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

**Consultation submissions**

**1 – 67**

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| **Submission 1 withheld at submitter’s request** |

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| **Submission 2** |

I would like to congratulate MoH for the way this strategy has been updated and I believe it has captured the key issues for older people.

This submission represents my views it is not on behalf of an organisation

My background is as a gerontology CNS for 5 years and for the last year Gerontology NP, my focus has been supporting patients and staff in residential care environments, so the most frail and most vulnerable of the older adult (OA) group.

Residential care related comments:

Hospital /ED presentations – it would be good to see national data collection for this, so we are really clear what we are talking about. The only way I have found to do this effectively is to filter planning and funding payment data with hospital presentation data (this has an error rate of the percentage of private paying individuals for ARRC care). The other piece of data that needs to be collected is the volume of presentations by an individual in the year before admission to ARRC compared to the volume of presentations to ED for the same individual after admission to ARRC – this would I am sure reduce some of the rhetoric about hospital being full of people from ARRC. It would also allow a focus on the “at risk of ARRC” group

Workforce if

* MoH really wants more nurses keen to work in ARRC something has to be done to improve industrial issues, pay parity with DHBs, safe on-call rostering (rather than on-call being expected of clinical nurse leaders for some 24/7 often without pay), paid release for professional development (not compliance education). MoH could put pressure on DHBs to open libraries to non DHB health professionals, open education sessions to non DHB,
* Grow alternatives to GP services in ARRC. Develop a funding model that encourages NPs and CNS teams (developing NPs) to service ARRC (NPs can buy GP supervision/support as required). A model similar to the independent midwives model, that buys primary care service for ARRC from NPs would go a long way towards enabling NP teams to work together to provide services for groups of ARRC facilities. This is better than giving money to ARRC to buy NPs as NPs understand the breath of their practice and what can be provided. This type of approach would be better than expecting NPs to develop primary care practices as generally they don’t have great business skills but really want to practice at the top of their scope (and there is a heap of research now demonstrating NPs are as safe as doctors and generally patients are more satisfied with NP services). Also with a single focus in older adults in ARRC NPs would be able to respond to emerging illness as they don’t have waiting rooms full of people they have to leave. This would then impact on hospital presentations

There is room for improvement in access to services for residents in ARRC. Simply by being in ARRC there is more limited access to allied health, equipment (these are not ‘denied’ but they are prioritised and people in their own homes are prioritised higher)- yes I know the argument – the bed day rate includes all those things, in practice i see limited access. Other barriers include DHB allied and nursing not accepting referrals direct from facilities they have to go thru GPs where inside the DHB allied and nursing can refer to each other

I am not sure that the high focus on diabetes in ARRC will have a large effect – generally food, exercise and medication becomes very routine and diabetes management becomes by comparison to people living independently relatively straight forward. Also by the time people enter ARRC they either have or don’t have the micro and macrovascular complications. With life expectancy extremely limited we are not going to have a big impact with this one.

Thanks for the chance to have a say

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| **Submission 3** | | |
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| Submission is: | Individual | |
| Representing: | Māori | |
|  | Non-governmental organisation | |
| Privacy preference: | Yes, I give permission for my submission to be published. I do not give permission for my personal details to be released under the OIA. | |
| Do you have any comments or suggestions regarding the vision for healthy ageing? | Not to be isolated from other age related health services and information | |
| Do you have any comments or suggestions regarding the actions for the goal of healthy ageing? Do you agree that the actions with a purple star are the right actions to begin with? | Yes. However there is a need to look at Maori processes of aging and what Pae Ora looks like for kaumatua koroua/kuia and whanau. This will look and demonstrated differently by kaimahi Maori and whanau at all levels of ones life | |
| Do you have any comments or suggestions regarding the vision for acute and restorative care? | Whānau Ora planning to be in place for all Māori kaumātua koroua/kuia and their immediate whānau. This also involves kaimahi Māori and Clinical Professionals to be skilled in Māori practice and a greater knowledge of Pae Ora | |
| Do you have any comments or suggestions regarding the actions for acute and restorative care? Do you agree that the actions with a purple star are the right actions to begin with? | To involved appropriate whānau leaders or spoke person at all coordinating meetings to reduce duplication of information sharing. Best Māori Practice when working with Māori (tika, pono, aroha) | |
| Do you have any comments or suggestions regarding the vision for living well with long-term conditions? | From Pepi to kaumātua promotion of healthy living to continue . Each kaumatua koroua/kuia come with a whānau not to be seen as an individual. | |
| Do you have any comments or suggestions regarding the actions for living well with long-term conditions? Do you agree that the actions with a purple star are the right actions to begin with? | Better involvement of Hapū and iwi organisations. Māori leaders of all disciplines and ages. Not forgetting rangatahi . How would they want to be looked after when they reach kaumātuatanga? | |
| Do you have any comments or suggestions regarding the vision for better support for people with high and complex needs? | Whānau Planning to be developed by working members of the whānau. | |
| Do you have any comments or suggestions regarding the actions for better support for people with high and complex needs? Do you agree that the actions with a purple star are the right actions to begin with? | Involve whānau at the beginning of all actions to supporting people with high and complex needs. Whānau to be engaged trained and deliver key issues to whānau Māori without takahi mana of all participants involved | |
| Do you have any comments or suggestions regarding the vision for respectful end of life? | Whānau involvement at all stages. A skilled health workforce that is knowledgeable in Te Ao Māori process for care of korua/kuia receiving end of life care. . | |
| Do you have any comments or suggestions regarding the actions for respectful end of life? Do you agree that the actions with a purple star are the right actions to begin with? | Whānau Māori involved at all stages. | |
| Do you have any comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions? | Utilise whānau Ora planning template to implement strategy. This will have all govt sectors working together to achieve Pae Ora for whānau, kaimahi katoa and service providers. | |
| Do you have any other comments? | Look forward to more integration of Māori processes within the strategy | |

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| **Submission 4** | |
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| Submission is: | Individual |
| Representing: | Older people care/ rest home medical service |
| Privacy preference: | Yes, I give permission for my submission AND personal details to be released under OIA. |
| Do you have any comments or suggestions regarding the vision for healthy ageing? | regarding providing medical services to older people at rest homes, I suggest the use of PMS and electronic prescription, we also need access to hospital letters and discharge summaries, and electronic access to lab results thanks |
| Do you have any comments or suggestions regarding the actions for acute and restorative care? Do you agree that the actions with a purple star are the right actions to begin with? | I also suggest access to funded physio and OT to rest home residents |

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| **Submission 5** | |
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| Submission is: | Individual |
| Representing: |  |
| Privacy preference: | Yes, I give permission for my submission AND personal details to be released under OIA. |
| Do you have any comments or suggestions regarding the vision for healthy ageing? | No. Good vision |
| Do you have any comments or suggestions regarding the actions for the goal of healthy ageing? Do you agree that the actions with a purple star are the right actions to begin with? | Yes. |
| Do you have any comments or suggestions regarding the vision for acute and restorative care? | A.C.C is spending huge amts/ of money on programmes and are less likely to provide finance for the provision of essential surgical intervention for results of falls etc. . No Surgery because of great expense to an individual leaves many with no life style or provision for one.. How does this provide a healthy life style and independence.? Unless this area of cop -out is remedied , the whole outlook remains very bleak for the elderly patients. |
| Do you have any comments or suggestions regarding the actions for acute and restorative care? Do you agree that the actions with a purple star are the right actions to begin with? | There is a huge gap in the Home support provision on discharge. Why cannot this be immediately set up and the patient and family be informed of the provision long before discharge of a patient home. There is a breakdown in the communication chain, because NOK are often hunting the service after discharge. Not a good practice. |
| Do you have any comments or suggestions regarding the vision for living well with long-term conditions? | Yes good goals. |
| Do you have any comments or suggestions regarding the actions for living well with long-term conditions? Do you agree that the actions with a purple star are the right actions to begin with? | No comment |
| Do you have any comments or suggestions regarding the vision for better support for people with high and complex needs? | Good goals...I believe Rest Homes and Retirement setups need to have a very high education in their services of emergency care for the elderly. Provision is often not there and very dangerous practices are being used. On emergency the need for paramedic advice needs to be the first and best options .Training needs to be established by these experts as well in the establishment's programmes with level of performance recognition for those training.. Home Carers also need this input.We need trained people caring for the elderly. Not just "kind ?" carers. |
| Do you have any comments or suggestions regarding the actions for better support for people with high and complex needs? Do you agree that the actions with a purple star are the right actions to begin with? | Equitable Access to services is very debatable. HOW do the elderly "get" to these services .????? TDHBD don't provide for transport to Waikato Hospital , where a huge number of Diagnostic appointments are made. . It is the same for surgery . Why do these ill elderly have to experience more trauma just to attend. There is a wide field of every sort of clinic to provide for expert specialist in put, but no provision set up for those requiring these to attend the appointments. Is this equitable access to services????? [ |
| Do you have any comments or suggestions regarding the vision for respectful end of life? | My main concern with the vision ,is that "IS it the family's wishes that are provided for ot the individual's??" Often ,sadly it is family and at times one spokes person, but not what the individual has wanted. |
| Do you have any comments or suggestions regarding the actions for respectful end of life? Do you agree that the actions with a purple star are the right actions to begin with? | people are afraid of what this means. IS it Eithanasia. ? Am I committing to something that I may change my mind about later and be stuck with the established statements? Whist this is a very good issue to air, please do explain what it means in plain language. Even demonstate a plan. |
| Do you have any comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions? | It is very apparant that the communication and liason between DHBD is not all that it should be. Often transfer of information is not sent on .Often G.P's do not get follow up notes. Is this just a poor clerical issue or is there really a communication lapse.? For the provision of co-ordination services for the patients , Hospitals need to get it right.. |
| Do you have any other comments? | Yes. I am on the drive for the resolution of Transport between hospitals. Whilst Taranaki has a major issue with no provision to Waikato our major governance hospital and provider of services, I note that there are other areas in the country that are experiencing similar glitzes, Please can this be investigated and some outcomes put forward. I would be very keen too have feed back please. |

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| **Submission 6** | |
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| Submission is: | Individual |
| Representing: | District health board |
| Privacy preference: | Yes, I give permission for my submission to be published. I do not give permission for my personal details to be released under the OIA. |
| Do you have any comments or suggestions regarding the vision for healthy ageing? | Will the "Workforce development" include use of thoroughly researched and documented findings of the HRC "Caring Counts" (2012) investigation? |
| Do you have any comments or suggestions regarding the actions for the goal of healthy ageing? Do you agree that the actions with a purple star are the right actions to begin with? | I don't have an opinion on this. |
| Do you have any comments or suggestions regarding the vision for acute and restorative care? | Anecdotally, I find the interface between DHB service and Residential care remains stretched due to: -competeing demands on both sides. e.g need to create flow through hospital beds increases need for Residential Care to accept referrals urgently. This is the reality, so I am not saying this is wrong, but under this stress, polarisation and assumptions can occur. -DHB workers are unaware of resources (un)available to Residential Providers, e.g social workers, legal advice, 1:1 nursing for residents requiring intensive support for a period of time |
| Do you have any comments or suggestions regarding the actions for acute and restorative care? Do you agree that the actions with a purple star are the right actions to begin with? |  |
| Do you have any comments or suggestions regarding the vision for living well with long-term conditions? | As mentioned initially, the Caring Counts HRC (2012) report discusses the importance of supporting and valuing carers in residential care facilities. |
| Do you have any comments or suggestions regarding the actions for living well with long-term conditions? Do you agree that the actions with a purple star are the right actions to begin with? | More than "regularising and improving training" is ensuring carers have the time/support to recieve training and resources to implement what they have learnt. Regular forums, for discussions, at times which may suit shift patterns and work duties. "One off" sessions may tick a box, but the on-going sessions may be an investment, and possibly more meaningful? |
| Do you have any comments or suggestions regarding the vision for better support for people with high and complex needs? | Goal 2, I believe spouses or children living and supporting their spouse/parent with dementia need more than the current "Package of Care" offers, i.e cleaning or showering. To be unable to leave someone alone at home, but who refuses day care, the carer desperately needs a regular time to be able to leave the house and rejuvanate or do errands.This is sometimes available with friends/family, but often not. |
| Do you have any comments or suggestions regarding the actions for better support for people with high and complex needs? Do you agree that the actions with a purple star are the right actions to begin with? | Is "Identifying fraility" an issue?, flexibility of resources to mitigate against risks, support autonomy, or delay need for transfer to residential care will not be helped by identifying the issue. I believe we already have systems to identify, so I owuld rather see energy put into the14(b). |
| Do you have any comments or suggestions regarding the vision for respectful end of life? |  |
| Do you have any comments or suggestions regarding the actions for respectful end of life? Do you agree that the actions with a purple star are the right actions to begin with? |  |
| Do you have any comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions? | 25 (d) and (e) are essential, so good to see included. 25 (b)will carers in residential care have a voice? this statement appears to exclude any interest in their perspective or valuing the work they already do |
| Do you have any other comments? | I am constantly inspired by the people I work with, both older people at a stage of needing some support/care (patients, residents or their partners), and the comittment and care of the people, at all levels, that offer thissupport/ care. There will always be issues within such a vast group of people, and rightly they are adressed. Unfortunately, the media do not balance their reporting with stories of staff going above and beyond to fill the gaps that resources do not allow for, and celebrate the extraordinary people I meet and work with everyday. I hope the people driving this strategy have had the opportunity to see the grass roots, aswell as the essential "big picture", which is already done in the Caring Counts HRC 2012 report. |

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| **Submission 7 withheld at submitter’s request** |

