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

**Consultation submissions**

**68 – 108**

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| **Submission 68** |

I welcome the review, lots of positive moves in it, so thank you for that. Suggestions, which may or may not be useful: There could be a subtle shift for some of the wording to help focus on *improving* health - rather than simply being resilient towards injury and damage - what I mean by this is that elderly, retired and health literate people have the perfect opportunity to improve their health. I may be mistaken, but I don't think any mention is given to specifically improving health in older age. Because elderly populations are often highly health literate, time rich, and interested in health, they are (often with a bit of guidance) able to implement positive lifestyle changes. As a practitioner, I feel like this aspect of care is perhaps underemphasised. One such sentence where this could be integrated: "Allied health staff (such as occupational and speech language therapists, dieticians and physiotherapists) offer a range of skills to support people’s rehabilitation, recovery and restoration" Perhaps the focus should be expanded: "Allied health staff can contribute to improving health of older people, support people in their rehabilitation, recovery, and restoration."

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| **Submission 69** |

Having read through the consultation draft I am concerned that it continues to show future strategies for older people based on the current model.

Whilst there will always be those who have need of a medical based older persons strategy, there are rapidly increasing numbers of people in their 50’s and 60’s who view their health and ageing quite differently to previous generations. Whereby the term “preventive healthcare” in the draft document refers to mainstream medical advice there are, and will continue to be, growing numbers of people who view preventive healthcare differently.

Preventive healthcare can and increasingly frequently does mean the taking of dietary supplements and other natural therapies as well as using natural health practitioners of various disciplines. When intervention is required by older people it no longer necessarily means visiting a medical practitioner or it means visiting one who practices integrative medicine.

Even in cases of acute care the “new” older generation will not necessarily accept ongoing medical care once the acute phase has passed preferring to use natural therapies.

This can and will extend to end stage care and it is important that rest home staff understand and respect the wishes of their residents who reject the standard medical based model and every care should be taken to ensure that the residents are given what they request and not what the rest home staff and management think they should have.

It would be a huge mistake to ignore the fact that people are changing and the “baby boomer” generation has different expectations of what growing old means compared to their parents and grandparents.

If the ministry ignores these important points now when planning the strategy it will backfire in the future.

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| **Submission 70** |

Hi. Sorry for slow response.

We had a meeting today here at Vaka Tautua of a few Pacific representatives from the health sector who had decided to hold their own workshop and we worked through the format and this will be sent through as a submission once the wider group have endorsed it.

This was very useful exercise and I also checked out the questions you sent below as it better informs my input to the EAG.

Briefly the feedback is:

People are not aware of the online forum at all.

They were not aware of the coming round of workshops ( so we will send that information around the group and encourage attendance). It would be useful to send something we could also put on social media as we use Facebook a lot to get such information around the community.

The workshop resources are very reliant on people having read the whole strategy document in an advance. Obviously this is what people should do but the reality is that many will not. So perhaps a powerpoint presentation that explains in summary what the draft strategy says on each key part of the action plan would be useful.

The narrative is good.

The action plan was well discussed and the conclusions the group all came to prior to attending today ( which I concur with) is that although Pacific people are recognised as being in the most vulnerable and high needs group with Maori this is not reflected in the first two years.

It is very noticeable that when we went through this together we were surprised at this as you would expect the actions targeting the most vulnerable would also be the most urgent to start addressing.

A n issue that also stood out as being totally missing was any mention of hearing and sight loss. We were all pleased with the oral health actions but didn’t understand why the other two issues were not considered important.

The last question about the possible derailment or serious limitation of the effectiveness of the strategy was answered very simply. If the Maori/ Pacific action points are not bought forward to begin in the first 2 years then this would be a major issue.

Hope this feedback is useful – I certainly found sitting in this group today of well-informed practitioners was extremely useful for me as it better focussed my thoughts in a way just reading things doesn’t do.

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| **Submission 71** |

This is a submission from Grey Power Horowhenua  Health Committee.

While we agree with the tenor of the Strategy Statement and all of the steps advocated in enhancing the health of our ageing population, the Strategy is basically an **interim** document, and we are more concerned about what what the Strategy Document  **doesn’t say.**

While the Strategy makes much (ie uses a lot of words) of objectives to enhance the health of older people, we consider it fails dismally to recognise and acknowledge that the health of older people starts way back with the health path available to a new-born child. Starting with measures to improve the health of 65+ people sounds very much like applying bandages to existing problems – necessary, but not getting to the root of the matter.

Our view is that one needs to take a step back from the Strategy and adjust  to a wider focus, and of course a much longer time frame is required.

     \* Our diet is a major contributor to national life-long problems.

     \* One in three New Zealanders is obese and as a consequence 35% of adults are overweight.

     \* These figures indicate that the MOH Childhood Obesity Plan should be consciously lurking in the background of this Health of Older Persons Strategy Plan.

Finally, Restorative Care as detailed in the Strategy, and even as it exists at present, is **far too disjointed.** There is a need, which the Strategy does not address, for over-arching co-ordination in the diagnosis, delivery and rehabilitation specialisations.. We suggest ‘Lead carers’ could be made responsible for the co-ordination and oversight of all the input services an individual patient may require,

for Grey Power Horowhenua Health Committee

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| **Submission 72** |

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| Organisation (if applicable): | RNZCGP, Hospice Waikato, PCAP |
| Position (if applicable): | GP, Palliative Medicine Advanced Trainee, PCAP member |

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

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

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

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[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training provider [ ]  Local government

\*[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Union

[ ]  Primary health organisation \*[ ]  Professional association

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

### Healthy ageing

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

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|  ‘die well’ is nowhere in the NZ Health Strategy, though it is good to see ‘respectful end of life’ in the HOP StrategyNo mention of Advanced Care Planning under the resilience heading – giving people a voice for the care they want, not just at end of life; especially important to discuss issues like this with those in early stages of dementia |

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

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| 4c seems like more of a priority that warrants attention sooner (enhance health promotion and service information to Maori, Pacific and other ethnic communities…). While uptake of technology might seem important from providers’ perspective I’m not sure consumers would see that as their priority. |

### 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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| A single person to coordinate care across services is a great idea.Again, advanced care planning may allow appropriate goals of care and ceiling of care to have been discussed prior to presenting to hospital – this may reduce inappropriate treatment or admissions.Integration of care must include urgent attention to shared records – information is either lost or duplicated (at some cost) when assessments, treatment, care plans are not visible between services and across sites. We need IT support to facilitate better communication between providers. |

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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| I think 6a needs to be a priority – supporting discharge planning and ongoing rehab directly impacts on hospital readmission rates, injury prevention, and maintaining care at home. This is an area not currently done well and needs attention. |

### 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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| Primary care and community support services ARE well placed to do this, but will very quickly be overwhelmed by the workload unless we resource them adequately |

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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|  Does 9d ‘those working in aged care’ mean all providers? This seems a bit vague when perhaps the GP workforce crisis warrants it’s own action point? Though we do need to recruit and retain staff across the spectrum (doctors, nurses, allied health, non-professional …).The priorities highlighted in 11-13 are good.  |

### 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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|  Shared health records are again a priority. Shared care plans accessible by all teams involved.Good to see recognition for carers and support workers, they do play a large role for this groupThere is large inequity for those in rural areas who have to travel large distances for ongoing follow-up, we could make better use of technology to support this (telemedicine, video-consults for example) |

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

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| Agree that 18a is 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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| Good to see advanced care planning coming in here – but we miss opportunities if we just leave them for end of life care, for those with long-term conditions they should be considered at the earlier stages (as discussed above).Good to raise the profile of death and dying as a normal part of life. |

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

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| 23a should be a priority, though I suspect it will be covered in the Review of Adult Palliative Care Services recommendations |

### 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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| Well set out with good priorities. Good to see a balance between strengthening professional services and the ‘non-skilled’ carers. |

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| **Submission 73** |

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| Organisation (if applicable): | MidCentral District Health Board |
| Position (if applicable): | Palliative Care Network Coordinator  |

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

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

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[ ]  Pacific [ ]  Consumer

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[ ]  Education/training provider [ ]  Local government

[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Union

[ ]  Primary health organisation [ ]  Professional association

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

### Healthy ageing

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

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| The overall vision for the Strategy is valued and appreciated as it encompasses a lifespan approach which includes respectful end of life care. As a Palliative Care District Group this approach is viewed as positive. |

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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| Establishing age friendly communities is very broad and a number of more detailed actions will fall out of this. Supported housing and improvement on health literacy are examples of focus areas. |

### 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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| Older people who enter acute care services may experience the following; * Do not return to baseline functioning
* Leave with additional chronic long term conditions/disability
* Experience/succumb to a terminal illness

Accessing MDT input in a timely manner, assessment and resources on discharge are critical to enabling return to the community safely.Physically being able to access services in an acute or restorative event e.g. physical in terms of access to buildings, distances and physical location of people and services particularly for those in rural areas. “Systems” will need to be person centred rather than service centred and will need to talk to each other.The quality of access to services and MDT will have an impact on discharge and potential readmission to acute care services.A system that enables supported recovery time is valuable as is a system that has capacity to support the family/whānau without undue financial burden. |

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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| Providing effective rehabilitation closer to home is seen as valuable and partnerships will be key to success. An early focus on this will have an impact of effectiveness.Knowing the persons wishes will be critical in appropriate access to acute services, ACP and Advance Directives will be critical in the planning and access of services for individuals.Regular cognitive function assessment will also be a key to effective planning of care and ability to self manage. |

### 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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| Those living with long-term conditions often access multiple services and these need to be well connected to reduce duplication. Care coordination and collaborative integration will enable reduction in duplication. |

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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| Workforce development through education and training will support living well with long term conditions. Information that is streamlined and accessible to multiple health providers will also enable timely supportive care to those with long term conditions.  |

### Support for people with high and complex needs

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

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| Access to information across a number of services will streamline care and assist in care coordination. Ensuring older people with complex needs have their own health goals and wishes central to actions and delivery of services. |

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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| Regular assessment and preplanning will mitigate a number of critical incidents. ACP and anticipatory care planning or action plans in place will support older people and care delivery.Workforce development and education will support those with complex need.  |

### 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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|  A quality focus needs to be reinforced with quality standards and measures.The sector needs to aware of what level of palliative care need can be supported in primary palliative care. |

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

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| Education; both public and across disciplines (undergraduate and postgraduate) is essential. A Last Days of Life Care Plan should be best practice regardless of care setting or diagnosis.Reference is made towards the person’s preferred place of care – this may change and alter as disease progresses and changes.A high level of mortality in ARC and acute care settings indicates that there need to be supportive spaces for those who are dying and their family and whānau, i.e. connected to the outside world and are less clinically focussed.Supporting end of life care at home has an impact on family and carers. There needs to be 24 hour care responsiveness for those in the community (i.e.24 hour DN service availability). A maternity leave is considered supportive to families and should it be time to consider support for those caring for Family members at end of life.Care after death needs to be included, including care of family/whānau – bereavement support and grief and loss support.Communication skills that are timely, respectful, sensitive, culturally appropriate and clear are critical in health care but particularly at end of life. |

### 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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| Having older people as part of the implementation process is critical. An outcomes and measurement framework allows for effective evaluation against progress to the Strategy goals. Information sharing across IT platforms will enable progress, improve quality and allow for effective measurement and evaluation. |

### Other comments

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| Bereavement support/follow-up/services are not evident in this document. The requirement for bereavement support will not be global however having systems to identify or assess for those at risk of, or are more likely to experience complicated grief and bereavement is required across the sector. Lack of bereavement support can have major health impacts.  |

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| **Submission 74** |

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| Organisation (if applicable): | Auckland District Health Board. |
| Position (if applicable): |  Chronic and Long Term Condition Directorate |

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

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

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[ ]  Service provider [ ]  Government

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[ ]  Primary health organisation [ ]  Professional association

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

### Healthy ageing

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

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

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

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### Acute and restorative care

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

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

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

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

### Living well with long-term conditions

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

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

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

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

### Support for people with high and complex needs

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

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

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

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

### Respectful end of life

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

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

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

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

### Implementation, measurement and review

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

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

### Other comments

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| **Submission 75** |

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| **Health of Older People Strategy** |
| **Page** | **Information** |
| **3** | * A significant improvement in the quality of health care in aged residential care, and we are making improvements in home and community support services
* Better quality information on health services for older people
 |
| **4** | Improved discharge planning, aiming to strengthen connections between acute hospital services and health services in the community such as CREST and START |
| **11** | We need better communication between health service users and providers, to ensure that services are as effective and efficient as they can be. |
| **13** | **Visions and objectives**Enable high-quality acute and restorative care, for effective rehabilitation, recovery and restoration after acute events |
| **17** | Rehabilitation is an ongoing process. Family and whanau involvement should form part of any rehabilitation plan, especially where an older person returns to their own home. |
| **19** | **Our vision for acute and restorative care**Older people requiring urgent or planned hospital treatment benefit from best practice restorative rehabilitation strategies, discharge planning and follow up support. |
| **P33** | **Action Plan**Acute and restorative care:**Goals:** Best practice restorative rehabilitation strategies, discharge planning and follow up support are in place for older people requiring urgen or planned hospital treatment.Older people are supported through recovery and the return home. |
| **Case Study - Tokoroa*** 81 year old gentleman has metastised melanoma and a short time to live.
* For the second time over four years he stayed at the Braemar Cancer Lodge while he had 5 weeks of radiation each time.
* In March this year he attended Oncology for results of CT Scan. Tumors were aggressive throughout his body and was told he had two months to live and would not last until Xmas 2016.
* After this meeting in March he returned home with his wife and his health has deteriorated every day – and requires help to move around, get out of his lazy boy chair and unable to shower himself.
* His wife is committed to all his 24 hour personal care while trying to do normal duties and snatching time during the day to get groceries and other needy items.
* Palliative nurse attended each fortnight and district nurse each week.

I presume that because he was not in Waikato Hospital there was no wrap-around care plan set up for him. Several weeks ago district nurses were able to get a few hours for home help.Last week this gentleman was admitted to Waikato Hospital to the Acute Medical Ward – and last week transferred to Tokoroa Hospital.He will be discharged this week, and already every day personal care and 2 hours home help has been put in place for this family and the hospital bed was put in the house yesterday.This gentleman who is dying, was disadvantaged because he was not a patient in hospital, but undergoing several weeks of radiation. This case shows all of us the void in a well planned system. In recent weeks he has been given one and half hours a week via the acute system. He has had no daily personal care since last March.Maybe we can learn from this and make sure people who are sent home  |

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| **Submission 76 withheld at submitter’s request** |

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| **Submission 77** |

DAH feedback on the HOP Strategy:

Ministry appears to have listened carefully to the feedback given by DAHs and included this in the plan.

Further feedback :

* The plan is very comprehensive with many actions required by DHBs that would require significant systems change and resources
* The plan may require some rebalancing as the items related to Drug and Alcohol have more prominence than might be expected and dementia for example, less prominence
* It would be helpful to prioritise the list of actions to set out those that are most important for urgent resolution-older people need to provide input into deciding this
* Measurement, particularly of outcomes will be very important to determine whether this plan is being delivered effectively
* There are some issues that have not been included and are of importance to the health of older people, including continence, foot care, sensory impairment and psychological therapies for common conditions such as anxiety and depression

In addition

Not sure I see a link with mental health services for the older adult – the strategy is very physical health orientated. Dementia is mentioned but other mental health presentations and the impact is not really there.

