaiāwhina, regulated and allied health professionals, informal and voluntary carers etc. it ignores the vital role of employers, and government immigration, regulation and education policy in ensuring that the objectives for a safe, efficient, flexible and sustainable workforce are met.
8. Unless employers, in both residential facilities and in primary health and community care, are bound to meet quality standards, and to contribute to the development of the (largely publicly-educated) workforce they rely on to deliver publicly-funded services, standards of care, fairness in employment, equity, and efficiency are likely to remain at the same dismal level identified in the Report *Caring Counts* (New Zealand Human Rights Commission, 2012). We would like to think that both the updated New Zealand Health strategy and this Strategy represented a step forward for the care of older people and workers in aged residential care, not an entrenchment of unsafe, unaccountable and outdated standards of care and staffing levels.
9. We **strongly recommend** that the Strategy includes a priority action around the development of indicators for safe staffing in aged and dementia care, and the establishment of mandatory standards. Former Minister Ryall’s mandatory implementation of a standard acuity assessment tool, InterRai, provides a good starting point, and hopefully evidence to inform the development of indicators to ensure quality, safety and fairness.
10. NZNO also recommends the long-term, integrated health workforce planning we have advocated for the past decade to address predictable skills shortages due to an aging workforce, overreliance on immigration, and new delivery models for health and social services.
11. The need to align government employment, training and education, immigration and regulation policy and action is self-evident and critical to meeting international commitments to fairness in employment, equity and sustainability and the United Nations Sustainable Development Goals (SDGs).
12. This approach would also enable consideration of significant global factors such as climate change which has very specific implications for older people (New Zealand Climate Change Centre, 2010). eg the small number of heat-related deaths for people aged >65years is likely to increase, and there are other issues such as food security and prices, increased respiratory disease from ground level ozone, increased melanoma, increased risk of depression and injury from more frequent catastrophic flood/drought events etc. which should be considered in the Strategy (Royal Society of New Zealand, 2016).

CONSULTATION QueSTIONS

Healthy ageing Actions 1-5

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 vision is excellent; we welcome the inclusion of respectful end of life.

We suggest:

* Page 10 – The comment on health workforce at the bottom of the page should be extended to include a commitment to developing safe patient/staff ratios, fair pay rates, and appropriate skill mix.
* Page 11- Under the integration column, there needs to be a mention of the need for improvement in the management of older people’s care at the primary/secondary acute interface, especially for those older people with dementia.

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?*

As indicated above, the actions are vague and self-evident eg **Action 1. Build social connectedness and wellbeing in age-friendly communities** merely indicates relationships which one would expect to already exist. We would expect local government as well as health agencies, particularly primary health organisations, community pharmacies, residential facilities, public health as well as NGOs etc. to be involved in this community level action. One assumes that the lead agencies will involve town planning, environmental agencies, transport etc.

**We recommend including:**

* **Advance care planning** at this “healthy aging” stage, rather than later on as indicated in Actions 19, 22, for example;
* an action around **financial literacy** /security eg promotion of access to independent, competent financial planning services;

1a We support prioritising the promotion of positive **attitudes** to aging which should also include positive measures to reduce ageism.

Actions 2a and 3 are important as they are about preventing harm.

We strongly endorse prioritising **supported housing and age-friendly communities** (Action 3e) but totally reject the added proviso of “*where this will also contribute to regional economic and social development*”. Supported housing is needed wherever people live; older people should not be used as a pawn in the building of residential aged care facilities. As our earlier submission pointed out, the concentration of aged care facilities in satellite suburbs eg Waikanae creates other social cohesion problems. This proviso prioritises large scale aged-care housing *apart from* rather than arising in local communities, and/or high value inner city aged care housing, which only a few can afford. The Strategy should be clear about its primary purpose and prioritise meeting older people’s needs.

4. **Improved health literacy** also needs to focus on the health needs of babies and children, as ageing grandparents provide care for babies and children. This needs to be achieved with sensitivity as advances in research and different standards mean that some practices have changed (safe sleeping advice, safe baby equipment, appropriate infant nutrition, etc). It is tragic to read of SUDI’s happening at grandparents’ homes while being babysat.

4d (and Action 13) **Supporting the uptake of technology.** Note our previous comments that new technologies can provide valuable health information and support, but cannot replace the therapeutic relationship with a health professional or social interaction. Elderly people (and health workers) need to have access to the hardware to engage with apps, the training and support to use them and to be aware that the audio and visual settings can be adjusted to work with declining vision, hearing abilities. The ‘digital divide’ that exists in some situations needs to be acknowledged and addressed.

We welcome Action 5 to **improve oral health** which should be a priority because of its critical importance in reducing pain, enabling good nutrition, reducing disease, and supporting self-esteem and social interaction which are vital for mental health.

The targeted health promotion initiatives intended to support Māori and other vulnerable populations needs to occur **within the wider context of whānau health.**

Acute and restorative care Actions 6-8

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?*

We support service co-ordination but do not support the ‘genericisation’ of services offered if it means a compromise in nature and quality of care received by the client. The Calderdale framework, for example, supports the interchangeability of various members of the inter-disciplinary team to limit client contact with different therapists, by allowing each to complete tasks traditionally done by others. However, there are risks with a generic model such as this.

We note that:

* again there needs to be a mention of the need for improvement in the management of older people’s care at the primary/secondary acute interface, especially for those older people with dementia;
* delayed discharge can be problematic, but so can poor treatment of older people with dementia and delirium while they are in the acute services. This is often due to a health professional knowledge, attitude and skills’ gap and requires education;
* this section has a lot about older people being prevented from entering acute care and older people exiting it quickly, but very little about their management while in the acute services (which can be appalling, especially for those with dementia); and
* the section on assessment is confusing. InterRAI was mandatorily introduced as the standard assessment too to avoid duplication of assessment tools.

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?*

Action 8a regarding the **primary/secondary interface** is critical and we support this action. We recommend an additional action around investigating admissions of older people, particularly from residential facilities where there is an expected level of nursing/GP support and the potential to identify preventative strategies and accountability. Eg is there was a correlation between staffing levels and admissions from potentially preventable causes eg bedsores, falls. We strongly recommend that both residential providers and health workers/professional organisations are involved in this action.

Living well with long-term conditions Actions 9- 13

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?*

The document earlier references the need to ‘improve access to **elective surgery’** (p4) but elective surgery is not addressed in the actions. We suggest that timely access to elective surgery is an essential aspect of a primary health care approach of early intervention to maintain function, and reduce chronic pain and prevent the development of more acute 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?*

Action 9 on **workforce education** is critical, but please note our earlier **recommendations** (paragraphs 16-18) with reference to:

* **updating the New Zealand Standard Indicators for safe aged-care and dementia care** to ensure minimum mandatory standards for safe staffing levels and skill mix in aged care;
* **long term health workforce planning** to address predictable skills shortages due to an aging workforce, overreliance on immigration, and new delivery models for health and social services; and
* **aligned employment, training and education, immigration and regulation policy** that is consistent with international commitments to fairness in employment, equity and sustainability and the United Nations Sustainable Development Goals (SDGs).

9. a & c. We support prioritising standardised training and education for the **kaiāwhina workforce** in home and community support services, but are concerned that the lead agency is identified only as the Industry Training Organisation, Careerforce. This work must continue to be developed in conjunction with Health Workforce New Zealand because of its key interface with, and implications for regulated health workforces.

9b.We note that family**/whānau support** is negatively impacted by the increasing mobility of families (especially those seeking work opportunities both within and beyond Aotearoa New Zealand) who may not be living near their aged family members. The strategy cannot be based on an assumption that family/whānau support is/will be available; provision must be made for those who do not have support.

9.f. This priority action to **enhance training, entry and retention of the workforce among Māori and Pacific people** needs to be amended to reflect the fact that there needs to be increased participation from these workforces in professional regulated roles. Māori and Pacific people (and migrants) are already disproportionately overrepresented in caring roles and significantly underrepresented in professional and leadership roles. Unless the strategy provides for professional training and education, this action will simply entrench the ‘brown underclass’ of workers in low paid jobs. The action should be specifically targeted towards increasing Māori and pacific participation in professional roles as per, for instance the Māori nursing strategy.

11 a & b. We support prioritising these actions around **dementia**. Nurses in Canterbury report that the **Dementia Care Framework** seems to be working well there. Progress has been made on the Cognitive impairment pathway; CT head scans are being reviewed and a number of education initiatives are being developed and implemented, including a national dementia education package, hosted by Goodfellows. In addition, there are more opportunities for participation in support and advisory groups, and more home support is available. Currently a variety of health professionals provide navigation, however I do think there are gaps in service here and that there is potential for this to be improved. Similarly there is more work to be done in secondary care regarding diagnosis, ensuring a standardized assessment process is utilised and that appropriate follow up is provided for patient and family. There may be a role here for a specific NGO.

11.d. **Ensure adequate funding of bulk funding packages for home support**. Member feedback suggests the need for caution here.ie “Don’t accept lowest bids from newer players entering the market that undercut existing providers to the detriment of clients (non-delivery of assessed hours of care) and staff (moral distress at being asked to reduce hours they have previously assessed the client as requiring).” A critical factor will be to ensure there are robust accountability and protection measures in contracts especially in relation to supervision, delegation, staffing levels and skill mix. The Health Practitioners Competence Assurance Act 2003 provides assurance and flexibility for health services.

13. See above comments on (4d)

Support for people with high and complex needs. Actions 14 - 21

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?*

Under goals, further clarify that older people with high and complex needs either have the resources to make choices and that the options available to them include more affordable options than at present.

We suggest adding something about growing the geriatrician workforce (medical and nursing), so that “people with high and complex conditions (*don’t*) have to navigate their way through more parts of the health and support system than usual” (p24) and there being a reduction in “all the clinicians they see, so they don’t have to repeatedly tell their story” (p25). InterRai and EPHR are useful in this context.

19 In this context, it is too late to be raising the topic of advance care planning; this needs to be promoted much earlier as mentioned in the healthy aging section.

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?*

Action 15 is critical as **home and community support services** for older people are, according to our professional nurses advisers “in complete and utter disarray!” We strongly recommend that these actions are prioritised.

20 We strongly support prioritising **improved medicines management** Action 20 as older people often end up in hospital (or return to hospital) due to medication errors and there is significant potential eg around polypharmacy to reduce costs, improve efficiency and access, and to optimise the use of medicines.

21 We support reducing work-related barriers to informal care and suggest that a start of sorts has been made in recent amendments to Employment Relations legislation that require employers to *consider* and formally respond to requests for flexible working hours. However, since employers are not obliged to accept requests, the potential benefits of supporting such care are considerably restrained. In practice nurses frequently deal with people whose work, income and health have been severely compromised by the demands of ‘informal caring’. As with parenting young children, the burden of care falls disproportionately to women and is a structural barrier to pay and employment equity. There are also intergenerational effects and cultural aspects to consider.

We suggest that work-related barriers to informal caring must be considered in a societal, whole of life context, as there are clearly very different support needs (clinical, financial, social) for informal carers relating to the circumstances of the person being cared for. The government has demonstrated its desire to standardise benefits, with some regrettable results eg people undergoing palliative care who are irrationally and cruelly required to register for work in order to get a benefit. It may be time to consider the more equitable and economic Universal Basic Income that some countries (eg Finland[[1]](#footnote-1)) and companies (eg Yincubator[[2]](#footnote-2)) have adopted, and others have advocated for and/or are considering [[3]](#footnote-3).

Respectful End of Life. Actions 22-24

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?*

We suggest amending the second goal to Technology can improve end of life care, since many see technology as a barrier to respectful end of life care.

We welcome including support for clinicians (“supporting people and their clinicians to develop advance care plans, p27) particularly in view of public discussion around end of life decisions.

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?*

22a Cost is a prohibitive factor in ensuring all New Zealanders can create an enduring power of attorney and this needs to be addressed.

Implementation, measurement and review. Actions 24-28

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?*

26 The workforce must be included in service design, development and review, and other decision-making processes. The workforce has a lot to contribute about what they observe working well and what past service recipients have responded to.

26.b. It would be wonderful if ARC RNs were able to engage in more care than simply co-ordination & documentation of care planning/medication rounds/delegation of care/incident reporting/assessment of residents in transition.

27. We support the prioritised actions but question how indicators for each DHB can be published within 2 years (27 d) before they are even developed (27b - which has no specific timeframe!) Implementation needs to be coordinated.

28 **Improve the knowledge base**. We agree that there is a need to collect data about kaiāwhina (does it need to be a *minimum* dataset?) but we also need to collect, collate and analyse data around the whole aged care health workforce, especially in relation to the high number of migrant workers, disproportionate number of disciplinary cases, few entry to practice opportunities, retention issues, employment conditions etc. Aged care workers are in the top 10 occupations for work visas, and nurses (a large proportion of who are in aged care) are in the top 20[[4]](#footnote-4) , but, as we have noted before, there is very little information about the multiple- entry pathways, and retention of aged care workers in Aotearoa New Zealand. While there are statistical data for the regulated health workforce provided by the Responsible Authorities under contract to Health Workforce New Zealand, they do not encompass the broader policy and employment context. Reliable date to inform a comprehensive health workforce strategy are necessary.

Other comments

NZNO thanks you for the opportunity to comment on the draft Strategy and we look forward to its further development and implementation.

REFERENCES

New Zealand Climate Change Centre. (2010). *Climate Change Adaptation in New Zealand: Future Scenarios and Some Sectoral Perspectives*. (D. S. W. Richard A. C. Nottage & J. F. B. and K. Jones, Eds.). Wellington: NIWA.

New Zealand Human Rights Commission. (2012). *Caring counts: report of the inquiry into the aged care workforce*. Retrieved from http://www.hrc.co.nz/eeo/caring-counts-report-of-the-inquiry-into-the-aged-care-workforce/

New Zealand Nurses Organisation. (2014). Nursing matters - NZNO’s priorities for health. Wellington: NZNO.

Royal Society of New Zealand. (2016). Climate change implications for New Zealand, (April), 1–71.

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| **Submission 192 withheld at submitter’s request** |

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| **Submission 193** |

SUBMISSION ON THE HEALTH DEPARTMENT’S DRAFT PLAN

FOR OLDER POPULATIONS

“Our vision for healthy ageing:

* Older people are physically, mentally and socially active; and healthy lifestyles and greater resilience throughout life mean that we spend more of our lives in good health and living independently.
* Everyone in the health system understands what contributes to healthy ageing, and takes part in achieving it.
* Older people are health smart, able to make informed decisions about their health and know when and how to get help early
* All older populations are supported to age well in ways appropriate to their needs.
* Communities are age-friendly with initiatives to keep people healthy, well-connected, independent, respected and able to participate fully in their communities and with family and whānau”

I am a widower since my wife's death five years ago. I am 86 years of age and I live alone in my own house in Nelson. I am President of U3A Nelson, a not-for-profit charity with over 250 members over the age of 50 dedicated to the provision of opportunities for life-long learning, and I am a member of the Nelson Tasman Positive Aging Trust. My submission is a private one although most of the members of both groups would I am sure support its suggestions. I am a retired registered psychologist and was senior psychologist in the Nelson Office of the Education Department's Psycholological Service and also worked extensively with the Family Courts in Dunedin, Nelson and Blenheim.

From my professional reading and personal experiences, I wish to comment on the above principles and the relevant section of the draft strategy.

I was diagnosed with Parkinson's Disease in 2004 and placed on the usual medication of Madopar. I joined the New Zealand Neurological Foundation at this time and still remain a member. Through their publications and access to international medical journals, I read widely on Parkinson's Disease and other brain disorders.