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| **Submission 8** | |
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| Submission is: | Individual |
| Representing: | Consumer |
| Privacy preference: | Yes, I give permission for my submission to be published. I do not give permission for my personal details to be released under the OIA. |
| Do you have any comments or suggestions regarding the vision for healthy ageing? | The vision, as with most visions, is fine. It is the implementing of it that is the proof of the pudding, as it were. |
| Do you have any comments or suggestions regarding the actions for the goal of healthy ageing? Do you agree that the actions with a purple star are the right actions to begin with? | I can't say I noticed any purple stars. |
| Do you have any comments or suggestions regarding the vision for acute and restorative care? | All of the above are important. In the past, this has been a serious shortcoming in the treatment of the aged - eg patients being sent home from hospital in the middle of the night without support at home and the like. |
| Do you have any comments or suggestions regarding the actions for acute and restorative care? Do you agree that the actions with a purple star are the right actions to begin with? | I found the purple star this time, and that action seems a logical place to start. The more preventative actions taken, the fewer the hospital admissions and the greater the wellbeing of the aged person. |
| Do you have any comments or suggestions regarding the vision for living well with long-term conditions? | Not really. This seems to cover the field adequately. |
| Do you have any comments or suggestions regarding the actions for living well with long-term conditions? Do you agree that the actions with a purple star are the right actions to begin with? | In this particular section there seems to be a huge number of purple stars and to implement all of these in 2 years will be an achievement indeed. I agree that all of these are important. As an ex-aged care nurse myself, I would suggest that a huge step forward would be to increase the training and remuneration of those working in the home provider sector. There appear to be few incentives for these people, often migrants, to improve their knowledge and skills. |
| Do you have any comments or suggestions regarding the vision for better support for people with high and complex needs? | Visions are great - it is the implementing thereof where the difficulty lies. If the vision is achieved, well done! |
| Do you have any comments or suggestions regarding the actions for better support for people with high and complex needs? Do you agree that the actions with a purple star are the right actions to begin with? | The purple stars generally are a good place to start, but you can't start them all at once. A scattergun approach is not helpful. |
| Do you have any comments or suggestions regarding the vision for respectful end of life? | It is good to see the provisions for care at the end of life. It would be a great pity if somehow the option for elective euthanasia were to come into the picture. |
| Do you have any comments or suggestions regarding the actions for respectful end of life? Do you agree that the actions with a purple star are the right actions to begin with? | Definitely education is the place to start. Because of a fairly common repugnance to look at the inevitability of death, this needs to be brought to the forefront of people's consciousness. |
| Do you have any comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions? | In my view the implementation is the important thing. I find in general that the 'outcomes' approach of many government departments is counter-productive. There are certain things in this life which cannot be measured. |
| Do you have any other comments? | All power to the Department for taking the trouble to consult so widely. So often the consumers, if you like to call them that, are left out of the consultative process, with the result that the conclusions and subsequent actions can be less than desirable. |

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| **Submission 9** | |
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| Submission is: | Individual |
| Representing: | Consumer |
| Privacy preference: | Yes, I give permission for my submission to be published AND my personal details to be released under OIA. |
| Do you have any comments or suggestions regarding the vision for healthy ageing? | I would like to see "Younger people know what they need to do while they are still young to enable them to remain healthy as they age" as healthy aging is related to your health when you are young- PREVENTION should be part a more overt part of the HOP strategy. |
| Do you have any comments or suggestions regarding the vision for acute and restorative care? | Those in acute care are aware of the special needs of the older person - this isn't really stated in document |

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| **Submission 10** | |
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| Submission is: | Individual |
| Representing: | Māori |
|  | Whanau in a carer role. |
| Privacy preference: | Yes, I give permission for my submission to be published AND personal details to be released under OIA. |
| Do you have any comments or suggestions regarding the vision for healthy ageing? |  |
| Do you have any comments or suggestions regarding the actions for the goal of healthy ageing? Do you agree that the actions with a purple star are the right actions to begin with? | I feel that to enable our Kuia and Kaumatua of all races to be cared for in their own homes if that is their wish there is a need to have carers who are paid a decent wage ie: not a minimum wage.I recommend that this be included in the first 2 years goals. |
| Do you have any comments or suggestions regarding the vision for acute and restorative care? | ­ Establish age-friendly communities in line with the Positive Ageing Strategy Increase the availability of strength and balance programmes in people’s homes and community settings Participate in the cross-government Ministerial Group on Family Violence and Sexual Violence Work Programme. Support initiatives that maximise healthy ageing through supported housing and age-friendly communities where this will also contribute to regional economic and social development. Support older people’s uptake of technology for communication with health providers and their family and whānau. Increase the accessibility of information on healthy ageing and health and social services through govt.nz, yourhealth, SuperSeniors and links to other websites, so that people can be more ‘health smart’. ­ Develop, implement and review prevention and treatment of injuries for ACC and health clients, including Regularise and improve training of the kaiāwhina workforce in home and community support services. Progress training packages to enhance the capacity and capability of kaiāwhina to support people with long-term conditions and their families and whānau, as part of the Kaiāwahina Action Plan. d. ­ Develop a range of strategies to improve recruitment and retention of those working in aged care. Enhance workforce capability and training pathways to encourage more entry and retention of the workforce among Māori and Pacific people Strengthen the implementation of the New Zealand Dementia Framework, and the actions specified in Improving the Lives of People with Dementia (Ministry of Health 2014). Encourage health, social services and communities to become more dementia-friendly Reduce the instance of complications from diabetes, particularly for people in aged residential care in line with Living Well with Diabetes: A plan for people at high risk of or living with diabetes 2015–2020 (Ministry of Health 2015), by providing tools, resources and quality standards. DHBs, primary care, providers d. ­ Develop commissioning and funding approaches for home and community support services that describe core aspects for national consistency, but allow for flexibility at the local and individual level. H Ministry of Health, DHBs e. ­Use interRAI assessment data to identify quality indicators and service development opportunities including with health providers. f. Work with Māori, Pacific and other population groups to develop culturally appropriate home and community support service models. Better coordinate and integrate rehabilitation for people recovering from a stroke by identifying improvements to business models, workforce and models of care. h. ­ Provide community-based, early intervention programmes for people with musculoskeletal health conditions (eg, the Mobility Action Programme Promote community support for older people with mental illness and substance misuse issues, to both reduce stigma among older people and helping them to seek treatment Include health apps targeting older people with long-term conditions in the health app library currently being developed.H b. ­ Promote use of tele-monitoring to monitor conditions and alleviate social isolation, especially among rural and remote locations. Explore possibilities for a frailty identification tool to enable primary and other health professionals to identify frail older people earlier. Develop standard referral and discharge protocols between aged residential care facilities, pharmacists, primary care (including providers of after-hours services and medicines advice), ambulance and hospital services. Ensure models of care and contractual arrangements provide equitable access to medicines management services targeting people receiving high-risk medicines and/or polypharmacy, people in aged residential care and older people with complex health needs living in their own homes. Examine options to reduce work-related barriers to informal care. I |
| Do you have any comments or suggestions regarding the vision for better support for people with high and complex needs? | Re: Family Funded Care: Hourly rate for carers should be on the par with residential care (Rest Homes) |
| Do you have any comments or suggestions regarding the actions for better support for people with high and complex needs? Do you agree that the actions with a purple star are the right actions to begin with? | Page 37: Goals: Please include: It is important that we pay, train and value these workers as part of the integrated ‘one team’. |

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| **Submission 11** | |
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| Submission is: | Individual |
| Representing: | Service provider |
| Privacy preference: | Yes, I give permission for my submission to be published, but do not release my personal details under the OIA. |
| Do you have any comments or suggestions regarding the vision for healthy ageing? | Healthy ageing includes social contact with family or friends. Adequate money for housing,food,medical,and dental needs. Realistic understanding of health services and what they can deliver. Access to services that are available and are funded and are in place |
| Do you have any comments or suggestions regarding the actions for the goal of healthy ageing? Do you agree that the actions with a purple star are the right actions to begin with? | Healthy ageing should include the concept of a healthy death and the need to avoid needless health interventions |
| Do you have any comments or suggestions regarding the vision for acute and restorative care? | I am now 75 years old and have spent my life in Health working for 54 years as a Medical Practitioner. Many elderly people know when there time has ended,they do not want intervention to extend their life,the want protection from suffering. The medical costs expended in the last 2 weeks of life has been calculated and the cost benefit is really low. Elderly people need to have a cultural change in their thoughts about procedures and medication that allegedly increase and improve their health. Good Health is well documented,it includes, correct weight,food and housing,avoidance of smoking, Alchohol and stress. This is a long duty. |
| Do you have any comments or suggestions regarding the actions for acute and restorative care? Do you agree that the actions with a purple star are the right actions to begin with? | A discussion about what society,the elderly and health professions feel is a reasonable and fair allocation of health services provide by the state It should not include Politicians. If people as individuals wish to have additional services these can be made available by private contractors. Some elderly have had no call on acute and restorative care, this could be recognised. So often to is the same patients that consume the resources. |
| Do you have any comments or suggestions regarding the vision for better support for people with high and complex needs? | Well . When I graduated antibiotic treatment for Tuberculosis removed a large group of older people from needingt parked. complex care,also Polio vaccine,HIV treatment ,screening for cancer allows simpler treatments the list goes on and there is unrecognised success in treatment and management of patients with high and complex. For adequate treatment of conditions patients must be aggregated in large numbers,they should not be scattered in un identifiable groups across the community. There is no room for patient groups to be managed by NGOs:it has not worked. |
| Do you have any comments or suggestions regarding the actions for better support for people with high and complex needs? Do you agree that the actions with a purple star are the right actions to begin with? | Support. It is very difficult to separate the people who should be in a support capacity from those who become involved on Political and treatment processes. Individual support people can be outstanding but complex patients and there needs goes on day after day ,year after year.. Care is piecemeal and patchy and often depends where you live. Patients with these problems are often isolated and hence get lost. |
| Do you have any comments or suggestions regarding the vision for respectful end of life? | Yes: Again in days past many patients has a personal relationship and agreement about how their death should be managed by their on Dr This has now been opened to include many more people and has become a community issue. |
| Do you have any comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions? | Actions are not about tick box technology,political correctness and measuring They are about a respectful discussion between all of us in the society we operate in. Many people have differing views about what should and should not happen |
| Do you have any other comments? | Medicine and it's surrounds moves forward and is ever improving At the risk of being labelled pretentious it has sufficient competent and dedicated young members who will always strive to good good and useful things. This is inspite of many people saying how awful everything is and the systems are broken. I have seen so many wondrous things happen in a Health I am totally optimistic that no matter what all problems are soluble. |

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| **Submission 12 withheld at submitter’s request** |

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| **Submission 13** |

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

Service provider  Government

Non-governmental organisation  Union

Primary health organisation  Professional association

Academic/researcher  Other *(please specify)*:  
Specialist Palliative Care

### 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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| N/A |

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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| N/A |

### 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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| N/A |

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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| N/A |

### 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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| Dementia is chronic, progressive, terminal condition for lots of older people. It can be supported to live well for a long time. Why no data of dementia in Fig. 6? |

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 c.d.f, 11 b.d.g.h, 12 a.b – are most appropriate actions to begin with |

### 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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| “Palliative care” is an approach of care supporting the person and his/her family, living with chronic progressive illness with high and complex needs. MOH should lead the population to acknowledge this global trend and facts. |

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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| Older person with high/complex needs should have primary palliative care team +/- specialist palliative care support. To facilitate future care planning conversation as well as dignity in old age. |

### 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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| Very positive 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?

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| \*23a – NZ is still very behind with little academic training for doctor, nurse and allied health on palliative care.  23a should be the priority and need immediate action to develop NZ capability of responding to global aging. |

### 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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| Hope the older people involvement would include people of minority groups, ie, ethnic groups, homelessness. |

### Other comments

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| Thanks |

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| **Submission 14** | empty submission |

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| **Submission 15** |

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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: | This submission is my personal opinion |
| When submissions are published online: |  |
| In the case of an OIA request: |  |
| 1a. Comments or suggestions regarding the vision for healthy ageing | I support the visions of the strategy. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | With regard to 'Respectful end of life' I believe an immediate action should be to investigate a robust and humane system of voluntary euthanasia, so people don't have to needlessly suffer for months and years if they wish not to. |
| 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 | The vision is good, but I would like there to be an additional vision of investigating and implementing a system that gives people the choice in when and how they die. To watch family members suffer while wanting to end it is gut wrenching and inhumane. I want to have the option to decide when my time comes. |
| 5b. Comments or suggestions regarding the actions for respectful end of life | As noted above, investigate a system of humane voluntary euthanasia. |
| 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 16** |

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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 |
|  | Trustee & Adviser # Community Trusts etc |
| When submissions are published online: |  |
| In the case of an OIA request: |  |
| 1a. Comments or suggestions regarding the vision for healthy ageing | Overall it was very good indeed albeit a bit wordy (and PC) for many Older People to read and participate in. It would be good to see a cut down version. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | No |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | P17 Delays in discharge from hospital - this is crap! People are discharged before they are ready - clinicians focus only on physical side without giving sufficient considerations to the emotional and mind side of the person - they are not giving sufficient consideration to the whole person. P18 Ambulance staff assessments - from experience (was a AO and have witnessed older person being delayed medical treatment a week by with a broken back) the vast majority of AO's are not sufficient well trained or equipped to provide adequate diagnosis and only delays and frustrates appropriate medical care. |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | No |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | No very good apart apart from length. |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | Purple star - 11e seems to be the most important one many the others are nice to have. |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | Smart Systems P12 - the paragraph or issue in para 1of page 25 should be brought forward here. Sort out methods for storing and recording patient details at hospitals incorporating hospitals, GP's, Pharmacies and Ambulance - one good IT system where data is captured and stored once. P24 Support for high needs - Hospital particularly Waikato need to reduce the time (older) people are held in A&E before being admitted to a ward for treatment and care. |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | P32 - Point 4 - Hospitals need to quickly sort out one decent IT system that allows all hospitals to view older person medical records where ever they are in NZ from other hospitals, GP's, Pharmacies, Ambulance without older person having to remember and repeat their life and medical history to every nurse, doctor, clinician, technician etc. - the systems should provide it once and any half decent system would allow these professionals to focus on providing health care - what they are trained for and not being reduced to highly paid clerks. Add new point reduced waiting times at A&E before admission to a ward - far too long and stressful particularly at Waikato. |
| 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 | No |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | Looks good, particularly involvement of Older People who can articulate there and others concerns and who have good network. |
| Do you have any other comments? | Priorities: 1 Sort out a good patient IT database system which all staff can access without continually asking patient who are not in a good state to remember or articulate. 2 Reduce waiting times at A&E 3 Allow adequate time for patients to fully recover emotionally, in mind as well as the bit of the body that is being treated - consider the whole person. 4 Cut out Ambulance Officer delays from people getting appropriate medical diagnosis, treatment and care. Overall a great start and look forward to consultation meetings and final report. |