Hope that is useful. If you have any questions or comments please let me know, I am happy to follow up with the group etc.

Thank you for the opportunity and sorry again we couldn’t squeeze you into the meeting last week.

Much appreciated,

DHB Shared Services

A national arm of TAS

PO Box 23075, Wellington 6140

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| **Submission 78** |

To Whom It May Concern:

**Re: Draft Health of Older People Strategy**

Thank you for the opportunity to provide feedback on the above strategy. As you may know, the Australian and New Zealand College of Anaesthetists (ANZCA), which includes the Faculty of Pain Medicine, is responsible for the training, examination and specialist accreditation of anaesthetists and pain medicine specialists and for the standards of clinical practice in Australia and New Zealand. ANZCA’s mission is to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine. The New Zealand National Committee (NZNC) of ANZCA has reviewed the draft strategy, and provides the following feedback.

Overall, the NZNC commends the Ministry on its draft Health of Older People Strategy. The strategy is comprehensive, and identifies a number of key components for improving the health and wellbeing of older people. In particular, the NZNC supports the following aspects of the strategy:

**Reducing inequity**: the NZNC strongly supports the focus of reducing the inequity in health outcomes that exists between different population groups in New Zealand. The NZNC commends the focus on removing barriers that prevent equitable health outcomes, and acknowledging that further work is required to improve understanding of how well health services work for different population groups. ANZCA also strongly supports the reference to the principles of The Treaty of Waitangi, and the importance of delivering services that are effective for Maori.

**Frailty**: The NZNC supports the suggestion that further research into frailty, and how to prevent or reduce the impact of frailty on the health of older people, should be undertaken.

**End-of-life care**: The NZNC supports the strategy’s focus on the right to a respectful end of life, and improving discussions between patients, their families, and health practitioners about death and end-of-life care. The NZNC notes that workforce planning and adequate resourcing for palliative care will be an essential component to support this aspect of the strategy.

There are also two key components of the strategy that the NZNC considers could be strengthened further:

**1. Perioperative care**

The NZNC strongly supports the strategy’s focus on acute and restorative care and restoring function after acute events. However, the NZNC considers further emphasis needs to be placed on the quality of the perioperative care of surgical patients. Anaesthesia and surgery have continued to increase in safety such that adverse events within the operating theatre are now relatively rare. However, there is significant scope for further health outcome improvement through pre-surgical optimisation, improved post-operative care and a reduction in failure to rescue from complication. The NZNC also considers the strategy should further emphasise pre-operative assessment for older adults, and the importance of improving discussions between patients, their families, and health practitioners about the likely outcomes and risks of any intervention, as well as the likely outcomes and risks of other courses of action, including *not* intervening. This is in line with the personal care planning articulated in the strategy. It is similarly in keeping with the intentions of the Choosing Wisely initiative being led by the Council of Medical Colleges in New Zealand. The value of prehabilitation before elective surgery to improve outcomes also needs to be recognised. Although prehabilitation comes at a cost, the potential benefits reflect the overall aims of the strategy, particularly in restorative care.

**2. Chronic pain and workforce planning**

The strategy recognises that chronic pain is highly prevalent among older adults. This is supported by research from the Ministry of Health, with the *New Zealand Health Survey Annual Update of Key results 2014/15* demonstrating rates of chronic pain increase with age. With an ageing population, chronic pain is likely to continue to increase in prevalence, making it a critical public health problem. Indeed, the *New Zealand Health Survey* found that the prevalence of chronic pain for New Zealand adults has increased from 17 per cent in 2006/07 to 20 per cent in 2014/15. Equity issues are also evident from the survey, with New Zealanders who live in socio-economically deprived areas experiencing higher rates of chronic pain.

Chronic pain is a major cause of health loss in New Zealand, accounting for at least 5 per cent of disability-adjusted life years from all causes, a burden similar in size to anxiety and depressive disorders. This is documented in the Ministry’s *Health Loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study 2006-2016.*

Despite the increasing prevalence of chronic pain, there is a shortage of pain medicine specialists in New Zealand. The Faculty of Pain Medicine has 27 Fellows currently practising in New Zealand, mostly on a part-time basis, equating to approximately 11 FTE specialist pain medicine physicians nationally. The NZNC therefore emphasises that adequate workforce planning will be required to ensure adequate care can be provided to older people suffering from chronic pain.

Thank you once again for the opportunity to provide feedback on the draft strategy.

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| **Submission 79** |

**Health of Older People Strategy Update-**

**Submission from Australian and New Zealand Society for Geriatric Medicine (ANZSGM) (NZ division)**

We thank you for the opportunity of making a submission on this revised HOP strategy.

The HOP strategy sits within the context of the overall NZ health Strategy with its five key elements of (1) people powered (2) Closer to home (3) Value and High performance (4) One team and (5) Smart system.

The HOP vision that “Older People live well, age well and have a respectful end of life in age-friendly communities” is laudable and is a vision we as a society fully endorse. It is upheld by five key outcome areas of (a) Health ageing (b) high quality acute and restorative care (c) live well with chronic conditions (d) support for high and complex needs and (e) respectful end of life care. Again these outcome areas are ones we as a society support.

The strategy covers all of the important issues in terms of headings and general content. However we see a gap, namely the functional decline or disability that does occur at increased frequency in older age. Disability and functional decline is alluded to in “timely acute and restorative care”, but only gets a brief mention in living with chronic conditions. Prevention and management of these chronic conditions is vital (as mentioned), but for many older people, their arthritis or multifactorial breathing difficulties or cognitive impairment are already established, with associated disabilities. It is these disabilities that limit an older person fully participating and these disabilities need managing, and prevention from worsening. Furthermore, under (d) support for high and complex needs, coordination, flexibility, closer to home are all mentioned and are entirely appropriate. Many other older people, particularly over 75 years, have some disability, but is neither high nor complex needs, yet it is vital that these people are also supported appropriately to maximise their participation and quality of life. Without attention to the mild- moderate end of disability supports, they will progress to higher need with greater complexity.

In addition, the document is light on the impact of *frailty* and *dementia*. Again these are alluded to under acute and restorative care, but if we are to successfully manage the increasing number of people with frailty and / or dementia, our systems of managing acute illness in frail older people needs to change. Prevention and mitigation of frailty, and preventing people transitioning from pre-frailty to frailty are neglected topics. Similarly patients with dementia need good acute and restorative care, but current models of providing this care do not serve this group of people well.

Access to podiatry, and transport issues (including driving) are only briefly mentioned but are important in the health of older people.

Heterogeneity with large variations in health, resilience, physical and cognitive functioning, is the hallmark of our older population. The WHO life course framework as illustrated on page 7 highlights that in older age, there is much greater variation in needs and abilities than in a younger population. Thus a multifaceted approach is needed for managing the health and disability needs of the older population. What works for the younger (e.g. <75), generally well older person needing preventative and short term approaches will not work for a moderately disabled person with multimorbidity. This will also be different to the needs of a frail older person with both frailty and dementia. A “One size fits all” approach will not work, and the strategy needs to have many approaches.

Whilst acknowledging the document is an over-arching strategy document with a large number of good statements of intent, it is frustrating with the lack of specificity and the failure to identify current gaps and ways to rectify them. Implementation plans also lack specificity and frequently have no defined time frame.

Furthermore, the implementation plans do not have funding attached and it is here where the laudable aims of the strategy are likely to fail. Many of the action points list DHBs as the lead agency, but these DHBs are already under tight fiscal restraint. They are unlikely to be able to implement new approaches without funding assistance

The overall impression of the strategy, given its opening concerns regarding population changes, is that there is no sense of urgency or direction. The ageing population was clearly signalled in the HOP Strategy 2002[[1]](#footnote-1), and continues to steadily increase. The proportion of older people (65+) has increased from 11.5% in 2002 to 15% now and is predicted to be 22% in 2033. There is an urgency to invest now in new ways of doing things, so that we can manage in another 14 years’ time (the cycling time for revision of HOP strategy). At present, it gives a vague and hazy feeling that changes will happen by ill-defined actions of departments or collaborations which barely exist.

The strategy talks of the health system being “data-rich” and we need to harvest this data and utilise it for enhancing the care of older people. We agree, and welcome this. However this will take investment in terms of time, software and money.

* The main datasets in the system are largely about resource use and are very light on relevant patient outcomes. For managing older people, we need data sets that capture routinely functional outcome measures.
	+ For example the current Ministry of Health system level measures relevant to older people are *acute hospital bed days per capita*, *amenable mortality* ((75years and younger) and *patient experience of care*. Of these, only the latter measures relevant patient outcome data and its value will depend on how it is collected and used. The amenable mortality metric specifically excludes the “old-old” age group (75+) which are the high users of the health (and disability) system. Function (or independence) is more relevant to older people, yet is not measured
* Large clinical data sets such as InterRAI are available, but the data is not readily accessible to clinicians at the coal face to use on a day-day basis. This needs to change with software that is interactive, intuitive and links with existing patient management systems so that this patient data is useable.

As with any strategy document the success depends on the implementation plan and whether this gets achieved. For many of the action points, there will need to additional funding for them to be achieved.

We are pleased to read that the Ministry of Health will review this strategy, and its delivery, every 2 years. We believe this is vital to ensuring the ideals are translated into practice. Such reviews should also maintain the sense of urgency mentioned above. The ANZSGM are happy to contribute ideas to this and we would welcome any approach.

Some specific comments include:

**1) Health Ageing**

Item 1. Build social connectedness and wellbeing in line with the Positive Ageing strategy.

Building age-friendly communities has a 2 year expectation of implementation. We have no knowledge on how the Office for Seniors might be able to do this, nor is the timeline achievable. This requires a societal change, with affordable community housing options that are warm, dry and well insulated. At present, one of the few options for older people who want to move into a supported community, is to consider moving into a retirement village. However the capital required precludes this as an option for the poorer older person, who perhaps needs it most.

Other options are all irritatingly vague in that they lack specific actions or time frames

Item 2. Increase Resilience through local initiatives.

Strength and Balance programmes. We support this, and think it is achievable with good evidence to support its efficacy. Many areas previously had such programmes and these need to be re-established if funding from ACC is reinstituted. There should be some population level targets to ensure programmes are not only implemented, but reach enough of the population, and have some relevant outcome measures (reducing falls)

Green prescription programme is valuable and should be supported

Resilience is already strong in many older people, and may have much to teach a younger population

Item 3. Work across government to prevent harm etc.

These should be existing initiatives for prevention of Elder Abuse, rather than new initiatives. Point e is vague as for item 1 above

Item 4. Improve Health Literacy are laudable, important but lack specific targets.

It must be recognised that the group of frailest, more dependent older people may have the least access (financial or cognitive skills) to such technologies

Improved health promotion to promote physical, mental and social activity is important

4e. This would need to be part of a wider information technology project.

Item 5. Improve Oral health etc.

Oral health is an important determinant of wellbeing and nutrition, yet current access to dental care is frequently unaffordable or inaccessible for a large segment of the older population. Financial barriers are huge. In addition, the oral health needs of residents in residential care are often neglected due to difficulty getting to dental care.

**2) Acute and restorative care.**

Item 6. Support effective rehabilitation closer to home.

6a. This should already be happening. Thus it is unclear what changes that the strategy is promoting. One target that is achievable is the development of early supported discharge schemes (accessible for frail older people) in all DHBs.

Item 7 Outcomes from Injury prevention

7a. We support the implementation of fracture liaison services and a national hip fracture registry.

Does this policy imply that the Ministry of Health (or other Ministries) will fully support the establishment and maintenance of the Hip Fracture registry? Currently it is partly, but not fully, funded.

ACC support is really important in assisting older people regain independence after injury.

However we as geriatricians are frustrated by some of the “silo” mentality of ACC, whereby it fails to acknowledge the differences in an older person having injuries, compared to younger person. For example, an older person previously managing independently at home alone, can have major problems coping with an arm fracture, yet ACC provides only the same supports as for a younger person with similar fracture.

Unilateral decisions by ACC to withdraw support also undermine the concept of coordinated, linked care, let alone the confidence of the older person. For coordinated care, with maximisation of independence, we need to breakdown the injury / health and disability dichotomy.

Enhancing and implementing require financial and other resources. Will these be available?

7b. “Big Data” – what is this and how does it fit with national data strategies?

Item 8. Reduce acute admissions

8a. Acute admissions are really important to ensuring an older person gets prompt, appropriate medical care when they need it. Therefore the majority of acute admissions are valuable and should not regarded as “bad”.

However we acknowledge that once in hospital, some older patients are disadvantaged and have functional declines that may be preventable. This strategy could be strengthened by plans to deal with frailty both in the acute hospital and in community. Frailty pathways, with practical alternatives need to be developed. We believe the strategy has a huge opportunity to influence what is appropriate acute care for frail older people, particularly in the hospital setting.

Is there a funding pool (even as start-up grants) that would help “Initiate” this?

**3) Living Well with Long-term conditions**

9. Those working with patients have training

All goals are admirable. We agree that training and support, and retention of care workers, and other community workers is vital to managing people with disability in the community. This training and support has been discussed for many years, and we do not see anything in this document that will change the current situation. Financial reimbursement (pay) and job satisfaction for care workers remain a key issues in workforce retention. Training of care workers needs to have financial incentives such as time spent training is paid for, and additional training/qualifications is rewarded by higher pay

ARC recruitment and retention has also been discussed for some time. There are similar issues to community care workers

10. Enhance cross sector whole of system working

We agree this is aspirational but actions are vague.

We support better liaison across pharmacists and other health providers, and the pharmacists’ role in medication management.

However it is vital that not only medication management, but reduction in polypharmacy is addressed. This requires major cross sectorial approach, starting with prescribers.

11. Delivery of services etc.

11a. Unclear what this means

11b. As with age friendly community mentioned earlier, the concept of “dementia friendly” society is laudable but action points are vague. More specific targets could be developed around appropriate management of dementia in different settings such as in acute hospitals, aged residential care or community initiatives to support people with dementia.

11h community based early intervention for musculoskeletal conditions are important, but can only do so much. For some people, timely access to joint replacement is essential and goes hand in hand with these initiatives

12. Informing individuals and the community

Probably would be of value to many people (including family and carers). Are there examples from overseas of how such strategies have worked? What is their penetration into the client group?

13. Technologies

Could be helpful. We support the use of new technologies but caution that they supplement rather than replace the personal contact needed to support frail older people living alone in the community.

Telerehabilitation techniques could be mentioned as ways of improving access in rural communities

**4) Support for People with high and complex needs**.

14. Frailty

14 a and b. We support the concept of identifying frailty in primary care, provided there is an action plan to manage frailty better. Community initiatives, including supported early discharge or augmented community supports may have a role.