My symptoms developed as I expected and my medication was steadily increased.

My wife became ill in 2010 with severe breathing problems resulting in low oxygen levels in the blood She became progressively less able to.walk unaided and I became her sole carer. She was placed on oxygen at home and, for the last six months' of her life, was on oxygen for 24 hours a day. She collapsed twice in the evenings and, because I was physically too weak, I was unable to lift her and had to call an ambulance. The second time she was admitted to hospital where she died on 30th September 2011.

After her funeral, I resolved to once again become active in the community believing from my reading that this would allow me to age positively and help postpone the onset of Alzheimers and/or Dementia; I joined U3A and became a member of two of the 50+ study groups and I resumed walking longer distances. Within two months I began to notice a definite improvement in my health and a significant reduction in the symptoms attributed to Parkinson's Disease. My initial belief was that the improvement was due to the lifting of the stress associated with my wife's illness.

But, in fact, for about four years' now I have had no active symptom's of P D and with the approval of the specialist physician at Nelson Hospital and my G P, I reduced my medication with no ill effects. After a consultation with a neurologist at the Neurological Foundation, I believe that my "disorder" was initially misdiagnosed and I have now ceased taking all medications for P D - still with no ill effects.

On this basis I wish to support the first of the principles for healthy ageing wholeheartedly but to state that it should be stated more forcefully and with greater emphasis. Every "patient" should be regarded and treated holistically and never as a collection of "symptoms".

I am absolutely convinced that my medical "problems" have responded to my being physically active, returning to active learning and challenges, being socially active, undertaking the responsibilities of being Secretary and now President of U3A and as convener and leader of two study groups and of my resuming playing bridge. And, I may add for some people, consideration of spiritual and cultural issues are also very important.

I am urging that there should be a huge emphasis on the first statement at the head of this submission and that every member of the health service be called upon to urge all aging patients to be active physically, mentally and socially and to actively study if appropriate. The use of "green" prescriptions should emphasize all aspects of life and there should be provision in Public Health Organizations for "counsellors" with knowledge of adult learning groups and specialist "mind-games" groups in the community.

The result would be an increase in "healthy aging" and independence which could be of benefit not only to older people but also to the Health Service itself.

I am happy for my submission to be published.

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| **Submission 194** |
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| Organisation | Visual Impairment Charitable Trust Aotearoa NZ |
| City/Town | Dunedin |
| This submission... | is made on behalf of a group or organisation(s) |
| This submission represents the views of: | Service provider |
|  | Non-governmental organisation |
|  | Consumer |
| When submissions are published online: | Yes, you may publish my submission |
| In the case of an OIA request: |  |
| 1a. Comments or suggestions regarding the vision for healthy ageing | Sounds good - but meaningless unless it's put into practice. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | Comments from VICTA workshop: vision care vital for healthy ageing. More important than dental care (can replace teeth with dentures, but eyes are irreplaceable). Failing eyesight 3x more common than dementia. Without rehabilitation, people with poor vision at high risk of falls, and social isolation. We need frequent, reliable public transport to access museums, exhibitions, countryside & keep up our interests - otherwise older non-drivers are excluded. Health professionals need to refer people with failing vision to VICTA early. Need govt docs in large print, need step edges and kerbs clearly marked in contrasting colour. Need safety rails beside awkward paths. Need safer road crossings, esp. near bus stops. |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | Comments from VICTA workshop: We need the ability to find out what help we CAN get, and then actually get it. |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | ACC needs to include vision checks and low vision rehabilitation in all falls prevention and treatment programmes. |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | VICTA workshop comments: Our needs change over time. We need more home visits to assess real needs. |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | "We are here. Where are you?" |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | Needs more emphasis on vision care - early diagnosis, treatment, and low vision rehabilitation is the key to staying active and independent with failing eyesight. |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | Accessible, comprehensive low vision rehabilitation services nationwide. Need clinics in local areas. |
| 5a. Comments or suggestions regarding the vision for respectful end of life | VICTA workshop comments: Want to die in home or a hospice. Need to get legal documents organised. Would like choice of having enduring power of attorney may be someone outside family. |
| 5b. Comments or suggestions regarding the actions for respectful end of life | Want natural coffins, or be buried in places where a coffin not required. Can you be buried in a winding sheet? Do you need a professional to draw up the documents? Make sure your children know what you want. Don't want millions of health $$$s spent on us in our last weeks of life. |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | Pedestrian safety and good public transport are the keys to optimising the physical and mental health of older people with failing eyesight, and keeping them active and engaged with their communities. Transport planners need to shift their focus from moving vehicles to enhancing the lives of people. Health planners need to work with transport planners on this issue. |
| Do you have any other comments? | Filling in forms and not seeing any changes for the better as a result makes these exercises seem like a waste of time - such experiences can lead to a why-bother-waste-of-time disengagement from the entire democratic process. I hope that doesn't happen with this consultation process. |

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| **Submission 195** |
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| This submission... | comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity) |
| This submission represents the views of: | former caregiver; media producer |
| When submissions are published online: | Yes, you may publish my submission |
| In the case of an OIA request: | Please remove my personal details from any response to Official Information Act requests |
| 1a. Comments or suggestions regarding the vision for healthy ageing | I would add: That communities are dementia-friendly with services and leisure activities that enable those living with dementia to express individual contributions to society. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | as above. |
| 2a. Comments or suggestions regarding the vision for acute and restorative care |  |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | yes. |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | 1. Increased outdoor and arts opportunities for those living with dementia. 2. Increased support for caregivers. |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | To maintain maximum opportunities for self-determination and expression for those living with dementia. Rest homes must be designed to provide ground-level access to gardens. |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs |  |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | Increased non-driving transportation. |
| 5a. Comments or suggestions regarding the vision for respectful end of life |  |
| 5b. Comments or suggestions regarding the actions for respectful end of life |  |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | Sustained regulation on the design of rest homes to include ground-level garden access. |
| Do you have any other comments? | As a caregiver and rest home volunteer I saw how those in permanent care can maximise their quality of life, provided that the rest home facility makes this a priority. Those living with dementia cannot articulate their needs but they still have them. Too many rest homes are designed as upper-level care. This robs residents of their remaining self-will and quality of life…particularly in a country such as New Zealand. Unrestrained garden access reduces stress and difficult behaviour. It benefits residents and staff within a respectful living environment. |

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| **Submission 196** |
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| Name | Arthritis New Zealand |
| This submission... | is made on behalf of a group or organisation(s) |
| This submission represents the views of: | Service provider |
|  | Non-governmental organisation |
| When submissions are published online: | Yes, you may publish my submission |
| In the case of an OIA request: | Please remove my personal details from any response to Official Information Act requests |
| 1a. Comments or suggestions regarding the vision for healthy ageing | Not all illness and disability can be prevented. Emphasis must be given to living well in the presence of illness and disability. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | We agree with the healthy ageing goals-do not see establishing age friendly communities as the priority action as this is hard to measure and is relatively subjective. We prefer to make the priority to work across government to co-ordinate assistance and develop initiatives that better address the physical and social determinants of health as this is more easily measured. We also see the need for equity of access to be recognised as a key factor in determining healthy ageing access to services such as podiatry, occupational therapy, and aids to daily living eg equipment . Arthritis New Zealand is prepared to play a lead role in promoting 1d-promoting volunteering, networking and paid work for older people. |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | We strongly agree with the need to co-ordinate care across specialties and across ACC. This care must also include the supporting agencies involved. |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | Agree with the priority of developing, implementing and reviewing prevention and treatment of injuries for ACC. We have concerns about the number of claims declined by ACC on the grounds of age related degeneration. We suggest that this section includes provision for monitoring the success rate of ACC claims made by older people. We also wish to highlight the importance of prehabiliatation, eg preparing well for surgery and access to services to prevent long term disability. These services need to be equitably available. |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | We strongly support this goal and note the high prevalence of arthritis in the older age group. The New Zealand Health Survey 2014-2015 shows 389,000 people are diagnosed with osteoarthritis. This figure is likely to rise exponentially. We also advocate long term aims including the increasing of access to online services and tools for older people including the skills to enable them to use them. |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | These actions focus on workforce training, recruitment and retention and while we agree that these are important the \* priorities in the draft are too narrow. We advocate service development plans for people with long term conditions as a priority. These plans should include a range of conditions and a service development plan for older people with musculoskeletal conditions is an essential. We also note that there needs to be acknowledgement of the importance of people learning to live with and manage pain. Arthritis New Zealand is willing to take a lead in this area. We agree with 10 b- the need to share educational resources and Arthritis New Zealand is happy to lead the facilitation of collaboration in the sector, noting that resource will be needed to do this effectively. We note that referral to appropriate agencies should include NGOs in addition to health professionals. |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | The need for flexible home and residential care services is essential. Included is equitable access to in-home services not based on ability to pay. |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | We see the priority as building responsiveness to frailty accompanied by promoting contracting models that enable people to move freely to different care settings. Exploring the possibilities of a frailty identification tool is more an operational step towards the above goals. |
| 5a. Comments or suggestions regarding the vision for respectful end of life | We agree with the outcomes in this area |
| 5b. Comments or suggestions regarding the actions for respectful end of life | No comment to make |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | We strongly advocate for meaningful consumer participation at all levels in the implementation, measurement and review of the strategy. The NGO sector should have more involvement in this process to ensure that it is consumer focused. Arthritis New Zealand is prepared to provide a lead on a funded basis on building consumer input |
| Do you have any other comments? | We strongly advocate for consumer representation and input on all aspects of this strategy. |

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| **Submission 197** |
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| This submission... | comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity) |
| This submission represents the views of: | Consumer |
| When submissions are published online: | Yes, you may publish my submission |
| In the case of an OIA request: |  |
| 1a. Comments or suggestions regarding the vision for healthy ageing | My experience and observation tell me that many older people who are no longer personally independent are part of a couple that stays living independently because of the care provided by the partner. This caring can be onerous and stressful and the support needed by the carer is a critical part of the health support system, so important desirable that it should be a specific item on the vision. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | I am generally in agreement. |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | Older people typically have multiple and interacting conditions; the integration of the range of support and treatments needs more focus in the strategy. |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | Nothing else. |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | I agree with the vision. |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | I generally agree. |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | Complex needs are so typical that wonder if that message is diminished by suggesting that people with complex needs are somehow different. |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | I generally agree. |
| 5a. Comments or suggestions regarding the vision for respectful end of life | This all seems so self evident that I wonder why it should be treated so specially. |
| 5b. Comments or suggestions regarding the actions for respectful end of life | No comment. |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | I have no comments on this. |
| Do you have any other comments? | One of my concerns and causes for anxiety is that when I can no longer take care of my wife at home and she needs residential care, my contribution to the cost of that care will eat up our savings. I can see the savings becoming so diminished that I will not be able to continue the way of life, relatively modest as it is, that we have set-up for our retirement years. I suggest that this is an issue that deserves consideration in the new strategy, since it embraces both social and health perspectives. |

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| **Submission 198** |
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| This submission... | comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity) |
| This submission represents the views of: | Consumer |
| When submissions are published online: | Yes, you may publish my submission |
| In the case of an OIA request: | Please remove my personal details from any response to Official Information Act requests |
| 1a. Comments or suggestions regarding the vision for healthy ageing | This vision seems to be very suitable. My only comment is that doctors should be trained in assisting people to die, which is the normal part of ending living. I have heard of cases when doctors disregarded 'Living Wills' and resuscitated people whose lives were nearing their end. The hospice movement gives brilliant service in this way and people die happy and with dignity . |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | I don't see purple stars |
| 2a. Comments or suggestions regarding the vision for acute and restorative care |  |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. |  |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. |  |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. |  |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs |  |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs |  |
| 5a. Comments or suggestions regarding the vision for respectful end of life | See my comments in early box |
| 5b. Comments or suggestions regarding the actions for respectful end of life |  |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions |  |
| Do you have any other comments? | This all sounds great. Implementing it is the struggle. |

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| **Submission 199 withheld at submitter’s request** |

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| **Submission 200** |
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| This submission... | comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity) |
| This submission represents the views of: | We are a cooperative of people interested in the advancement of Advance Care Planning |
| When submissions are published online: | Yes, you may publish my submission |
| In the case of an OIA request: | Please remove my personal details from any response to Official Information Act requests |
| 1a. Comments or suggestions regarding the vision for healthy ageing | It is great to see ACP threaded through the draft strategy. All of us are going to die and our chances of dying well are substantially increased with good ACP. It would be good if we included this specifically in the vision: Older people are supported to think about what matters most to them, and are supported to use that insight to talk about and plan for their future and end of life care and treatment. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | To effectively support people to age well in ways appropriate to their needs we will need to ensure they have the opportunity to think about what really matters to them, what would make their lives rich, full and meaningful, to talk about that with the people they care about and who care for them and to work as a team to plan for aging well. This will require the workforce has good communication skills and coaching/care planning skills. Knowing what really matters to a person is also the starting point for enabling that person to make informed decisions and their health. It is recommended that increasing the workforce communication and care planning skills should be a key first step. |
| 2a. Comments or suggestions regarding the vision for acute and restorative care |  |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. |  |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | Advance care planning is most effective when the thinking and talking about what matters to a person, and how that might or might not affect the care and treatment choices they make, are started ideally before any diagnosis, but atleast following on from a diagnosis of a long term condition. It would be good to see ACP included in the living well section and in the associated actions and not exclusively seen as an end of life process. |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | It is recommended that an action is added to action 12: 12 c - Ensure older people and their families are supported to do Advance Care Planning by providing resources and skilled staff to support the thinking, sharing and planning for future care and treatment that is driven by what really matters to them. |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs |  |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | People need to know they are entitled to health and social care that supports them to be the person they value being and to do the things they value doing. They also need help to articulate (thing and talk about) what is important to them and what they need. It would be good to see Action 16 (a) second bullet point amended to "assist older people to articulate what is important to them and to support them in setting and achieving individual objectives that align to what matters most to them" |
| 5a. Comments or suggestions regarding the vision for respectful end of life | It is great to see advance care planning as a key theme in this section. The ACP Cooperative was concerned that limiting ACP to dying older people may result in ACP only being seen as part of the dying process and not part of general care planning for all future AND end of life care and treatment. I would like to reiterate the opportunity to include ACP in the health aging, living well and high, complex sections to encourage early conversations and thinking about what really matters to people and for that to underpin all care and treatment, not only at end of life. |
| 5b. Comments or suggestions regarding the actions for respectful end of life | Good communication and care planning/coaching skills are required to support people with care planning, including ACP. It would be important to specifically state this as an action in this section. It could be included as action 22 b - increase the capability (communication/care planning/coaching skills) of the health and social workforce to support older people to think about, talk about and plan for their future and end of life care. |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions |  |
| Do you have any other comments? |  |