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| **Submission 17** |

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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 |
|  | while retired, I have been seconded for 7 months to the hospital as Acting Professional Advisor for Physiotherapy |
| 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 | There is great scope for getting volunteers or offering small reimbursement to retired health professional who could in fact have some advisory input towards new groups or initiatives that this strategy is attempting to achieve. As a group, we do have insight into what the older person currently may require, the course of many chronic conditions and strategies for culturally sensitive input. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | yes having age-friendly communities would be good increasing the availability of strength ad balance programmes will require much creativity in some areas as the oversight issues may be difficult. Here in Palmerston North, we are fortunate to have scope to explore using resources that may include Massey and UCOL. What we currently do not have is a developed pathway/spectrum to provide care for balance and strengthening from the remedial to the well-fit grouping. Costing is another issue of providing opportunities that can be afforded by those individuals who are living solely on the government pension |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | All of these are good goals. There are systems in place that do impede this happening. re early discharge - yes doing rehabilitation with in a person's home is and excellent way to proceed as goals can be tailored to me the functions a person needs to have to return to former level of function. However this is dependent on having adequate equipment to ensure safe care of individuals who perhaps are now disabled and the equipment process/ home carer support process is almost impossible to access rapidly especially if something more complex such as a particular frame or bed or housing alterations and these can take up to 8 or more months to achieve. alternatively having interim care places located in the community where rehabilitation, recovery with some support and staging function are almost non existent. Further community rehab teams are not formed in most areas of this country another aspect with all of this planning is that Allied Health is not adequately represented at the planning level and in fact we do have a very important role to play and in the therapies areas, we do have the skills/mindset to plan with individual/whanau along their concerns and goals not what "we feel is best for them" |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | The goals are excellent and all that is required is process, adequate staffing - which includes good clerical support- Again, please include Allied Health Therapies in the detailed planning as they will be able to give you insight into the gaps and barriers that currently exists |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | Health literacy - GP practices are good places to start. While they now are incorporating Nurse Practitioners into the practices who have added huge value to the care that individuals with chronic problems receive, they have yet to include Allied Health - specifically OT and PT who actually could provide good education, some screening for function, direct individuals and whanau/caregivers to practical supports At home and community workforce - especially the carers who attend to individuals in their homes and are generally paid very low wages, I wonder if there isn't a better way to use this resource especially in urban areas. Specifically, can housing or overnight facilities be set up and workers assigned to specific places such as retirement communities where many people may require assistants with personal cares and instead of the carer having to drive all over the area (costing gas and car wear) they can be allocated the same number of individual in an area where all they have to do is walk for place to place. Or in a situation where there are individual flats for the young disabled to have one or two extra units that support staff can live in and a roster set up as to duties required by the individuals living in these units |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | Having interdisciplinary teams does strengthen the process of service delivery. Respectful listening and sharing of ideas in the teams is very important and while there is likely to be a designated director, all need to have input, including the clerical support workers who probably have to manage all of the data that is coming in. Please don't forget them |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | Education is a key here, but remember that many families especially those in the rural areas have already been expected to take on more and more care/responsibility or perhaps they are highly resistance to outside suggestions. Having worked in very remote areas of the Taraura region, several aspects were clear. Providing face to face input while I feel is essential to good exchange and planning is very expensive and it seems more reasonable to provide "traveling teams" who go to areas for perhaps a week or so to provide the input that those with long term issues could access. Utilising electronic means to access/support people is another thought |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | I think actions are excellent and I am trying to imagine them being utilised in our most remote areas. Again a basic team that has good high quality electronic links to our more scarce resources might assist in this - much like the current practice of provincial hospitals utilising consultants in the larger urban centres Please note that while I am speaking more in the health mode, that teams may be made up of different individual who are better suited for the area in which they live |
| 5a. Comments or suggestions regarding the vision for respectful end of life | yes - I believe that end of life care should be around providing support to the individuals and their whanau as they approach this. Whether it is possible to have more open forums or encourage small groups to have death talks over coffee or more exposure to healthy end of life realities to bring back into normalcy rather than something to be feared. Life cycle awareness so to speak Most elderly people actually will be quite open about the fact that they are near death and I think that family/friends need to feel open to embracing and cherishing this person and relaxing with them into their dying process |
| 5b. Comments or suggestions regarding the actions for respectful end of life | certainly having the advanced care plan and epoa in place is important. having the palliative care support excellent - again the rural areas will be harder to provide such care when a person perhaps is frail but insistent on remaining at home There is a fine line as to how much actual physical care can be provided by family so much support is needed to give options that are acceptable even if it is similar to small hospice facilities located within an acceptable distance from the family home |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | The suggestions do look good, but the realities will be very different 1. while including the workers in the feedback process, getting them to have the time or even having the electronic skills to do a survey is likely to be difficult 2. there will need to be dedicated clerical staff hired to manage the initial input of the data - this is a group who are very under rated and very over worked. The success of your projects depends on having dedicated staff and not add on work to current staff 3. Training of the carers workforce will required dedicated staffing to ensure continuity and should not be dependent on ad-hoc input from workforce who have other positions in the health sector such as nursing, physio, OT. They won't have the time to properly oversee |
| Do you have any other comments? | It is good to see that these issues are being thought about and strategies put in place to utilise NZ health dollar as optimally as possible. As a consumer of health in the over 65 population, we have been 'joking' for years that we should just band together after retirement and look after each other as we are very aware that the health system will be burdened if we all become frail too soon and live for too long in this condition I would like to say again that Allied Health Therapy does need to be included in the early stages of planning as our experience has been here in MidCentral, that the doctors and nurses plan initiative and just assume that we will be available. We are a small group and can only be spread so far, so do need to have input at early levels to assist with making sensible plans. Allied Health have much to offer especially in the area of returning to independence, maintaining independence and working with families/individuals Certainly at the DHB levels there are now Executive Directors of Allied Health in place and they would be a good resource for starters to assist with identifying individuals or issues that will arise from this proposal |

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| **Submission 18 withheld at submitter’s request** |

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| **Submission 19** | blank submission |

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| **Submission 20** | |
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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: | Clinician working with Older people across settings |
| 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 |  |
| 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 | The strategy provides a framework to develop new models of care. It is useful to highlight the difficulties with home care supports and community services that impact on ability for older person to manage at home successfully |
| 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. | The importance of developing skilled MDT teams that can support people living with long term conditions is emphasized. The fragility of the community workforce will have a significant impact on this. Ongoing development of primary care models that do not rely on current GP models is needed Primary care initiatives that include things like falls prevention etc is important - services that have been lost over the last 5 years |
| 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 | Addition to Strategy to include competency and capacity. The current process of PPPR is costly and unwieldy. A review of this process will be useful over the next few years |
| 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 | Excellent addition to the Strategy |
| 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 21 withheld at submitter’s request** |

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| **Submission 22** |

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| Organisation (if applicable) | Te Puna Oranga |
| This submission... | is made on behalf of a group or organisation(s) |
| This submission represents the views of: | Māori, Service provider |
| 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 | Maori are represented by whanau , Hapu, Iwi and Maori communities within their regions as a voice at regional, and national levels |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | yes |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | yes |
| 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. | They have rights to be safe in care of whanau to have advocacy that understands whanau and can relate in area's of elder abuse by specialist kaupapa Maori provider's in the area of elder abuse. |
| 3b. Comments or suggestions regarding the actions for living well with LTC |  |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | That Kaupapa Maori trainers be contracted to work and train in these area's with whanau caregiver's. |
| 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 | yes |
| 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 | Maori specialists who work in Kaupapa Maori family violence sector's are consulted are included. |
| Do you have any other comments? |  |

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| **Submission 23** | empty submission |

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| **Submission 24** | empty submission |

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| **Submission 25** | empty submission |

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| **Submission 26** |

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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: | Māori |
| 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 | Submission: More appropriate funding be given to a Maori Organisation based in Tamaki Makaurau - Counties Manukau, Auckland called Te Oranga Kaumatua Kuia Dissability Support Services who \* provide services specifically targeting Maori elderly kaumatua and kuia. \* provide more targeted funding for Maori elderly kaumatua and kuia. \* Channel funding through Whanau Ora model. In this case Te Pou Matakana. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | Agree with the suggestions regarding the actions for the goal of healthy ageing. |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | Certainly agree that best practice restorative rehabilitation strategies, discharge planning and follow-up support are in place for older people requiring urgent or planned hospital treatment •Older people are supported through recovery and the return home •Family and whānau receive support to assist older people to recover from acute events •The number of people readmitted to hospital following hospital treatment reduces. |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | agree. |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | •Improved methods of early detection and prevention mean that fewer older people are affected by long-term conditions or frailty •Older people with long-term conditions retain the highest level of mental and physical function possible; they enjoy life, and their communities respect them •Older people with long-term conditions have a range of tools and support to enable them to live well with their conditions •Older people with long-term conditions are ‘health smart’, and are actively self-managing their conditions to a practical and comfortable level, making living well with long-term conditions closer to home more accessible |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | •The workforce that supports older people with long-term conditions, including the health workforce, home and community support services and family and whānau carers, has appropriate resources, structures and training •Health outcomes for vulnerable older populations with long-term conditions are approaching equity with outcomes for the population as a whol |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | agree that older people with high and complex needs •have the information and freedom to make choices about the care and support they receive •know that health professionals understand their wishes and support needs •are assured that information about their circumstances and their needs flows easily between health professionals •from different ethnic groups and in rural locations have equitable access to services, and experience equitable outcomes •move easily to and through care settings that best meet their needs •have reduced need for acute care |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | •Families and whānau have the information and training they need to best assist family members and the stress of caring does not damage their own health •District health boards have data from various sources and know the value and quality of the care they provide for older people in their district. Where it is falling short, they are able to learn from other DHBs. |
| 5a. Comments or suggestions regarding the vision for respectful end of life | Agree with the vision for the goal of a respectful end of life: •People die where they feel comfortable and safe, and are able to have their loved ones provide support. •Dying older people are able to identify and articulate their fears, goals and care needs, and how they wish family, whānau, caregivers and friends to be involved in their end-of-life care. •People talk comfortably about the subject of dying and preparing for death, and individualised care plans, advance care planning and enduring power of attorney are much more widespread practices. The health workforce, family and whānau and friends respect and upheld the needs and wishes of older people •Technology improves end-of-life care. Providers know if advance care plans are in place, routinely check whether medicines need to be reviewed, and support monitoring at home |
| 5b. Comments or suggestions regarding the actions for respectful end of life | •Health service providers coordinate palliative care in such a way that all of those who support people dying in old age are aware of plans, and know their role in carrying them out •All teams are responsive to the cultural needs of different groups •The health system educates, supports and advises family and whānau of dying people and the health workforce in meeting the needs of people receiving end-of-life care. |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | Certainly support the proposals for implementing measuring and reveiwing the actions as proposed by the discussions raised throughout this document. |
| Do you have any other comments? | none. |

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| **Submission 27** |

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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: | Service provider |
| 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 | - |
| 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 | This submission relates only to the section entitled ‘Support for people with high and complex needs’. My experience is in the medical assessment and management of people with significant cognitive impairment and especially those with the complications of dementia. Although the draft strategy rightly takes a broad and high-level approach, there is little mention of those older people who have advanced dementia and who need specialist aged residential care. Support to allow older people to live in the community must be a priority, but there will always be a minority who will require residential care. There is also little mention of the legal provisions that can assist in the care of older people with high and complex needs. Three areas where the stated vision will not be achieved with the planned actions are covered by this submission. There may well be other issues in the draft strategy but comments have been restricted to the limited area of my practice. Some comments are only applicable to Auckland due to the size of the urban area. 1. Quality of Dementia Unit facilities The regulation of aged residential care facilities is relatively light-handed and the ability of DHBs to insist on better quality facilities is very limited. Currently the model of service provision is a commercial profit-driven one in which the quality of care is not the primary consideration. The draft strategy does mention “….DHBs need to commission services in a way that will provide older people with quality care in the right setting at a sustainable cost….” but does not suggest any changes to the current regulatory framework or contracting model. My view, developed from dealing with such facilities, is that the current arrangements do not promote high quality of care of those people with high and complex needs requiring dementia unit level care. One of the most prominent issues illustrating the above issue is that of the availability of secure outside space for residents of dementia units. There are no binding regulations for the amount or availability of outside space in dementia units and consequently the developers of new dementia units sometimes attempt to minimize this potentially costly provision. There also appears to be a reluctance to have people with dementia visible to residents of nearby apartments or units. Both evidence and experience suggest that people with dementia benefit from the ability to walk freely in a safe environment. The ability to go outside also can mitigate some of the behavioural and psychological symptoms of dementia (BPSD) and there are obvious health benefits from fresh air and sunshine. There is also a human rights argument that people should be not be kept inside permanently. High quality dementia units, both in New Zealand and overseas, have large outdoor spaces with paths, grassed areas, shade, outdoor seating, and multiple points of interest. The provision of outdoor space also increases the possibilities for activities such as gardening. Without changes to the regulations or the contracting arrangements I do not believe there will be any improvement in the provision of secure outside space or in the quality overall of dementia units. 2. Range of aged residential care facilities. Currently there are four types of ARC facilities being: • Rest Home • Private Hospital • Dementia Unit • Psychogeriatric Hospital The vast majority of older people with high and complex needs who need residential care can receive the care they need in one of these types of facilities. However there are smaller groups of older people who are not easily cared for in one of the four types of existing facilities. Although these people are very much a minority, in a large urban area such as Auckland the numbers can be significant. This issue relates to the outcome “having flexible home and residential care services that suit the needs of the increasingly diverse older population”. Examples of these categories include: • Older people who do not speak English. Unfortunately in Auckland there are situations where older people with high and complex needs are accommodated in facilities where no other residents or staff speak their language. There are many more situations where very few others speak their language. Obviously this is far from ideal and compromises the care and quality of life of those individuals. Some facilities have evolved to have staff speaking the more common languages such as Cantonese or Mandarin. However those older people speaking less common languages or dialects often have little option. Given the size of greater Auckland the establishment of some facilities specializing in certain languages would be feasible. The current model of service provision alone will not produce any facilities with an emphasis on the less common languages. Some element of central planning and/or financial incentive will be required to realize the vision of “older people with high and complex needs from different ethnic groups and in rural locations have equitable access to services, and experience equitable outcomes”. • Older people with dementia who behave in a sexually inappropriate fashion. A small number of older people with high and complex needs, usually men with specific types of dementia, develop sexual behaviours that pose a danger to the public. These individuals need care in a secure environment where other residents are male, where a high proportion of staff are male, and where activities are appropriate to them. There is no facility in Auckland specifically designed to meet this need, although they are available overseas. Again some form of central planning and/or financial incentive will be required to meet this need, which is quite small but has implications for the safety of children and women in the community. • Older people with dementia who are relatively high functioning but tend to wander. A number older people with dementia would be quite appropriate for rest home level care but have the sole BPSD problem of wandering and becoming lost. With the current range of facilities these individuals must be accommodated in a dementia unit. This has the effect of placing the person with other residents who have much lower functioning, which is highly undesirable in terms of maintaining appropriate stimulation and social interaction. A facility with rest home level of care, but with a discrete secure perimeter, would allow an optimal mix of independence, stimulation, and interaction, while balanced with safety. Again some form of central planning and/or financial incentive will be required to meet this need. • People who have early onset dementia (less than 65). Unfortunately dementia can occur in people aged in their 40s and 50s. These individuals are physically more active and have differing needs and interests than people in their 60s and above. Overseas there are specific facilities for people with early onset dementia and I suggest there is room for at least one such facility in Auckland. These examples have demonstrated that the current mix of aged residential care facilities, while appropriate for the vast majority of people with high and complex needs, do not ensure “people are in the right place to receive the care and support that most appropriately meets their needs”. 3. Barriers and delays in PPPR Act actions Barriers to appointing EPOAs Ideally everybody should appoint individuals to the roles of Enduring Power of Attorney for both Welfare and Property at an early stage in their life. However this is by no means the norm and many people have not made the appropriate arrangements. Since the recent amendments to the PPPR Act it is my view that even fewer people are assigning EPOAs due to the cost. In order to optimize the care of older people with high and complex needs there needs to be measures to encourage the early assignment of EPOAs. Delays in PPPR Act orders In the common situation of an older person not having an EPOA it is necessary to apply to the family court for a Welfare Guardian, Property Manager, or a more specific order such as a Placement Order. This process can take many months and involves significant effort from families and/or clinicians. It is not unknown for older people to wait for months in an acute hospital or other facility for this convoluted legal process to be completed. In contrast Mental Health Act proceedings, which are also presided over by family court judges, occur efficiently, promptly, and with a known timeline. I propose that a ‘fast track’ option for PPPR Act orders is developed, in a similar fashion to MHA processes, for older people with high and complex needs who are assessed as not competent to make decisions. The ‘fast track’ pathway would require universal agreement by the whole family and the clinicians about the planned course of action. There would also need to be appropriate protections and reviews as in the MHA. Any complex or controversial cases would not be suitable for the ‘fast track’ and would proceed through the current full process. These modified processes would help people “move easily to and through care settings that best meet their need” as stated in the vision for older 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 28** | empty submission |