15 Quality of home and community supports

We support the concepts of choice, flexibility, maximising independence and culturally appropriate supports. However we add a caution that the most vulnerable, frail or cognitively impaired individuals may not be able to make such choices. With increased choice, there needs to be mechanisms to ensure coordination and continuity of care, and that the choices are appropriate to the level of needs

16. Integration

 All reasonable options, but lack detail to comment further

17. Long term mental health and addiction

Supported

18. Aged residential Care

18a. We are not sure what these protocols might achieve. This implies one size fits all approach, whereas heterogeneity is hallmark of individuals living in aged residential care. Are there examples of their successful implementation?

18b-c. Are reasonable ideas to explore

What is missing from the strategy is a review of the model of provision of medical services to ARC. At present, it is ad hoc, reactive rather than proactive and is variable across providers. The cost of after-hours visits often results in inappropriate transfer of the person to acute hospital services

18d. ARC providers currently provide services to non-residential clients. This could be expanded, but there is a real risk of “resident capture” (e.g. Dinner Bed and Breakfast scheme in Canterbury resulted in excess permanent entry to ARC[[2]](#footnote-2)). This is both a risk to the individual’s independence and also a fiscal risk, but can be mitigated by using different funding models.

19. Integration of Information

Although devoid of operational detail these ideas are supported.

20 Improved Medication management.

Supported in principle. Polypharmacy management needs to tackle prescribers as well.

21 Resilience of Carers and Whanau

On looking at the Carer’s strategy, much of the work has already sat with MSD and not MOH, and DHBs as indicated here. Why the change? Financial support for carers is a major factor for allowing some families to be able to care for their loved ones

**5) Respectful end of life.**

 22-24 Supported*.*

6) Implementation, measurement and review.

 25. Implementation plan must happen

 26a-f. Supported in principle.

27. This will be difficult as the strategy is not rich in tangible “outcomes”. As mentioned earlier, it is vital that relevant patient health/ functional outcomes are measured, rather than service delivery or resource use measured.

27d. Which indicators? Publishing indicators are only relevant if their accuracy is assured, they are valid, robust and are reproducible. We have not seen any such indicators in this document, so at present do not support this

Thank you for the opportunity to comment on this strategy.

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| **Submission 80** |

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| --- | --- |
| Organisation (if applicable): | The New Zealand Society of Diversional Therapists  |
| Position (if applicable): | Vice-President  |

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

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

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

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

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

[ ]  Do not publish this submission

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

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

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

[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training provider [ ]  Local government

[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Union

[ ]  Primary health organisation [x]  Professional association

[ ]  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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| Investing in Diversional Therapy Professionals that can be the missing piece on Allied Health will be the Key in supporting individuals’ physical, emotional and mental capacity. In the draft we are focusing in many strategies that will help us to support people to live longer, but by living longer we need to take into account meaningful things to look forward and this is where Diversional Therapy plays a huge role on the strategy.  |

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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| Once again we believe that NZSDT could play an important role when supporting our population to become more physically, mentally and socially active.  |

### 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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| Finding out an individual’s goals and motivations is a key part of developing a personalised care plan, and provides a way to recognise and respect cultural preferences and this is exactly what Diversional Therapists focus on. Spot on!  |

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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| We believe that effective rehabilitation closet to home is Key to acute and restorative care also.  |

### 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 Diversional Therapy is a great instrument when supporting people 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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| People with Long Term Conditions retain the highest level of mental and physical function possible; they enjoy life, and their communities respect them. And Diversional Therapy plays an important role in the ‘Living Well’ strategy.  |

### 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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| Diversional Therapy can enhance individuals maintaining choice and control when they need significant support through proper programs.  |

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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| Looks good to begin with.  |

### 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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| I think is a good vision to begin with.  |

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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| Good actions to being with.  |

### 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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| Training is extremely important and plays a key role on achieving this goal.  |

### Other comments

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| I would like to take the opportunity to say Thank you to MOH for the great Workshops and FORUMS across New Zealand, where we have been able to meet with people, hear different opinions, share points of views but mostly, to try and work together to find what we feel could have a great outcome for our elderly population in New Zealand.  |

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| **Submission 81** |

This submission is made on behalf of a group or organisation. It represents the views of a district health board. You may publish this submission and personal details do not need to be removed from responses to OIA requests.

FROM: Geriatricians, Older Persons health Specialist Services, Canterbury District Health Board.

In general, we support much of the action plan outlined in the strategy. We are happy to see a focus on dementia, including supporting carers (11 a and b), inclusion of loneliness (28b) and the highlighted need for identification of frailty and improved support for this in the primary care setting (14 a and b) as well as prioritisation of improved training and conditions of the kaiawhina workforce (9a, c, d) and of nursing staff in the aged residential care sector. We have the following comments and recommendations: The strategy prioritizes many important health issues for older people, but we are concerned that there is no identified additional funding or details as to funding streams that will enable this work to be completed. It will be very difficult for DHBs to plan and implement this strategy without additional funding. We have strong reservations that this strategy will result in additional Ministry of Health mandated targets, with the DHB focussing on meeting targets to the detriment of doing what is right for individual patients. We are concerned that the action plans are not specific enough to effect real change. We would prefer to see dementia and frailty included each time health conditions in older people are mentioned (rather than omitted as it was in Fig 6 p 21), as we see these as (often unidentified) major drivers of demand for health services in this age group. We are concerned that admission avoidance schemes (8a, 18b) may increase the difficulty some older people have in equitably accessing appropriate acute and sub-acute medical care, particularly if they are homebound or in aged residential care. Such schemes need to ensure that the quality of care given is not compromised. In general there is an over-emphasis on keeping older people out of hospital, whereas the majority of the care of older people in the acute setting is medically appropriate. The National Strategy for Health must focus on keeping the whole population well in the community, and on reducing the inappropriate use of acute services by all age groups. We would like to see definition and greater dissemination of the concept of restorative care into the wider community, including patients, their whanau and support community, and all health professionals. While 6a is an admirable goal, the target and outcome need to be more clearly defined, and must include rural communities. Rather than trialling the integration of funding and service delivery (16) in specific locations for people with high and complex needs, we recommend national implementation of an interdisciplinary team model with strong links to primary care for older people with complex needs (rather than multi-disciplinary teams p 18, which is a more silo-ed model). The interdisciplinary team model consists of a team of health professionals working collaboratively across traditional boundaries, which can be flexibly involved as the older person’s needs change, both acutely and gradually. We suggest the strategy include student training in integrated models of care and working as a team as this is key in geriatric medicine. Advance care planning currently features only in end of life care. This needs to be moved earlier in the pathway of older people as these conversations need to occur at multiple points in an individual’s life course. We are pleased to see the inclusion of oral health in the strategy but feel it needs to be prioritized. The Ministry must recognize that additional funding will be required to provide appropriate dental care, for example, to those who received subsidised dental care. We would like to see phrasing such as “families and whanau have the information and training they need to best assist family members and the stress of caring does not damage their own health” changed to be less critical of the choices carers make. For example, “…families and whanau have the information and training they need to best assist family members and manage the stress of caring while valuing their choice to provide support”. We have concerns about “outreach” activities by aged residential care facilities (18d). There is evidence that this can result in increased risk of institutionalisation if there is not a focus on preserving independence and autonomy. Regarding people with high and complex needs, 15a needs specific wording about improving models to deinstitutionalize aged residential care facilities. Statement 15c, “promote contracting models that enable people to move freely to different care settings most suited to their need” needs further clarification as the meaning is not clear. We have concerns if this implies more ready access to respite care or aged residential care without appropriate assessment to address possible reversible reasons for reduced independence. Additionally, night cares are often required to support people in the community. This is presently a large gap in service, and should be addressed in this strategy. We suggest that 21a clarify if this will include financial compensation or increased access to sick leave for carers. We believe that healthy ageing includes communities that are sustainable with diverse and adequate housing for older people, with adequate transportation. Finally, we would like to see a reference about general sustainability of world resources included in the discussion about social determinants of health. We hope these suggestions are helpful. Thank-you for the opportunity to comment.

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| **Submission 82** |

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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 | This is an awesome vision. There needs to be massive education to ensure health professional include older people in planning their care - my recent experience is that the older person is treated with paternalistic concern and wishes ignored, i.e. wants temporary rest home placement but application declined multiple times. Total lack of family involvement in planning. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | What is an age friendly community - seems that we can't even get support services into families in an appropriate way let alone organise community support. |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | I agree with the vision, there is certainly a long way to go. Our area does a have CART team who assessed my family member as being able to go home when she couldn't even weight bear. Currently there is confusion amongst team embers and clinical staff as to what is happening and how. |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | The only purple star is around ACC. Many elderly folk do not have an ACC related injury and as such do not fit this category. 6A is a more sustainable goal and would reach more elderly people. |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | Earlier surgery for joint replacements would allow the elderly to maintain independence prior to surgery and after instead of having 1-2 year wait to see consultants then 3-6 months of tests before reaching an elective surgery list then perhaps waiting 4-6 months and then being reassessed only to discover that in the mean time the person health has deteriorated and they are not fit enough to proceed. Often the debilitating pain is what causes decreased function and during this long waiting period little or no support is available. |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | I think that reviewing and decreasing funding thresholds and criteria to allow people to access support earlier to maintain function and independence. Kaiawhinas are important but if the older person can't even access them there is not point.  |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | I support the vision and my current experience fails short of even being consulted about my older persons care. |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | We need to cut through all the red tape , see what is required and do it. Too many people have their health compromised because of funding constraints.  |
| 5a. Comments or suggestions regarding the vision for respectful end of life | This is an awesome vision. Again it appears that no one seems keen to initiate these discussions. Surgeons say health can be fixed but sometimes it is better to let the family choose. Clear discussions of what people can expect after surgery would enable families to make better informed choices. A consultant saying "this is big surgery you know" does not in anyway support the person to understand what it will be like for them. |
| 5b. Comments or suggestions regarding the actions for respectful end of life | Totally agree with these purple stars! |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | I really support the publishing of indicators with a word of caution- sometimes people cannot even get into a service and publishing indicators simply forces DHB's to find ways to look good but not necessarily meet the needs of their populations. |
| Do you have any other comments? |   |

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| **Submission 83** |

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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 | This section highlights the workforce required to meet the needs of older people - to recruit and retain a workforce will require funding changes that allow for people to be paid according to the work they do. It must be established that dementia care requires a highly skilled workforce both HCA and qualified staff. |
| 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 | A skilled workforce in the community to provide rehabilitation. Currently in the Nelson area there is very limited access to allied health in the community. If people could have intensive support on discharge this could be reduce as safe independence increases.  |
| 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 InterRAI assessment tool needs to be utilised to provide adequate funding to support someone with long term conditions and complex needs. The tool highlights outcomes that a different for each individual however the funding for each person only goes into four levels. This is not providing person centred care when you may have a rest home resident with more complex needs requiring more input from GP/.RN/care staff. People who experience dementia often have higher needs than a hospital level care person as they are mobile, but need support from staff to meet all ADL's.  |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | Recognising that the workforce required for adequate care in dementia setting have a certain skill set - training, remuneration and retention must be priorities to ensure our most vulnerable group of older people is cared for appropriately. Dementia friendly health services - this needs to be an expected standard from all services such as lab, GP, DHB services. Dementia care is everyone's responsibility. |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | The InterRAI assessment tool needs to be utilised to provide adequate funding to support someone with long term conditions and complex needs. The tool highlights outcomes that a different for each individual however the funding for each person only goes into four levels. This is not providing person centred care when you may have a rest home resident with more complex needs requiring more input from GP/.RN/care staff. People who experience dementia often have higher needs than a hospital level care person as they are mobile, but need support from staff to meet all ADL's. |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | Recognising that the workforce required for adequate care in dementia setting have a certain skill set - training, remuneration and retention must be priorities to ensure our most vulnerable group of older people is cared for appropriately. Dementia friendly health services - this needs to be an expected standard from all services such as lab, GP, DHB services. Dementia care is everyone's responsibility. |
| 5a. Comments or suggestions regarding the vision for respectful end of life | The first statement is one I resonate with strongly. I work in a dementia facility that cares for people assessed as requiring dementia level care (stage 3). The facility is stand alone - no other care level is delivered here. The strategy highlights that older people should be able to die where they feel comfortable and safe. This has been a very disturbing issue for me as a nurse in this area. We have people admit to us from home, often in distress due to the significant losses and changes they are going through. Over time the person accepts this is home, they get to know the staff and they trust them. As they approach end of life their care needs become more complex. The staffing levels and 'level of care' that stage three is contracted to provide is no longer able to be met. The person requires reassessment and is moved to hospital level care - at a time when they are most vulnerable, and a time when they would most need to feel comfortable and safe. In twelve months I have had to discharge seven people to hospital level care who have died within a week of entering the new facility - this is not meeting the vision of the strategy at 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? |   |

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| **Submission 84** |

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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: | a group of independent living in a retirement village |
| 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 | We wondered what an age-friendly community means. Throughout the document there were several terms not defined which people found hard to understand - there is a need for definitions. 'Health literacy' was another term not understood. 2.c. we cannot see why nurses, social workers, occupational therapists should be added to those doing green presciption with a copy going to primary health carer. Are strength and balance programmes about preventing falls? In 3. b. we wondered about this as a priority - is that not being done now? We strongly recommend that there needs to be government funding for oral health care. Strong feeling was that more pensioner units must be built to house those who vulnerable and unable to afford to buy and/or rent. Throughout there was quite a lot of discussion about the age of eligibility for superannuation and a feeling that it needs to be re-addressed - should it be raised to 66; or those who work fullitme get none until retired; those who are employed part time get a proportion. There was a strong message of the need for CLEAR COMMUNICATION.  |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | We had some questions about the actions marked with a purple star - see above. 4. e. we agreed this is important. 4.f. there was a feeling that there is enough information available - it is not well advertised where to find it. |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | There was quite a cynical feeling about 6.a. if it is not provided for younger people then it will not get provided for the elderly. There were stories of the lack of care when a person was sent home - things promised but did not happen. Experience has been minimal to no support follow up at home. There was a question how do we find out what is available and access it? Comment was made about late notice of family meetings which made it really difficult to attend. There was a feeling that families did not know who to ask to speak to for assistance, 7.b. What is 'big data'. |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | 7.a. we thought it was already being done. |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | 9.a. we all felt that the government has to increase funding so that those who work in private aged care sector earn the same as those in the public sector. We all agreed that national training programmes need to be developed and instituted. 11.b. all levels of society need to be dementia aware so that people do not suffer from stigma. 11.e. what is interRAI assessment data? |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | No we agreed the purple stars seemed to be appropriate. |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | We felt those with high and complex needs usually have the support they need. 14.a. 'fraility identification tool' we assume this is measurement document - correct? 16.c. we felt this ought to be a priority. |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | 18.a. we agreed this was a priority. |
| 5a. Comments or suggestions regarding the vision for respectful end of life | We felt that Advance Care planning is important. A comment was made that the medical profession needs to be on board with it. |
| 5b. Comments or suggestions regarding the actions for respectful end of life | no comment |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | not looked at |
| Do you have any other comments? | Two issues kept coming up - first the costing of this document. It was felt that there needs to a costing put alongside such a document so that its goals can be reached albeit slowly. the second issue was that of everyone over the age of 65 getting the pension even if they are working. We recognise that it will be sometime before we have the final document but do think the above needs to be addresed.  |