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| **Submission 201** |
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| Organisation (if applicable) | Auckland Council Seniors Advisory Panel |
| This submission... | comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity) |
| This submission represents the views of: | Retired older woman |
| When submissions are published online: | Yes, you may publish my submission |
| In the case of an OIA request: | Please remove my personal details from any response to Official Information Act requests |
| 1a. Comments or suggestions regarding the vision for healthy ageing | Great vision - however you need to find ways to share those inclusive statements with local government policy makers, especially those in Auckland, who envisage catering for older people as something that's costly and done at the expense of other groups (such as younger people, or the rainbow community). |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | Absolutely - especially the age-friendly community initiatives. Again, Auckland Council policy and strategy managers and staff will need to be challenged to remove their ageist lenses and enter a brave new world where older people and their opinions and contributions to civil society are valued and enabled. The Auckland Council talks about investing in their Empowered Communities Approach, but seems reluctant to use it in practice! You could add some references that link into the current work in the health system around developing System Level Measures to improve patients' experience of health services - for example around initiatives to promote the uptake of e-portals; and innovative strategies to increase the responses of diverse older people about their experiences accessing health services, which can be used to improve the quality of those services. Please note that this is NOT a request to develop quantitative league tables that promote competition between providers/services/regions, but to commit appropriate resources to delve into the quantitative feedback and translate that into improving services in a timely manner. |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | Great vision statements - though I didn't note any references to the importance of assessing social networks when older people are returned to their communities. Please be aware of hearing losses which are amplified when communicating over the phone, and in environments with poor acoustics and lighting. Asking for information to be repeated, repeatedly, is demoralising. Ageing with an invisible handicap such as age-associated hearing loss is stigmatising. Concentrating on hearing and listening means that attentional resources to memorise information are often not available, so having information shared orally and in written form (with appropriately sized text) is essential. The WHO Age-friendly Cities policy framework refers to the importance of linking medical and social care - which is really a Whanau Ora approach. I hope that your actions articulate that clearly! |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | There need to be innovative ways of encouraging older people to actually create an Advanced Care Plan (ACP). I participated in the ADHB development of resources for this initiative (Conversations that Count) - but life has been so busy, purposeful and full that I have yet to complete my own ACP! |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | Given the importance of health eating on older people's well being - I'm disappointed that you don't deal with the excessive costs associated with dental care. |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | Actions need to recognise the capacity offered by the nursing workforce to deliver appropriate and timely care that supports people living in the community who are managing long-term conditions. Reward those who care for older people by paying them appropriately. |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | Well articulated vision. |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | Purple star signals are fine. It's worth while reading this review 2016 review: REVIEW ARTICLE Brief on the Role of Psychologists in Residential and Home Care Services for Older Adults Tanya E. Davison,1 Deborah Koder,2 Edward Helmes,3 Colleen Doyle,4 Sunil Bhar,5 Leander Mitchell,6 Carol Hunter,7 Bob Knight8, and Nancy Pachana6 1Department of Psychiatry, Monash University, 2Specialist Mental Health Services for Older People, Royal Prince Alfred Hospital, 3Department of Psychology, James Cook University, 4Australian Catholic University, Villa Maria Catholic Homes, 5Department of Psychological Sciences, Swinburne University of Technology, 6School of Psychology, The University of Queensland, 7Carol Hunter Psychology, and 8School of Psychology and Counselling, University of Southern Queensland And also this article: Social Vulnerability Scale for older adults: Validation study\* DONNA M. PINSKER1, VALERIE STONE1, NANCY PACHANA1, & STEPHEN GREENSPAN2 1School of Psychology, University of Queensland, Brisbane, Queensland, Australia and 2Department of Psychiatry, University of Colorado Health Sciences Center, Denver, Colorado, USA Abstract The Social Vulnerability Scale (SVS), an informant-report of social vulnerability for older adults, was piloted in a sample of 167 undergraduate students (63 male, 104 female) from the University of Queensland. Participants aged 18 – 53 (M 1⁄4 25.53 years, SD 1⁄4 7.83 years) completed the SVS by rating a relative or friend aged 50 years (M 1⁄4 71.65 years, SD 1⁄4 12.49 years): either someone with memory problems, stroke, dementia, or other neurological condition (n 1⁄4 85); or a healthy older adult (n 1⁄4 82). Excellent internal consistency and test – retest reliability were demonstrated, and the SVS effectively differentiated healthy older adults from those with a neurological condition based on proxy ratings of social vulnerability. The SVS is a potentially useful adjunct measure of older adults’ capacity to reside independently. Keywords: Aging, assessment, cognitive disorder, memory and cognition, neuropsychology, rehabilitation, social cognition, social vulnerability The funding for GP visits of 10-15 minute slots are not realistic for the provision of compassionate care for older people. I highly recommend that you policy analysts are mindful of Robin Youngson's text "Time to Care' when you develop actions related to caring for vulnerable older people. Time is the Cinderella resource in the health system - I'm extremely conscious of this as I am currently providing health consumer input into the SLM Patient Experience measures for metro Auckland, and am amazed at the limited time lines to get this ground-breaking work done; especially when the MoH and HQSC do not appear to be on the same page. It's very revealing! |
| 5a. Comments or suggestions regarding the vision for respectful end of life | No |
| 5b. Comments or suggestions regarding the actions for respectful end of life | Particularly support these: d. ­ Incorporate home and community support users’ experiences into Health Quality and Safety Commission-led patient experience work. e. ­ Include representatives of DIVERSE older people in DHB regional forums. This action (below) will need input from diverse stakeholders: ­ Develop a system to evaluate progress against the goals of the Health of Older People Strategy and support the health system to be person centred and focused on maximising healthy ageing and independence. |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | Develop a social network tool (e.g. Wenger's Support Network Typology) that identified people's social connectedness. If every GP had this as part of their diagnostic framework they could recommend treatment options that take the social context of the patient's life into consideration. My PhD thesis demonstrates how this tool can be used. |
| Do you have any other comments? | You've created a very user friendly interface to provide feedback. Much appreciated as I'm rushing through this at the last moment. I look forward to reading the final iteration of this document. Please note that I didn't attend your Auckland consultation as it involved a 70Km round trip - and I simply didn't have the time to drive across to the airport to participate on the day you were there. I'm surprised that given the population of Auckland you didn't hold consultations in the North, east, south and west. I realise that flying in from Wellington it suites you to drop into a base close to the airport, but hope that you'll be able to activate health consumer networks and provide at more opportunities to engage in the future. Last comment - whilst I'm comfortable using digital technology to communicate, many older people who are not digital natives prefer face-to-face discussions. Nga mihi! |

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| **Submission 202** |
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| Organisation (if applicable) | Policy Manager, PHARMAC |
| This submission... | is made on behalf of a group or organisation(s) |
| This submission represents the views of: | Government |
| When submissions are published online: | Yes, you may publish my submission |
| In the case of an OIA request: |  |
| 1a. Comments or suggestions regarding the vision for healthy ageing |  |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing |  |
| 2a. Comments or suggestions regarding the vision for acute and restorative care |  |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. |  |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. |  |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. |  |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | PHARMAC believes that a shared definition of ‘vulnerable group’, ‘priority population group’ and ‘high and complex needs’ is missing from the strategy. The lack of a clear definition creates inconsistencies within the Strategy and the roadmap action plan - for example, Pasifica people are only acknowledged explicitly in the long term conditions section of the Strategy; furthermore, there is no mention of why the Asian group population has been included in some parts of the Strategy but not others. Relatedly, we note the absence of reference to populations with disability as a disadvantaged population group throughout the strategy, and recommend the more explicit inclusion of this group in both the strategy and in the roadmap of actions. |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs |  |
| 5a. Comments or suggestions regarding the vision for respectful end of life |  |
| 5b. Comments or suggestions regarding the actions for respectful end of life |  |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions |  |
| Do you have any other comments? | General comments: PHARMAC supports the Strategy’s focus on operating collaboratively with social sector and communities towards a health system that works for every older New Zealander. We agree with the principles of sustainability and effectiveness of care, support and treatment for older people. PHARMAC staff appreciate the shift in language from health to wellbeing. We note the challenge of assessing the effectiveness of prevention measures in health using a value for investment angle, as often it is difficult to directly link the investment required for preventative interventions across the wider population with general health outcomes for specific groups. The use of a social investment approach may help address some of these challenges yet more work is needed in this area. PHARMAC supports the renewed focus on culturally appropriate interventions; and suggests cultural needs could be added to ‘physical, emotional, social and spiritual needs’ in the respectful end of life section (page 27). Challenges and opportunities: From 1 July 2016, PHARMAC began using 15 Factors for Consideration when making its decisions. One of the factors is the 'impact on government health priorities’. It is important for our work to understand clearly the relative importance of health strategies and actions plans. To aid this a description to support the graph on page 6 would be helpful. PHARMAC is supportive of the need to better understand risk factors for poor health (page 3). The document seems to narrow the analysis and actions to social isolation, certain medical conditions and frailty. We suggest expanding the action plan to include social determinants of health. This would promote reaching out to those not currently engaged with the system and can be a powerful tool to work together across government. Enabling technology: Advances in technology are acknowledged in the Strategy as an opportunity to make improvements to health access and health outcomes. We recommend that the distinction is made to identify cost-effective interventions in technology to improve the efficiency of the system. Furthermore, to avoid the risk of exacerbating the existing digital divide for older people and ‘vulnerable groups’ we recommend identifying the most effective targets for technological advances in health. In most cases the health system will gain greater benefit from General Practitioners, nurses and carers using compatible new technology versus promoting technology to individual patients. Placing the responsibility of being tech smart on the individual patient carries the risk of confusing being health smart and being tech smart. Patients need to first and foremost be health smart. The system can then support patients accessing what they require at different stages of life/illness through the most appropriate use of technology. An opportunity that is reflected throughout the Strategy is the ability to share the huge amount of data that is available across the system. We support the emphasis on the sharing of data. However, we also want to emphasise it is the analysis of the data that results in benefits (ie. the data needs to be set up and disseminated in a useable and meaningful form). |

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| **Submission 203** |
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| This submission... | comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity) |
| This submission represents the views of: | Family |
| When submissions are published online: | Yes, you may publish my submission |
| In the case of an OIA request: |  |
| 1a. Comments or suggestions regarding the vision for healthy ageing | I have recently supported an elderly member of my family move from independent living to residential (hospital level) care. While it is early days for her integration into the rest home, my observation to date is that the care is not of a high standard. Therefore, my comment on the vision statement, is that it is not accurate to state that the ideal is being attained. Not everyone in the health system is performing adequately. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | In particular, I wish to comment on the quality of food presented to residents in rest homes. Days have a certain monotony for the elderly when they are less able to act on their own. Consequently, meals become a very important part of the enjoyment of life. What I have observed, however, indicates that meals are often uninteresting and the quality of the food is seriously deficient. River Mill bread is not suitable. Not only do the menus lack interest, but the poor health-giving quality must impact negatively on the residents' energy and vitality. |
| 2a. Comments or suggestions regarding the vision for acute and restorative care |  |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. |  |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. |  |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. |  |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs |  |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs |  |
| 5a. Comments or suggestions regarding the vision for respectful end of life |  |
| 5b. Comments or suggestions regarding the actions for respectful end of life |  |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions |  |
| Do you have any other comments? |  |

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| **Submission 204** |
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| This submission... | comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity) |
| This submission represents the views of: | Non-governmental organisation |
| When submissions are published online: | Yes, you may publish my submission |
| In the case of an OIA request: | Please remove my personal details from any response to Official Information Act requests |
| 1a. Comments or suggestions regarding the vision for healthy ageing | Vision is clear and positive |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | Particularly keen to see 3.d. progressed and pleased it is starred. Appropriate affordable supported rental housing is a real need and a huge gap (see Grant Thornton review of aged residential care 2010). I am a volunteer with Abbeyfield Dunedin and we have an enormous challenge to raise sufficient capital/equity to provide affordable rental supported accommodation. Yet the Abbeyfield model supports all the health outcomes this strategy is aiming for, delays/prevents/reduces need for rest home/hospital care and helps people remain well, socially connected and independent. Suggest active dialogue with community housing providers like Abbeyfield NZ (one of the few specialised in older people's wellbeing) in progressing this action |
| 2a. Comments or suggestions regarding the vision for acute and restorative care |  |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | Again Abbeyfield can offer short term rehabilitation support, in certain circumstances - where appropriate DHB funded carer support is combined with a short term vacancy in one of our facilities |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | Good vision |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | The wage levels of the aged care workforce must be addressed via government funding models if recruitment and retention of workforce is going to be improved. The administration of home support agency's services is often appalling - while the frontline workers are usually fantastic in my experience There is scope for greater efficiencies in the delivery of home support in a facility like Abbeyfield where more than one resident qualifies for home support, yet it is all done on an individual basis, so multiple home support agencies and carers are involved daily, when the job could be done more effectively and efficiently by fewer carers working the same hours for longer periods. |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | There is no mention of lower income people's equitable access to support in this vision. Lower income people with high and complex needs have no supported living options beyond their own home until they reach rest home care level needs. This impacts hugely their support options. |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | Again, look at the Abbeyfield model and the contribution it can make towards physical and mental health outcomes and reducing pressure on rest home/hospital level care. |
| 5a. Comments or suggestions regarding the vision for respectful end of life |  |
| 5b. Comments or suggestions regarding the actions for respectful end of life |  |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | Agree with including older people in service design, development and review - and NGO service providers like Presbyterian Support, Age Concern, Abbeyfield who have a depth of experience and expertise in working towards similar outcomes |
| Do you have any other comments? |  |

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| **Submission 205** |
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| Organisation (if applicable): | Seniors Council MNZ (NZFMC) |

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)

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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)*: ethnic minorities

### Other comments

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| --- |
| The Seniors Council of Multicultural New Zealand (NZ Federation of Multicultural Councils) appreciated the opportunity to participate in the consultation rounds during the review of the Health of Older People Strategy.  The Seniors Council has a particular interest in research into:   * Forms of Elder Abuse involving ethnic people in New Zealand eg. physical, emotional, psychological, financial abuse. * Incidence of such abuse on the part of family of ethnic people in New Zealand. * Incidence of such abuse on the part of institutional care givers and other service providers in respect of ethnic people in New Zealand. * Strategies to mitigate the risk of such abuse.   The Seniors Council is also interested in:   * Issues relating to the involvement of ethnic people working in * institutional care giving and other service provision roles in respect of ethnic people in New Zealand eg. recognition of overseas qualifications and work experience, use as interpreters/translators, pay and conditions of employment.   The Seniors Council would be grateful if the Strategy document could give due weight to the interests outlined above. |

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| **Submission 206** |
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Thank you for providing an opportunity for Taranaki DHB to provide feedback on the Draft Health of Older People Strategy and for agreeing to a short delay in making our submission.

Our feedback on each specific goal and its associated actions is provided on the attached template.

We congratulate the Ministry of Health for leading the development of this Strategy, particularly given the current and impending challenges associated with an increasing ageing population.

We particularly like the approach that the strategy has taken in covering the spectrum of older people’s needs through from healthy ageing to respectful end of life care. We are also pleased to see some emphasis on the wider determinants of health, and the consideration of broader health challenges such as social isolation, access to technology and ensuring health literacy. The Strategy also makes clear reference to the important role that service integration will play in improving access to timely services for those with greatest health need.

In terms of improvements, it is our view that the Strategy could be further strengthened by reducing the number of actions but providing clearer detail about how the remaining actions will be achieved. We acknowledge that the current list of actions reflects the outcome of consultation to date, but we believe a smaller number of more hard hitting actions may be more achievable when it comes to implementation of the Strategy.

A further improvement could be made by strengthening the focus on dementia in the Strategy. Dementia in older adults poses particular challenges for sufferers, carers, family members and health services. The impact of dementia, and the need for dementia friendly services across all areas of health and social care, is growing and this issue is a significant gap within the current Draft Strategy.

In the meantime we look forward to the completion of this strategy, which once complete will be used to inform the development of a local Health of Older People Strategy for the Taranaki DHB.