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| **Submission 29** |

|  |  |
| --- | --- |
| Organisation (if applicable): | Capital & Coast DHB |
| Position (if applicable): | Primary Care Clinical Advisor, General Medical Practitioner Provider |

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)

X is made on behalf of a group or organisation(s) - **both categories**

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

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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

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?

|  |
| --- |
| This is good I particularly like the concept of “Age Friendly Communities”. A great foundation for a comprehensive way forward. |

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?

|  |
| --- |
| Most definitely |

### 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?

|  |
| --- |
| Excellent vision. |

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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| Yes definitely! Will not be effective without a significant investment. In my view $311,000 yearly from ACC for 3 years as proposed for Capital & Coast DHB by ACC is not adequate. The funding needs to be realistic, ie, doubled and ongoing not planned to end after 3 years. This is setting us up to fail. |

### 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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| Goals are appropriate but there is a major disconnect between the goals and actions. I am pleased that there is an emphasis on specific work force provision and training for older persons care. However |

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 foundation to enable better care for old people in the community will reply on the primary medical care that is available to them. I don’t see any commitment to allocating new 1° care funding to allow this to happen, a very similar problem to 2 (b) but at least there is some new funding in 2b from ACC. |

### 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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| In order of importance:   1. Identify frailty (ie, frail and prefail) in primary care 2. Share care plan electronic for all carers 3. Focus on proactive and preventative management. |

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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| --- |
| Problems: Challenges   1. unlocking interRAI data resource so fit for GP medical care planning has not been solved. 2. Unless specific new funding for frail older person in primary care then this won’t happen. It will be the “emperor’s new clothes: fable repeated. |

### 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?

|  |
| --- |
| Excellent. |

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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| Will not occur without targeted funding for ACP and enduring POA for the needy. Hopefully the health ministry funding for the Palliative care model may assist. |

### Implementation, measurement and review

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

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### Other comments

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| Currently the vast majority of health funding for older persons goes to secondary care and the nature of that beast will not willingly change. I have now spent 3 years inside CCDHB advocating and working very hard to make some progress in encouraging the bigger vision many of us have. If caring for older persons in their community is better care for them and better value for the health dollar rather than spending the large sums of money we currently utilise attempting to care, often very inappropriately, for these same older persons in secondary care at the bottom of the cliff.  Unless specifically ring fenced new money is provided for the primary medical care that frail older persons require, we will never be able to demonstrated the economic rationale for this let alone the better quality of care.  We are currently facing the classic evidence paradox. Our current model requires secondary care to care for frail older persons in hospital and without primary care being funded to do it differently we will never have the evidence. The Bright Study in NZ has already demonstrated that simply identifying frail older people in the community makes little difference. A fully funded new model of community care offers an alternative. |

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| **Submission 30** | empty submission |

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| **Submission 31** | empty submission |

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| **Submission 32** |

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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: |  |
| 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 |  |
| 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 |  |
| 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? | Error: On page 8 you have a graph that clearly shows those with disabilities will live longer than those without. If this is the case then the whole of this Strategy is nonsense!!!!! Approach: The whole of the strategy is based on a reactive approach to becoming 'old' - it does not look at the education and proactive measures that should be taken for towards those 'due' to enter old age. For example on page 21 you have a graph that shows how addressing many of these issues BEFORE 65+ would have an even greater outcome for the older population. Be PROACTVE not REACTIVE. Proofing: Please note that a vowel leading suffix means the ending silent vowel of a word gets dropped in 98% of cases - i.e. age becomes aging not ageing - this finished in the late 1800s!! Spelling error: in NZ English Dietitians have two 'Ts' - only Australian and American English use the 'C' but the rest of this document is written in NZ English - so consistency would be appreciated. 'aiga was mentioned several times near the beginning of the document but not afterwards. If they are different from families and whanau then you should indicate their position throughout the Strategy - if they are not (i.e. they fall into the definition of family or whanau), then they shouldn't be mentioned as an isolated carer in the first place. |

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| **Submission 33** |

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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: | Māori |
|  | Whanau in a carer role. |
| 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 | Please include: Older people are given the opportunity to receive resources and funding that is suited to their needs and in a timely manner. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | I feel that to enable our Kuia and Kaumatua of all races to be cared for in their own homes if that is their wish there is a need to have carers who are paid a decent wage ie: not a minimum wage plus on a 24 hour basis. I recommend that this be included in the first 2 years goals. |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | ­ Establish age-friendly communities in line with the Positive Ageing Strategy Increase the availability of strength and balance programmes in people’s homes and community settings Participate in the cross-government Ministerial Group on Family Violence and Sexual Violence Work Programme. Support initiatives that maximise healthy ageing through supported housing and age-friendly communities where this will also contribute to regional economic and social development. Support older people’s uptake of technology for communication with health providers and their family and whānau. Increase the accessibility of information on healthy ageing and health and social services through govt.nz, yourhealth, SuperSeniors and links to other websites, so that people can be more ‘health smart’. ­ Develop, implement and review prevention and treatment of injuries for ACC and health clients, including Regularise and improve training of the kaiāwhina workforce in home and community support services. Progress training packages to enhance the capacity and capability of kaiāwhina to support people with long-term conditions and their families and whānau, as part of the Kaiāwahina Action Plan. d. ­ Develop a range of strategies to improve recruitment and retention of those working in aged care. Enhance workforce capability and training pathways to encourage more entry and retention of the workforce among Māori and Pacific people Strengthen the implementation of the New Zealand Dementia Framework, and the actions specified in Improving the Lives of People with Dementia (Ministry of Health 2014). Encourage health, social services and communities to become more dementia-friendly Reduce the instance of complications from diabetes, particularly for people in aged residential care in line with Living Well with Diabetes: A plan for people at high risk of or living with diabetes 2015–2020 (Ministry of Health 2015), by providing tools, resources and quality standards. DHBs, primary care, providers d. ­ Develop commissioning and funding approaches for home and community support services that describe core aspects for national consistency, but allow for flexibility at the local and individual level. H Ministry of Health, DHBs e. ­Use interRAI assessment data to identify quality indicators and service development opportunities including with health providers. f. Work with Māori, Pacific and other population groups to develop culturally appropriate home and community support service models. Better coordinate and integrate rehabilitation for people recovering from a stroke by identifying improvements to business models, workforce and models of care. h. ­ Provide community-based, early intervention programmes for people with musculoskeletal health conditions (eg, the Mobility Action Programme Promote community support for older people with mental illness and substance misuse issues, to both reduce stigma among older people and helping them to seek treatment Include health apps targeting older people with long-term conditions in the health app library currently being developed.H b. ­ Promote use of tele-monitoring to monitor conditions and alleviate social isolation, especially among rural and remote locations. Explore possibilities for a frailty identification tool to enable primary and other health professionals to identify frail older people earlier. Develop standard referral and discharge protocols between aged residential care facilities, pharmacists, primary care (including providers of after-hours services and medicines advice), ambulance and hospital services. Ensure models of care and contractual arrangements provide equitable access to medicines management services targeting people receiving high-risk medicines and/or polypharmacy, people in aged residential care and older people with complex health needs living in their own homes. Examine options to reduce work-related barriers to informal 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 | Re: Family Funded Care: Hourly rate for carers should be on the par with residential care (Rest Homes) |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | Page 37: Goals: Please include: It is important that we pay, train and value these workers as part of the integrated ‘one team’. |
| 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 34** |

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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: | Individual |
| 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 |  |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | To begin with, as long as the actions are evaluated regularly and changed (challenged) at regular intervals. |
| 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. | Work force required to be trained to ensure adequate care is provided for all peoples with long-term conditions. This training should be affordable and accessible to each person who wants to be a valued member of the workforce. |
| 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 | Making the ability for EPOA and welfare guardianship easier accessible and affordable for all. Currently the cost is a barrier to have these in place when people are well and can make an informed decision to their future wellbeing. |
| 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 | Having an advance care plan available to all with education regarding the benefits that occur when these plans are completed during periods of wellbeing and not left for end of life. These conversations are difficult for some people. Education ensuring cultural, spiritual and full understanding of consequences of actions are required for all. |
| 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? | Having the barriers of cost taken away from preparation of EPOA and welfare guardianship could decrease the extensive time in hospital beds while these are prepared. Thus stop the 'bed blocking' that occurs. |

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| **Submission 35** |

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| Organisation (if applicable) | Wellington City Menzshed Charitable Trust |
| This submission... | is made on behalf of a group or organisation(s) |
| This submission represents the views of: | Non-governmental organisation |
|  | Charitable Trust |
| 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 | Great concept |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | You say ... 1. Build social connectedness and wellbeing in age friendly communities a. ­ Establish age-friendly communities in line with the Positive Ageing Strategy. c. Work across government and with local interest groups to improve access to, and coordinate assistance to socially isolated older people and develop initiatives that better address the physical and social determinants of health. d. Promote volunteering, networking and paid work among older people, as a means to support their self-worth and encourage social connection. In the five years of our existence, caring for the older men in your city we have made many approaches to the Wellington Council, the Office for Seniors and the Minister of Health but there has been no action. When will it happen? |
| 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. | Great conceptsGreat concepts but in the five years of our existence no help has been offered by national or local government or DHBs. Our health education sessions for the elderly have been provided by individual practitioners and non-governmental organisations. |
| 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 | Great concepts |
| 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? | Wellington City MenzShed was established as a registered charitable trust five years ago. It's specific purpose is to care for the older men in our city. There are those who have lost touch with family and now live alone and isolated. There are those who retire and find rather than respect, they are regarded by the world as "past it" and of no further value. Both groups suffer from depression the early onset of the health issues of ageing. We provide a place where these men can find the companionship of others run the same boat. We help them to revive old skills an learn new skills by engaging in community work. We make or repair toys and furniture for child care centres, schools and community groups Working together restores the mens' sense of self worth and well being. We add in health education as part of the process. The UK is facing the same issue of NZ with substantial increase in the numbers elderly outstripping demands on its health services. Research shows that if you keep the elderly active and well socialised they will remain health longer. Britain's National Health Service ran a world wide competition for ideas to keep the elderly active and socialised. Ten applicants from around the world were shortlisted as the world "Bright Sparks". The City Menzshed was one of those. The ideas were shared at an international conference in UK . We couldn't afford to go so we participated via a video link. Nine of the ideas were at them concept stage "if we did this, this might happen". The tenth from City MenzShed was able go say "we do this and this does happen". We won a prize of thousand pounds. We told the then Minister of Health, the Office for Seniors, and the Wellington City Council. They all said thank you for telling us, but did nothing. For four years we have worked from an yellow stickered earthquaked risk building. Signing in each day to admit we are there at our own risk. Despite this we regard our friendly landlord as a saviour because without his support we would not exist. We look forward to something beyond the fine words and vision to some practical action. |

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| **Submission 36 withheld at submitter’s request** |

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| **Submission 38** |

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| --- |
| **Submission 37 withheld at submitter’s request** |

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| --- | --- |
| Organisation (if applicable): | Dietitians New Zealand |
| Position (if applicable): | Honorary Life Member; Committee Member on the Special Interest Group for Nutrition in Gerontology |

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

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

Remove my personal details from responses to Official Information Act requests

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

Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training provider  Local government

Service provider  Government

Non-governmental organisation  Union

Primary health organisation √ Professional association

Academic/researcher  Other *(please specify)*:

### 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 is comprehensive. The importance of age-friendly housing, (both in the community and in retirement villages) cannot be over-emphasised, given the focus on older people living independently for as long as possible. Ensuring that the design of these homes allows for safe living is important, for example – we often see microwave ovens over stove tops of on top of fridges – space saving, but unsafe for frailer and ageing older people living independently. There will be other features that must be considered here too, and it is important that designers consult with user groups to ensure these needs are met.J:\Dietitians NZ\Submissions\2016_08_08\Press 8.8.16.jpg |

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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| --- |
| Yes, the asterisked actions are appropriate  Dietitians NZ considers that nutrition of older people is an important aspect of healthy living. It is significant that a number of nutrients are required in amounts greater than in a younger person, at a time in life when it can be more difficult to achieve and the risk of malnutrition is high. There should be an additional action point**: Improve healthy eating and food and nutrition knowledge of older people living independently.**  Strategies for this could be :   1. Work with provider organisations, especially medical practitioners to ensure that body weight in older people is monitored and unplanned weight loss is addressed. This may require referral to a dietitian 2. Increase access to reliable food and nutrition information, referral to cooking classes (e.g Senior Chef (CDHB) or healthy eating classes (Age Concern or NZ Nutrition Foundation) |

### 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 endorse the use of multidisciplinary teams to coordinate the care of older people returning to their homes in the community, and support the introduction of appropriate training for people able to deliver first line care, for example, user friendly and appropriate nutrition advice. Care is needed however, to ensure that those with specific or higher level needs are appropriately referred. |

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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| While reducing acute admissions is a great goal, access to timely hospital admissions for hip replacements and other excessively painful conditions that compromise the older person’s ability to maintain independence and appropriate quality of life is critical.  Add 6 b to actions: Rehabilitation services should include restorative Meals-on-Wheels, to ensure that a person being discharged in a timely manner has a specifically planned and limited restorative meals on wheels plan.( A pilot study was conducted by Dietitian Kaye Dennison and others some years ago – the time is right to relook at this work.) |

### 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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| Early management and rehabilitation of long term conditions is critical, and when this management is not enough, secondary or tertiary level care should be available – see above – to avoid further unnecessary costs to the healthcare system. |

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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| --- |
| Yes, especially those relating to the training and support of carers, and improved pay rates for these people who generally do a wonderful job often under very difficult conditions. Improving their lot is a top priority in our opinion.  We also strongly endorse 9 e, re better utilisation of the allied health workforce to enhance the care of older people in primary care, home care and residential care  Dietitians NZ considers that special attention should also be afforded to malnutrition risk, which may be considered either in this section (action 10) or the next (actions 14 & 15) – or both. However, although New Zealand data on this issue are low, and more research is currently being conducted, international figures for western societies like NZ show high levels(up to 70%) for malnutrition risk in the older age group, both in those living independently and in residential aged care. |