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| **Submission 85** |

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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 |
|  |  Professional association |
|  |  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 | Comprehensive and holistic vision. |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | They are important to implement as soon as possible. Although action points 1b, 1c, 2b, 3a, 4a, 4b, and 4d are also strategies that should be implemented as soon as possible to improve health of the older person. |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | It is great that the vision aims to improve discharge planning and that older people are supported in their recovery in the community to allow early discharge planning and reduce readmission. Great to see the Allied Health professionals were an important part of the workforce to achieve this as Allied Health professionals are often not recognised in health strategies/plans. |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | All of those actions are important and should ideally be made priorities. |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | Good to promote self management of conditions as this will help in reducing hospital admission and complications arising. Allied Health professionals e.g. Physiotherapists, Occupational Therapists; are a good workforce to engage to help achieve the vision. |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | Action points 9b, 9e, 9g, 10b, and 12b should also be prioritised highly as they are important in maintaining older persons health. Particularly making better use of the Allied Health Professions and the skills and expertise they offer to help older persons and their families and carers manage their health conditions. |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | Good to see sharing information between health professionals is highlighted as well as reducing the need for acute care which compromises the older persons quality of life. |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | A frailty identification tool is important to identify those at risk earlier and implement actions to help them as soon as possible. Other action points that should also be prioritised are 14b, 15a, 15c, 16a, 16d, 17a, 18b, 18c,18d, 19a, 19b, 19c, and 20a. Particularly improving patients quality of life and access to services in residential care e.g. access to health professionals such physiotherapists to help maintain older persons mobility and function. |
| 5a. Comments or suggestions regarding the vision for respectful end of life | Great that end-of-life care is being discussed and that older persons should be able to express their wishes for their care. |
| 5b. Comments or suggestions regarding the actions for respectful end of life | Action 23a is another action point that should be prioritised to ensure that older persons care is well managed at all levels at the end of their life. |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | All of the highlight actions are important to prioritise. 27e is another point that should be prioritised as there are discrepancies between DHBs and hospitals, so knowing how DHBs are performing and why some DHBs are performing better than others may allow for reflection and sharing of information to improve care for older persons. |
| Do you have any other comments? | Allied Health are currently underused professional group which have an important role in managing older persons health throughout all aspects of acute, rehabilitation, and prevention/management of health conditions. Ensuring smoother relationships and services with residential care and improving the management of patients within residential care is essential to avoid acute care being required. Ensuring DHBs implement these actions points and consult health professionals that are directly involved in patient's care to help implement the actions. As well as allowing sharing of information and communication between health care providers is essential. |

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| **Submission 86** |

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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 | \*To become more holistic orientated. The Ministry of housing, Social Welfare, Work and income, Ministry of Social Development and Non Government Organizations need to work together free from political short term patching ad hoc solutions. Eg. Social housing which has come to a head as a perfect storm with Govt's choosing to sell off Govt. stock but not doing their research for the long term ramifications or un intended consequences. This also was a decisions of many local councils over the years to 'get out' of the business of being 'landlords' to 'council pensioner flats'. This in turn has huge health and welfare implications for the above ideals. There also needs to be simple solutions. Te Puia Marae Community was a prime example of Whanau Ora. Lets' do it! |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | Yes, but must be done with in a community, (not one size fits all approach) Auckland after all is made up of communities so is the Bay of Plenty or West Coast South Island. If Govt. agencies. change political direction over the next 10 years, and become once again 'political footballs' nothing will be achieved. Just another bureaucratic exercise and waste of taxpayers revenue.  |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | As a resident in a retirement village in Te Puke, Bay of Plenty., am fortunate to still be able to drive, in a safe surrounding etc. many in Te Puke and the rural surrounds (30 Kms fom the nearest medical centre,) Longer, up to 60 Kms to Tauranga or Whakatane hospitals -our DHB area at present. Transport is a growing problem, Very few specialists travel to out lying areas. Ve Few Doctors now do 'home visits' it seems. Practitioner nurses, Whanau Ora staff with all the necessary skills takes time to grow.Networking and communication between agencies is important. Modern techno. used in an ethical way will be helpful. |
| 2b. Comments or suggestions regarding the actions for acute and restorative care. | The Bay of Plenty where I live is rapidly becoming the 'Retirement Village' capital of New Zealand. Those that have planned may be buying, renting, been admitted to the various types of care facilities available. This may be skewing the DHB's health care providing compared with other areas.There may need to be ' satellite centres ' for acute, medical social ' triaging at Mount Maunganui for example. to service Te Puke Maketu,Pukehina Paengaroa. Who pays for this? |
| 3a. Comments or suggestions regarding the vision for living well with long-term conditions. | With the rapidly changing infrastructure in our communities, EG. banking, postal, churches, cultural, etc. isolation of those that remain in these communities may find new ways of doing things hard to adapt to, should long term health issues prevent or restrict, therefore become isolated within that community needs to be considered |
| 3b. Comments or suggestions regarding the actions for living well with long-term conditions. | Yes, the quality of wrap around services and support to the clients depends on the expertise and relationship with the 'healthcare professionals' and the teams that provide that service. |
| 4a. Comments or suggestions regarding the vision for better support for people with high and complex needs | The ideal and reality for those with long term needs in2016 with the shortage of accommodation and the resources to pay for that accommodation above the cost of healthcare may need a review first by Govt. agencies.Waipuna hospice and other like-minded NGO;s play an important role in supporting cancer and other long term needs, What percentage of the health dollar do they save the Govt. I wonder? |
| 4b. Comments or suggestions regarding the actions for better support for people with high and complex needs | Yes, communication, collaboration, co operation and action plans between all parties is open and clear direction with a client centered model and positive outcome for all.  |
| 5a. Comments or suggestions regarding the vision for respectful end of life | Listening more to what the clients wishes are. Education on death and dying to our communities from a young age.Change of attitude and denial culture. |
| 5b. Comments or suggestions regarding the actions for respectful end of life | Yes |
| 6. Comments or suggestions regarding the proposals for implementing, measuring and reviewing the actions | Just that the recent discussions on use of Marijuana and other restricted products needs to be sorted soon. |
| Do you have any other comments? | This is a big subject and not only affects the older population, but the wider community as NZ's population grow, health needs become more complex and the ability to service that need. Psychiatric/mental health is part of that health model but seems to be still the 'cinderella' service. Stigmas continue. Yet probably much of our wellbeing depends on good mental health. The wholistic approach should continue to be developed. Psychiatric units within hospitals may need to also have community based facilities that are well supported. Police, Mental health teams, Ambulance etc., need better resources, to differentiate those with health issues. Thanks |

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| **Submission 87** |

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| Organisation | SVS Living Safe |
| 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 | A trend I have noticed in the services we offer as an agency working in the field of domestic violence is older people, usually men, who cannot cope with the struggle of coping with a partner with dementia and end up displaying abusive or violent behaviour towards their spouse. We offer support for those men with coping strategies that they are finding useful.  |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | A trend I have noticed in the services we offer as an agency working in the field of domestic violence is older people, usually men, who cannot cope with the struggle of coping with a partner with dementia and end up displaying abusive or violent behaviour towards their spouse. We offer support for those men with coping strategies that they are finding useful.  |
| 2a. Comments or suggestions regarding the vision for acute and restorative care | Support for older men especially coping with the frustrations around aging generally. |
| 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 88** |

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| Organisation (if applicable) | NZ Dental and Oral Health Therapists Association (NZDOHTA) |
| This submission... | is made on behalf of a group or organisation(s) |
| This submission represents the views of: |  Professional association |
| 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 New Zealand Dental and Oral Health Therapist Association (NZDDOHTA) supports the Ministry of Health’s vision that older people live well, age well, and have a respectful end of life in age-friendly communities. |
| 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 | NZDOHTA strongly believes dental and oral health therapists have an important role to play in the implementation of this strategy. In order for older people to live well and stay well, they need good oral health. The cost of private practice dental and unaffordable for many. The burden to provide care falls on the public sector.  |
| 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 | In order for older people to live well and stay well, they need good oral health. The cost of private practice dental and unaffordable for many. The burden to provide care falls on the public sector. At 31 March 2016, there were 917 registered dental therapists with an annual practicing certificate[1]. Dental and oral health therapists provide basic restorative, preventive and periodontal care to people 18 and under. This workforce is currently undervalued and underutilised, there is no reason why this workforce cannot and should not be employed to work with adults other than historic entrenched barriers that promote professional discrimination. Over the years, university training for oral health therapists has expanded and extended the scope of training. The extension of scopes to allow oral health therapists to work with the adult population will provide significant additional capacity in a more cost effective manner to treat older people and assist them to be pain free and maintain good oral health. The current restrictive practices mean that the adult population in New Zealand are missing out on affordable dental care delivered by a group of credible practitioners. We strongly urge that the Health of Older People Strategy include: 1. Oral Health as a key objective to ensure older people are kept pain free and in good oral health. 2. An initiative to enable universities and the Dental Council to extend current training to include adult scope be introduced. In addition, bridging training should be made available to the existing workforce to enable the existing workforce (over 900) can be utilised to provide cost effective service.  |
| 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 | In order for older people to live well and stay well, they need good oral health. The cost of private practice dental and unaffordable for many. The burden to provide care falls on the public sector. At 31 March 2016, there were 917 registered dental therapists with an annual practicing certificate[1]. Dental and oral health therapists provide basic restorative, preventive and periodontal care to people 18 and under. This workforce is currently undervalued and underutilised, there is no reason why this workforce cannot and should not be employed to work with adults other than historic entrenched barriers that promote professional discrimination. Over the years, university training for oral health therapists has expanded and extended the scope of training. The extension of scopes to allow oral health therapists to work with the adult population will provide significant additional capacity in a more cost effective manner to treat older people and assist them to be pain free and maintain good oral health. The current restrictive practices mean that the adult population in New Zealand are missing out on affordable dental care delivered by a group of credible practitioners. We strongly urge that the Health of Older People Strategy include: 1. Oral Health as a key objective to ensure older people are kept pain free and in good oral health. 2. An initiative to enable universities and the Dental Council to extend current training to include adult scope be introduced. In addition, bridging training should be made available to the existing workforce to enable the existing workforce (over 900) can be utilised to provide cost effective service.  |
| Do you have any other comments? |   |

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| **Submission 89 withheld at submitter’s request** |

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| **Submission 90 withheld at submitter’s request** |

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| **Submission 91** |

**SUBMISSION**

# from: Age Concern New Zealand He Manaakitanga Kaumātua Aotearoa

# to: The Ministry of Health

# on: Health of Older People Strategy

5 September 2016

1. **Age Concern New Zealand**
2. **Background**

Age Concern is a charitable organisation working for older people in New Zealand. Our vision is for older people to live a valued life in an inclusive society. It is our mission to promote wellbeing, rights, respect and dignity for older people. We are active and vocal on relevant issues and work to assist older people to stay connected with their family, friends and community.

Age Concern interacts with over 7,650 older people every week through our national office (“Age Concern New Zealand”), 32 local Age Concerns (“Age Concerns”) and two affiliated services. We have over 4,500 volunteers who gift around 5,000 hours of their time per week. Our total volunteer hours across all services equates to a fiscal sum of $3.7 million per year based on minimum wage. We also have over 150 paid staff throughout New Zealand who work almost 4,000 hours per week, and 34 Boards to provide governance for all Age Concerns and Age Concern New Zealand.

Age Concern New Zealand is one of many social service providers reliant on funding from government agencies, specifically, but not limited to, providing elder abuse and neglect prevention services, services to enhance social connectivity for older people and services to provide health promotion programmes. Age Concerns are also funded through philanthropic trust grants, contributions from clients to their services and individual donations.

Demand for our support and services has grown significantly over the years, mirroring the growth in the older population, increasing longevity and the Government’s “positive ageing” and “ageing in place” strategies. Funding services to a growing group of older people is increasingly challenging. To continue to be effective and to be able to successfully meet the needs of New Zealand’s growing ageing population, funding needs to be: **adequate** – reflecting current and future demographic changes, supporting more people to age in place; **flexible** – enabling new services to be developed to reflect the needs of an ageing population; and **reliable** – enabling service providers to plan with confidence and effectiveness.

1. **Services**

Age Concern New Zealand is New Zealand’s lead organisation providing services to abused older people as well as education about elder abuse and neglect. Our **Elder Abuse and Neglect Prevention Service** aims to keep older New Zealanders free from abuse and neglect. There are twenty Age Concern members who offer funded services, whilst some areas are not covered, for example Northland, Thames, Waitaki, Marlborough etc.

Age Concern New Zealand runs approximately 43 **health promotion programmes** that focus on empowering older people to have better health outcomes, assisting older people to remain independent and to age in place, ensuring older people are socially connected and ensuring older people feel valued and respected.

Age Concern New Zealand is New Zealand’s primary organisation dedicated to delivery services to reduce loneliness. The **Accredited Visiting Service** operates nationally and provides regular visits from caring volunteers to older people who have become isolated and lonely. In addition, Age Concern provides a range of other social connection activities developed at the local level in response to the needs of older people in their communities. Together, these services help older people to remain healthy, connected and respected.

You will see here on this list above that many of our Age Concerns offer services that can help to increase mobility for older people, including transport to medical appointments, grocery and personal support shopping, day trips, confident driving classes, provision of total mobility vouchers as well as falls prevention classes, exercise groups, coffee and lunch groups and more.

1. **General comments**

*"As we get older, our rights do not change. As we get older, we are no less human and should not become invisible."[[3]](#footnote-3)*

**Archbishop Desmond Tutu**

Age Concern New Zealand supports the overall vision of the strategy, and the five outcome areas that inform its framework. We support the overall focus of the strategy on maintaining the functional ability of older people, maximising their independence, and preventing and delaying disease and the onset of disability.

We support the positive overall view of older people, their capabilities, and their lives presented in the strategy, and the emphasis on:

* The contributions of older people to society.
* The importance of removing societal and environmental barriers to healthy ageing.
* The increased focus on the importance of social connection and participation as part of healthy ageing.

The strategy is an opportunity to plan for population growth and get the necessary services and programmes in place to ensure that older people are well served by government and that promote respect and dignity for older people.

1. **An all-of-government approach for older people and future sustainability**

Increased life expectancy is a crowning achievement of our society. The challenge of our times and generation is to ensure that there is increased life expectancy, along with a decent quality of life which extends to all older people whilst living personally fulfilled lives and accessing affordable, quality and appropriate services. By 2061, there will be 1.5 million people aged over 65. To plan for an ageing society requires national coordination of resources and an all-of-government approach.

This approach is supported by the Sustainable Development Goals[[4]](#footnote-4) that “ensure that no one is left behind” and “reaching the furthest first”. To achieve this an all-of-government approach is urgently required to ensure that Government services and protections are in place, fit for purpose, and better coordinated for the well-being of older New Zealanders. An integrated, planned approach will ensure that there is a consistent approach across government agencies with supportive law and policy, service development and delivery, and innovations for older people. This approach is about being proactive, investing, planning and monitoring for the future. It is also about respect, rights and dignity for older New Zealanders.