Thank you once again for providing an opportunity to give feedback on the Draft Health of Older People Strategy.

|  |  |
| --- | --- |
| Organisation (if applicable): | Taranaki DHB |
| Position (if applicable): | Portfolio Manager Older People |

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)

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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)*:

### 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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| This vision for the goal of Healthy Ageing is supported by Taranaki DHB |

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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| While we understand the driver for including the ‘establishment of age friendly communities’(action 1(a) ) into the strategy, this initiative is very resource intensive and relies on leadership and support from local councils to be successful.  Amendments to the Local Government Act (2002) in 2012 led to the removal of local government’s focus on promoting social, cultural, economic and environmental wellbeing of communities which has served to re-orientate some local authorioties Many councils move away from community development initiatives such as this. This will pose a real challenge to delivery of this action at the local level.  The action would benefit from some clarification around what could constitute an ‘age friendly community’ in this context – for example, is this action focused on the WHO model of age friendly communities/cities or could this extend to smaller communities such as age friendly employers, age friendly hospitals, dementia friendly health services, and so on.  Taranaki DHB would like to recommend that action 1(c) – coordinating assistance to social isolated older people is a priority for the first 2 years given the detrimental health and social impacts caused by social isolation in the elderly. This action also needs to be more clearly defined – it states that assistance will be provided to socially isolated older people (which suggests it aims to address social isolation) but also focuses on addressing social determinants of health. It is not clear if this is an action to tackle social isolation (which is a significant issue in communities, particularly rural communities where the problem is compounded by geographical isolation) or whether the reference to socially isolated communities is purely a target group for the delivery of initiatives aimed at addressing social determinants of health. We also feel that greater clarity is required around the role of MSD as a lead agency.  4c – The Ministry of Health has a lead role as the funder of health promotion services and should be included as having some responsibility for this action  4e/f - Support older peoples uptake of technology is identified as an action for DHBs and Primary Care. Whilst having a role to play, this action would not be able to be achieved without the participation of other stakeholders and agencies to address the infrastructure constraints in rural communities (fro example Broadband access). |

### 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 vision for the goal of Acute and Restorative Care is supported. |

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 prioritisation of improving outcomes from injury prevention and treatment – action 7(a) – is supported.  Taranaki DHB also considers action 6(a) – supporting effectively rehabilitation closer to home as a priority action due to potential cost saving implications of restoring independent function wherever possible to reduce reliance on long term funded support services such as residential care.  A number of excellent, evidence-based rehabilitation programmes are operating in DHBs around the country and there would be significant benefits in establishing a mechanism for sharing this information (e.g. a national information data base for Health of Older People services). This would support the goal of using ‘best practice restorative rehabilitation strategies, discharge planning and follow up support’ as well as guiding the development of initiatives to reduce 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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| The vision for the goal of living well with long-term conditions is supported.  However the clinical focus on intervention for to support older people to live well with long term conditions needs to be considered within the context of wider social factors and the impact that these have on the management of multiple long term conditions. These factors include poverty, transport, housing, carer/whanau support and cultural needs. Strategies to improve management of long term conditions need to consider the role that other agencies can play in responding to these wider social factors. |

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 prioritisation of action 8(a) – training for the HCSS workforce is supported, although Taranaki DHB  would like to see this Strategy ensure that training requirements are nationally consistent. We would also like to see the Strategy go a step further and support the development of a national service specification that would ensure minimum levels of service for HCSS. Any training programmes need to take account of the increased complexity of HCSS clients, and the need for appropriate clinical oversight of the unregulated workforce in HCSS.  The prioritisation of action 9(d) and 9(f) is also supported. The sector is predominantly low paid (caregivers and support staff on minimum wage) and pay rates for skilled workers (e.g. RNs) are typically at the lower end in the aged care sector. However it should be noted that one of the main barriers to improving recruitment and retention of those working in aged residential care are salary rates.  With respect to action 9(f) – enhancing training pathways for Maori and Pacific peoples – it would be good to see some national consistency in how this is applied, such as through national workforce development programmes, to ensure equity in support for this workforce.  Taranaki DHB would like to see action 10(c) – implementation of relevant actions within the Pharmacy Action Plan (2016 – 2020) – to be a priority action for the first two years. The creation of a national database of evidence based initiatives from around NZ (as mentioned earlier) would support the action to ‘share examples of innovative models of care that can be adapted to support pharmacists…”.  Action 10(b) – increasing physical activity levels – is an important action to support prevention of longer term health issues, however the decision to leave this to ‘providers’ to lead risks no action being taken at all as there is often a tendency for providers (assuming this means NGO providers) to focus on those actions that are supported by funding or compliance requirements. We would like to see consideration given to being more specific about who will lead this work (e.g. local Sports Trusts).  Taranaki DHB has some concerns with respect to action 11(d) – “development of commissioning and funding approaches for HCSS that describe core aspects for national consistency, but allow for local flexibility”. Commissioning and funding approaches vary significantly across the country.TDHB believe there are more gains to be made by developing a national service specification for HCSS in the first instance and the funding implications of such a shift being explicitly evaluated as part of any change process  The other prioritised actions in this section are supported although it is noted that DHBs will find it challenging to implement those actions for which they have been identified as a lead without specific funding, particularly new initiatives such as 11(h) – community based early intervention programmes for people with musculoskeletal health conditions and telemonitoring initiatives. |

### 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 for the goal of better support for people with high and complex needs is supported. |

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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| Action 14(a) is supported as a priority action although we would recommend that this work is led nationally. The clinical needs associated with frailty will not have regional variations, so it makes sense that a nationally consistent frailty tool is developed. This will need good engagement with local clinicians however as part of the development process.  With respect to frailty, the Strategy in its current form makes limited reference to interRAI and the potential to use interRAI (and other similar data sources) to undertake risk stratification that could enable preventive interventions (e.g. for frailty, falls) to be carried  Taranaki DHB would like to see the promotion of contracting models that enable people to move freely to care settings most suited to their needs – action 15(c) – a priority for the first two years to ensure older people and those with disabilities can access the most appropriate care for their needs. However it is noted that there is a degree of national work that needs to underpin this to ensure that funding streams are more flexible, and that those aged 50+ are not financially disadvantaged as they move across different funding streams in order to access most appropriate care or to exercise personal choice. Current siloed funding models prevent development of good quality age appropriate and need appropriate services. We would recommend that this action is re-worded to state “Promote contracting ***and funding*** models…” with MoH leading this action, supported by DHBs and ACC.  The prioritisation of action 18(a) – development of standard referral and discharge protocols – is supported, however it is recommended that this is supported with some national guidelines to ensure national consistency in approach to this action. It is also recommended that DHBs are included as a joint lead partner, with MoH, for action 18(d) – “explore options for aged residential care facilities to become providers of a wide range of services to older people including non-residents”  Taranaki DHB would like to see Primary Health Care as a joint lead agency with DHBs for action 20(b) – models of care and contractual arrangements to provide equitable access to medication management services.  In terms of general feedback, the impact of dementia is not fully reflected in the draft strategy. There appears to be little acknowledgement of the prevalence of dementia and the rising impact this will continue to have on expenditure, health services and the population as a whole. We would like to see the document provide more explicit reference to dementia, its impact on older people in New Zealand, and the need to plan for the challenges ahead. |

### 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 vision for the goal of a respectful end of life is supported. |

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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| Action 22(a) is supported as a priority action, however we note that there is a significant role for primary health care and DHBs in increasing awareness of ACP and EPoA. Some clarification is needed around where responsibility for ACP lies.  There appears to be a gap in terms of the role for aged residential care in this section given the significant role that ARC providers play in this area. It would be good to see an action that highlights the role of ARC in providing good quality end of life care, delivered by a workforce that is appropriately trained and supported by specialist providers. There is significant potential in this area to broaden the palliative care workforce to make more use of Nurse Practitioners and Clinical Nurse Specialists, particularly to provide support to the aged care workforce (both HCSS and ARC).  The other actions in this section are supported. |

### 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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| With respect to actions in section 26, it is recommended that the Strategy makes explicit reference to the HQSC document ‘Engaging with Consumers – a guide for DHBs’ to ensure all DHBs are using best practice approaches for consumer engagement. |

### Other comments

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| Taranaki DHB supports the proposal to change the name of the Strategy from the ‘Health of Older People Strategy’ to the ‘Healthy Ageing Strategy’.  We would like to see the number of actions reduced if possible, so that the Strategy contains a few hard-hitting actions, with clear detail about how they will be delivered and who has responsibility. This will ensure successful implementation and allow MoH to monitor progress against the strategy.  The Draft Strategy currently has a lack of reference to the specific needs of Maori and would be improved by making clear reference to the importance of addressing the cultural needs of kaumatua and the importance of reducing health inequality for Maori.  The potential for interRAI data to support the implementation of a number of actions is not clearly articulated. It is recommended that MoH engage with the national interRAI project team as part of its consultation (if it has not already done so) to identify where interRAI can be used as an enabler to delivery of actions aimed at identifying and addressing clinical risk factors such as frailty, falls and dementia.  Finally the actions within the Draft Strategy are all framed by agency and provider. It is recommended that the wording of some actions is changed to reflect the importance of patient centred care in their implementation. |

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| **Submission 207 withheld at submitter’s request** |

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| **Submission 208** |

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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)

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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)*:

### 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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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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### 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?

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### Support for people with high and complex needs

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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| 15a and b need a \*  18d explore options “with reference to evidence-based international best practice” |

### 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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| --- |
| 26a, c, d, e, f  In Dunedin there were only 3 older people at the consultation in February. Next time a priority would be to find out how to contact older people in order to canvass their views. Otherwise this process is not valid as the data will be biased only to the views of people who work in the area of ageing and health but are mostly not from the general public. |

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| **Submission 209** |
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| --- | --- |
| Organisation (if applicable): | Whanganui District Health Board |
| Position (if applicable): | Chief Executive Officer |

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)

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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)*:  
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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| Support the vision:  Probably what is missing is the notion of individuals planning for their older age |

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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| Support the actions:  Action 3 - Working across government to prevent harm etc. also needs to include HQSC and ACC so that falls, pressure area infections etc. are covered.  Action 4d – important as growing dependence on health literacy.  Action 4e – agree – needs to be recognition of the increasing use and understanding of technology which is developing at a rapid rate.    Other comments: Healthy aging needs to include promotion of ‘advance care planning’ and EPOA. |

### 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 the vision, however the title may not be right – could be interpreted that restorative care does not have a place in acute care.  Vision needs to also include a comment on balancing treatments, particularly invasive treatments for older people and benefit. |

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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| Support the actions:  Action 7a - should also include ARC residents.  Action 6a - this action is not considered comprehensive enough to give context to meaning. Include other nursing groups, e.g. community based nurses. Integrate with NGOs who provide funded and unfunded support to those at home rehabilitating.    Other comments:  Consider wider application of the interRAI suite of tools such as the acute care tool for use in inpatient and rehabilitation wards. Support interRAI as assessment tools across the system including ED screener, palliative, mental health supplement. Ensure a consistent set of tools used for integration – more streamlined and across funders.  Individuals should be cared for in the least restrictive environment. A review of the legal framework to ensure that there are liberty safeguards for those people who lack capacity, in a similar way to how human rights are managed in regards to detention under the Mental Health Act.  The document is silent on models for acute care for older people with conditions that have a predilection for delirium and how they get better managed.  Consider a delirium pathway, raising awareness of delirium for health professionals and service providers. |

### 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?

|  |
| --- |
| Support the vision |

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 the actions as outlined:  Action 11e - needs to be also noted that general practice/primary care have a key role for modifying the CAPs (clinical assessment protocols), for example, unmanaged pain for living with long term conditions etc. Would like to see more emphasis on the assessment being used as a health planning tool for the individual.  Currently the focus is on the assessment and the allocation of support which is led by NASC.    Integration of assessment tools with leadership nationally to support DHBs. Consideration of discharge planning and reduction of multiple assessment tools where this is able. Nationally led guidance on this preferred.  Action 9d – agree – but needs to be more explicit that this action refers to home and community support sectors. In addition, needs to include that there is adequate remuneration particularly for support workers.  Action 9e - this action needs escalating to within 2 years.  Action 11 - ‘expand and **sharpen**’ could the word ‘smarter’ be used instead of sharpen?  Action 13 - opportunity to expand this section to include a wider range of technology. The term ‘active assisted living’ is commonly used to describe a range of technology which can help people to live safely and independently in their homes |

### 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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| --- |
| Support the vision |

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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| Generally support the actions:  Action 15a - opportunity to add that person centred is taking an ‘holistic’  Action 16a - don’t mention reducing harm and DHBs should also be taking a role  Action 19 - role of InterRAI as an enabler should be included  Action 20 - role of nurses should be added including nurses who can prescribe and nurse practitioners  Action 14a - InterRAI have developed a frailty tool  Action 14b - does not have an asterisk – suggest this is also given priority  Other comments: There is a need for more choice of living accommodation for older people that does not limit to living at home at one end of a spectrum and aged residential care at the other. Aged residential care, shared care, flatting, and other types of support need consideration to provide choice and enable other aspects important to wellbeing to continue. This includes improving social inclusion, efficient and affordable living for older folk and sensible supports from a wider community. Policies and actions that do not penalise varying living arrangements may need consideration (led by MSD). |

### 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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| Vision supported. |

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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| Support the actions:  Action 22 and 22a - action should be included in healthy aging  There should be an action that there is a review of the person’s Advance Care Plan  NZ needs one agreed definition of palliative care |