### Support for people with high and complex needs

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

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| --- |
| No. We support greater flexibility of residential care services – and believe that a more client-centred approach rather than a task-centred approach is beneficial to residents. Greater integration between residential care and home based care is a positive concept. The Eden Alternative is a model worth considering. |

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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| --- |
| Yes, asterisked actions are appropriate for early attention. See also our comments above on malnutrition risk – a measure of frailty.  Dietitians NZ strongly endorses any action in the aged residential care sector that promotes independence and choice for residents. There is much research promoting client centred care in relation to meals, timing, choice (some self service), assistance, meal patterns, dining environment etc. that suit residents, rather than staff scheduling. This relates back to enabling greater support and training (and pay rates) for residential aged care workers – an urgent action in this area of support for people with high and complex needs. |

### 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?

|  |
| --- |
| Good |

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?

|  |
| --- |
| The asterisked action is appropriate for more urgent attention |

### 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?

|  |
| --- |
| These look fine – there is a lot of work to do and we trust that there is the resource to drive the strategy through to 2026 |

### Other comments

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| Dietitians New Zealand has a special interest group for Nutrition in Gerontology, comprising registered dietitians with expertise in the nutritional and dietetic care of older people. Many of this group work in private practice. We are available to provide expert advice on nutrition to the Working Group on this HOPS, and/or on any issue relating to the nutritional care of older people living independently, in aged care facilities with more complex needs, or undergoing rehabilitation before returning to their normal living situation.  Currently in New Zealand, dietetic services in residential care are not publicly funded, and are not always provided by DHBs, especially when resources are limited. This can create a gap in a comprehensive service model, and we are aware of a Canadian model that mandates a certain level of intervention, based on resident numbers.  Nutrition is one of the core components of healthy ageing, but is often overlooked, or it is assumed that 'everyone is an expert in nutrition.' Too often lip service is paid to nutrition, with little follow through. Dietitians, as the experts in nutrition, should be engaged as key members of all healthy ageing initiatives. What constitutes 'healthy eating' for the general population may no longer be appropriate for older adults, especially in the later years. Malnutrition is common in older adults and contributes to increased risk of falls, fractures, frailty and functional decline. A comprehensive and proactive approach is needed to address nutrition issues of older people, across the continuum of care. This should include training and upskilling of health professionals, care providers as well as community organisations. We need more quality initiatives as well as frequent audits to achieve improved nutritional well-being of our older people.  While we are aware that the Health of Older People’s Strategy is not looking to isolate or silo specific health professionals, we wish to take this opportunity to raise this as a matter for consideration as we see the client base in our aged care facilities becoming more complex and needy, when specialist advice should be easy to obtain when it’s required. |

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| **Submission 39** | empty submission |

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| **Submission 40** | empty submission |

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| **Submission 41** |
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| Organisation (if applicable) | Wairarapa DHB |
| Address | PO Box 96 |
| City/Town | Masterton |
| Postcode | 5840 |
| Country | New Zealand |
| This submission... | is made on behalf of a group or organisation(s) |
| This submission represents the views of: | District health board |
| 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 | As a health professional I wholly support the vision for healthy ageing. Ideally older people will stay in their own homes, in contact with friends, family and their community. This is not always possible and older people enter Aged and Residential Care (ARC). Unfortunately much of the ARC sector is privatised and profit driven at the expense of our older people. As a health professional who visits patients in these settings, it is my opinion that as a society we need to properly invest in aged care, by having much higher requirements for staffing levels, training, services etc |
| 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. | MOH will need to invest more in the Allied Health workforce |
| 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 42** |

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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: | immigrant |
| 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 | the issue here is the financial freedom to be able to attend activities as well as the financial ability to provide adequate appropriate housing. the financial ability to make alterations to home should you become incapacitated by hemiplegia or other physical disability. the financial ability to ensure a safe and secure environment. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | volunteerism is a pipe dream in the world of today. train and equip a volunteer with the knowledge and skills to care for the elderly and they will immediately seek paid employment. |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | provision of an integrated health record system must be developed and implemented to ensure that all providers enter clinical notes on the same platform which is access controlled. |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | provision of an integrated health record system must be developed and implemented to ensure that all providers enter clinical notes on the same platform which is access controlled. this will also prevent "Dr hopping" to ensure that there is no wastage of resources. educate the public not to utilise tertiary facilities unneccisarily, which leads to wastage of resources and delays in treating those needing care more urgently. |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | affordable initiatives to ensure participation in wellness activities such as smoking cessation, weight loss with increased activities. making facilities "free gyms" available for use by vulnerable populations...used only by the older persons. |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | family carer training and education - when training has been undertaken the family member will want to utilize those skills for paid employment with a revolving door effect. |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | need to develop and implement a single platform health record system where all health care providers are privy to the same information and can communicate across disciplines. |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | need to develop and implement a single platform health record system where all health care providers are privy to the same information and can communicate across disciplines. |
| 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 | currently all health care professionals are functioning in silos. need for broader interactions on a single health record platform |
| Do you have any other comments? |  |

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| **Submission 43** | empty submission |

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| **Submission 44** |

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| Organisation (if applicable) | Clevercare Limited |
| This submission... | is made on behalf of a group or organisation(s) |
| This submission represents the views of: | Service provider |
| 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 | Tens of thousands of elderly New Zealanders have and rely on medical alarms, many of them subsidised through the Disability Allowance. All legacy technologies fail as soon as the wearer leaves the front gate. This works against keeping people healthy, well-connected, independent, and able to participate fully in their communities. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | Yes - but we would add a 3(f) Support older people's uptake of new technologies which improve their safety and independence while allowing them to remain physically active and involved in their communities. Our firm offers a locally developed, proven, 3G mobile alternative monitored medical alarm system which is proving popular among those New Zealand families who can afford it. We firmly believe that making solutions like ours more widely accessible would go a long way to supporting capacity-enhancing behaviours in older people, and reducing barriers to participation. |
| 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. | Some people living with dementia cause enormous anxiety and impose substantial costs on emergency services due to wandering and becoming lost, confused and disoriented. Confining them to secure facilities is detrimental to their wellbeing and physical health. Our firm offers technology which allows families and carers to quickly and accurately locate the person in such cases, and can provide early warning of the person departing a safe area or entering a danger area. The improved peace of mind and cost savings can be huge, and great uptake of this technology would improve outcomes. |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | Under 9 we believe there should be some mention of ensuring that initial and continuing training stays abreast of new technologies to assist those living with long term conditions. Under 13 we believe that there should be mention of promoting the uptake of mobile safety and support technology to improve the lives of families living with dementia. |
| 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? | Congratulations on an excellent document. We would welcome any opportunity to provide more information about how we might be able to help. Please visit our website www.clevercare.co.nz for more background. |

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| **Submission 45** | empty submission |

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| **Submission 46** | empty submission |

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| **Submission 47** | empty submission |

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| **Submission 48 withheld at submitter’s request** |

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| **Submission 49** |

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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: | Elderly persons |
| 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 | The elderly who suffer from the all-too-common alzheimers frequently experience difficulty with some aspects of driving, leading to sudden changes of lanes, changes of speed or braking, wrong turns, failure to comply with give-ways, wrong decisions at roundabouts, etc. If it is brought to the attention of a Doctor, that Doctor may recommend a driving assessment. The assessments are not administered by NZ Transport Authority, but are done by private firms. A test costs $600. The $600 is no problem for some of the more fortunate retirees, but it is a voluntary thing, and many do NOT want to take it, since firstly they could be scared of losing their license, and secondly $600 is a totally unaffordable sum for many who already struggle to meet their daily expenses. As far as I am concerned, this is a problem that affects everybody on the road. Pensioners who really need this test either cannot afford it or do not wish to risk losing their license, so don't take it and remain driving. They are a danger to everybody else on the roads. If it were government-funded, then they would take it - or could be directed to take it by their doctors. The Auckland memory team are aware of about 50 people who are on their books in the Auckland region that really should not be driving. We are a third of NZ's population, so there would possibly be around 150 known to the medical profession in NZ. Assuming that only a half of those who are in this category are 'known', then we could say that there are around 300 people on the roads who will some day kill or maim someone else - an avoidable statistic. If the government funded it, it would cost around $180,000 only. Assuming the system was abused (as all government-funded systems are) and the outlay were quadrupled, it would still be under $1m. Surely even avoiding a single serious accident that could ruin the lives of a family would be worth the outlay of such a paltry amount. |
| 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 | The elderly who suffer from the all-too-common alzheimers frequently experience difficulty with some aspects of driving, leading to sudden changes of lanes, changes of speed or braking, wrong turns, failure to comply with give-ways, wrong decisions at roundabouts, etc. If it is brought to the attention of a Doctor, that Doctor may recommend a driving assessment. The assessments are not administered by NZ Transport Authority, but are done by private firms. A test costs $600. The $600 is no problem for some of the more fortunate retirees, but it is a voluntary thing, and many do NOT want to take it, since firstly they could be scared of losing their license, and secondly $600 is a totally unaffordable sum for many who already struggle to meet their daily expenses. As far as I am concerned, this is a problem that affects everybody on the road. Pensioners who really need this test either cannot afford it or do not wish to risk losing their license, so don't take it and remain driving. They are a danger to everybody else on the roads. If it were government-funded, then they would take it - or could be directed to take it by their doctors. The Auckland memory team are aware of about 50 people who are on their books in the Auckland region that really should not be driving. We are a third of NZ's population, so there would possibly be around 150 known to the medical profession in NZ. Assuming that only a half of those who are in this category are 'known', then we could say that there are around 300 people on the roads who will some day kill or maim someone else - an avoidable statistic. If the government funded it, it would cost around $180,000 only. Assuming the system was abused (as all government-funded systems are) and the outlay were quadrupled, it would still be under $1m. Surely even avoiding a single serious accident that could ruin the lives of a family would be worth the outlay of such a paltry amount. |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | No other suggestions |
| 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 50** |

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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: |  |
| 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 | Housing and age friendly communities, which is inclusive, a place where the old and young live alongside each other. Communities that understand dementia, where children learn about dementia in schools, where employees learn about dementia in their training for example in the UK with Dementia Friends. Communities understand the rights for those with dementia and other disabilities to self determination, involvement in decisions and choices. That these are supported as much as possible. |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | I think organisations need to focus on working together, sharing information that supports older people in their transition and in having a review process. It needs to be multidisciplinary in manner not just in hospital but extending into the community.Information needs to be accessible and provided at the older persons pace, in a way that they can understand and ensure that their human rights and dignity are being respected. More support for whanau both financially and in anticipation of time off work. The support needs to be gender neutral. |
| 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 51** |

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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: | Service provider |
|  | Non-governmental organisation |
|  | Aged Residential Care and Community Housing Provider |
| 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 | Equity - Housing is a major and growing issue and there is evidence that we will see increased levels of homelessness and poor quality housing impacting on health and well being for the elderly. How this issue is addressed and what tools and resources will be made available both to the elderly and to support services/communities will affect the ability of people to stay well. Also the processes by which communities are engaged and involved in processes to address their own issues is important. Having age friendly communities is laudable but what will this mean and how will communities be supported and resourced. How will local bodies be engaged in this process? The same with resilience - this is as much an issue of social justice as much as it depends on the individuals participation and engagement around managing their own heath and well being.I don't see any reference to the aged residential care sector and how they will be involved - especially the not for profit and community owned providers who often have strong community networks and engagement. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | Yes - laudable suggestions with the qualifications per above. I also wonder if we are providing services in the home at the expense of the well being of many elderly and their families. We see a number of elderly comming to our day programme who are isolated and vulnerable. Often the answer is seen to provide more services when in fact there is a need to rethink with the elderly person their residential options. An elderly person can see large numbers of health workers enter their homes, which is in itself intrusive and dis-empowering. I note that often families are equally stressed about their elderly relative and find it difficult and confusing straddling a range of complex bureaucratic interventions. Somehow we need to rethink and streamline interventions where the elderly person is in the centre. Also we need to engage local residential care providers - currently we tend to work in silos - there may be opportunity to investigate innovative models within communities that recognise and practice a far more integrated model of care - it may be that local communities could be more readily engaged as to how these may look for their own community. |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | One comment is that discharge planning sometimes seems more orientated to DHB's budgets than any inclination to maintain or improve the individual's well being. We have seen elderly people discharged in the middle of the night with little planning or consultation with the individual, their whanau or with providers. This reflects a silo'd model of care that highlights a lack of awareness by those in the hospitals on what resources are in the community and what resources are available to the elderly person. It does not take into account well being and prevention of future re admissions. Also I wonder about access to key support services for the elderly and their families - especially counselling. Often they encounter huge personal change and loss of key functions and abilities. Families are often very stressed and are frustrated by a system that often does not understand their circumstances. |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | The steps especially 6 & 7 will help considerably. Naturally the question will be in its implementation, what resourcing is available to all concerned, how communities are involved, who the elderly person & key support person(s) is and what support there is for the family. It may be that instead of revamping current service models we investigate new models that are more flexible, community orientated, that more readily engage the elderly person and their family without the confusion of a lot of people being involved, moving in and out of their lives. |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | Despite that fact that we are living longer the reality is that as we get older we get sicker - it is a question of when not if. While prevention is an obvious and important strategy, preparing and supporting people to live with illness and disability is equally important. I note there is no mention of the aged residential care workforce which needs good resourcing and to be given the right tools by which they can support older persons. Equity for the aged is intertwined with inequities experienced across the whole population - by addressing the broader issues of inequity we will help address inequity for the elderly. |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | Yes all actions are laudable if implemented. I will be interested to see how funding models develop to meet local and individual needs - I believe this will be critical to any success when it comes to improving health and well being. Writing as on involved in aged residential care the use of InterRAI is fraught with difficulties - access to training, cost, lack of resourcing etc.etc. While it may provide some good information and help at a national level, we cannot forget that what happens at local level is what ultimately impacts for better or worse on the individual. |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | There has been a lot of talk about improving health status in our populations but little evidence especially that some of the so called changes/restructuring to health services have contributed to this or in fact made things worse. while the above goals are good, I remain skeptical that there is a political will to invest in health in ways that will actually make a difference. My sense is that decisions are based on political imperatives and often whole communities are left out of the equation. The proof will be in the implementation and in the abilty to engage all parties in processes that mean positive change and improved outcomes for the elderly. |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | These are laudable actions, however whether there is success or otherwise will be dependent on how all key stake holders are engaged, the level of buy in and the implementation processes. |
| 5a. Comments or suggestions regarding the vision for respectful end of life | Sometimes there is a discrepancy between what the family wants and what the the older person wants. There is both the need to educate and prepare people for death as well as ensure good access to counselling services. |
| 5b. Comments or suggestions regarding the actions for respectful end of life | I strongly support having a palliative workforce closer to home - just ensure the resources come to support these services. I support informing people on advance care planning and EPOA. It is also important that families understand these and what they mean for their elderly relative. . |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | The processes for planning, implementation, measuring and reviewing are as important as the actions themselves. How the key stakeholders are engaged and informed will shape the success of the plan itself. Key questions I believe are important include - how will local communities be engaged - notably local bodies and organisations - rural communities especially can often be overlooked. It is notable that this consultation process has not reached significantly into the rural regions. Also how will the process engage with and respond to diversity of need. Finally what influence will this strategy have on the development of a range of residential care options? Over recent years we have seen a massive growth of Villages and the involvement of large 'for profit' corporate organisations, but correspondingly a decline of the 'not for profit' sector in the provision of aged care - has this been at the expense of the more vulnerable and margionalised in our communities? How has this influenced growing inequalities especially when it comes to accessing healthy, affordable good quality housing. What support will be provided to those services working with specific populations with high health needs? How will these group be engaged in the implementation and evaluation of services to them? |
| Do you have any other comments? | Thank you for the opportunity to provide a submission. However while I remain skeptical I am hopeful that we will see significant improvements in the provision of services to the elderly. Equally important is how services and communities are supported and resourced so they can obtain maximum benefit from and utilise the strengths each community has to support their own. I am hopeful that there will be greater support to the not for profit sector and community owned services whose focus is so often on those experiencing difficulties with access and with complex high health needs. the current funding arrangements - especially in aged residential care undermines viability and the ability of these organisations to address their local community needs - leaving fewer resources to address the very challenging issue we now face. |