The failure to act and address how services for older people will be funded in the future, will result in an erosion of life conditions for older people and failure to develop challenges into opportunities. In a future scenario with no leadership on issues for older people, older people will be seen to be a burden to the taxpayer, rather than assets who have much to contribute to their families, communities and economy. Changing the conversation on ageing and older people requires government leadership, courage, vision and planning to address the different socio-economic situations and life-courses of people as they age.

**Transforming the conversation about ageing: a social model of ageing as seen as active ageing**

In planning for an ageing society, the conversation about ageing must change from the service model based on needs to the participatory and empowering model based on rights and obligations. The conversation has to change as older people are living longer, working longer and contributing more to society. We are seeing a disruption of the traditional conceptualisation of life course. A traditional, linear view of life course has informed public policy. According the WHO, “public-health policy must be framed to maximise the number of people who experience these positive trajectories of ageing. And it must serve to break down the many barriers that limit their on-going social participation and contributions”.[[5]](#footnote-5) The Health of Older Peoples Strategy is well placed to adopt and articulate a social model of ageing.

The social model of ageing can be traced to the UN Convention on the Rights of People with Disabilities[[6]](#footnote-6) and the WHO’s active ageing[[7]](#footnote-7).

The social model of ageing recognises the diversity of life-courses, promotes positive self-image, recognises on-going contribution, and has the potential to generate new opportunities and innovation. The social model of ageing is derived from how the UN Convention on the Rights of People with Disabilities has conceptualised the social model of disability. To clarify: ageing is a not a disability. Importantly it focuses on the person’s potential rather than assumptions.

A social model of ageing is similar to the WHO’s “active ageing” concept which “applies to both individuals and population groups. It allows people to realize their potential for physical, social, and mental well-being throughout the life course and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance”[[8]](#footnote-8). A social model of ageing goes further than “active ageing” by changing the discourse on ageing by focussing on systemic change to address physical and attitudinal barriers regarding how older people live their lives.

The social model of ageing articulates the human rights of older people and is based on treating all people equally with dignity and respect. At the same time the model recognises that there are older people with high and complex needs but it is also recognises that there are a large cohort of the population who will still be working beyond the retirement age and have valuable skills and knowledge that has implications for the economy and community at large.

**Mainstreaming Diversity**

 The Government’s Positive Ageing Strategy recognises diversity as one of the important issues. The Health of Older People’s Strategy has diversity in the actions but this should be included in the outcome areas. The health strategy for older people should give recognition of how women, Maori, Pasifika, Asian, migrant, refugee-background, people with disabilities and LGBTI communities can access services with dignity and respect. Health care and support services need to ensure the workforce is trained and knowledgeable these communities.

The following should be considered:

* Access to health services for non-English speakers should be better provided for clients. Accessible funding and a common national approach across DHBs and private providers should be developed. This will involve having clear policies on interpreting, how this is funded and the most effective usage. The lack of a coordinated national approach to interpreting for non-English speakers across private and public health services should be an urgent priority.
* For communities whose world-views are outside the Western paradigm there should be mainstreaming of cultural concepts into health and care services. This makes the interventions and interactions around “alternative” medicines and all-of-life therapy, relevant and appropriate for those communities. Integration of holistic non-Western health practices that promote well-being and resilience to give recognition to new-comer communities and other minorities, as well as other approaches.
* Older people from LGBTI communities must be better served by the health system. Clearly this will require a workforce that is aware and sensitive to LGBTI issues. This is particularly relevant to understand transgender and intersex health issues and needs.
* The strategy has recognised that there is diversity amongst older people but this needs to further acknowledge the diversity of life-styles and life-cycles that is resulting in the reformulation of the traditional, linear approach to life course. Older people are already changing vocations, retraining, taking advantage of technological developments, moving between cities and rural centres, responding to the opportunities based on ageing, or moving between flexible work, volunteering, personal and family commitments. Perspectives on the traditional life course must change.

Health care and support professionals must be provided with training to understand the needs of their diverse clients. Healthy ageing has a crucial role in enabling older people to have a higher quality of life experience. A health system should support these positive opportunities but also support those with high and complex needs to continue community participation.

**Equality and equal access: challenging barriers**

We acknowledge that the draft Strategy seeks to respond to the needs of vulnerable communities. The strategy needs to go further by ensuring that equality and equal access for all New Zealanders is enshrined. A refresh of the draft Strategy is an opportunity to review the attitudinal and physical barriers that communities experience in how they access health and support services.

**Ageism** is a barrier to access health care and support service. Ageism can take many forms, including prejudicial attitudes, discriminatory practices, or institutional policies and practices that perpetuate stereotypical attitudes. These negative attitudes have serious consequences for older people and society at large. These barriers can limit good policy development and limit policy options. They can also seriously affect the impact of the quality of health care and support. Despite the best intentions, stereotyping of older people becomes a self-fulfilling prophecy by reinforcing inactivity and the deficits that results from internalisation. These attitudes are pervasive when older people are at their most vulnerable and require care. Prejudice stems from observable biological declines in older people. Health conditions and disorders such as dementia are mistakenly understood to be part of normal ageing. By focusing on the assumptions about physiological and psychological decline, little or thought is given to of the positive aspects of ageing, the personal achievement during this time and the socio-economic contributions made by older people.

In regards to vulnerable communities, barriers still exist in accessing health and support services. A study[[9]](#footnote-9) by the Ministry has confirmed that there groups who experience barriers. However the study did not cover **attitudinal-type** questions and therefore the effect of attitudinal barriers on accessing health care and support services is unclear. An earlier study from 2004 looking at cost as a barrier[[10]](#footnote-10) to services recommended an increase to subsidies. Consideration should be given as to how barriers for all vulnerable communities can be addressed.

An approach looking at all types of barriers, including those that arise from living in small remote areas, should be prioritised. In the long term this approach is cost-effective as it focuses on health outcomes for vulnerable communities and their families.

**Pandemic and natural disaster planning**

Pandemic and natural disaster planning needs to ensure the health needs of older people are included. During disasters older people are particularly vulnerable as they might be frail, unable to access information, or not have the same level of connectedness as the rest of the community. This means that they are more at risk and planning for pandemics must ensure that older people are included.

As we have seen with the recent events in Havelock North with contaminated water, older and younger people were most at risk but the effect on older people was devastating. In that situation Age Concern Havelock North were active in supporting older people by supplying water and food. Pandemic and disaster relief planning must consider the health of older people and the role of non-government organisations in supporting the community.

1. **Submission questions**

### Healthy ageing

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

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| Age Concern New Zealand welcomes the vision that older people should “live well, age well and have a respectful end of life in age-friendly communities”. We support the adoption and promotion of the concept of Healthy Ageing as an overall orientation for the Strategy. The use of Healthy Ageing aligns with the right to the enjoyment of the highest attainable standard of physical and mental health for older people. In line with this and international obligations, we recommend that healthy ageing concept expands to include a stronger focus on a social model of ageing. * In line with population projections, the ageing of our society and the potential, we propose that the Strategy adopts a social model of ageing.
* In accordance with this approach, we believe that the Health of Older People Strategy should be renamed: “Healthy Ageing”. We understand that opposition to this naming approach is based on healthy ageing concept not being indicative of the older people focus. The inclusion of “Health of Older Peoples Strategy” as a subtitle would be appropriate.
* A system outcome should be included focused on affordability of health care and support services for older people to ensure everyone has equal access. Affordability is a significant concern for older people that has an impact on well-being, resilience and life-course.
* The outcome areas should include responding to the diversity of older people. This recognises the diverse life-courses of older people and ensures that that there is a focus on gender, sexuality and ethnicity/race.
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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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| Age Concern New Zealand is of the view that there is a dire need for an all-of-government approach that provides a leadership on all matters relating to older people. As a society with an ageing population, leadership, vision and planning are urgently required to ensure that the country has adequate resources and skilled workforce to meet the needs of older people. This approach will reduce duplication and ensure that services are delivered to those that need them the most and are not restricted by narrow contract interpretations or Ministry mandates.* Age Concern New Zealand believes that the non-government sector plays a vital role in providing services, support and education. The role and function it plays should be recognised. The impetus should be for government and non-government sectors to work together to develop better health outcomes and quality of life for older people. Working together means recognition of expertise, contributions, independence, and support to improve services and delivery, address gaps based on genuine collaboration and partnership models. This approach should give security of contract tenure so that community based services providers can deliver value for money and high quality programming for government and relevant, appropriate and community-based services to the older person, whanau and the community.
* We have expertise in social inclusion, health promotion and neglect and abuse prevention of older people. For the actions and priorities relating to Age Concern New Zealand’s expertise and service delivery, we suggest that Age Concern New Zealand be named as the NGO lead organisation.

Healthy ageing 1.* The Ministry is well placed to initiate an all of government conversation about ageing and how this relates to planning for the future work of government services. This will require an across agencies’ governance structure, a more integrated work programme and joint funding initiatives for the ministries based on collaboration and partnership models.
* Integrating the social model of ageing or active ageing is key and should be one of the early actions that is developed under the Health Ageing approach. This approach will inform other actions, such as updating the 2001 Positive Ageing Strategy in line with the change that is required for older New Zealanders.

c.* Age Concern New Zealand is New Zealand’s primary organisation dedicated to delivery of services to reduce loneliness and promote inclusion. Age Concern is often the first port of call for older people in their communities, offering support, expertise and services dependant on local needs. These local services enable older people to live healthy, independent, socially-connected, safe and respected lives.
* Age Concern New Zealand is active in this area and is interested in contributing to this action. Age Concern New Zealand should be listed as the NGO lead working on connecting socially isolated older people.

d.* Volunteering, networking and paid work are important for the well-being of older people and their participation in society. For many older people, part-time work is an option for engagement with society and financial security. We suggest that this action has involvement of a government agency to develop part time, paid work opportunities for older people within government services and programmes.
* The Accredited Visiting Service uses volunteers to reduce social isolation and loneliness. Our services also promote intergenerational contact, if required.

2.* Age Concern New Zealand welcomes the focus on strengthening community initiatives to strengthen resilience with focus on strength and balance for all New Zealand communities, including those most at risk.
* Age Concern New Zealand runs approximately 43 health promotion programmes that focus on empowering older people to have better health outcomes. These programmes assist older people to remain independent and to age in place. This ensures older people are socially connected where older people feel valued and respected.
* We support the focus on vulnerable communities but recommend that this should also include communities who are rural-based, usually in small towns who face the increasing closure of services, and newer communities to New Zealand who might be socially isolated through limited family connections and health vulnerabilities.
* Age Concern New Zealand has expertise in this area. Age Concern New Zealand should be listed as an NGO working on health promotion with focus on strength and balance programmes for older people.
* We recommend support to access hearing and sight services. Older people not being able to hear or see contributes to them falling.

3.b.* Age Concern New Zealand plays a significant national role as the leading expert and national service provider addressing elder abuse and neglect prevention, as well as the provision of education about elder abuse and neglect. Our Elder Abuse and Neglect Prevention Service aim to keep older New Zealanders free from abuse and neglect. Whilst there are commonalities with family violence, elder abuse and neglect has a different focus and approach within a different context and issues. Age Concern New Zealand would like to see a greater expansion of activities focused on elder abuse and neglect prevention and education. The NGO sector has a role to play in this area and Age Concern New Zealand welcomes collaborating and providing advice on this area to improve the lives of older New Zealanders. Early intervention around elder abuse and neglect reduce long-term costs.
* Age Concern New Zealand recommends that the cross-government Ministerial Group’s work programme includes a stream on elder abuse and neglect, and activities.

4.e.* We recognise that technology is an enabler and play a role in improving the quality of life of older people. However technology can reinforce social isolation by reducing human contact. We recommend that social isolation be assessed when using technology based health solutions.

f.* Age Concern New Zealand supports the focus of improving access to information about health ageing. We recommend that access issues for non-English speakers is included. At the same time, an approach to improve access for older people to technology either because of cost barriers or life experience should be included.

5. * Age Concern New Zealand supports the focus on oral health.
* This section should be expanded to include access to sensory services, such as hearing and sight services. For many of the older people we work with, affordability of these services are out of reach and older people do without getting a hearing aid or glasses. Accessing these services has a significant impact on people out of the main centres. Whilst we recognise that there are discounts and, in some cases, subsidies, this has an impact on independence, resilience, health and well-being. Access to these services ensures that older people have reduced injuries from falls and better quality of life experience.
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### Acute and restorative care

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

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| * We support the focus on high quality discharge of patients where the older person’s health is paramount. Moving an older person out of health care too quickly, has direct implications on the support mechanisms a person might have. By not focusing on the health outcomes and wishes of the person, there could be a cost implication if the older person has to return to institutional health care if the person is discharged too soon.
* Ongoing consultation and collaboration with community members is essential throughout service planning and review processes if services are to be truly person/family/whanau and community focused.
* When a person is discharged into the community, carers need an adequate level of support to ensure that the older person’s health outcomes are protected. If this approach is taken, carers should be given the appropriate recognition, training and support to ensure that they are prepared for the discharged event and care of the older person. We urge caution about moving the costs to communities as this will put pressure on spouses and families who might be working through their own vulnerabilities, or don’t have the level of community support.
* By not building, supporting and assessing a community infrastructure, for example through a community care plan, older people can be subject to abuse and neglect as families might not be in a position to provide support. In some circumstances after the discharge the older person has to start taking care of themselves regardless of their level of ability, for example their ability to have a shower.
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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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| **Acute and restorative care*** To ensure that older people get the best support and live a high quality of life, moving towards an integrated case management system should be considered. The World Health Organisation’s Report on Ageing and Health suggests that a strong case-management system should focus on the following: “the individual’s needs are assessed, a comprehensive care plan is developed, and services are managed and driven towards the single goal of maintaining functional ability”. WHO suggests that this means a single point of entry and coordination through a case manager who helps with assessments, shares information, and coordinates services across health workers and care providers. According to the WHO, this approach has benefits for the older person’s health, medication management, community care and is achievable even in situations of constrained resources. This approach should be integrated into these actions and can be used for long-term care as well.

6. a* Discharges should be quality-based and not simply a matter of moving patients home to free up beds without consideration for an older person’s health needs and support.
* An “ageing in place” approach needs to be properly scoped and clearly enunciated. The social cost and implications should be better understood and how recognition for carers is accorded. Ageing in place has implications for women’s workforce participation and their future prospects in the labour market as women do more care-giving work.

8. a* We support an innovative approach but this should not be at the expense of quality of service and acceptability of care and support to the older person.
* We recognise that technology is an enabler and can improve quality of life for older people. As indicated above, social isolation must be assessed when using technology based health solutions. We need more research into assistive technology and the ethical implications of its use.
* Community care should be assessed using criteria that assesses health outcomes for older people and the level of community support.
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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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| * Long term conditions for older people can be debilitating, reduce independence and resilience. As indicated above, we support the development of an integrated case management system with a case manager focus that has an all of health system and community focus. An integrated case management approach has particular relevance to long-term care, see above for more details.
* Health care workers are already under pressure “to deliver more with less”, but the health care workforce is reducing through ageing and is not replaced at the same rate. The perception is that health and support sectors are not desirable places to work. In keeping with the population growth and the anticipated need for health care and support, the medical and care workforce has to grow to ensure equitable access for all New Zealanders.
* Funding for caring roles needs to reflect the vital and important role that it is, supporting our communities most vulnerable.
* The community care model needs to assessed to determine barriers, relationship between this model and the health outcomes for older people, the constraints experienced by carers and the impact of caring on the carers’ own career development/potential.
* Care and support workers sectors should be regularised and professionalised with appropriate recognition put in place.
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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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| **Living well with long term conditions*** The actions seemed to be based on what the Ministry of Health will do and does not focus on partnership and collaborations.
* As indicated above, priority action should be focused on developing an integrated case management system.