### 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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| Support the actions:  26c - would like to see this action a priority |
| **Other comments:**  Themes  Whanganui DHB believes the Health of Older People Strategy would be strengthened as follows:  **Framing**   * More clarity about how the Health of Older People Strategy aligns with the NZ Health Strategy, Disability Strategy, the Carers’ Strategy and how it connects to other central government services and Votes. * Clear articulation of short, medium and long-term outcomes in the Strategy. Reference to the international literature and processes for defining Patient Reported Outcomes – what do older citizens and the subpopulation of older citizens who are patients want? This is a strategy for the people of New Zealand rather than for those of us, clinicians and managers, who provide that health care. What we see as the needs of the population may differ from what that population sees as our national needs. There is also a significant literature base that ties these two sets of needs and deliverables together under sets of co-design principles. This is also about consumer sovereignty and each of us taking personal responsibility for our current and future health and resilience. Thank you for using Outcomes. * Alignment of actions with the priorities identified in the strategy, to clarify how the actions will deliver on the strategy. * Reference to sequencing, timing and inter-dependence of the steps that need to be taken in order to deliver on the strategy. * Amend the title to provide a more positive message – suggest ‘Healthy Ageing in NZ’ – with the message that ageing is a community responsibility. * Acknowledgement that the strategy is not for people over 65, rather it is about a whole of community response to ageing. * If the intent of the strategy is to provide a 20-year horizon, it does not take into account the rapidly ageing population. * It lacks ‘bravery’ around the conversations that need to be had with communities as we face increasing demand alongside limited resources – there is little mention of what investment is required and affordability. Much more focus on this is required. An integral part of any strategy is the business model including a focus on each of the major resource areas: capital, infrastructure especially IT, human resources, technologies (drugs, devices, imaging, diagnostics and regulated IT) and models of care. Expectation of communities will need to be explicit as there is likely to be tension between investment required/affordability and community expectations. * Affordability needs to be considered by Treasury. New Zealand has just reached the tipping point where we will have more citizens who don’t pay tax as opposed to those who do – Japan has just reached the same position. The ageing population is now largely baby boomers. We have worked hard, paid tax and have expectations about how we will be supported by governments as we age well. We as a country have some difficult funding decisions to make. It is no use having a strategy of any type that we can’t enact because we have not worked through the short, medium and long term investment strategy! Everyone simply becomes frustrated and then we make knee jerk short term decisions and we lurch from one band-aid reactive decision to the next! * The language in the document is currently aimed toward health and social sector professionals rather than at individuals within our communities.   **Focus**   * Stronger focus on the determinants of health and how sectors can cooperate to influence determinants, and build resilient communities. For example, housing as a major determinant of health is not well acknowledged in the strategy. The highest weighted determinant in the NZ Dep Index is connectivity, especially for the older population. The value of all types of social connectivity including the internet and mobile phones is vitally important. Hence the value of the Government’s high speed broadband programme. Broadband access is arguably most important for those individuals who are older and live in more isolated communities and circumstances. There is literature that supports this approach as do the NZ Dep Index weighing’s. * Recognition of environmental access and urban design links to the health and wellbeing of all New Zealanders: * The current housing stock in New Zealand is likely to be the housing many New Zealanders will use as they age over the next two decades and suitable changes need to include universal access. It might be useful to include some reference to the work of the Commissioner for Financial Capability, Dianne Maxwell (formerly the Retirement Commissioner). Dianne’s data about the financial status of the ageing New Zealand population is really sobering and cuts to the chase about the affordability of suitable housing and of care for our ageing population: <http://www.cffc.org.nz/the-commission/the-commissioner/> * It might also be useful to draw attention to the work of the Office of the Minister of Seniors, Hon Maggie Barry. They have a lot of information about the Business of Ageing and the importance to the New Zealand economy of keeping our senior workforce, not just the health workforce, engaged and productive.   <http://superseniors.msd.govt.nz/about-superseniors/osc/index.html>   * Local authorities and government departments to be committed to universal access in all public buildings. * There is a need for social housing models (e.g. Abbey Field model). * Separate provision of care from purchase of accommodation. This would mean that people could access the level of care they need in a variety of settings. * Describe the mechanisms that can provide the platform to work across sectors, for example, *Health in all Policies.* * Recognition that mainstream services might not work effectively for Māori – consider kaupapa cultural care models: * Build Māori capacity to actively contribute to their own iwi, hapu and whanau * Improve Māori participation and decision-making in the health and disability sector * Ensure that health and disability services are effective for Māori as well as all New Zealanders. * Recognise Pacifica and Asian care practices as well. These populations have equally important cultural support and care practices. Their elder populations are often very isolated, especially through inequalities, social circumstances and language. * The strategy would benefit from more focus on the consumer engagement and co-design, with less focus on agency responses. We need to stop telling people what is best for them and actively listen to what they want. We may get some surprises and some valuable, cost effective new learnings. * The cross sector focus is positive, however in many cases the lead agencies assigned against actions do not align with current expectations of agencies. Ministers’ expectations across agencies need to be more visible, with joint accountability where this is required. * More focus on how we are going to develop a workforce to meet future need. And how we will pay for the education, ongoing CPD and employment of those workforces. We also need to consider whether / or not those workforces need to be regulated and to what level, if so how will we best achieve that and what investment will be required to obtain those agreed outcomes. * More focus on technology as an enabler to support ageing communities. This technology is largely IT infrastructure and enhancements of existing technologies especially, drugs, devices, imaging and diagnostics. It is not about sensors, robots etc. First in class IT based technologies such as sensors and robots that interact directly with patients and aide in their health care all need to be regulated. The FDA has published on this type of regulation. Other ‘purchase over the counter’ / ‘direct to consumer advertised’ IT technologies are ‘nice to haves’ for those that can afford them but by in large will need significant, sustainable investment of funding in assessment, regulation, procurement and maintenance if they are to be introduced on a national level into every day support and care. There is also a generational issue to be addressed if this type of introduction is to occur. Baby boomers are not necessarily IT literate. The cost of this type of literacy education programme and the capability to set up and maintain such a programme needs to be considered. It might be better and more cost effective to let such a programme evolve as the Gen Xs and Gen Ys age. * The focus on dental is supported, however there is no mention of continence, hearing and vision. These are very significant omissions. Hearing and vision have a huge impact on the national economy and on prosperity and productivity indices. * More focus on people with an intellectual disability and ageing needs. Especially the ageing of the caregivers. * There is no reference list in the document. We need to make decisions being cognisant of the available evidence, business and clinical, and the gaps in that evidence and therefore our assumptions, levels of risk related to business models and potential mitigations.   General comments:   * Very health care system and health care professional focussed. Not very citizen, family or community focussed * Does not have enough facts and trends in the fore note to catch the interest of the community or the deliverers of health care. The ageing population and our expectations as a society represents a significant burning platform. We want everyone to engage and rise up to the challenge. We need to paint the right picture about the issue and then the vision moving forward. * A lot of the body of the document is very general. If it is a strategy it needs more focus and it needs to set the scene for transformational change. We need to be brave and bold but at the same time wise! * The Actions are limited and not very innovative – rather motherhood and apple pie. There are lots of areas that are not even mentioned and many disruptive potential options missing. * There is no evidence base provided at all, not even in describing the case for change * There is no business strategy - funding modelling and affordability modelling, CB framework, deliverables and outcomes measures. As such it is a clinical plan not a strategy. Think this is a missed opportunity. | |

Attachment received containing feedback from WDHB Risk and Audit on the text of the consultation draft.

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| **Submission 210** |

Notes provided in hardcopy and unavailable electronically

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| **Submission 211** |
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| Organisation (if applicable): | New Zealand Dental Association |
| Position (if applicable): | CEO |

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)

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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)*:

### 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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| Agree with the draft vision – Older people live well, age well and have a respectful end of life in age-friendly 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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| As background to our submission the New Zealand Dental Association (NZDA) wishes to bring to your attention to an important document relating to Older People’s oral health: **Our Older People’s Oral Health: Key findings of the 2012 New Zealand Older People’s Oral Health Survey** published in December 2015 by the Ministry of Health. From this document the Association wishes to emphasise the following.  **“Oral health refers not only to the absence of oral disease – primarily tooth decay and gum disease- but also to the contribution made to overall health and wellbeing, and quality of life.”**  The findings of this survey show that;   * Parallel to the ageing population in New Zealand there is also emergence of ageing dentate population. * As a result of older adults retaining more of their own teeth, there is significant unmet need. * Levels of untreated decay among dentate older adults is concerning with 61% living in residential care and 43% living in their own homes reported to have untreated coronal decay on one or more teeth. Furthermore, 34% living in residential care and 32% living in their own homes reported to have untreated root decay on one of more teeth * Only 29% living in residential care and 45.5% living in their own homes reported having ‘very good’ or ‘excellent’ oral health * One in five older adults living in residential care and a quarter living in their own homes reported that their oral health impacted their day-today functioning and wellbeing.   The NZDA wishes to highlight these challenges that should be considered as part of the background for action areas to improve oral health of older people;   * Like all New Zealanders, older people must have an acceptable level of oral health to socialise, eat, speak and be free of pain. * Since most oral diseases are progressive and accumulative over time, the risk of developing oral diseases increases with age. The Our Older People’s Oral health survey findings have highlighted significant unmet need among older people. * The results of this survey demonstrates the need for immediate actions to tackle poor oral health among older people, particularly those living in rest homes. * Oral healthcare for adults receives virtually no public funding in New Zealand, and without any immediate actions to address this issues, the increasing dental treatment needs compounded by co-morbidities experienced by older people is only expected to increase the burden on New Zealand’s public health system and health expenditure.   Oral health is closely related to general health and people’s quality of life. We cannot expect older people to live well and age well without improving their oral health. A decline in oral health and function can affect an older person’s health and can place considerable pressure on public resources. Since we understand that the actions set out in this draft strategy is critical we recommend including at least one of the action areas under the 🟏 category. Under action area 5 we recommend including action C “Disseminate updated information and advice on dental care to older people family, and carers in communities and aged care organisations”. This could be achieved effectively through the extension of current training programme offered by NZDA/MoH for caregivers of older people. The report prepared by the NZDA on ‘*Options for the achievement of improved oral health for older people through education of caregivers working in residential facilities and home support settings*’ identifies effective delivery method for such a training in New Zealand.  We also recommend the Ministry to consider forming an advisory panel of dental experts to develop appropriate referral pathways and to identify innovative care arrangements for oral health care of people living in aged residential 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?

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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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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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| We recommend;  Recognition that good oral health is an important element in the prevention and management of chronic conditions such as diabetes. This could be achieved by inclusion of oral health care services for people living with long-term conditions. |

### 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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| To consider inclusion of oral health indicator(s) for older people in the outcomes framework and indicators to assess, support and improve the oral health as well as health outcomes for older people. |

### Other comments

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| Engagement with the NZDA and other relevant bodies to discuss and establish ways to implement action areas suggested in this submission. |

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| **Submission 212** |

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| Organisation (if applicable): | AgedAdvisor |
| Position (if applicable): | Advisory Board Member AgedAdvisor, GM AgedAdvisor |

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)

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Do not publish this submission

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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 *(over 150 older people living in hospital and resthome care facilities have contributed to this submission)*

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)*:

### 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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| AgedAdvisor has approached over 400 ARC facilities and asked them to encourage their resthome and hospital care residents to complete the information sheet we put together for the Living well with long-term conditions section. We were aware that many ARC residents would be unable to complete a submission on their own but were very keen that their voice was heard in regard to how they saw their needs being met.  We have received feedback from over 155 residents and have collated it into one submission for this section which seemed to be the most relevant for those in ARC facilities to focus on. |

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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| 9. Support and training to deliver high –quality, person-centred care – (collated from over 155 individual responses of those living in ARC throughout NZ to the draft strategy)  While many residents are very pleased with the care they receive on a daily basis from their individual ARC facility most also had recommendations for improvement so that they would receive high-quality, person-centred care.  Key issues included   * ARC Staff Training Needs to be   + Regular   + On-going   + In-depth   + Compulsory for all   + Consistent   + Caring   + National Training Standards and Qualifications for caring * Integral elements of staff training should include * Courtesy/respect of older people * Resident focussed and resident friendly * ‘Kind Hands’, ‘Kind-touch’ with residents * Specialist care – medical, behaviour, mental health etc * Individualising care for each resident * Encouraging maintaining independence/autonomy * Change, loss and grief to help residents cope with physical transition to ARC and functional/mental decline * Knowledge of events/occasions within facility and in local community * Listening skills * How to deal with issues raised (listening/action) * Genuine caring, showing empathy * Caring is about people, Not profit * How to share resident information between staff * Increased staff / resident ratio   + Especially during the weekend and on night shift   + This would allow for staff to spend time with residents and really listen to what each person needs * Acknowledgement of the difficult job staff have   + Better pay   + Better conditions   + Incentivise training – link training with wages   + Appreciation of staff * Senior Management in ARC to be more visible and involved with residents |
| 10. Enhanced cross-sector, whole-of-system ways of working  Many residents in ARC felt that there was good communication about their needs and their condition/s between staff in the ARC and between GPs/Specialists. They also felt they were listened to in many cases. However they did believe that there were a number of areas for improvement   * Communication   + Keeping resident involved in the decision making about their care needs   + Keeping resident informed of personal matters   + Encourage family members to be more involved in overall view of resident   + Better information exchange between agencies so ARC is more accessible if needed rather than numerous hospital admissions   + Agencies to share information better (timely, without prejudice) all the time rather than at the ‘last hour’.   + ARC facility staff to action prescribed ‘support’   + Easier to keep track of all agencies in ARC much more difficult to do this in community setting   + More open communication between agencies and ARC, less gate-keeping * Individualised care   + Sleeping times and care needs of individuals met   + Medication dispensed to fit resident needs and lifestyle   + Resident issues need to be treated with importance and respect not trivialised   + Resident input encouraged   + Resident feedback encouraged   + Encourage residents to maintain as much autonomy as possible –including GP approved self-medication as needed * Administration   + Streamline paperwork so medical help is engaged sooner   + More staff in the weekend would reduce the breakdown in communication   + Resources shared equitably   + Care should be consistent and continuous * Residents in small towns need to be catered for within their community * Increased budget for operations that would improve quality of life of older people * Better management of older people transitioning different levels of care |
| 11. Expand and sharpen the delivery of services to tackle long-term conditions  A number of residents acknowledged that they were happy with the level of service they received to deal with their long-term conditions. Others, felt there was room for improvement.   * Ageing in Place should be seen to mean different things to different people rather than ‘pushing’ for older people to stay in their own homes   + All options offered to older person and their family so they can make an informed choice   + Care organisations need to provide consistent quality home care   + Better co-ordination of home care services   + Loneliness in own home needs to be acknowledged and addressed * Dementia and Special Care   + More training for staff   + All ARC to have secure care   + Endeavour to keep spouses in same facilities even if separate care levels   + More support for mental health * Spouse and family member carers   + Increased funding   + More support provided to carers at home   + Spouse/family who act as carer in ARC facility and then have to pay full price for care that isn’t given need to be compensated * Products need to be consistently available at no or reasonable cost (ie incontinence pads) * Clear guidelines about procedure for voicing concerns about inadequate agencies * Encouraging capable family members to take residents out rather than just visiting * ARC management to encourage team work * ARC management to minimise micro-management of staff * Regular checks and maintenance of individual and community disability aids in ARC * Increased staffing and consistency * GP workload reduced so they have more time to listen to older person rather than just prescribing medications ‘another pill for another ill’ * Individual residents needs meet * More outdoor activities for all in ARC * Ministry for Senior Citizens - fulltime |
| 12. Inform individuals and 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  Most people who replied were reasonably satisfied with being in an ARC facility at this time. While they did note things that might have helped them stay in their homes longer others said they had been well informed but that it was time for them to move in care for a variety of reasons including; giving family ‘peace of mind’, no younger family to provide support, health considerations, they wanted company, moving to be closer to siblings/spouse. Some older people in ARC facilities noted that they were still very much part of their community whether the ‘old’ community or the ‘new’ ARC one. Some also indicated that not everyone want to stay connected to a community.   * Easy access on all care options needed (without prejudice) * Better financial understanding of ARC * Ability to trail various ARC until ready to move in * ARC and community to be more involved * GP to have time to advise on help available and how to access this * Better access to health supports including earlier diagnoses of chronic conditions * Ministry of Senior Citizens * Home care support increased * More support for spouse carer so they can remain active in the community – early intervention * Kind empathetic neighbours * Help with completing forms * Ensure that all health providers include alternative health options * Important to have contact with family but maintain own independence * Encouraging positive outlook, gratitude, and mindfulness * Have plans in the event of ‘what if …’ * Having time to decide where is best to live |
| 13. Use new technologies to assist older people to live well with long-term conditions  Many replies from older people indicated that they were not very aware of the possibilities of technology and felt that a telephone was sufficient. Several acknowledged they had a computer or a cellphone. Others felt it was ‘beyond’ them to use it. Still others indicated they used various technologies to keep in contact with family. Several did not think that technology (robots) should replace human contact and were concerned about the expense of any technology.   * Therapy with pets * More day trips in nature, to the sea etc * Create better avenues for communication * Take, show photos – bringing back happy memories * Involvement with schools |

Attachment received that collected responses from aged care residents.