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| **Submission 52** |

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

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

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

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

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

Do not publish this submission

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

Remove my personal details from responses to Official Information Act requests

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

Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training provider  Local government

Service provider  Government

x Non-governmental organisation  Union

Primary health organisation  Professional association

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

### Healthy ageing

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

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| Healthy aging needs to be supported by healthy environments, combatting ageism, ensuring inequalities are addressed and valuing older people. There is to much emphasis on page 14 on individual knowledge and lifestyle choices. People who are valued and involved in our communities and who live in environments they can safely negotiate and are economically independent will clearly age more healthily. These issues need to be noted here. |

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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| More attention needs to be paid in this document to addressing external factors. It is hard to age in a healthy way if you don’t have access to health care or live in a cold house or are subjected to intimidation or bullying.  Age friendly communities is a good start. This would have to involve education and taking a good look at how various forms of media depict older people. In the last two months at least two mainstream media outlets have featured opinion pieces about stopping older people voting “because they are going to die”. |

### 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 is a laudable goal. Currently services are much to dependant on the rather ridged systems of intersecting agencies “approving” things like support in the home which can delay hospital discharge.  These services need to be made more accessible and flexible.  Restorative care also depends on the quality of community support services. The current level of both education and 2wages for personal carers does not support high quality service provision and needs to be addressed in this section. |

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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| This should not just focus on people with injuries. Rehabilitation services are urgently needed if we are to support supported discharge. The connection between hospital and community also needs to be strengthened and there are significant workforce development needs. These issues need to be addressed more clearly here. |

### 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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| Once again external factors need to be addressed. Poverty, inequality and other social issues affect how well we age and how health we are.  Long term illness vary between men and women so it is also really important that we add having a gender lens here as well as looking at other differences. |

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 need to add research into long term conditions will be done that examines the differences between men and women and different population groups so that they can be properly detected and treated (eg. Heart disease in women).  As we noted above attention to social inclusion and external environmental factors should be added here. |

### Support for people with high and complex needs

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

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| We need to add that the safety and dignity of people with high and complex needs is protected and that the services that they use or are resident in are monitored. Aged Concern has noted the high level of elder abuse that occurs in families but also in aged care facilities. |

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

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| We do not agree this should be the primary aim. Frail older people Are still able to identify their own needs. We believe that to support this group one of the most urgent actions required is attention to the safety, rights and dignity of people in aged care facilities and preventing abuse of those who are cared for at home |

### 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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| We agree with the proposed outcomes. We think that this section should also include that hospice type facilities should be accessible to older people who are very ill so that they can die with dignity. |

### 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 agree that meaningful consumer representation and involvement must be part of service development and evaluation. We note that NZ older people are a very diverse groups and large age range. It is also important to hear from both ethnic and cultural groups who are often missed out of consultation processes and have lower health service access rates. |

### Other comments

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| We applaud the time that is being taken to develop this strategy and believe that many of the goals are also laudable. We believe that to encourage healthy aging we must take the following approach:  1. Promote Gender and age equality  2. Recognise diversity and the social determinants of health  3. Ensure Gender and age sensitive health care practice and research  4. Address high risk illnesses and chronic disability taking into account gender and socio cultural differences  5. Include measures to enhance quality of life and support independence such as improving street safety  6. Taking a human rights based approach |

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| **Submission 53** |

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| Organisation | Inclusion Aotearoa |
| This submission... | is made on behalf of a group or organisation(s) |
| This submission represents the views of: | Māori |
|  | Non-governmental organisation |
| 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 | The vision is good but needs to include something that reflects the ability of many older people to contribute to one another's well-being through community development principles. e.g. In our communities older people use their gifts, talents and time and expertise to support one another and in other community endeavours. Using a true community investments approach we could reduce costs. (Note that the strategy does not take into account the need for a change in the relationship between people and the state, as noted in the UK Carnegie report: The Enabling State. Future costs will continue to rise if we ignore people's abilities and talents to support one another.) |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | Health ageing goals: I suggest changes to 1 and 1a and then would support it being the right action to begin with. Changes I suggest are: 1. Build social connectedness, mutual support and well-being in age friendly and diverse communities 1a. Provide leadership and support for the development of age friendly and inclusive communities in line with the Positive Ageing Strategy and WHO Guidelines. d. needs to include the words 'reciprocal support' |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | no |
| 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. | no |
| 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 | no |
| 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 | no |
| 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 | 28b should read" increase understanding of links between housing, loneliness and health status...." |
| Do you have any other comments? | I think what is here is mainly okay but it is what is missing that worries me. Fundamentally it continues to focus on services and not on ways communities can be supported to meet their own needs. There are some creative ways overseas to save costs and improve quality of life which could be trialled here e.g. Shared Lives (UK) and Homeshare (Melbourne) where younger people live with older people rent free in return for 10 hours support. With good vetting, matching and monitoring such things have been shown to be effective. That one might even help solve Akd's housing crisis and enable young people to save for a mortgage. There are other such possibilities and these are not even considered in this strategy which focuses on building more expensive services and not on building communities. I am hoping to trial such cost saving community building organisations but was told that I cant get funding from the DHB because DHBs only fund services. Frustrating and disappointing. |

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| **Submission 54 withheld at submitter’s request** |

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| **Submission 55** | unallocated |

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| **Submission 56** |

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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: |  |
| 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 | Older persons weight has to be under control and that goes for the whole population. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | They are appropriate |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | This is good. More community resources are needed, more nurses and allied health. |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | this is good |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | Yes this is all good but much more money is needed in the community for allied health, nurses and doctors. |
| 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 | DHB's need to create their own medical centres, a public alternative in the communities. These medical centres should have district nursing, public health nursing, GP's which can do minor surgery. Also a room for allied health to access in these medical centres. This eliminate a lot of visits to hospitals and the private GPs can compete with themselves. Private health care is detrimental for NZ. You want a close service for the elderly, where the DHB's can monitor the population through own computers systems and pathways of communication. Also, a DHB pharmacy on site of where the DHB medical centre is will be important. Above will eliminate a lot of hospital admissions. |
| 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 | This is very good. Put A LOT of money and thought into end of life. Palliative nurses and palliative doctors are far too few and DHB's need to have an alternative in the communities rather than hospice. Create a postgraduate programme for palliative care and end of life for doctors and nurses. Registered Nurses, not enrolled. also the discussion around legal euthanasia is important and need to be passed in parliament. No one should have to be drugged up on morphine until they die cause we are not allowed to medically allowed to euthanize. |
| 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 | fine |
| Do you have any other comments? | Study the Swedish health care system and copy this. |

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| **Submission 57** |

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| 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 | I would like to see cheaper access available for things like glasses and hearing aids in particular as many elderly people make do with reading glasses from the warehouse resulting in problems that don't get diagnosed. Doing voluntary work amongst older people I have seen many become disassociated and lonely through loss of hearing because they cannot afford to pay the excessive prices for somthing that only lasts 5years |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | I think these's ideals are sound but wonder just how they would be delivered or are they just going to be another "policy" |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | These items would be a tremendous help in recovery to independence especially no 1 |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | Yes I do |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | I believe that no 1 item is imperative to long term good active living. To often the damage is done by the time they get to hospital |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | I believe mental health issues are often not diagnosed in the older patient. |
| 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? | I just found it a bit exhausting having to finish it all at once so had to miss some out |

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| **Submission 58** |

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| Organisation (if applicable) | ADHB |
| Address | Grenlane Clinical Centre |
| This submission... | is made on behalf of a group or organisation(s) |
| This submission represents the views of: | District health board |
| 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 | Re : Suppport for People With High and Complex Needs. At the recent Consultation in Auckland I reflected afterwards that we have not emphasised enough the policy area covering informal carers. These carers are not yet fully recognised for the full time work involved and it is a stressful position to be in , given the ageing population. In Auckland we have carers in their 90s looking after spouses, with their own health issues. Relief options remains highly variable around the country and are not costed into DHB budgets evenly. This policy need fits into nos 15-6 in the Consultation Document .and needs more strength in the policy . |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | a/a |
| 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 59** |

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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: | Academic/researcher |
| 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 | "Mental health" is referred to rarely in the draft and when it is mentioned, it tends to be in the context of 'long-term' conditions. The word 'depression' is mentioned only twice. Given the emphasis implied in the vision statement, above, it would be helpful if the Strategy included a stronger focus on teaching health professionals and social service providers to better recognise, screen, refer, treat and manage depression, anxiety, and alcohol use disorders. |
| 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 |  |
| 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? | The word ‘suicide’ does not occur at all in the draft Health of Older People Strategy, and ‘suicide prevention’ is never discussed. This is a significant omission since: i. Older adults, especially older men, have a high rate of suicide. For example, in 2012 (the year for which the Ministry of Health provides most recent suicide data) the rate of death by suicide among men aged 75-79 (23.8 per 100 000), and among men aged 85 and older (22.1 per 100 000) was twice as high as the rate in the general population (12.2 per 100 000). http://www.health.govt.nz/publication/suicide-facts-deaths-and-intentional-self-harm-hospitalisations-2012 (accessed 28/08/2016) ii. The official rate of suicide in older adults is likely to undercount suicides; the actual rate is likely to be considerably higher. iii. Numbers of older adult suicides can be expected to increase with the demographic changes in the ageing population giving rise to a larger population of older adults. iv. Rates of suicide in older adults can be expected to increase in the larger population of older adults as competition for health and financial resources impact on the quality of life of older people. In addition, it is important to note that: v. Suicide risk is increased in older adults, especially men, with mental disorders (commonly, depression, but also alcohol abuse), physical illness, functional decline and social disconnection (Conwell et al, 2002). vi. Depression is common in older adults, but is often under-diagnosed, and untreated or under-treated. When it is recognised and adequately treated, quality of life is enhanced (Conwell et al, 2002; LaPierre et al, 2011). vii. Older adults are more likely to die in their first suicide attempts than younger people, for several reasons: they make more determined attempts, using more lethal methods; they often live alone and are less likely to be found or be able to seek help if they try to abort an attempt; they are physically more frail and less likely to withstand the physical insult of an attempt. A focus on early intervention with those at risk of suicide is needed to avoid older adults reaching the point of making suicide attempts, since those attempts are often fatal (Conwell et al, 2002). viii. Older adults are less likely than younger adults either to have reported suicidal ideation or to have sought mental health treatment prior to their deaths. However, most older adults who die by suicide do visit their primary care physician in the last three months before they die. These visits provide an opportunity to screen for depression and suicidal ideation. ix. Legal changes to the status of assisted dying, which may occur in New Zealand, risk normalising suicide as a rational response to stresses and life problems. This is especially likely to occur in older adults. x. In excess of 30% of New Zealanders now live alone, including many older adults, who may be at risk of becoming socially isolated, especially once they retire. For all these reasons, the Health of Older Persons Strategy should include explicit reference to older adult suicide and to suicide prevention, including specification of strategies and measures that that can be undertaken at policy, DHB, community and individual levels to minimise risk of suicide in older adults, improve diagnosis and management of depression, and enhance quality of life. In particular, it should be noted that: i. Several interventions offer significant promise for the prevention of suicide in older adults. Most of these interventions focus on treating depressive symptoms. Because older men often do not seek treatment for mental health problems, the most effective approach to recognising and treating mood disorders in older adults may involve integrating evidence-based depression treatment into the work of primary care centres, social service agencies, and NGOs and organizations involved in the care of older adults, and educating health and social service providers about recognition and treatment of depression in older adults. Collaborative care models in primary care that combine pharmacological and psychosocial treatments for depressive symptoms may be particularly useful. ii. Policies and programmes that foster social connectedness can help promote mental and physical health, and recovery from depression, physical illness and injury. Specific emphasis should be focussed on providing these policies and programmes for older adults who may be most isolated or vulnerable. For example, social isolation can contribute to suicide and suicide attempts among older adults whose partner, family or friends have died; those who are geographically isolated from close family members; those who live rurally; those with disability, infirmity or illness; those who are GLBTI; those who have lost their driving licences and have limited transport options. For all of these groups their limitations or marginalisation may make it difficult to stay connected with others. iii. The New Zealand Suicide Prevention Strategy (NZSPS, 2006-2016) tends to focus on youth. There is no focus on older people, and only two minor references to ageing. https://www.health.govt.nz/system/files/documents/publications/suicide-prevention-strategy-2006-2016.pdf The growing older population should also become a focus of suicide prevention with clear, dedicated plans for the older adult sector. The NZSPS is currently being revised and the Ministry of Health should develop common explicit goals for older adult suicide prevention between the NZSPS and the Health of Older People Strategy. iv. While each DHB now has a localised suicide prevention plan, many of these plans are focused on youth. All DHBs should be encouraged to broaden their suicide prevention plans to include a focus on the older age group. v. Communities, families and individuals can be encouraged to foster strong, positive and helping relationships between older adults and younger family members or younger members of the community. For example, volunteering in the community, mentoring or tutoring children or young people, belonging to a faith-based or spiritual community, are all activities which can mitigate isolation and loneliness. vi. Older people can be encouraged to develop hobbies and interests, which protect against depression, social isolation and a lack of purpose. vii. Communities, councils and businesses can be encouraged to provide meeting spaces (cafes, gyms, libraries, drop in centres) which provide opportunities for social participation or contact for isolated older adults. viii. Health and social services to address mental and substance use disorders, as well as suicide prevention, should be provided in a range of settings, including crisis centres, health centres, GP clinics, retirement villages, rest homes and hospices. Home-based services can also be provided (e.g., visiting nurse services, domiciliary psychotherapy, or respite care). Suicide is a significant public health problem in older people. A strong evidence base supports a range of interventions for suicide prevention and promotion of an improved quality of life for older people. A comprehensive strategy for the health of older people must acknowledge suicide risk and include evidence-based strategies to promote suicide prevention. References Conwell Y; Duberstein PR; Caine ED. Risk factors for suicide in later life. [Review] Biological Psychiatry. 52(3):193-204, 2002 Aug 1. Lapierre S; Erlangsen A; Waern M; De Leo D; Oyama H; Scocco P; Gallo J; Szanto K; Conwell Y; Draper B; Quinnett P; A systematic review of elderly suicide prevention programs. [Review] International Research Group for Suicide among the Elderly. Crisis: Journal of Crisis Intervention & Suicide. 32(2):88-98, 2011. |