9. * A skilled work force development is crucial aspect to ensure that older people receive good care. To get more health professionals specialising in gerontology, this should be incentivised and encouraged. At the same time, more research on ageing and associated should be encouraged. A research-based agenda can drive innovations and the development of new opportunities and ways of doing things.

g.* Respite care and support for family carers is critical to ensure that that they can meet their own obligations and caring for older people.
* Recognition of the role played by family carer-givers is an important part of building a community care model. It would be short-sighted and against the ethos of healthy ageing not to give recognition and support to the family care-givers themselves.

10.* This action should focus on an across sector governance of responding to an ageing population. It is important that we have across government leadership, planning, investment and capability development.
* Services providers should be integrated into the system and available to older people to access and choose their provider.

b. * Increasing physical activities amongst older people is a specialist area and there should be support to build capacity and capability of skills and knowledge. Ensuring that older people participate in physical activities and remain active has ramifications for their health prospects and has the potential to keep costs down for government and community carers. Good planning and coordination are essential.

11. a* We support the focus on dementia but suggest that the actions be built up to take a more pro-active approach. Such an approach could include screening prior to the onset of dementia.
* Here again an approach focused on a care plan with a case manager will ensure that there is less duplication, clarity on roles and responsibilities with a focus on ensuring that the older person’s health and wishes are considered.

12. a* Reducing stigma relating to mental health requires a concerted effort and this action should have a lead and a planned approach for community support.

13. a* We support the use of technology as this can be a cost saver but the ethical considerations should be assessed, as well other barriers.
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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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| Affordability for the older person should be included in this outcome area. The cost of health care services and support has a significant impact on peoples’ decisions and choice.  |

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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| **Support for people with high and complex needs*** The strategy should include an action for assessing the barriers to services for older people outside the main centres. We have heard of older people relocating to rural centres to access cheaper housing, and in keeping with this, access to health care and support services should be assessed.

15.* A new approach to the sharing of patient information is urgently required. Such an approach has the potential to reduce duplication and the time that older people spend navigating the health system. Having access to health records will allow a person to move between different services without being hindered and would emphasise the focus is on the health outcomes of the older person. This includes visibility of the health plan with the NGO sector, where appropriate.

16. a* We support the appointment of a lead caseworker to support an older person to navigate the health and support system. We recommend that trials focus on a community-based lead case worker who has a degree of autonomy. The person should be tasked with taking a whole of system view to achieve the best health outcomes that is in accordance with the wishes of the older person.
* We note that there is a conflict between “minimise the need for the most expensive health and support services” and “right to the enjoyment of the highest attainable standard of physical and mental health” for the older person. The right to health is protected by international human rights conventions.

18. a.* The health needs and wishes of the older person should be included in the discharge protocol.

21.* Respite care should be tailored to the older person’s wishes, the carer and their cultural needs.
* Alternative models of respite care should be explored and trialled, including in home respite. All respite should be delivered with a restorative focus to limit functional decline.
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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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| We support the focus on the future preparedness of the health care and support system. A planned approach using care plans should focus on the wishes of the older person. The diversity of cultural competency and knowledge needs to be urgently developed for health care, well-being and dying. |

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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| * End-of–life considerations must recognise the diversity of ways that people die. This should be included in planning. Cultural approaches should be built into the care model to ensure that there is respect and dignity. Alternative health models and well-being should be included that give an older person choice on what services they use.
* The model of care needs to include the movement of older people between institutional, community and respite care models. This has to be done in a manner that respects and provides dignity to older people.
* Public awareness of advanced care planning and power of attorney are essential. These aspects relate to financial abuse which is an increasing complaint from older people who assess our services.
* Respite care for people who live alone should be considered and to provide respite for carers.

22. a.* We support the priority action of early participation in advanced care planning.

23 a, b* These should be priorities.
* Core elements of end of life care should be an integral part of standard practice for all relevant health professionals and care workers.

24a, b, d.* These actions are urgent.
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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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| * We recognise that there are collaborations and partnerships taking place across the sector but there is an urgent need to have an all of government approach to ensure that older people’s needs and the population projections are given appropriate attention and planning.
* We support a centrally-engaged approach focusing on capability and capacity of the NGO sector as it relates to service development and delivery. For an organisation such as Age Concern New Zealand, this means having a centralised and integrated approach to service development.

28. * We support a knowledge-based approach to health care and support service development.

b.* We support research on loneliness and health status. The research agenda should not be used to minimise costs.
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### Other comments

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| **Funding and age cohort increase**The Strategy is silent on matching increased population growth in older age groups and funding to meet increased health care needs and support. Through their extensive working life older people have made a significant contribution to the tax base, skills, knowledge and will continue to contribute to society as they enter advanced age. **Affordability** A significant concern for older people is affordability of health care and support services. These concerns have a direct impact on the older people’s well-being and resilience. The increasing cost of services is an important issue for low and medium-income families and vulnerable communities. Within this framework there is scope for innovation in delivery. If services are provided within the community, the social impact must be assessed. Health care services must be person-centred and good quality.**Consistent national coverage of services for older people**Age Concern provides services and support for older people across New Zealand. There are geographical areas that are not covered by funding contracts and older people are more at risk. For example Northland, Thames, Waitaki, Marlborough[[11]](#footnote-11) etc. are not covered and are without services. Age Concern New Zealand would like to see consistent coverage across New Zealand to ensure that older people are better supported. Age Concern New Zealand should be the lead agency.  |

Thank you for this opportunity to comment. We welcome any questions you may have about our submission.

**Age Concern New Zealand**

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| **Submission 92** |

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| This submission was completed by: (name) | Central Regional HOP PMs  |
| Organisation (if applicable): | Central Regional HOP Portfolio Managers |

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

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

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

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

[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [x]  District health board

[ ]  Education/training provider [ ]  Local government

[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Union

[ ]  Primary health organisation [ ]  Professional association

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

### Healthy ageing

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

|  |
| --- |
| This theme is well supported by contributors to this feedback. There is agreement between the links of social isolation and healthy aging, though preference for language that is more positive such as ‘social inclusion’. Recommendations that actions rising from this section are overt in later sections of the document and translate into an implementation plan. Important to emphasise support of the community – including non funded and informal supports. Actions that will strengthen the volunteer sector. |

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?

|  |
| --- |
| Work towards aged friendly communities has existed for several years, some in its infancy, others more advanced. The mandate for actions within the aged friendly communities framework does not go far enough to ensure this translates into environmental changes such as building consents, town and urban environment planning. Agree the right office (Office for Seniors) to take the lead on this. District and Regional Councils need to have a role. 1.c – escalate this to a more timely intervention. Social inclusion link to other determinants. The area of oral health is welcomed but concern that other equally importance aspects are being overlooked such as continence, vision and hearing for older people. These other issues link to better social inclusion.  |

### 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?

|  |
| --- |
| Agree, ACC and HQSC as joint leaders for improved outcomes from injury prevention to treatment and rehabilitation. |

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?

|  |
| --- |
| Currently over assessment occurs between allied health disciplines (social work, PT/OT, nursing and NASC. Competing professional opinions on discharge and service models for intervention are widespread. Consider gaining national agreement on supported discharge models which reduce over assessment and streamline using the most efficient of resources to return people back to community. Suggest work towards models of primary care ‘pulling people from hospital’ not people being pushed out of hospital.Consider intervention actions that ensure the right tools are appropriate for supporting older people to feel safe on discharge and in their own homes. Timely in home rehabilitation outside the ACC model which covers other non ACC users of services. Consider wider application of the interRAI suite of tools such as the acute care tool for use in inpatient and rehabilitation wards. Support interRAI as assessment tools across the system including ED screener, palliative, mental health supplement. Ensure a consistent set of tools used for integration – more streamlined and across funders.Consider actions that interface with Ministry of Justice for timely interim or personal orders to facilitate discharge/placement support for those who cannot speak for themselves. Low numbers might infer the issue is not significant, but this is not the case when average length of stay is impacted, individuals are exposed to hospital environments unnecessarily for protracted periods and these time delays add burden of cost on DHBs. Pathways that are sensitive to older people and are consistent nationally provide greater clarity for families, clinicians and services on a way forward. Individuals should be cared for in the least restrictive environment. A review of our legal framework to ensure that there are liberty safeguards for those people who lack capacity in a similar way to how human rights are managed in regards to detention under the mental health act.Restorative care should also include acute care.#6.a is not considered comprehensive enough to give context to meaning. Include other nursing groups eg community based nurses. Integrate with NGO’s who provide funded and unfunded support to those at home rehabilitating.The document is silent of models for acute care for older people with conditions that have a predilection for delirium and how they get better managed. Consider a delirium pathway, raising awareness of delirium for health professionals and service providers.  |

### Living well with long-term conditions

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

|  |
| --- |
| Contributors generally agree with this section. There is general disregard in primary care for modifying the CAPs (clinical assessment protocols) within the interRAI tool due to time capacity constraints. For example, unmanaged pain for living with long term conditions etc. Would like to see some direction linking other assessment tool data and requirement to support, subject to necessary resources to enable more rigour in health planning for the individual. Integration of assessment tools with leadership nationally to support DHBs. Consideration of discharge planning and reduction of multiple assessment tools where this is able. Nationally led guidance on this preferred.  |

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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| --- |
| Action (e) “better utilise the allied health workforce…” needs escalating to within two years. Significant loss of workforce including social work, OT, PT is impacting on primary care supports to the wider general practice team. 13.a regards to health apps, we would like to see expanded options not just reliance on technology as this group may not succeed in the uptake of health apps. Frail older people do not engage in the smartphone technology (the platform for the apps) therefore usage may be variable and not system integrated. Need to ensure frailty is seen as a ‘long term condition’.  |

### 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?

|  |
| --- |
| There is a need for more choice in living accommodation for older people that does not limit to just living at home at one end of a spectrum and aged residential care at the other. Aged Residential care, shared care, flatting, and other types of support need consideration to provide choice and enable other aspects important to wellbeing to continue. This includes improving social inclusion, efficient and affordable living for older folk and sensible supports from a wider community. Policies and actions that do not penalise varying living arrangements may need consideration (led by MSD).  |

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?

|  |
| --- |
| General agreement exists for these actions. Lacks actions to bring EPOA/ACP earlier in the lifespan when chronic conditions are present. These items should not be limited to palliative care and end of life. Actions that provide a consistent model across NZ and support IT platforms for data to be accessed are put forward for consideration. 14.(b) does not have an asterisk – suggest this is given some priority in support of older people with frailty now rather than later in the strategic roll-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?

|  |
| --- |
| Generally supported.  |

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

|  |
| --- |
| Support all the outcomes noted in the document. Education needs to line across undergraduate and postgraduate education and be realistic regarding the availability and accessibility of educational opportunities. Support for the last days of life care plan when dying is identified. The high in-hospital mortality indicates the need for appropriately supportive spaces for people dying in the acute care space. This links to physical environments that are appropriate for care. If we up-skill primary/community then dying in hospitals should be the exception. |

### 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?

|  |
| --- |
| Extend the link (page 41) 26 (d) so this work feeds to District Health Board Funding and Planning divisions as well as hospitals and primary care. There is strong support for the aging consumer as part of design and implementation of the actions. Strong theme of co design from start to finish.27(b) Ensure the methodology for measurement of the indicators is reliable and valid. Include an outcome framework. |

### Other comments

|  |
| --- |
| 1. Omitted areas include growth in the interface between people with an intellectual disability and aging needs.
2. Recognition that mainstream services might not work effectively for Maori – consider kaupapa cultural care model;
* build Maori capacity to actively contribute to their own iwi, hapu and whanau
* improve Maori participation and decision making in the health and disability sector
* ensure that health and disability services are effective for Maori as well as all New Zealanders
* ensure that we think beyond narrow definitions of health and work across sectors to achieve a wider vision of good health for everybody...would be useful to ensure a consistent planning process.

 We are supportive and committed to action 2b. Expand the provision of targeted health promotion activities and services to increase resilience among Maori and other vulnerable older populations who have poorer health status. We are supportive of the respectful end of life and in particular bullet point 3 on page 27. This is a key action that will effectively support our kaumatua to remain active and well as long as possible.Ensure the strategy carries a strong equity focus and health priorities are articulated specifically for Maori. Recognising elder Maori and kaumatua needs, finding out what they think is most important to them. Ensuring we have quality ethnicity data and information more broadly. Improvement in access rates – policies that drive this. 1. The EPOA/ACP involvement is linked to end of life care. Suggest that there is a continuum that identifies ‘planning for retirement/aging’ which incorporates other actions such as health promotion, physical activity, environment and housing planning.
2. The interface between people with active mental health needs and aging needs but are not elderly is not overt and is a growing dimension for suitable community and accommodation options.
3. The document does not ‘speak simple language’ and would benefit from a lens that considers removing “*health speak*”.
4. Environmental access and urban design links to the health and wellbeing of all New Zealanders.
* The current housing stock in New Zealand is likely to be the housing many NZers will use as they age over the next two decades and suitable changes need to include universal access.
* Local authorities and government departments to be committed to universal access in all public buildings.
* There is a need for custodial care accommodation (e.g. Abbey Field model).
* Separate provision of care from purchase of accommodation. This would mean that people could access the level of care they need in a variety of settings.
1. Social inclusion. There is a plethora of community services, groups, gatherings of like minded people who provide support. They are unsung and unrecognised by professionals. Support and encourage their growth. These are the natural supports that underpin the funded services.
2. Infrastructure around sustainable and suitable transport options to support aging living is inferred under ‘age friendly communities’ but does not get specific action. Suggest more overt connections in this space.
3. Consideration of future homelessness/custodial care and models of living which will impact and drive residential care in part. Suggest any model of care work considers emerging trends/needs.
4. Support for a strong NASC to enable effective oversight and management of supports and equitable access regardless of age, condition or disability type.
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| **Submission 93** |

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| **Submission 94** |

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| Organisation (if applicable): | Presbyterian Support, representing the seven regions |
| Position (if applicable): | General Manager, Services for Older People PSSC |

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

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

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

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

[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training provider [ ]  Local government

✓ Service provider [ ]  Government

✓ 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?

|  |
| --- |
| Vision is great – however healthy ageing begins a long time before we are aged. This document fits with the Health Strategy and other associated document which is great. I wonder if it is inclusive enough of new groups of older people such as people who had life long disabilities but are healthy in their context |

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?

|  |
| --- |
| 1a. Involves City/District Councils as well as DHBs/NGOs etc. There are opportunities to create and utilise some innovation funding – set standards2a We had these and they got dropped – appropriate research to support these so that we don’t see saw in and out of programmes that have great benefits 3a and 3e √√4e and 4f √√ |