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| **Submission 213** |

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| Organisation (if applicable): | NGO Council of the  NGO Health & Disability Network |
| Position (if applicable): | Secretariat to NGO Council |

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)

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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)*:

### 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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| 1. Ageing is a natural part of life, so the Strategy should not ‘over-medicalise’ this period of life. 2. We are generally supportive of the high level vision and goals and the life course approach in the Strategy. However, "Given the poorer health experienced by Māori”, this acknowledgment seems to be an add-on rather than a commitment to a Māori lens across the whole Strategy: "this also involves delivering services that are effective for Māori.” (p13). It’s in the Action Plan that this matters most, but the Māori dimension needs to come through more strongly across the whole Strategy. 3. Related to this are issues relating to a potential growth in the ageing Māori population. In the next decades we expect that Māori will be living longer - but are the health and social services ready to support older Māori in ways that are appropriate for them? For example, in remote, rural areas – places such as Takapau see many young people leaving town and larger numbers of older people on low incomes without access to public transport etc. It is unclear how these older people will access services if they lose the ability to drive and don't have family members to provide transport. 4. The importance of community and whanau supports are vital as most older people (especially Māori, Pacific and Asian) stay in their own homes rather than go into residential care – this highlights the need for cross-sector work to address broader issues of housing, poverty, elder abuse, crime, scams and discrimination. It also raises issues of shifting responsibility to the lowest paid workers (e.g: home support staff). 5. From a public health perspective, there is too much reliance on government institutions to be leading what are essentially social changes in creating a more age-friendly society.    * The draft Strategy makes no mention of local government, which obviously has a much more local focus, and in many areas has a strong history of caring about and providing services for older people.    * There are mere tokens of acknowledgement of the role of Māori society, that has cried for a long time for greater support to enable them to care for their own. Where is Whanua Ora in this?    * Based on the current list of Actions, NGOs are considered as having only one useful function: to mobilise volunteers [1 (d)].      + 4 (c) is a good example of how the Strategy assumes that existing institutions have some capacity and capability to provide for people with whom they are actually quite out of touch:        - “Enhance health promotion and service information to Māori, Pacific and other ethnic communities and priority groups to enable greater care accessibility and engagement.”      + Community-based NGOs are well-placed to lead work in areas such as this.    * Rather than DHBs and primary care offering people “health promotion” and "service information”, the Ministry and DHBs should be enhancing the work of existing Māori, Pacific and other NGO health service providers already engaged with the people who need support and the communities that can provide it at grass roots level. 6. While many agree with the overall intent and direction and the key principles driving the Strategy, NGO providers have expressed disappointment that greater consideration has not been given to the mental health needs of older people. We well know that rates of depression are high in older people and are often exacerbated by loneliness and isolation. Much of this remains untreated. Despite the pervasiveness of these issues, mental health does not feature in the graphs of key conditions associated with ageing. This requires more attention, so a more in-depth look at the mental health needs of older people can enhance the current draft Strategy. 7. From a disability perspective it is good that the Strategy is linked clearly to the Disability Strategy, and acknowledges that disabled people will often have high and complex needs as they age. However disabled people as they age are not a homogeneous group. It would be useful to more strongly acknowledge that better support is needed for the population of older disabled people who throughout their lifetime often have not enjoyed the same level of health as New Zealanders as a whole. The particular challenges, of access and communication for example, which make it difficult for disabled people to access good health care, will be exacerbated by ageing. The development of action plan strategies for people with high and complex needs should particularly include the needs of disabled people. 8. As noted previously, various population groups experience inequity in health outcomes prior to reaching old age, so services need to be sufficiently flexible and responsive to deal with these variations and provide appropriate supports – not with a one-size-fits-all approach. 9. While the Strategy’s context (page 6) acknowledges the other inter-related strategies that also have potential to impact on the health of older people and the services they receive, it is not clear how this inter-connectedness will be managed in a practical sense. More work to build these connections and consistency will be required. |

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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| 1. A variety of non-government, non-profit service providers (NGOs) can play a supporting role in this action plan. In particular, NGOs are very good at visitations, predominantly working in people’s homes. There is an opportunity for community-based NGOs to play a role in:  * Supporting local interest groups (e.g. being the ears and eyes in the homes) in coordinating assistance to address any physical or social determinants of health.  1. Additionally NGOs could support and play a role in initiatives such as:  * 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 * Strengthen the capability of provider organisations to understand the range of health literacy needs of older people, and improve the accessibility and responsiveness of services. * Many lifetime support services for disabled people are provided by NGO agencies, and strengthening their capability to support people as they age - without assuming a need to change living situation and provider - would be beneficial in enabling a dignified life without undue disruptive change.  1. Some of the challenges limiting NGOs’ ability to do this more effectively are:  * Workforce training  (including raising awareness with GPs, etc of what services NGOs an offer) * Technological solutions and funding of these (including for individual clients) * Funding priorities that limit opportunities for prevention and innovation. |

### 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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| 1. Many non-profit NGOs are well placed to support this action plan. Of particular interest is the plan to ‘support other initiatives to reduce acute admissions, for example by extending paramedic roles, improving after-hours triage for aged residential care facilities, developing acute geriatric care pathways and applying technological solutions.’ 2. There are many challenges in achieving this aim, from funding to capability; however many NGOs, such as community ambulance services can play a key role in the provision of unplanned healthcare. 3. There is also potential for NGOs to be much more active in the assessment process – in fact DHBs should outsource assessment to NGOs. Some NGOs have made the observation that whilst the interRAI assessment process provides obvious benefits, there is potential for greater awareness and respect for the holistic needs of older people. Particularly for ageing disabled people who may have experienced holistic assessment and support services throughout much of their adult life. 4. Some NGOs are already active in areas such as falls prevention and rehabilitation, which can support the action plan initiative to:  * Develop, implement and review prevention and treatment of injuries for ACC and health clients. |

### 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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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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| 1. Issues of polypharmacy are not sufficiently considered in the Strategy. As people age and attend multiple health practitioners they frequently receive multiple prescription medicines, so they are at increased risk of harm arising from the drug-drug interactions. The Strategy is unclear about the need for ongoing medicines reviews for people taking 5 or more medications and whether there will be capacity for the health system to routinely do this? 2. Aligned with the issue of polypharmacy should be greater discussion about giving older people sufficient information to make decisions about their treatment goals. Because older people get treatment from multiple health providers (such as specialists for their heart, their arthritis, their eyesight and their cancer), frequently there is no one overseeing the total medicines picture and talking through with the older people what their aims are (e.g. they could stop taking one medicine that makes them feel awful, but will only realistically extend their lives by one or two months). This is both a polypharmacy and a health literacy issue. 3. Managing patients who are living with long term conditions is an area where non-profit NGOs are already active and ready to play a more pivotal role in the action to ‘Expand and sharpen the delivery of services to tackle long-term conditions’, not only in how we improve managing an acute or chronic (or exacerbation) situation that we see now, but through better planning of how community partners are going to manage conditions such as dementia. 4. Workforce capability development and partnering with other healthcare providers to develop local referral pathways, are required in managing many of these conditions in the community. 5. We are pleased to see that the importance of the kaiawhina workforce is recognised and promoted – particularly in this section and in restorative care – however issues related to training and employment conditions must not be underestimated. |

### 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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| 1. People with high and complex needs include those people who have had significant mental health challenges across their lifespan and who are now ageing. This group needs special attention and this has not been acknowledged in the Strategy. We know well that this group has seriously compromised health and higher levels of mortality, so many age earlier and do not make it to old age as they die early.  Non-profit mental health services find it very challenging when someone who has been in residential mental health services becomes older, as there is often little recognition of the complex physical and mental health issues that people experience. They are sometimes moved out of the ‘home’ into another facility for older people (because “they are taking up a mental health bed”), when they could have been better responded to in their existing ‘home’ if services were provided to them in-house by people equipped to support older people. Disabled people can be similarly affected by such policies/approaches. Equally problematic is that some older people’s facilities will not take people with pre-existing mental health issues when they do get to the point where they require a higher level of geriatric-related care. 2. The Strategy could be enhanced with greater recognition of the compounding physical health care costs (both personal and to the state) when mental health and addiction issues are not addressed. It is a well-known fact that addiction in older people (particularly alcohol and prescribed medicines abuse) still contributes greatly to other health care costs and this is perhaps not given the prominence it should be. 3. Non-profit NGOs can help reduce frailty in the community as part of the initiatives to:  * Explore possibilities for a frailty identification tool to enable primary and other health professionals to identify frail older people earlier * Integrate funding and service delivery around the needs and aspirations of older people, to improve health outcomes of priority population groups * Improve access to mental health and addiction services among older people with high physical health needs, and improve integration of these services with residential care or home care services * 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.   *And a new suggested initiative to:*   * Better integrate services for disabled people who have received lifetime supports to be supported appropriately and with dignity as they age without unnecessary disruptive change. |

### 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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| * We support the ‘respectful’ focus of this objective, but emphasise the need for this ‘respectful’ approach to come through in all services and be a focus for all providers and clinicians. |

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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| * Community-based NGOs can play a key role in supporting ‘greater palliative care closer to home’, however resources will be needed to develop the workforce and fund the services to deliver this – currently many hospices have to supplement government funding with other grants and donations to deliver services. |

### 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 is not clear, what part of the Ministry of Health will have accountability for implementation of the Strategy – while it has been developed by Policy staff, its implementation will result from a variety of service commissioning and funding decisions made in various parts of the Ministry and DHBs, etc. Who will take an overview and have overall accountability for the Strategy and the power and influence to direct change where this is needed? |

### Other comments

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| **About the NGO Health & Disability Network**  **Origins**  The NGO Health & Disability Network (formerly the Health and Disability NGO Working Group) has partnered with the Ministry of Health since 2002 to implement the [*Framework for Relations between the Ministry and Health and Disability NGOs*.](http://ngo.health.govt.nz/resources/ministry-health-publications/framework-relations)  The Framework identifies key areas (communication, consultation and capacity/capability building) where working together can strengthen the sector and achieve better health outcomes. It complements the [*Kia Tutahi Standing Together Relationship Accord between the Communities of Aotearoa NZ and the Government of NZ,*](http://www.dia.govt.nz/KiaTutahi)which was signed by the Prime Minister and many others in 2011.  **Network membership** We had 521 NGO members and 114 affiliate members on 30 June 2016.  (These NGOs range from small providers with one FTE employee, to large multi-million dollar agencies with more than 2,400 paid staff.)  98% of Network members are registered charities. Based on data from the Charities Register[[5]](#footnote-5), we know the following about these members:   * Member NGOs received $1.75 billion in combined annual government funding. * Member NGOs paid more than $1.53 billion in annual salaries and wages to 21,383  full-time staff and 18,295 part-time staff. * In an average week, a total of 1.2 million hours were worked by paid staff and 155,445 hours provided by approx. 36,598 unpaid volunteers. * 33% of member NGOs had a net annual operating deficit in their last reported financial year, so had to draw on reserves to continue delivering services.   The Network’s membership represents more than half of those not-for-profit NGOs that receive Vote Health funding to provide services in New Zealand communities.  The activities of the NGO Network extend far beyond the voting membership as many non-members attend Forums and workshops and provide feedback via Network projects and surveys.  **About the NGO Council**  The elected NGO Council connects with health and disability organisations to hear views and convey issues and ideas to the Ministry. The Council is made up of three Māori Health representatives, and two representatives from: Pacific Health, Mental Health and Addictions, Personal Health, Public Health, and Disability Support Services.  NGOs that receive Vote Health funding (i.e. have contracts with the Ministry of Health and/or DHBs) can register in a maximum of two categories, and are registered to vote as follows:   228 in Disability Support Services  117 in Public Health   147 in Mental Health and Addictions  116 in Personal Health   118 in Māori Health   24 in Pacific Health |

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| **Submission 214** |

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| This submission was completed by: | South Island Palliative Care Workstream (Sharon Adler) |
| Organisation (if applicable): | South Island Palliative Care Workstream |

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

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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)*:

x Māori  Regulatory authority

Pacific x Consumer

Asian x District health board

Education/training provider  Local government

x Service provider  Government

x Non-governmental organisation  Union

x Primary health organisation  Professional association

Academic/researcher x Other *(please specify)*:  
Regional Alliance

### 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?

|  |
| --- |
| * Healthy Aging goals are good. * Advance Care Planning (ACP) is missing from this section. As ACP is also part of living well (including establishing individual goals and priorities) we feel it should be more fully discussed here, rather than in the ‘Respectful End of Life’ section where it sits currently. To ensure all older people have the opportunity to participate in ACP it should therefore be incorporated into the current goals. |

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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| --- |
| * We are supportive of the actions. They help set the stage for the smoother transition, management and coping when the health deteriorates * Engagement in ACP could be part of the action points, as this would support increased resilience and help to establish a sense of control over the health for individuals * Linked with ACP could be communication skills training for health professionals to support the building of trust and partnership with patients when their health does deteriorate. It would also enhance effective engagement in ACP. |

### 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 goals miss out on the idea that acute care needs to be delivered in a way that prevents and/or minimises deconditioning. * The acute care environment needs to be alert to the deterioration of older people despite active treatment and the consequent risk of dying. Palliative care needs to be woven into acute and restorative care to ensure that symptom management is a priority and they have timely access to end of life care if needed. * Rehabilitation can begin while acute care is underway rather than waiting for it to be a separate phase. * Restorative goals are good. |

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?

|  |
| --- |
| * Agree with actions noted. * Include an action that addressees minimising deconditioning during acute care and starting rehabilitation concurrent with acute care where possible. * Please add a goal recognising the role of palliative care and the skills required to prepare older people and their families and whanau for death in the acute care setting, when the expectation was recovery. |

### 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?

|  |
| --- |
| * We are largely supportive of this section. * Specific mention that ACP is a very important component of this section would be useful (even though the detail of ACP will have hopefully been dealt with in the first section). This helps to set the stage for improving management of the transition to a more palliative approach in a timely and appropriate manner. * There needs to be some mention about supporting health professionals to recognise when it is appropriate to consider incorporating a palliative approach to care. This will also contribute to ‘living well with long-term conditions’. * The risks of social isolation, loneliness and complicated grief needs to be considered and included. |

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?

|  |
| --- |
| * We are supportive of the actions. * As per 1b above, please include an action for Advance Care Planning including adequate staff support and communication skills training. * An action outlining the training of staff in the timely transition to palliative care of people with long-term conditions is also required. These points could be incorporated into action point 9 and/or 11. |

### 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?

|  |
| --- |
| * As per 1a above, please include Advance Care Planning into section on Support for People with high and complex needs. * The need for clear links with specialist palliative care services is required as these are the very patients where a culture of excellence in decision-making, symptom management and transitioning to palliative care is vital. Preferences for care at the end of life need to be identified and not left until it is too late. |

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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| --- |
| * As per 1b above, please include an action for Advance Care Planning. * Action18, *Better integrate services for people living in aged residential care.* Please add a subgoal to build links with specialist palliative care services. |

### 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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| --- |
| * Really appreciate that this section has been included in the Strategy * Recommend the goal, *People talk comfortable about dying and preparing for death,* be first. * Add ‘integrated’ to the goal, *Technology improves integrated end-of life care*. Essentially this is aiming at the technology that will provide a shared medical record, which will integrate services and improve the quality of end of life care. * The final goal may be expressed more clearly as follows: *“Expert advice and support is available to families, whanau and the healthcare workforce during the end of life phase”.* * We recommend a wording change in the final sentence in left column, bottom of page 27, to “*We should expect … respectful, high-quality, timely palliative care [rather than service] at the end of life”.* Palliative care is an approach to care, rather than a service. * We would also suggest reference to the National *Last Days of Life* guidance document, ‘*Te Ara Whakapiri’.* * The vision should include palliative care being provided in a timely manner (which ACP and forward clinical planning will facilitate). * ACP is better placed in the first section, as if it is primarily dealt with in this section, the implication is that ACP is about end of life. Rather ACP is about all future healthcare, and the ACP process should be incorporated into a person’s healthcare journey early. * The goals in the respectful end of life section need to be tightened up and re-ordered. All are relevant and necessary however could be better written. |