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| **Submission 60** |

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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 | "age friendly communities" - providing it is the wish or desire of the older person. P14 - talks about "growing age friendly communities" . Perhaps there should also be awareness of the need for support of the existing community links the older person lives in especially as their physical/mental health declines. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | P31 1a: for me it is more important that the older person is 'placed' where they are most comfortable which may mean within the 'family'. It would require careful listening to the older person's because of the wide and varied desires expressed. P32 2a agree P32 4 e&f agree |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | P17 3rd last paragraph: Listening carefully to the wishes and workingWITH the older person to achieve their priorities. Yes to last par. but wonder if "rehabilitation' is the right word! |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | P33 6a Aim for a "one-stop shop" for all aftercare and support services. With a careful assessment and prioritising of the older person's needs/wishes they should only have one/two people to see to the co-ordination the action. P33 7a N.B. integration of services (as above) |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | P20 There seems to be a far greater recognition of the need to meet each individual's priorities which is likely to mean the wish to stay in their own home or a similar environment. P22 N.B. Like the Health workforce comment |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | P34 Like 9a,b,c 11d 12a |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | P24 General agreement with the outcomes expressed there being much more focussed on the individual and a team approach. "Care Plan" noted and would encourage the widespread use of an "Advanced Care Plan" |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | P37 Agree 14a 15a YES, c P38 16a,c 18a,c P39 19c 20c 21b |
| 5a. Comments or suggestions regarding the vision for respectful end of life | Commendable My experience of the 'palliative care" model as run in the Wairarapa DHB seems to work well. Perhaps it is that experience which has been hoping that the health strategy being considered might be influenced by such an approach |
| 5b. Comments or suggestions regarding the actions for respectful end of life | P40 22a yes 23 Need for greater support for palliative care P41 Yes |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | P41 26 Yes to aim to include older people in the design of all stages 27 Makes sense to evaluate. |
| Do you have any other comments? | It seems a pity that few 'consumers' are aware of this document. It has only come to my notice in the last six days. Sad! |

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| **Submission 61** |

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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: | Service provider |
|  | Asian |
| 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 | As a support worker in the communities, the one point like to address will be transitional patients growing into older age. In their early age Had stroke, Parkinson, kidney failure, diabetes, disabilities due birth defect, accident while they were in the younger stages they get a lot of rehabilitation, as soon they get into older age of 65, rehabilitation have not been met or discharge them. Read your draft it seem only dementia patients include in your draft, but other illness have exclude in the draft. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | MOH should have community Health educator to carry out the action plan or advocate to ensure your vision aim and objective have carry out |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | See Nurse staff can be able speak the language, or health care assistant to support needs of the patients. |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | Don't understand what is meaning of purple star? |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | As long service is continues to support them |
| 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 | Interpreter Staff can speak more then one languages. |
| 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 | If that is patients wishes and needs are with a plan, to let people involve know of their responsibilities to carry out duty of the dying person. |
| 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 62** |

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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 | I believe that care needs to be taken to ensure that people who no longer drive have time-effective and low-cost ways of being able to visit family and friends in hospital on a regular basis. I note that to get to the hospital in my city that caters for older people's health from my home (if I could not drive) would take me an hour each way with two buses, a 10 minute walk x 2 from the bus stop to the main entrance of the hospital and then another long walk x 2 to the appropriate ward or treatment site. This is unacceptable, particularly for older people, and will cause devastating effects on their health and the health of those they are not able to visit in hospital on a regular basis. These issues must be solved or we will see more older people with mental and physical illnesses cause by stress of the difficulty of both accessing treatment for themselves and visiting loved ones (who themselves will be stressed by having few visitors). |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | I don't know if the action plan notes are ranked but I agree Ia is the most important all long as it targets the issue I raised 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. |  |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | Consider the transport issues for people with these conditions. Having to take half a day travel to and from treatment, wait for the appointment, have the appointment and then travel home is unacceptable for these people. Something better needs to be organised for them and those they want to support in hospital with visits. |
| 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 | Travel to and from the hospital in a cost-effective and a short time way is crucial to the well-bing of older people. |
| 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 | Palliative care available to ALL where ever they live. |
| 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 63** |

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| Organisation (if applicable) | Anglican Living |
| This submission... | is made on behalf of a group or organisation(s) |
| This submission represents the views of: | Service provider |
| 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 | Include in the vision, carers of those who are ageing to be well supported in their role. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | Good quality, age-appropriate housing is a pre-requisite for healthy ageing and should be a priority for action also (for every older person, not just those needing supported housing). In the same way that oral health is identified for action, so too should be hearing and eyesight. Funded services for all of these will remove what for many is a significant barrier to good health. Communication doesn't count for much if you can't read (afford prescription lens) or hear (have correct hearing aids). |
| 2a. Comments or suggestions regarding the vision for acute and restorative care |  |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | Vision for "family and whanau receive support to asist older people recover from acute events" (p19) is not reflected in the actions. Disagree with purple star against ACC - just as important for all, and ACC clients are arguably already better supported, e.g. to receive timely surgical interventions. |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | Lacks recognition of significant co-morbidities. Dementia needs to be more prominent in the vision (there in action 11) |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | Agree with 9d being a priority. Funding is a significant issue. |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | Generally support these, but it would be good to recognise the level of co-morbidities. |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | Add support for integrated electronic medication systems. |
| 5a. Comments or suggestions regarding the vision for respectful end of life | Disagree that "technology improves end-of-life care". Human relationships do that, and technology may assist in some instances, but not everybody dies in a health care facility. |
| 5b. Comments or suggestions regarding the actions for respectful end of life | Advance care planning does not by itself resolve long-standing family issues that may prevent a person from dying 'in peace'. The psycho-social-spiritual elements need to be addressed for the wellbeing of the dying person to be realised, and this requires a specialised resource sometimes. |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | Regularly' is meaningless without timeframes... could mean regularly every 10 years. #26 talks about research, but overall the document is light in its research and development aspirations. |
| Do you have any other comments? | Overall the strategy is fairly good, but the action steps need to be further developed before the vision will be realised. |

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| **Submission 64** |

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| Organisation | Arohanui Hospice |

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

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

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

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

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

Do not publish this submission

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

Remove my personal details from responses to Official Information Act requests

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

Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training provider  Local government

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 vision overall is good – the statement on page 5 makes no mention of supporting people to die well or comfortably. The wording “…, is designed for value and high performance….” may be better phrased by saying “delivers value and high performance”. Working as one team is aspirational – collaboration and communication are integral to success. The strategy needs to take account of the fact that there will be an increase in the number of older people in the community well beyond the next decade and at least make mention of this so that the plans made in the next 10 years form a solid foundation for the increased demand that will occur right out to 2050 and beyond. The vision statement on page 13 is more focussed, succinct and relevant. The words “have a respectful end of life in age-friendly communities” is brief – the narrative expands on this a bit but should also be consistent no matter what the person’s diagnosis or care setting. |

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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| Healthy aging actions – establishing age-friendly communities is a broad action that will result from many smaller actions – it is almost the end outcome of the other actions. Social connectedness can be built by the community – strength and balance programmes run in the community can be an example of this. Supported housing is an important area to focus on – maintaining independence and social connectedness. Improvement of health literacy needs to happen in earlier years and to flow on into older age. |

### Acute and restorative care

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

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| Acute and restorative care needs to happen in a timely manner – will need resourcing to achieve this. Systems need to be streamlined and to talk to each other.  Barriers to “one team” will have to be addressed and produce a focus on needs and delivery of such |

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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| Acute and restorative care actions – 6a is important and partnerships are key to the success – this needs to be an early focus. Work has been done in prevention of falls and injuries – keep this up. Reduction of acute admissions that can be better managed in the community is important and should be a priority.  Regular assessment of cognitive function will be a key to effective strategies of care that involve self management. |

### 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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| Reduction in duplication is important – comorbidities are common and services should be connected and streamlined to reduce duplication. Care coordination may facilitate this. Integration also important. |

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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| Living well with LTC – education is vital. Release time for staff to attend education in ARC is an issue – need to better resource ARC which in turn will help recruitment and retention. Point 11 is a priority.  Urgent attention to the training of HCA is critical along with a “team” approach in ARCF- as opposed to a rather hierarchical system at present with low esteem of HCA |

### 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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| Coordination of and access to information is important. Vision looks good. Achievement is the key ☺  The right support at the right time is going to be crucial to avoid inappropriate care, clogging of acute space and deterioration of patients who are waiting for effective care. Integration is important to reduce inefficiencies. |

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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| Promotion of contracting and funding models that facilitate care in settings that meet peoples needs – reducing barriers created by current contracting and funding models. Point 16, especially d. needs to be a priority. Improving access to ARC facilities – bed numbers and types of beds need to be flexible and funded. Assessment wait times can be a barrier to timely care. Funding of medication management services – agree this needs to be a priority. |

### 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 is good – would also like to see a mention of the health system supporting and resourcing sufficient highly skilled palliative care specialists. Also needs to be a mention of care after death- care of the family and whanau; bereavement support and grief and loss support.  The role of specialist palliative care in empowering ARCF staff in these regards warrants mention.  Also, it may be of interest to note that 25% of our palliative care patients are under 65 years of age – different supports may be required for younger people, some of whom have young families and many of whom are working – as their illness progresses, financial issues arise when they are unable to work. |

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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| Respectful end of life care – needs to have a quality focus and be high quality care no matter what the diagnosis or care setting. Increase in advance care planning will help, but education in palliative care across primary and secondary care is also important – and support of staff in ARC to provide palliative care – all of these things will help to reduce inappropriate admissions to ED. Advance care planning alone will not suffice. Urgent attention to specialist palliative care workforce and funding for hospices to be able to match specialist salaries in DHBs would be helpful. Additional training positions and reduce barriers.  Support for carers in the community is important – 81% of our patients are cared for entirely in the community (own homes or in ARC). |

### 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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| Working with older people at the outset of service design is critical.  Agree that a minor ailments and referral service via pharmacy would be a useful method of treatment and triage as general practice is overloaded. Ideally the information should be integrated and shared. |

### Other comments

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| Sharing of information and the IT platform needs to be addressed. The people within the health system have the willingness to make positive change and to implement the strategy but the health system does not have the current resource ($ and staff) or IT infrastructure to be 100% successful.  Wouldn’t it be good if there was one real time prescribing, dispensing and administration platform! Again we have multiple platforms…. |

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| **Submission 65** |

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:

Remove my personal details from responses to Official Information Act requests

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

Māori  Regulatory authority

Pacific  Consumer

Asian x District health board

Education/training provider  Local government

Service provider  Government

Non-governmental organisation  Union

Primary health organisation  Professional association

Academic/researcher  Other *(please specify)*:

### Healthy ageing

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

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

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### Acute and restorative care

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

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| If an older person has a medical condition associated with a sudden decline in health, timely and expert decision making is fundamental. Effective communication lies at the heart of this decision making process. Any health intervention that is contemplated needs to address the important issue of reversibility and the capacity to benefit from that intervention. Any decision that is made also needs to take into account the goals and values of the patient. Decision making may be enhanced if family, whanau and or close friends are constructively engaged as part of this process.  In the event of a sudden deterioration where the patient lacks the capacity to make a decision, it is important to emphasise that surrogate decision makers clearly understand that any decision that is made is dependent upon their knowledge of what the patient would have wanted and **not** on their perception of what the patient would have wanted. Pressure from relatives for sometimes unrealistic interventions is recognised as an adverse set of circumstances and is a significant risk for non beneficial and wasteful interventions to occur. Following on from this observation, to pursue a treatment option that is not aligned with what the patient would have wanted is actually diminishing the patient’s right to receive care that is aligned with his or her values. Such circumstances can also be the source of moral distress for doctors and nurses.  Health professionals and doctors in particular need to hone their skills in communication. It has been said that “the type and intensity of health care that a patient receives is ultimately determined by a conversation” These comments emphasise the central role of clear thinking and articulation of options so that when a patient makes a decision, this “choice” is facilitated in a fashion which clearly represents the choice that is robust and consistent. Such decisions can be made in circumstances when emotion can play a part in diminishing the objectivity and clarity of decision making. It is important that a skilled health professional can probe the vagaries that are inherent in the consent process. The term “relational autonomy” goes some of the way in describing this sometimes complex process.  In addition to the previous statements that address complex decision making at the individual level, when decisions are made to proceed with potentially non-beneficial treatment, the matter should be addressed through the lens of “stewardship”. Health resources are always under pressure. At an individual level it is important that health practitioners take account of the utility of any intervention. If the utility is very borderline then a decision to proceed needs to be rigorously reflected upon. In this way the perception would be that the responsible reflection outlined indicates that person is trying to use resources in a responsible manner. The corollary of this is that at a national level health interventions undergo rigorous assessment of potential benefit.  Reference *“Non-beneficial treatments in hospital at the end*  *of life: a systematic review on extent of the problem” International Journal for Quality in Health Care, 2016, 1–14*  What I have written here |

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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### 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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| With the anticipated increased requirement for palliative services coupled with the unlikely matching increase in the palliative workforce, there needs to be a dissemination of palliative expertise so that a much wider range of health practitioners is able to professionally fulfil these needs. This requires more than just workshops, conferences , and educational material. There will need to be significant investment in widening the skill base of the medical and nursing workforce to the extent that the increasing needs of patients will be effectively met.  There also needs to be research on why people tend to die in hospital and in care facilities rather than at home. This trend is worldwide therefore I know there are no easy answers. But this is a major health need given the view expressed widely in surveys that patients want to die at home.!! |

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

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### Implementation, measurement and review

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

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### Other comments

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| **Submission 66** |



Blind Foundation Submission

**Update of the New Zealand Health of Older People Strategy**

This is the Blind Foundation’s submission on the New Zealand Health of Older People Strategy.

The Blind Foundation is the main provider of rehabilitative, support and advocacy services for blind and low vision New Zealanders. The Blind Foundation has approximately 12,000 clients throughout the country.

**Our Purpose**

To enable people who are blind or have low vision to be self-reliant and live the life they choose.

**Our Vision**

Life without limits

Kahore e Mutunga ki te Ora

**Four Key Priorities**

1. Independent living
2. Access for all
3. Reach more people
4. Building a Foundation for the future

The Blind Foundation advises government, business and the community on inclusive standards to ensure that the people we represent can participate and contribute equally. We have four major contracts with government. We value our relationships with officials and ministers. We seek to act as a trusted advisor and specialist on the blindness sector. We are a long-serving and expert provider of services to the sector.