### 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?

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| --- |
| Concern about how accidents are treated differently than those with acute and long term illness - there are inequities and they should be eliminated. There is a focus on reduction of hospitalisation however this needs to be a focus on appropriate admissions – more positive view and should lead to person centred services rather than services designed to meet the needs of DHBs  |

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?

|  |
| --- |
| 7a √√√ Great stuff and needs to be happening and is a,b,c,d,e – this is currently happening and working/developing well, so ideally placed in the first two years11 √√13 – need to understand there will be gaps if we wholly rely on technology as many older people are not tech literate and this will continue for many baby boomers so there needs to be other ways of accessing information |

### 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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| --- |
| Remember mental health, mental health is included in the WHO group of long term conditions, however in the graph - figure 6 it is not there.Enabling technologies may rely on broadband etc that is not available rurally and may not be for quite some time  |

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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| There is a lot of workforce work here to be done and it is all going to be done by the MOH and DHBs - I hope this means that they are looking at funding the NGOs who actually do most of the work in the community aged residential care with these people. These areas of work need to identify that they include and require the presence of NGOs. 9b - workforce issues need to consider the high number of English as a second language staff and also the cultural understanding of non NZ workers. There will be a deficit in leadership as the number of non NZ RNs are working in this sector and this will impact on quality of service - this needs to be addressed at a educational institute level/ higher than provider level 11b Developing age friendly communities is not just about health and needs to include people already working on these District and local councils  |

### 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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| --- |
| Reducing avoidable admissions = ensure appropriate admissions.There needs to be a greater focus on model(s) of service which may improve access to services. Integrated one team is a great goal however there needs to be more focus on work place and increasing diversity of the work force – this is an area of risk. Clinical access to all health providers – needs to be a MOH focus and funded as such. |

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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| --- |
| This is an area that needs greater focus/services and it is of course the most challenging!Requires significant work force input and the comments above about including those doing the work not just the funders. |

### 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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| End of life not just for older people – ACP needs to start in adult.There is a disparity in dying at a hospice and in an aged care facility – FUNDING!!!!? Conversations about euthanasia are occurring – this document is silent on the tough stuff. |

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?

|  |
| --- |
| This is an area that is well done. Just unsure that it addresses/has given consideration to the needs of people with life long disabilities who are now ageing  |

### 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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| --- |
| 25 a - Unsure that this time frame will be achievable given the time of the year that it will happened ? Christmas and New Year. Time frames need to be credible and achievable otherwise it makes a nonsense of all the hard work that has gone into achieving this  |

### Other comments

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| --- |
| This is a massive document - unsure of the life of this strategy - does it have an end date - Concern about the $ required to do this - because if no $ then it will failA huge piece of workforce work and not sure it cover s the issues of rurality and places where the work force is older and international The opportunities for submission have been great - love the blog use but see limited use for this as an indicator of the beginning of this technology so we do need to be mindful of not over relying on older people being able to access information |

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| **Submission 95** |

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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: |  Education/training provider |
|  | 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 am a widower since my wife's death five years ago. I am 86 years of age and I live alone in my own house in Nelson. I am President of U3A Nelson, a not-for-profit charity with over 250 members over the age of 50 dedicated to the provision of opportunities for life-ling learning, and a member of the Nelson Tasman Positive Aging Trust. My submission is a private one although most of the members of both groups would I am sure support its suggestions. i am a retired registered psychologist and was senior psychologist in the Nelson Office of the Education Department's Psycholological Service and also worked extensively with the Family Courts in Dunedin, Nelson and Blenheim. From my professional reading and personal experiences, I wish to comment on the above principles and the relevant section of the draft strategy. I was diagnosed with Parkinson's Disease in 2004 and placed on the usual medication of Madopar. I joined the New Zealand Neurological Foundation at this time and still remain a member. Through their publications and access to international medical journals, I read widely on Parkinson's Disease and other brain disorders. My symptoms developed as I expected and my medication was steadily increased. My wife became ill in 2010 with severe breathing problems resulting in low oygen levels in the blood She became progressively less able to.walk unaided and I became her sole carer. She was placed on oxygen at home and, for the last six months' of her life, was on oxygen for 24 hours a day. She collapsed twice in the evenings and because I was physically too weak I was unable to lift her and had to call an ambulance. The second time she was admitted to hospital where she died on 30th September 2011. After her funeral, I resolved to once again become active in the community believing from my reading that this would allow me to age positively and help postpone the onset of Alzheimers and/or Dementia I joined U3A and became a member of two of the 50= study groups and I resumed walking longer distances. Within two months I began to notice a definite improvement in my health and a significant reduction in the symptoms attributed to Parkinson's Disease. My initial belief was that the improvement was due to the lifting of the stress associated with my wife's illness. Bur In fact for about four years' now I have had no active symptom's of P D and with the approval of the specialist physician at Nelson Hospital and my G P, I reduced my medication with no ill effects. After a consultation with a neurologist at the Neurological Foundation, I believe that my "disorder" was misdiagnosed and I have now ceased taking all medications for P D still with no ill effects. On this basis I wish to support the first of the principles for healthy ageing wholeheartedly but to state that it should be stated more forcefully and with greater emphasis. Every "patient" should be regarded and treated holistically and never as a collection of "symptoms". I am absolutely convinced that my medical "problems" have responded to my being physically active, returning to active learning and challenges, being socially active, undertaking the responsibilities of being Secretary and now President of U3A and as convener and leader of two study groups and my resuming playing bridge. And,I may add for some people, consideration of spiritual and cultural issues are also very important. I am urging that there should be a huge emphasis on the first statement at the head of this submission and that every member of the health service be called upon to urge all aging patients to be active physically, mentally and socially and to actively study if appropriate. The use of "green" prescriptions should emphasize all aspects of life and there should be provision in Public Health Organizations of "counsellors" with knowledge of adult learning groups and specialist "mind-games" groups in the community. The result would be an increase in "healthy aging" and independence which could be of benefit not only to older people but also to the Health Service itself.  |
| 1b. Comments or suggestions regarding the actions for the goal of healthy ageing | See 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. |   |
| 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 96** |

**This submission is made on behalf of SPORT BOP**

Thank you for the opportunity to feedback on this draft document. We ourselves have been working on a national document together with Sport NZ focussing on the needs of older people related to participation in Community Sport. This document focusses on the significant role that physical activity plays in influencing the health and wellbeing of older people. Our document ‘Older People and Community Sport’ is also in the consultation phase. There is definitely alignment and complimentary messages between the two documents which is very advantageous.

Obviously being a ‘Regional Sports Trust’ we are feeding back on your document with a ‘physical activity’ lens in mind. For this reason, we have chosen to feedback in our own format given that some parts of the document are not as relevant to our business and areas of expertise as others.

Below, you will see general comments relating to the document and then we have followed with more specific feedback relating to certain parts of the document :

* Given the changing demographics for this population, and the significant growth in over 65s in the coming years, it is imperative to have strategies that address the identified needs of this age group. Given the timing of both your document and the ‘Older People and Community Sport ‘ document (referenced above that will be released later in the year(, this is the ideal opportunity to work together across sectors to ensure a coordinated approach to improve the health and wellbeing for older people.
* Research strongly supports the role physical activity plays for those over 65; reducing risk factors for long term conditions, maintaining independent function through improving strength and balance as well as social benefits such as reducing loneliness and improving community connectedness. We note there is not a lot of detail included in this document regarding the significant role physical activity can play. I acknowledge it is briefly mentioned in places, however I think this could be expanded on to illustrate how important physical activity is in contributing to improved quality of life through enhanced health and wellbeing. I am aware you have comprehensive guidelines ,’ Physical Activity guidelines for over 65s’ though I did not see this document referenced in this draft.
* Much of the content aligns with our findings and knowledge. One example is regarding ‘one size doesn’t fit all’ and as you mention ‘Older People are by no means an homogenous population group.’ We agree that how older people spend their days is significantly influenced by social , environmental , economic factors and resulting functional ability and these factors all relate to their participation in community sport also. You also mention ‘person centred’ which we strongly support as our approach is ‘participant focussed’ and the challenge for us all across sectors is really understanding the needs of this population and planning interventions accordingly. As part of our recent work, we contracted independent qualitative research to gain direct feedback from older persons. It is from these findings that we gained insights and confirmation that participation in physical activity through sport and recreation for older people can have many benefits.
* We support the need to work across sectors and as you state ‘investment approaches present opportunities to work in more integrated and longer term ways across the health and social sectors, for improvements in both health and social outcomes’. We believe there are significant benefits that can be gained through the **sport and recreation sector** working more closely with the health sector; a focus on prevention for Older People and maintaining functional abilities through regular physical activity. A successful model already illustrating working across sectors is the Green Prescription programme funded through local DHBs with close links with health professionals ( which is also reference in this document).

**Specific Feedback relating to content within the Health of Older People Strategy: Consultation draft’**

Please note text in blue relates to content taken from the document.

**Page 3 – first paragraph**

Everyone is ageing and wants to age well. That New Zealanders are living longer ever before is a major success story, and most older people are fit, healthy and active.

We would question the above comment that most older people are active. Given the tables below ( Source: MOH 2012 )illustrate a significant decline in physical activity levels post 65 ( and increase in inactivity ) we think this sentence needs reviewing. It may be that a clearer definition of what ‘active’ means is required.

 

**Diagram Page 6**

**The Health of Older Peopple Strategy in its government context**

Regarding the sections with related strategies and work programmes, we would like to request consideration of including on the list the ‘Older People and Community Sport’ document should timing work when both documents are finalised and released for use. In addition, given the role physical activity plays in the health and wellbeing of Older People would your own guidelines for those over 65 be appropriate to be referenced here?

**Taking a life Course approach - Page 7, first paragraph**

How well we age is influenced by our genetics, our upbringing, how healthily we live in younger years*……*I wonder if there is opportunity here to expand on the concept of ‘healthily’ and within the healthy lifestyle concept, specifically mentioning physical activity and nutrition given the key roles they play.

**Challenges and Opportunities - Page 8**

We are living longer, but the age to which we are likely to live in good health and without disability is not increasing at the same rate as life expectancy. At the age of 65 years, we can expect to live half of our remaining lives either free of disability or with functional limitations that we can manage without assistance*.*  Again, I think this is an opportunity to reference physical activity and the significant role it can play in improving functional status and quality of life.

**Staying Healthy and independent in Older Age – Page 10**

We have an opportunity to reinforce and accelerate the positive trends we have seen in recent years. By focusing on preventing illness and by making it easier to choose healthy options ( like eating healthy food, not drinking alcohol, or only drinking at low risk levels, and undertaking regular physical activity), we can help people to avoid developing long term health conditions or slow the development of these conditions.

The above paragraph does not seem to capture the severity regarding the incidence of long term conditions , and although there may be positive trends evident in focussed interventions, there are not positive trends in slowing the growing statistics regarding Type 2 Diabetes, Obesity and Cardiovascular disease. This remainder of the paragraph does go on to illustrate both tailored and population approaches are required and this could be an opportunity to again reinforce the need to work across sectors for optimal outcomes.

**Vision and Objectives – Page 13**

Agree with the Vision and Objectives and in particular we feel the Sport and Recreation sector can influence these 2 in particular:

* Prioritise healthy ageing and resilience throughout people’s older years
* Ensure people can live well with long term conditions

**Healthy Ageing – Page 14**

This section includes ‘The World Health Organisation estimates that more than half of the health conditions older people experience are potentially avoidable through lifestyle changes. There is increasingly clear evidence that healthy lifestyles, and physical and mental resilience are determinants of health in older age*.*  Given the significance of this , shouldn’t more detail be provided as to what is meant by lifestyle changes and including the role of physical activity.

**Resilience – Page 15**

The third paragraph talks about the importance of social interaction and connectedness. Recent research completed as part of developing the Community Sport document explored this notion and Community Sport was a significant contributor to influence social interaction and connectedness and in fact this was often the primary motivator in people choosing to participate.

**Action Plan on Pages 31-33 relating to Healthy Ageing**

Specific comments:

* 2a increase the availability of strength and balance programmes in peoples homes and community settings. Think this is a narrow focus as many people over 65 will benefit from physical activity, but for many beyond the scope of strength and balance programmes and we need to ensure a spectrum of offerings are easily accessible to all. Acknowledge that the Sport and Recreation play a leadership role in this space however we feel it is important to work collaboratively in this space rather than health focussing only on strength and balance initiatives.
* 2c Review the Green Prescription Programme, including the potential for other health professionals to prescribe *.* Absolutely agree that there is significant benefits to be gained for older people participating in the Green Prescription programme – we don’t think the issue is how many people can refer, as feel there is benefit in the referral coming from primary care and the GP practice , but perhaps there needs to be greater awareness within the health sector regarding the role of physical activity and associated benefits for those aged 65 and over . This can continue to be done from a combination of local and national communications. We have found that widening the scope of who can refer can provide challenges with inappropriate referrals.
* 4b. Encourage services and providers to promote healthy eating, physical activity and healthy lifestyles and prevent alcohol-related harm*.*  ‘Encourage’ is not encompassing enough and collaborate / support or similar should be considered. We think there needs to be careful consideration of resource allocation within the health sector and the cost effective prevention interventions that can save health dollars longer term.
* 4f. 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’In our experience and through feedback through our recent focus groups ( as part of our qualitative research ) older people access information via a range of formats, and seems those listed here are all via websites. Think will need a broader approach through access to written pamphlets and information, radio etc as not all older people have access to the internet, especially those living in rural isolated communities of whom many are the most vulnerable.

**Living well with long term conditions – Page 20**

Outcome area: *‘Improving our ability to slow or stop the progress of long term conditions towards fraility’* Would a decrease in quality of life or increased disability be just as important as ‘’frailty’?

**Action Plan on Pages 34-36 relating to Living Well with Long Term Conditions**

We think goals 9 and 10 need much more explicit reference to the role of physical activity given the significant benefits that can be achieved both in physical health conditions, but also mental health.:

* 10b Share educational resources and good practice on effective ways to increase physical activity levels among older people with debilitating health conditions to support service improvement. Obviously this will be beneficial, however it is much wider than ‘sharing resources’ and there needs to be a dedicated cross sector approach to ensure together we can make significant progress towards getting the older population more active.
* 11c Reduce the incidence of complications from diabetes, particularly for people in aged residential care …… We are unsure as to why those in residential care are identified as priority. Given the growing prevalence of Type 2 Diabetes and the high incidence of those living with this condition, would they not deserve the same focus towards reducing complications and again regular physical activity can play an important role here.

Thank you again for the opportunity to feedback and am happy to discuss any points further as required.

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| **Submission 97** |

Living well with long-term conditions – Your Comments.

9. Ensure that those working with older people with long-term conditions have the training and support they require to deliver high-quality, person-centered care. How could the support and training of those working in health and aged care be improved to better meet your needs?

Research shows that the provision of putting the elderly into such collectives is a major contributor to increasing dementia and Alzheimer’s. It takes away many reasons for wanting to be involved with younger generations. It is replaced with entertaining , caring and loss of independence and desire to contribute to life. (I could enlarge as it is a big subject ).