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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| * Need an action to normalise/socialise concepts of death and dying as a normal part of family life. * Action *#22 Ensure widespread and early participation in advance care planning* needs a part b. *The Health Care System understands and implements Advance Care Plans*. * Include communication skills training in order to support and achieve effective and timely conversations with patients and families about the transition towards end of life. * Appropriate implementation of Advance Care Plans also needs to be specifically mentioned. |

### 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?

|  |
| --- |
| * We support the use of a co-design approach in the development and review of services. |

### Other comments

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| * Thank you for the opportunity to participate. * We are of the understanding that each section is not meant to be mutually exclusive, and that although aspects of care may be discussed in one section, they may also be relevant to another section. Could this be made more explicit in the introduction? * We congratulate you on the excellent VISION statement on page 13. |

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| **Submission 215** |
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| Organisation (if applicable): | Nelson Tasman Hospice |
| Position (if applicable): | Nurse Practitioner |

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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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

**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?

|  |
| --- |
| We are mainly supportive of this section. Of note, Advance Care Planning (ACP) is missing from this section. As ACP is also part of living well (including establishing individual goals and priorities) we feel it should be more fully discussed here, rather than in the ‘Respectful End of Life’ section where it sits currently. To ensure all older people have the opportunity to participate in Advance Care Planning should therefore be added to, or integrated into, the current goals. |

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?

|  |
| --- |
| We are supportive of the actions. We feel they help set the stage for smoother transition, management and coping when health deteriorates. Engagement in ACP could be part of the action points, as this would support increased resilience and helps to establish a sense of control over their health for individuals. And linked with this could be communication skills training for health professionals – to support the building of trust and partnership for when health does deteriorate, and effective engagement in ACP. |

### 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?

|  |
| --- |
| We are generally supportive of this section. It would be good to see something about the need to prevent or minimise deconditioning during the acute care phase. |

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?

|  |
| --- |
| We have no specific comments to make. |

### 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?

|  |
| --- |
| We are largely supportive of this section. Specific mention that ACP is a very important component of this section would be useful (even though the detail of ACP will have hopefully been dealt with in the first section). This helps to set the stage for improving management of the transition to a more palliative approach in a timely and appropriate manner.  In addition to the four bullet points at the beginning of this section, palliative care often becomes a component of care for people living with long-term conditions, when disease-modifying treatments are becoming more limited or no longer possible. This does not necessarily mean the person is approaching end of life, and often a palliative approach is provided alongside some active, disease-modifying treatments. Perhaps there needs to be some mention about supporting health professionals to recognise when it is appropriate to consider incorporating a palliative approach into their care – which of course also contributes to ‘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?

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| --- |
| We are supportive of the actions. In addition, please consider incorporating the need to initiate and re-visit ACP conversations, and ensuring adequate staff support and training to do so – this would include communication skills training as an important component. Please also consider adding an action around training in the timely and appropriate incorporation of a palliative approach or treatments into the care of people with long-term conditions – these points could be incorporated into action point 9 and/or 11. |

### 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?

|  |
| --- |
| We are supportive of this section, although we have a couple of suggestions. It is particularly important for this group of people that ACP together with clinical planning is initiated/re-visited as a priority, in order to support a smooth, timely transition to palliative care if/when this becomes appropriate. The need to recognise when a palliative approach would be beneficial is also particularly important for this group of people. |

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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| --- |
| It would be useful if ACP and palliative care training and support relevant to long term conditions, is incorporated into the goals. |

### 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?

|  |
| --- |
| * We really appreciate that this section has been included in the strategy. * We recommend that the goal, *“People talk comfortably about death and dying”* be the first goal in the list. * We would suggest that ‘*integrated*’ be added to the goal, “*Technology improves [integrated] end of life care.”* * The final goal may be expressed more clearly as follows: *“Expert advice and support is available to families, whanau and the healthcare workforce during the end of life phase”.* * We recommend a wording change in the final sentence in left column, bottom of page 27, to “*We should expect … respectful, high-quality, timely palliative care [rather than service]at the end of life”.* Palliative care is an approach to care, rather than a service. * We would also suggest reference to the National Last Days of Life guidance document, ‘Te Ara Whakapiri’. * The vision should include palliative care being provided in a timely manner, which ACP and forward clinical planning will help with. * As stated previously, the detail of ACP is better placed in the first section, as if it is primarily dealt with in this section, the implication is that ACP is about end of life. Rather ACP is about all future healthcare, and the ACP process should be incorporated into a person’s healthcare journey early. |

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?

|  |
| --- |
| We are largely supportive of these actions, taking into account the recommendations above. We would also suggest incorporating the need for communication skills training in order to support and achieve effective and timely conversations with patients and families about the transition towards end of life.  Appropriate implementation of Advance Care Plans also needs to be specifically mentioned, we feel. |

### 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?

|  |
| --- |
| We support the use of a co-design approach in the development and review of services. |

### Other comments

|  |
| --- |
| We are of the understanding that each section is not meant to be mutually exclusive, and that although aspects of care may be discussed in one section, they may also be relevant to another section. I wonder, if this is correct, whether this needs to be made more explicit in the introduction.  Thank you for the opportunity to participate in this important review. |

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| **Submission 216** |
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| Organisation (if applicable): | Southern DHB |
| Position (if applicable): | Portfolio Manager, Older People, Planning & Funding |

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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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?

|  |
| --- |
| * This section is missing any reference to Advance Care Planning, which would give older people, while they are still healthy, the opportunity to think about what is important to them as they age. * Healthy Aging goals are good. |

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?

|  |
| --- |
| Recommend adding an action for Advance Care Planning. |

### 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 goals miss the need for deconditioning to be prevented or minimised during acute care delivery. Also rehab should begin while acute care is ongoing, rather than waiting for it to be a separate phase. * Restorative goals are good. |

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?

|  |
| --- |
| * Agree with actions noted. Please add action that addressees minimising deconditioning during acute care and starting rehab simultaneous with acute care where possible. * Please add action to write National Service Specification for Assessment, Rehabilitation and Treatment 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?

|  |
| --- |
| * As per 1a above, please include Advance Care Planning into section on Living Well with Long Term Conditions. * Need a goal to redesign Primary Care to support 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?

|  |
| --- |
| * As per 1b above, please include an action for Advance Care Planning. * Include goal to redesign Primary Care to support Living well with long-term conditions. |

### 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?

|  |
| --- |
| * As per 1a above, please include Advance Care Planning into section on Support for People with high and complex needs. * Need goal to redesign Primary Care to support people with high and complex needs, allowing primary care to deliver more pre-emptive rather than reactive care. |

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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| --- |
| * As per 1b above, please include an action for Advance Care Planning. * Please add action to redesign Primary Care to support people with high and complex needs, allowing primary care to deliver more pre-emptive rather than reactive care. * Include action to write National Service Specification for Needs Assessment and Service Coordination Services that includes the role of interRAI and Case Management where required. * Action 18 *Better integrate services for people living in aged residential care*, both actions a) and b) need to address ‘in hours’ in addition to after hours. |

### 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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| * Recommend the goal, *People talk comfortable about dying and preparing for death,* be first. * Add ‘integrated’ to the goal, *Technology improves integrated end-of life care*… . Essentially this is aiming at the technology that will provide a shared medical record, which will integrate services and improve the quality of end of life care. * The final goal, *The Health system educates, supports and advises family and whanau of dying people and the health workforce in meeting the needs of people receiving end-of-life care*, is very clunky. *Expert advice and support is available to families, whanau and the health workforce involved in end of life care* is a bit more clear. * Really appreciate that this section has been included in the Strategy. |

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 an action to normalise/socialise concepts of death and dying as a normal part of family life. * Action *#22 Ensure widespread and early participation in advance care planning* needs a part b. *The Health Care System understands and implements Advance Care Plans*. |

### 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 |

### Other comments

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| * Vision: *Older people live well, age well and have a respectful end of life in age-friendly communities*, is excellent. * Life course approach is excellent. |

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| **Submission 217** |
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| Organisation (if applicable): | The Nathaniel Centre |
| Position (if applicable): | Director |

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)

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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)*:

### 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 agree with this vision, in particular the need to address social and environmental risks and the importance of growing age-friendly communities. However, we notice that the Strategy vision does not address the underlying social, cultural and institutional drivers that are contributing to the present context and are impacting negatively on the health and wellbeing of the elderly. Two major and often under-emphasised risks for the elderly at present are loneliness and abuse/neglect. For example, the New Zealand Longitudinal Study of Aging described only a minority of participants as ‘not lonely’ (48.8 percent); the rest were considered ‘moderately lonely’ (41.2 percent); ‘severely lonely’ (7 percent); and ‘very severely lonely’ (3 percent). Age Concern reports that it receives 2000 referrals each year of older people facing abuse (financial, physical, sexual and psychological) and neglect, and it is generally accepted that only 16 percent of actual abuse incidents reach service agencies. |

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?

|  |
| --- |
| We agree with the actions and in most cases the priorities seem about right. We do have concerns about the choice of the ‘lead’ agency in some cases; for example, Item 1: ‘Build social connectedness and wellbeing in age friendly communities’ has 3 ‘lead agencies’ listed as well as NGOs; this is a critical and large task and to be done well would require significant input across several sectors (health, housing, social welfare, local councils, NGOs, local community groups), as well as public awareness campaigns. We also have some concerns about the level of involvement of the elderly themselves; given that this is about them, and if the changes are going to work for them, they need to be engaged and participating - ‘leading’ from the grassroots level; ‘nothing about them without them’. |

### 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?

|  |
| --- |
| No comments. |

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?

|  |
| --- |
| Priorities seem about right. |

### 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?

|  |
| --- |
| No comments. |

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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| P. 20 notes that ‘we can expect the numbers of people living with long-term conditions to increase as our population ages’ and that ‘increasing numbers of people will be caring for and supporting family and whanau members’. However, apart from ‘d. Develop a range of strategies to improve recruitment and retention of those working in aged care’ [it is not clear what ‘improve recruitment’ means] there appears to be no intention to actually grow the trained workforce – health professionals, allied health workforce or carers. In addition, family members are now, in most cases, all fully engaged in the workforce, not necessarily by choice but rather necessity; it is difficult to envisage where the ‘increasing numbers of people caring for family and whanau members’ will come from. |

### 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?

|  |
| --- |
| No comments. |

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?

|  |
| --- |
| No comments. |

### 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?

|  |
| --- |
| We agree with this vision and in particular the focus on preparing the health system for future palliative care needs. Demographic trends showing an aging population will mean there will be a growing need for palliative care services for some years to come, as is noted on p. 27. |

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?

|  |
| --- |
| We have concerns about the emphasis on the use of ‘an advance care plan’, particularly in the way it is often viewed, and is signalled here – as ‘a plan’, often static, that is prepared in advance and used by health professionals and families as an indicator of the elderly or dying person’s present wishes. People change their minds, especially when they experience an illness or disability that they previously only imagined. We much prefer the concept of ongoing ‘conversations’, rather than plans, with families, carers and health professionals. We support the idea of a ‘health care proxy’ someone known to and chosen by the patient, with whom the patient has regularly discussed their wishes.  While the ageing population is noted, p.27, there is little reference to the need to grow the palliative care workforce or palliative care services. Point 23 is titled ‘Build a greater palliative care workforce closer to home’. However, the ‘actions’ listed refer only to incorporating core elements of end-of-life practices in standard practice for health workers and using new technologies to support people in their homes. In view of the well-established fact of the increasing elderly population, we consider that planning for an increase in the need for palliative care services and palliative care workforce should be a priority. |

### 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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| --- |
| We support the proposed actions; in particular the inclusion of older people in the implementation process. We consider that this group should be engaged in all aspects, it is about them, and just as other groups are ‘consulted’ on matters that affect them, so too should the elderly be consulted and engaged in the process. |

### Other comments

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| **Submission 218** |
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| --- | --- |
| Organisation (if applicable): | Grey Power New Zealand Inc. |
| Position (if applicable): | Secretary/Advocacy Co-chair, Chair Health Advisory Group, Chair Aged Care and Retirement Villages National Advisory Group (respectively) |

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)

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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)*:

### Healthy ageing

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

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| Grey Power understands that the vision/goals as presented in the strategy are very worthy; however, they take little cognizance of either individual attributes, some of which are outside a person’s control or the likely cost to the tax-payer of achieving optimum health for people as they age.  ▶ The vision statement uses nice flowery words but there will always be sick older people. Prevention of illness will work for some but not everyone. The strategy needs to reflect on those who become unwell as well as those who are fortunate to enjoy good or reasonable health.  Our concern therefore is that the vision concentrates on the benefits of ageing for those who are able to enjoy good health but as stated by J. Davey and K. Glasgow “those who make demands on health … services may be stigmatised and blamed for not making sufficient preparation or taking due responsibility for their health and well-being.”[[6]](#footnote-6) This is problematic because although there is an appreciation that individuals have some responsibility for their health there are a range of factors, often outside a person’s control, such as socio-economic, environmental, cultural and genetic which are implicated.[[7]](#footnote-7)  ▶ Grey Power policy is to support vision statement four regarding age-friendly communities  **Recommendation:**  ▶ Grey Power recommends that the government appoint an older peoples’ commissioner to assist healthy ageing by speaking out for older people especially those who are vulnerable, and at risk of social isolation, discrimination and to ensure that they receive the support and services they require. The Ageing Well in Wales experiment has disclosed that their commissioner works to make Wales a good place to grow older.[[8]](#footnote-8) |

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing. 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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| Action 1.a – Grey Power believes this should be a high priority although there is no detail on how these actions will occur. For instance, how do age-friendly communities prevent illness? The strategy needs to explain this.  However, we think that the top priority should be action 1.c. This action would at least start to overcome social Isolation and the availability of health services for those who cannot afford them. Action 1. d should also be a higher priority  Action 2. a and action 3. b, & e, - Grey Power concedes that they are important but action 5. a, b & c should have high priority.  **Recommendation:**  Grey Power recommends that a genuine effort be made to take account of the structural and individual factors which play a part in healthy ageing.  For instance, some services which are required to ensure healthy ageing are not readily available to many older people. It is well-known that poor oral health, hearing impairment, visual disability and other conditions contribute to ‘systemic health problems’[[9]](#footnote-9) and Grey Power is well aware that many of its’ members and other older people cannot afford to visit the dentist or to obtain hearing aids and that surgery for cataracts is quite severely rationed. |

### Acute and restorative care

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

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| Grey Power agrees that the vision/goals outlined in this part of the strategy are commendable. However, we wish to comment on the vision statement 5.  If support to reduce further hospitalisation etc. is to be realised the underpinning factor is adequate government funding to supply the care required. We have been told that often the support is provided for too short a time - older people can take much longer to recover and that the constant cutting of home support erodes the wellbeing of many people.  **Recommendation:**  Grey Power recommends that support is more available and accessible. And that greater emphasis be placed on the affordable access to doctors and other health professionals because early intervention is likely to reduce further hospitalisation and achieve healthy living and independence. |