The Blind Foundation has a long-standing and valued relationship with the Ministry of Health and we welcome this opportunity to comment on the draft strategy and to offer our support in its implementation.

# Introduction

## In 2015 the Blind Foundation completed its strategic plan for 2015 to 2020[[1]](#footnote-1). The plan’s strategic priorities align well with the Ministry’s draft Health of Older People Strategy (HOPS). In summary:

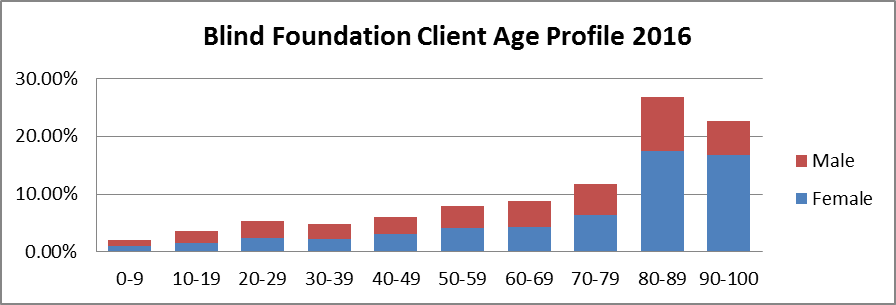
## The Blind Foundation’s research indicated that we only deal with a portion of the population in need. To address this health inequality, the Blind Foundation seeks to “Reach More People” and is developing programmes to do this.

## Accessibility in its broadest terms was also judged to be a major deficiency that has an enduring impact on social outcomes for all people with disabilities, not only those with vision loss. We are gratified to see accessibility feature in the Health of Older People Strategy. “Access for All” is a strategic priority for the Blind Foundation.

## The Blind Foundation strategic priority “Independent Living” also resonates with the Health of Older People Strategy. The Blind Foundation’s rehabilitation services aim at maximising the individual’s functional independence. The broader social and common outcomes of this are consistent with government’s investment approach. With time, we expect to see evidence of reduced acute admissions for falls and mental health and other vision related co-morbidities.

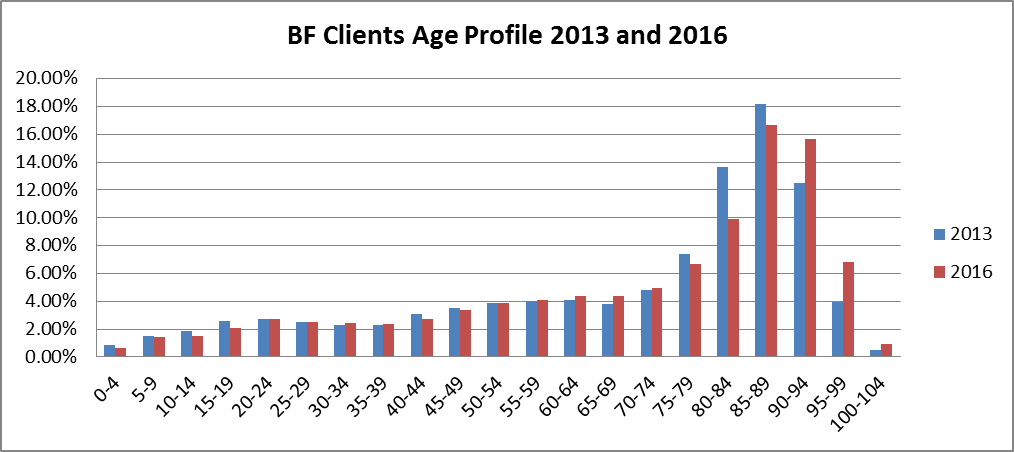
# Blind Foundation’s Client Base

The Blind Foundation’s client base is predominantly the older age groups; 66% are aged 64 and older. Also, females outnumber males by about 40%.



This is due to the prevalence of major sight diseases in the elderly, such as cataract, macular degeneration and glaucoma. Treatments will reduce the impacts of these diseases in some cases. But the overall increase of numbers in the vulnerable population aged 64+ indicates continued growth in the numbers of people who will require vision-related rehabilitation and support services over the next three decades. Currently the Blind Foundation research indicates that about 75,000 New Zealanders have visual acuity of worse than 6/12, and we estimate 66% of these are aged 64+. [[2]](#footnote-2) Of these, about only 8,000 are currently clients of the Blind Foundation.

The age profile is changing rapidly. The chart below shows that the 90+ age group has increased from 17% of the client group in 2013 to 23.5% in 2016. This trend is expected to continue.



Some key attributes of the health profile of Blind Foundation clients are as follows[[3]](#footnote-3):

* 35% regard their health as either fair or poor.
* 46% feel their general practice doctor has a limited understanding of their visual disability.
* 72% are taking regular medications.
* 86% report they do not receive medical information (medicine labels, consent forms, advisory pamphlets, doctor’s letters etc) in a suitable accessible format.
* 77% indicate they are not full independent and require some measure of day-to-day assistance with tasks of daily living and household management.

We do not have hard evidence but we believe an increasing number of Blind Foundation clients are living alone for longer. This has implications for the types and volume of services that will be required in the future. Not the least, we expect to deliver rehabilitative and social support services to an increasing number of clients who are also suffering from dementia. We are beginning to see the need for much more community-based support services and the importance of peer-to-peer support[[4]](#footnote-4).

# Alignment of Vision and Objectives

## Healthy Ageing

The strategy’s objective for healthy ageing hinges on older people maintaining their functionality (HOPS, page 14). This is a core value for the Blind Foundation and is found in its strategic priority of “Independent Living”. Blind Foundation programmes ensure that people have the skills to adapt to the impact of blindness and low vision[[5]](#footnote-5). Our practical experience is that vision plays a very important role in enabling older people to retain their independence. A study commissioned by Vision Australia[[6]](#footnote-6) found that there was a significant positive social return (including reduction in forward welfare liability) based on the increased numbers of people with blindness or low vision over the age of 64 who were able to remain in their own homes.[[7]](#footnote-7) This also benefits caregivers and enables greater social and economic participation by those who might otherwise be in care. Our experience in New Zealand parallels the Australian work. The Blind Foundation’s strategic priority aligns with the government’s investment approach.

The Blind Foundation works with people who are blind or have low vision for the remainder of their lives and is able to monitor and encourage a person’s resilience. We continue to assess the client’s needs and capabilities over time so the support and skill can be adapted as the person ages.

The Blind Foundation also has a strategic priority of “Access for All” (HOPS, page 15). This is also an essential element, as independence of older people has to extend into all aspects of the community. The accessibility of buildings, streets, transport systems and information systems is vital. This requires an all-of-government response, and the Blind Foundation is currently working with other leading disability agencies on advocating for legislative and regulatory changes to meet the accessibility challenges of the next two decades.

## Acute and Restorative Care

The Blind Foundation’s services for older people include the post acute follow-up where vision loss has come about quickly or has followed an acute episode. Where vision loss is profound, the rehabilitative approach aims at replacing vision with sight substitution skills that help maintain the person’s independence. It is important for the Blind Foundation to maintain close contact with public hospital services to ensure the prompt referral of clients. Recent research by the Blind Foundation indicates that more than half of the eligible clients from district health boards may not be referred.[[8]](#footnote-8) This will lead to inequalities of care, and we are researching the reasons for this and ways to improve the care pathway. The strategy’s proposal for a single point of contact between secondary care and community-based services (HOPS, page 18) and shared assessment process, will help the client’s transition and return to the community. The Blind Foundation also puts stress on the assessment of the client’s needs and capabilities to create an individualised care plan that suits the client and family or whanau.

## Living Well with Long-term Conditions

In almost all cases, vision loss is for life. This underlies the Blind Foundation’s client care model that follows the person’s life stages. The Blind Foundation thinks considerable investment is needed across the health and disability care sectors to provide both clinical services and the psycho social support that will be required (HOPS, page 20). We also suggest that the mix of services has to be reviewed. The Blind Foundation’s practical experience is that recreational services are vital to maintaining older people. The Blind Foundation is seeing increasing interest, for instance, in its technology training services, and older people becoming avid users of technology that is fundamental to independent living.

# A National Eye Health Strategy

The Blind Foundation is currently developing a proposal for a National Eye Health Strategy that will address many aspects of the Health of Older People Strategy, but it resonates very strongly with the HOPS reference (page 21) to prevention, detection and the need for public awareness. The Eye Health Strategy proposal is being developed by the Blind Foundation in conjunction with other eye health professionals and will deal with:

* developing the understanding and perception of eye health in the public and political sectors
* committing to research that will support an evidence base for progressing eye health initiatives
* developing the continuum of eye health for the New Zealand market to ensure there is a clear understanding of the pathway the public should follow as they progress through the system.

The priority populations noted also resonate with the Blind Foundation’s experience. Within our strategic priority of “Reach More People,” the Blind Foundation intends to improve the uptake of services by Maori and Pacific peoples. Both are underrepresented in Blind Foundation client numbers. This was researched within the prevalence study mentioned earlier, and it was found that both groups were similarly underrepresented in the DHB data on which the study was based, so we believe priority population issues are widespread.

## Support for People with High and Complex Needs

The Blind Foundation is able work within teams to support people with high and complex needs where vision loss is a factor. Typically the Blind Foundation’s services are delivered in the person’s own home, which is consistent with the strategy (page 24).

# Action Plan

The Blind Foundation thinks the action plan supporting the strategy is well thought out and is a welcome addition to other recent sector strategy documents that lack the pragmatic approach shown here. We particularly approve of the allocation of responsibility and the inter-agency approach. We note the references in the action plan to non-governmental organisations in relation to the importance of community care. The Blind Foundation is confident in its role but wishes to draw the Ministry of Health’s attention to the recent report “Effective Social Services” by the Productivity Commission. It is not our intention to review that report but its comments about the fragility of the NGO sector; long-term financial sustainability and maintaining its workforce need to be recognised in the strategy if the action plan is to be achieved.

## Suggestions for Inclusion in Action Plan Section

We have a number of suggestions for inclusion in the action plan that will help the early uptake of services by people with sight loss:

1. The body of the HOPS, as well as some points in the action plan, refer to priority populations (page 22). This includes people with disabilities and members of specific ethnic groups, which aligns with the Blind Foundation’s client base and services.
2. There are a number of ways in which we can minimise the harm of sensory loss and the loss of functional ability in older people. Timely recognition of emerging sight and hearing issues, for example, appropriate assessments for functional impact and better approaches to enablement can make a significant difference to how well people are able to live and participate in everyday life and remain independent.
3. We suggest inclusion of screening and treatment for eye health to minimise the risk of negative outcomes from conditions such as macular degeneration, glaucoma, and other progressive conditions.
4. We recommend that a reference in the action plan section of the document reflect the point above on timely functional assessment. We note there are specific action plan points regarding other specific issues including dementia, oral health, diabetes, musculoskeletal health, mental health, physical and sexual abuse, and drug/alcohol addiction.
5. There are several mentions of using technology to get more health and disability information and social connectivity to older people, including some action plan points about this (4e, 4f, 13a, and 13b). Many of the action points, such as increased information, education, social integration, and person-centred approaches, rely on the ability of the older person to access information and services. Vision/hearing impairments are a fundamental yet often overlooked obstacle. The Blind Foundation could provide increased/improved training for residential/medical staff, caregivers, other service providers, community members, and family/whanau to improve how health services are accessed by people with vision and other sensory impairments.

# Conclusion

The Blind Foundation is of the view that the strategy being proposed is credible and well designed. The emphasis on a life stages approach and the importance of social and community supports is a vital change from the institutional and mostly technical approaches of the past. Within its own area of expertise, the Blind Foundation is proactive in forming networks for eye health care that aim to maximize the individual’s independence and social and community participation for as long as practical.

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| **Submission 67** |

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

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

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

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

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

Do not publish this submission

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

Remove my personal details from responses to Official Information Act requests

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

Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training provider  Local government

Service provider  Government

Non-governmental organisation  Union

Primary health organisation  Professional association

Academic/researcher  Other *(please specify)*:

### 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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| It would be useful to make the connection between being healthy and living in a healthy home, i.e. warm and dry.  The CDHB part-funded a Healthy Homes Programme for several years which reduced hospital admissions by 29% for people with relevant health conditions. This funding has ceased which is remarkable considering the outcome. Work with EECA and other partners to reintroduce this programme. |

### 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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| Train hospital staff specifically to understand dementia-related behaviour and what it is like for someone with dementia to be taken out of the safety of their home into hospital and the challenges this creates for everyone involved including the family. This would reduce challenging behaviour (from all parties!). |

### 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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| --- |
| Take an holistic approach to the person living 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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| Provide a designated navigator to help them get through the system, particularly for those with multiple co-morbidities. |

### 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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| Navigators will be crucial. |

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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| Use the knowledge gained through looking at why some ARC providers can provide care to people with high and complex needs more appropriately and successfully than others, including appropriate hospital admissions and quality end of life care. What are the key factors that make them successful and how can these factors be packaged in a way that assists those ARC providers that areless successful to rise to this standard.  Get Carer Support funding sorted. It is unwieldy, unnecessarily bureaucratic and the amount paid is far too low.  Look at how to provide night sitter services. Carers of people with dementia, for example, are more likely to opt to put their loved one into an ARC facility if they are exhausted. It is expensive, but it must be more cost effective than having people go into ARC more quickly than is necessary.  Find a standard Carer Assessment tool (more than InterRAI currently provides) that can be used nationally to gauge how carers are managing and what supports are needed.  Provide funding for technology to the equipment providers, so things like electronic medication management can be rolled out. |

### 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?

|  |
| --- |
| Great to see this included. Missing from the Health 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?

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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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| Utilise older people and their families’ experience of services – secondary, primary, and community. Mandate that DHBs have to Interview a certain number of people aged over 75 each year as part of their quality improvement cycle and utilise the feedback to improve services. |

### Other comments

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| Where is research in this document? There are so many opportunities to fund and support, e.g. community providers to carry out “grass roots” research that can be easily translated nationally. |

1. <https://bf-website-uploads-production.s3.amazonaws.com/uploads/2016/03/Blind-Foundation-Strategic-Plan.pdf> [↑](#footnote-ref-1)
2. Blind Foundation Prevalence Study of Blindness and Low Vision in NZ. The 6/12 visual acuity measure is generally the threshold at which people begin to need services. [↑](#footnote-ref-2)
3. Blind Foundation Client Survey 2014, questions 60 to 68. [↑](#footnote-ref-3)
4. Blind Foundation Recreation Survey 2013 [↑](#footnote-ref-4)
5. Blind Foundation Strategic Plan 2016, page 8 [↑](#footnote-ref-5)
6. Australian equivalent of the NZ Blind Foundation [↑](#footnote-ref-6)
7. Vision Australia "Independence in the Home," VA 2009 [↑](#footnote-ref-7)
8. Prevalence of Blindness and Low Vision in New Zealand, Dr S Thornley. Blind Foundation unpublished paper, 2016 [↑](#footnote-ref-8)