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care. 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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| Grey Power endorses the actions to assist in goal achievement but we are uncertain whether action 7.a is the top priority although we would agree that 7. b, statement 4 is essential. Nevertheless, supported discharge with home and community assistance must take cognizance of the fact that there are older people without home support.  We also request that action 6. a. especially discharge planning is noted. This raises concerns because from our experience this planning needs to be better implemented. It is not in a patient’s interest to be asked as they are leaving the ward if they require home-help. Discussions and proposed actions should be discussed with family and professionals long before discharge.  Also we have heard stories of older people discharged late at night or early morning who have difficulty obtaining transport home to an empty house, or people who have been transported to a hospital out of their district by ambulance and who are unable to find affordable transport home. Also the support for rehabilitation etc. through partnerships with health professionals and family and whanau, in some cases may be wishful thinking by the Ministry of Health because, as stated above, not all older people have family available to assist with the provision of care  In fact, “keeping in touch face-to-face declined with increasing age, while staying in touch by phone increased. Older New Zealanders were less likely than younger people to have face-to-face contact as their main way to keep contact with supportive family living in the same town.”[[10]](#footnote-10) And we know that much more than a phone conversation is required to assist older people who are recovering at home after receiving either planned or urgent hospital treatment  Perhaps the desire to reduce/protect Government spending is part of this strategy. |

### Living well with long-term conditions

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

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| As a vision Grey Power commends this but overall we are concerned about the viability of the goals. For instance, the first point of improved methods of early detection and prevention of long-term conditions or frailty will not help vulnerable people who cannot afford to visit the doctor and delay seeking help until it is too late to prevent such frailty. And although we are aware that the OECD poverty line indicates that older people have an adequate standard of living, the EU income indicator discloses that the picture is not so rosy. If this strategy is a ten year or more project the situation will worsen because the current protective components of New Zealand superannuation and high home ownership are not guaranteed.[[11]](#footnote-11) Therefore we are concerned because ‘there is a close correlation between low socio-economic status and poor health’ as we have stated already |

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions. 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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| Actions 9. a, c, d, f - Grey Power recognises that there is a need to regularise and improve training for the caring workforce etc. and Grey Power has long advocated on this issue; however:  ▶ Is the Ministry prepared to fund the providers to pay care workers extra in recognition of their levels of training achieved? We believe until such time as this happens there will continue to be a high turnover of unskilled and underpaid care workers.  ▶ Will the Ministry of Health take a more proactive oversight into how District Health Boards are providing training especially for family carers? This is an area where saving money seems to be the dominant factor for District Health Boards.  Actions 11. a, b, c, d, e, g, h, - Grey Power agrees that all these actions are necessary to expand and sharpen the delivery of the services mentioned but we are concerned, given that the health sector has been under-funded for years and is not keeping pace with health needs across the board[[12]](#footnote-12),[[13]](#footnote-13) that if these actions are prioritised other crucial health funding areas will miss out  Action 12. a – Grey Power agrees that this is an admirable action but we have no details of how this will occur.  Action 13. a & b – the use of new technologies is problematic for many of Grey Power’s cohort. The Minister of Seniors (Grey Power annual general meeting – April 2016) has told us that approximately 35% - 40% of older people are able to access and use computers, tablets and smart-phones etc. From what we hear it is the older group – those in their late 70s, 80s and up (those more likely to be living with long-term conditions) who are unable or do not want to use this technology. Therefore, although we know that the up-take will increase we are concerned that this group are dis-enfranchised now and will be in the near future. |

### 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. Do you have any comments or suggestions regarding this vision?

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| Once again Grey Power commends the vision although the practicalities of achieving the goals, given experiences of older people that we are aware of, will require considerable motivation from funders to reverse many of the current practices that occur and also vary between DHBs. For instance, it will be necessary for the Ministry of Health to look into which facilities closer to people’s homes have been closed down. |

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs. 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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| Action 14. a, – Grey Power would support the concept of a frailty identification tool but this support is subject to answers to the following: which questions would the tool contain, who would administer it and how it would be administered etc.  Assuming the end result of the tool, after frail older people have been identified earlier, is to decide on the services required, DHBs need to recognise that they have to provide the care that has been assessed as necessary. The sooner a case mix system is in place so that all in need receive similar care where ever they live, the better.  Action 18. a & 20.c, – Grey Power would support these but we are unsure whether they are top priorities.  Action 20. b, - We understand that this is aimed at keeping carers in paid work outside of their caring duties and although we are aware that there are social and economic advantages to this we would hope that which-ever options are decided upon the well-being of both the carer and the cared-for would have top priority, remembering that well-being encapsulates more that economic productivity or a way to save tax dollars at the expense of carers. |

### Respectful end of life

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

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| --- |
| Grey Power endorses the vision/goals |

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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| Action 22. a – Grey Power believes that patient-centred care comes ahead of awareness of advanced care planning and enduring powers of attorney. The level of palliative care needs to be increased, then the public made aware of the improved service available.  Action 24. b - Grey Power endorses Te Ara Whakapiri: Principles and guidance for the last days of life especially the seven principles which include care as person-centred, as respectful, individualised and tailored to the person who is in their last days of life, communication is clear and respectful, transitions of care are seamless, services are sustainable, services are flexible enough to be able to be provided across all health care settings and to cater for variations in population needs and access to resources and equipment is consistent nationally. Plus, that the workforce providing care is the right workforce. Consequently, this action should be implemented immediately.  **Recommendation:**  Grey Power recommends that:  ▶ DHBs take more responsibility for ensuring that those sent to satellite hospitals for palliative care are treated like those in a recognised hospice. There are a number of these places where palliative care patients are placed in geriatric wards and treated by geriatric trained nurses. These patients and their families deserve the same treatment as those in a hospice.  ▶ Age care residential providers be required to provide more palliative care along with a payment system to provide this care.  ▶Adequate funding is provided for rural district nurses who supply palliative care.  ▶ The patient’s comfort and dignity and the assistance to their family must be paramount. Therefore, outcome statement one - a respectful end of life, tailored to the physical, emotional, social and spiritual needs of an individual and their family and whanau be implemented. |

### Implementation, measurement and review

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

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| Action 25. a – Grey Power agree that an immediate implementation plan is essential  Action 26. d, e & f – Grey Power endorse the inclusion of older people in all aspects of the service design, development and review and other decision-making processes. Inclusion in DHB regional forums must be a compulsory requirement.  Action 27. a, c & d – We believe that progress evaluation which involves the concept of person centred and focuses on healthy ageing and independence is essential however where is the client power in the monitoring and review of processes in the implementation of the strategy?  Action 28. b & c - Grey Power considers that all providers need constant monitoring of the implementation if the strategy is to work and that the older people who are affected by the negative health issues must be part of constant improvement of the knowledge base, especially through the use of qualitative research  If the implementation etc. is to be monitored only by Government Departments and DHBs then this whole consultation process becomes a token gesture.  **Recommendation:**  Grey Power recommends that progress evaluation, as noted above, be a central plank to this strategy because we understand that no published evaluation of the 2002 strategy by the Ministry of Health occurred and that the objectives of the strategy had not been achieved by DHBs during the term of the strategy. [[14]](#footnote-14) |

### Other comments

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| Grey Power would like to comment on the following:  ▶The older peoples’ health strategy is built on the New Zealand health strategy which states that:  ‘All New Zealanders **live well**, **stay well**, **get well**, in a system that is **people-powered**, provides services **closer to home**, is designed for **value and high performance**, and works as **one team** in a **smart system**.[[15]](#footnote-15)’  We are concerned, as were the Council of Trade Unions in their submission regarding the up-date of the New Zealand Health strategy, that the above vision is not clearly defined. The phrase ‘live well, stay well, get well’, is less appropriate than ‘start well, live well, end well’[[16]](#footnote-16) - it seems to us that this latter statement is more appropriate for older people.  Definition of the term ‘people-powered’ is also of interest. Grey Power hopes this means genuine involvement, i.e. older people as partners, at all levels, and we are most disappointed at the omission of consumer and client input.  Also although Grey Power appreciates the ‘close to home’ access for older people, will that mean that equity, accessibility, and quality are assured, given that we have already been involved with two research projects (The Aged Care Report and Caring Counts) which disclosed that the workforce are poorly paid, some are insufficiently trained etc.? [Ibid].  ▶ Social investment theory – Grey Power is a little anxious about the ‘social investment’ explanation provided on page 10 of the draft strategy which on the surface appears beneficial but in reality is only concerned with half of the cost/benefit analysis. Cost to the government seems to be the focus and does not appear to be balanced by benefit to individuals and the community [Ibid].    Family and whanau – Grey Power would like to reiterate their belief that the strategy places too much emphasis on the family providing care. In some instances, family members do not live close or have the time due to work commitments to care for older family members. The strategy needs to face up to reality. Younger highly paid people do not understand the needs of older people.  We wish to thank the Ministry of Health for the opportunity to respond to their draft document because older peoples’ health is probably one of the foremost issues which our approximately 65,000 members request us to advocate on and their concerns underpin many of the comments made in our submission. |

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| **Submission 219** |

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

Consumer

### 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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| --- |
| Could have been worded far more simply. Really, nothing new. |

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?

|  |
| --- |
| Broadly speaking, yes. |

### 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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| --- |
| Working WITH people- yes! Mid central DHB well down this route. |

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?

|  |
| --- |
| Yes- common sense prevailing? What is the purpose of a national hip fracture registry? Didn’t realise that “leads” actually speak to each other? |

### 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?

|  |
| --- |
| “Access to technology” (3rd line)- are “you” going to buy me a computer or restore my sight ot enable me to use one? |

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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| --- |
| 9f- Discriminatory! Aren’t we all simply people who live in NZ? Not a lot new in this section. |

### 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?

|  |
| --- |
| We’re back in the arena of common sense. |

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?

|  |
| --- |
| Yes. What’s a “frailty identification tool”? That’s a new phrase of “speak”. |

### 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?

|  |
| --- |
| I have clear and personal views as to the NEED to legalise euthanasia. |

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?

|  |
| --- |
| Locally, these topics have and are still being widely explained and discussed. Horses to water? Consumer responsibility and choice. |

### 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?

|  |
| --- |
| A lot of this already happen within the DHB area, and is being developed further. |

### Other comments

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| --- |
| Why is NZ so dislocated that it has 20(?) DHBs, all defensively protecting their services? The variability of services throughout the country is shocking. How about ONE national health service? All GPs should be WITHIN the system- who trains as a doctor wanting to “run a business”? Too much talking/discussing/consulting- too many words- how about some action?  *From an 80 year old resident, wholly reliant on State Superannuation and a little Disability Support.* |

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| **Submission 220** |

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)

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)*:

Consumer

Maori

Pacific

Other- retired South Island Alliance Older Persons representative, former Greypower NZ representative

### 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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| All **words.** What if it all goes well as suggested and then there is a major happening and another journey or pathway is needed. |

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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| As above- Arthur Lydiad was really fit and healthy and he died. Also my younger sister who was healthy as notes and she is no longer here. Good plan but help not readily available. Why change something that is working and set up another!! **Words!!** |

### 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 all individuals and there will be wide variations in our support people. Live alone can be a challenge. Assessment tools is only as good as those involved. **Words again.** |

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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| You need to be doing this with the current people- there needs to be something to grow from. Not enough support now. Now do you empower the **consumer?** |

### 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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| **TOOLS?** What does this mean; also there needs to be support that is available when needed not 2 years away. Use the **now**  to look to progress to the future! |

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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| This section is a challenge indeed, once again a lot of **WORDS & TOOLS??** If this could be available now and then progress on. We are all human beings with needs. |

### 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’s a lovely vision! However if a person lives alone, needs support to have the energy to go forward, therefore need more people trained eg. The walking in other people’s shoes training. Training people-oriented. |

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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| Choice!! Consumers need to know what is available- health professions (GPs, nurses, hospital staff, ALL). Need for navigators outside of family. I have put in capitals YES- HOW?? |

### 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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| Respectful for who? As one grows older a planned end of life can change- advance planning needs to be continually updated. Final sentence my question is “TO WHOM” mean final sentence pg 27. |

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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| Yes- but question costs? Add spiritual needs to the cultural needs. Once again these are **words** when does the person get to have a conversation and **with whom?** |

### 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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| I have made lots of comments on this page- how were the older people involved as individuals or was this organisations and government leaders, were people shoulder-tapped. How will the process be to include reps on DHB regional forums |

### Other comments

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| I needed to be resuscitated 10/9/14 and the journey is not available so would suggest that what happens to people now needs to be happening so can plan for the future.  I felt pg 36 one of the most important- you can target the future, however what about the now?  This appears to be judgemental, however as a person who has been involved as a consumer for many years and is aware of how things are, and now as an isolated older person of 85 years who is trying to do all as this paper says and finding the pathways not easily available, so anything in this paper that may help to support those in the future would be great. I knew the pathways but they were not readily available. If one has a condition for the first time then one does not know the pathways they may travel.  Thank you for the opportunity to comment. |

1. http://basicincome.org/news/2015/06/finland-new-government-commits-to-a-basic-income-experiment/ [↑](#footnote-ref-1)
2. https://www.theguardian.com/technology/2016/jun/22/silicon-valley-universal-basic-income-y-combinator [↑](#footnote-ref-2)
3. <http://basicincome.org/news/2015/04/guy-standing-the-growing-precariat-why-we-need-a-universal-basic-income/>; https://thestandard.org.nz/ubi-universal-basic-income/ [↑](#footnote-ref-3)
4. <http://www.interest.co.nz/opinion/83184/bernard-hickey-says-surge-low-skilled-migration-frustrating-natural-forces-supply-and> [↑](#footnote-ref-4)
5. [Charities register data](https://www.charities.govt.nz/charities-in-new-zealand/the-charities-register/) downloaded 15 August 2016. Data is only as accurate as the information provided by listed charities. [↑](#footnote-ref-5)
6. Davey, J & K. Glasgow (2006) Positive Ageing – A Critical Analysis, *Policy Quarterly,* Vol 2 p.25 [↑](#footnote-ref-6)
7. Healthy Ageing Evidence Review - http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Health-and-wellbeing/Evidence%20Review%20Healthy%20Ageing.pdf?dtrk=true [↑](#footnote-ref-7)
8. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/498776/future-ageing-in-wales.pdf> [↑](#footnote-ref-8)
9. Healthy Ageing Evidence Review - <http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Health-and-wellbeing/Evidence%20Review%20Healthy%20Ageing.pdf?dtrk=true> &

   Koopman-Boyden, P. S. van der Pas \* M. Cameron, *Wellbeing – Social Connectedness and Economic Standard of Living among 65 – 84 Year Old in New Zealand – 2007,* Working Paper 9 – Presented to the NZ Ass of Gerontology Conference, Hamilton 14-16 November 2007 [↑](#footnote-ref-9)
10. Statistics New Zealand (2015). *How supportive are our families?* Retrieved from www.stats.govt.nz. [↑](#footnote-ref-10)
11. Waldegrave, C. (2014) Old and Poor or Old and Cared for? Some policy reflections on data from the first two waves of NZLSA, *Policy Quarterly,* 10 (3) p.60 [↑](#footnote-ref-11)
12. Bagshaw, P. (2016) Our health care system is falling behind, *The Press,* A7, 5/09/2016 [↑](#footnote-ref-12)
13. Rosenberg, B, (Policy Director/Economist, NZCTU), Keene, L. & Director of Policy and Research, Association of Salaried Medical Specialists, *Paper on Health Number 14, 7 June 2015. Did the Budget provide for Health, 2015*

    [↑](#footnote-ref-13)
14. See the Hope Foundation Report – author L. Stewart, the NZCCSS document, *Help Shape a Strategy for Health of Older People,* July 29 2015 and the Horn Report 2009 [↑](#footnote-ref-14)
15. Health of Older People strategy – consultation draft (2015) p. 5 [↑](#footnote-ref-15)
16. Rosenberg, B, (Policy Director/Economist, NZCTU), December 2015, *Up-date of the New Zealand Health Strategy,* Submission to the Ministry of Health, p.6 [↑](#footnote-ref-16)