This is evident on the changes being made to entry age, Originally when first initiated, age of entry was 55. Today, for the purpose of increased profit, many (or most) are lifting the entry age. First it was to 65 (The so called retirement age eg Qualifying for the Super fund) but now to 70 and even suggestions of 75

Prevention surely lies in encouraging people to be more independent and able to contribute rather that creating a situation where they are “Dependant”” I.e. removing the reason for living!!!

*10. Enhance cross-sector, whole of system ways of working. What is your experience of how health professionals and aged care facilities work together to support you when you need them? (Have they listened? Did they pass on information? Do you have a story of communication working / not working?)*

*My stories at* ***an age of 88*** *are based on observations of others in care facilities Too many cares are more focused on least fuss and max comfort for themselves. Thankfully there are exceptions. BUT it is mainly focused on the carers own earning and easier to sedte than to encourage*

Too much of this is focused on “Care Facilities which is the ambulance at the bottom of the cliff’ Greater focus required on prevention and this focus is required urgently in the commercial owners of “Retirement Villages “” *suggest that the majority of Retirement Home owners have their focus on dollars Living well with long-term conditions – Your Comments. Please read each MOH draft statement (9-13) below, and then answer the questions provided. You may like to think about personal experiences to assist in answering these questions. Feel free to attach extra notes if you have more that you would like to say on any question. Your feedback will then be included as part of an independent submission by Aged Advisor NZ to the Ministry of Health. Submissions close on 7th September 2016. 9. Ensure that those working with older people with long-term conditions have the training and support they require to deliver high-quality, person-centered care. How could the support and training of those working in health and aged care be improved to better meet your needs?*

My personal research shows tremendous anomalies and differences with regard to how Retirement Homes are run and the fact that there is little or no regularity laws concerning this.

For instance, compare the regularity laws now operative in Australia.

 In NZ companies and owners we have in License to occupy”” a majority that focus on a 30% take on the original price paid operative when the person leaves or moves Also Capital gain that may occur is ignore as too and permanent improvement made by the occupier have to be under a signed contract that they will NOT be part of the above. The above 30% is claimed to be required for refurbishing when you leave.

BUNK as very frequently the refurbishing isn’t carried out. Only a clean and face lift.

An Australin company which is also operative in NZ has a 20% deduction BUT it also takes into account any capital increase in market values and or improvements. This company also makes many other efforts to provide and care for their resident well being

The weekly fees Charged by many of the companies where ownership “of the home is allowed are exorbitant and continually increasing”.

 *11. Expand and sharpen the delivery of services to tackle long-term conditions What do you think needs to improve in the long-term health and aged care services that you have been involved with?*

Prevention as in 9 and10. And some badly needed legal regulations more in line with Australian Governments. Currently “Retirement Homes “are one of the biggest cash cows in NZ for the owners.

 Encourage the focus to be more on helping and encouraging older persons to remain active and involved with society so as to maintain their own worth and independence.

Address the diet of older persons and move to healthier eating habits. This needs to include a move away from WHITE Bread because it is the cheapest. It isn’t good for health Sugar and salt also fall into this category *Eating, Exercise,. and encouragement aren’t top priorities*

*12. Inform individuals and the community so that they are better able to understand and live well with long term conditions and get the help they need to stay well. What would you (and your family) have needed to know for you to have been able to live and stay connected for longer within your community?*

Acknowledge and address the shift in cultural values where today’s young are moving away for being corers of their parent and would rather hand them over to the system and others to care for them. In acknowledging start educating young people more emphatically to the fact that they themselves will also become elderly and how would they want to be treated. A big question

*13. Use new technologies to assist older people to live well with long term conditions. How do you think technology (ie. telephone, cell phone, computer, robots etc.) could assist you to live well - yesterday, today and in the future?*

*Modern communication technology isn’t necessary as valuable as thought and it is replacing direct and personal LOVE AND CARING. Interseting that prophecy warns us of this happening. It has its place for those that can master its use but it also is too invasive and less value than prcieved by many*

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| **Submission 98 withheld at submitter’s request** |

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| **Submission 99 withheld at submitter’s request** |

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| **Submission 100** |

***SUBJ: SUBMISSION HEALTH OF OLDER PEOPLE STRATEGY:***

Tena Koutou Katoa.

I hereby submit my submission on the above mentioned strategy.

My submission is as follows:

* I confirm that I am a carer for my disabled brother under the Family Funded Care scheme.
* Housing: We have experienced this is lacking in the Whangarei area for our Kaumatua. Example: Our 70 year old cousin arrived back from Australia to live in April of this year and has been residing with us: he applied for a pensioner flat plus went to view privately owned flats since his return to no avail. He now feels disillusioned and is returning to Australia in a couple of weeks’ time.
* Pay Parity: I receive the minimum wage of $15.25 per hour and even though 2 of his carers are registered nurses no payment is received on their qualifications under family funded care we strongly believe payment on qualifications should be paid as per rest homes and homecare agencies.
* 24 Hour Care: From my experience if you are taking care of your whanau wanting to continue to live at home there is no such thing as payment for 24 hour care; this has been clarified by the service provider. It is disappointing that if we were to put my brother into a rest home he would receive 24 hour cares.
* Resources: We have had to fight for my brother’s equipment taking over a year to receive them. He is classed as a high risk needs client.
* Cultural Needs: We have been very proactive in asserting our Maoritanga/Whanautanga but have been discouraged at times where the name whanau is misunderstood by some even politicians. For example family funded carers only apply to whanau residing with the client; My elder sister who took care of our brother for over ten years, was employed by an agency and when he moved to live in his own home she did not qualify as a family funded carer; she chose to move out of her family home, leave her children and husband and live with him so she could continue caring for her brother, returning to her home on her days off. We absolutely believe our cultural belief of whanau links extends to every corner of the world was trampled on.

I am encouraged by the draft plan which would be beneficial to our Kaumatua but I must stress individual needs vary and one glove does not fit all.

I thank you for your time and consideration.

I look forward to feedback in the near future.

Nga mihi nui

(Family Funded Carer)

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| **Submission 101** |

Written by: David Wilson, GP at Mercury Bay Medical Centre, Whitianga

davidgfwilson@gmail.com

On Behalf of: New Zealand Rural General Practice Network – but a personal view. I give permission for my personal details and submission to be published.

I am a rural/remote GP, providing 24-hour care including care in an Aged Residential Care (ARC) facility, and palliative / end-of-life care. I provide education to 6th year medical students. I am deputy chair of the New Zealand Rural General Practice Network and I represent Midlands PHO on the National Rural Health Advisory Group. For six years I represented the NZ Royal College of GPs on the Palliative Care Council.

This response is an attempt to “rural proof” the strategy. I acknowledge that “rural” often, but not always, represents a more Maori and disadvantaged population.

**Rural care is more expensive and will almost always need “more buck per bang”**

In answer to the questions:

1. Goal of Healthy Ageing

While being connected may be easier in rural environments with extended families and more connected neighbours, it may also be harder for geographical and other social reasons. To stay connected will actually cost more in petrol and other costs both for the person and organisations providing services. Driving is more of an issue when it is no longer possible, with less alternatives available. This increases isolation and loneliness.

Cell phone coverage and adequate internet services are far less likely to be available.

Decent internet/cellphone access should be available to all as a priority.

This is vital where rural connectivity is perceived as slipping further and further behind urban areas: not surprising as the big dollars are obviously attracted to areas of increased population.

I agree dental care is often overlooked or in the too hard basket. Could there be visiting services for at least examinations in ARC and other elderly communities?

1. Acute and Restorative Care

While you rightly discuss easing back into the community, and it’s usually handled very well, discharge from secondary and tertiary care can be insensitive and inappropriate to rural communities.

Example 1 – this is a quote from a discharge note written to me just last month from a hospital doctor concerning a patient in her late 70s being discharged late in the evening from the hospital: “*the Bed Manager says she has to go despite her home being over 3 hours away”.*

No mention was made as to whether transport had been arranged or if the family/whanau were simply requested to come and get her. Obviously I wasn’t the only one being stunned by the decision.

This example really doesn’t look good. Communication and (geographical) sensitivity are the key.

Everyone benefits from reduced unnecessary admissions, especially rural areas where transport home can be such an issue: so long as patients can be left in a safe environment. It makes it even more important to work out if hospital admission is really going to change things – especially in end-of-life care – below.

1. Long term conditions

Rural care is the same as urban but really needs good cellphone/internet access all areas to be equitable.

In all areas but especially ARCs workforce caring for the elderly is hopelessly inadequately funded. You get what you pay for – when people can make more money stacking oranges in supermarkets you will be less likely to attract a happy stable workforce (its not rocket science!)

In many areas more support is needed from psycho-geriatric services, and due to increased numbers in the patient numers in this demographic, this need will obviously increase. Having said that, I personally feel much better supported in the last couple of years.

1. High/Complex needs

On a practical level interRAI recommendations can be arduous to perform, and then take far too long to be implemented. The situation may be aggravated in rural/remote areas with less alternatives where things can rapidly become untenable or even dangerous

A Frailty Identification Tool is excellent. Health care workers are often discouraged from using this term but it is realistic.

Discharge protocols must be sensitive to geographical realities.

Specifically there must be better realistic support for ARCs after-hours. These facilities often fare better in rural communities where healthcare support as well as St Johns is available 24/7.

1. End of Life Care

This is where rural/remote environments can actually lead the way in areas not covered by a local hospice in increasing the ability to care for unexpected events and decreasing unnecessary and uncomfortable transfers to far-away A/E units ill equipped to deal with such cases.

Example 2: from a rural township an hour away from any A/E hospital: as described to me by the daughter of the patient: “*Dad had had prostate cancer for many years, but had basically reached end-of life care. On Saturday morning he quickly developed severe pain, which was not helped at all by the drugs he had. The district nurse was summonsed who sympathised but said that as no appropriate drugs had been prescribed and as there were no doctors on-call locally the only option was to go to the A/E an hour away. They didn’t; his pain was increasingly distressing until he died on the Sunday night.”*

What was worse is the real cherry on the top of this story: a doctor was found to sign a death certificate a short time after he died.

I hope this is rare, but it’s a true story and shows how far we have to go in education, communication and the art of pre-emptive prescribing and getting drugs available in areas with limited pharmacy presence.

This goes back as well to quality of care in ARC facilities and adequate staff payments there. More forward thinking has to be instilled in healthcare workers; communication between services is vital and I acknowledge huge strides have been taken in EOLC communication between carers in many areas.

In the future society will have vastly increased numbers and proportions of elderly and, especially for me, end of life care patients. This has huge implications for the ability of primary care to cope with it because that’s where the pressure will be felt.

1. Review

Always include rural/remote voices in DHB regional forums, and pay attention to end of life care. How would you like to be treated?

Thank you for reading my comments.

David Wilson

Deputy Chair

New Zealand Rural General Practice Network

**This submission is based on views of the NZRGPN Executive Board but may not reflect the full or particular views of all of its members**

Additional comments by Sharon Hansen, Chair of NZRGPN and Nurse Pracitioner

Goal of Healthy Ageing

Connection with family, neighbours and friends in rural can be affected by the following factors:

* People in small communities are more interdependent, therefore tend to know of each others circumstance and situation
* Family may move for work or opportunity
* Public transport may be difficult at best or non-existent
* Access to services that are readily available in urban communities may be non-existent
* Coverage for cell phones, and reliable broadband may be non-existent
* Elderly may have fewer opportunity to connect with community activity for example falls prevention, or senior net
* Visiting services may be irregular, inconvenient, or do not visit often enough.

Reintegration from care situation:

* There are still too many examples of poor discharge planning, e.g. elderly people who live alone being sent home late in the evening or through the night, in a taxi after a visit to emergency departments.
* Cost of the ambulance service.
* Lack of appropriate respite care.
* Lack of appropriate care in communities, e.g. for spouses who may require permeant care being sent to more distant communities.
* Timely information sent to the general practice on discharge.

Long term conditions:

* Travel costs for carers is an issue resulting in a high turn over of staff. Elderly people may find constant change of carers very difficult to cope with. Travel for carers is much more of an issue for rural people
* Out-of-hours care for the elderly can be very distressing, people have been known to sit in pain all night in consideration to calling out volunteers or disturbing their neighbours.

End of Life Care

* Access to medications, appropriately trained staff, and respite care.
* Regular visits by end of life care specialists.

I think that David’s response is a lovely example of the anecdotal stories that we have from our practices.

I have been more succinct, however I can understand what David is saying. My own mother sat in pain all night two nights ago because she thought she would be disturbing both myself and the volunteer ambulance people on a bad night (it was snowing), if she activated her ambulance buzzer.

Kind Regards

Sharon Hansen

Chair

New Zealand Rural General Practice Network

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| **Submission 102** |

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| https://www.ageconcern.org.nz/images/ACNZ/logo.jpg |
| Our vision is for older people to thrive in an inclusive society for all ages |

29 August 2016

Health of Older People Strategy: Consultation Draft

 Feedback Submission to the Ministry of Health

This submission is made on behalf of Age Concern Counties Manukau and Age Concern Auckland

We also work in partnership with a wide range of other groups such as the South Auckland Positive Ageing Netowrk, RSA’s, Grey Power, Mental Health Foundation, Alzheimers Auckland, Asian, Maori and Pacific Island seniors groups, Rest Homes, Retirement Villages and Health, Financial and Legal providers. These groups represent and provide services to several thousands of older people including their carers and whanau.

# Overview of Age Concern

Age Concern is committed to promoting wellbeing, rights, respect and dignity for older people. Our vision is that older people live a valued life in an inclusive society.

There are four Age Concerns in the Auckland region – Auckland, Counties Manukau, North Shore and Rodney – that are part of a nationwide network of 33 Age Concerns. All are registered charities.

Across Auckland, there are approximately 8,000 members. Members are mostly aged 65+ and are members because they are interested in our information, advice and services.

Our Purpose

Age Concern promotes wellbeing, rights, respect and dignity for older people.

Our Vision

Older people thrive in an inclusive society for all ages.

Our Guiding Principles

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| Dignity | To respect the dignity and uniqueness of every person as an individual and as a valuable member of society. |
| Wellbeing | To ensure that older people are given the opportunity to achieve physical comfort, engage in satisfying activities and personal development and to feel values and supported. |
| Equity | To ensure that older people have an equal opportunity to achieve wellbeing by directing resources to help those disadvantaged or in greatest need. |
| Cultural Respect | To respect the values and social structures of Maori and people of all cultural and ethnic backgrounds, and demonstrate respect by working together to gain mutual understanding. |
| Social Inclusion | To ensure that older people are socially included in society and are free to participate as citizens in community and civil life. |
| Relevance | To reflect the needs of older people, and those that support them, in our community. |

# Meeting needs through our services

According to Age Concern New Zealand, of the 606,409 people aged 65 years and older living in New Zealand, approximately:

* 50,000 suffer from chronic loneliness and isolation (8% of the older population);
* Up to 60,000 are victims of elder abuse or neglect (3-10% of the older population);
* 73,000 suffer from some level of financial hardship (12% of the older population);
* 39,000 live below the poverty line (6% of the older population).

Our services
Through our programmes, Age Concern aims to achieve the following outcomes:

* Reduce social isolation and loneliness and the significant detrimental impact this can have on physical and mental wellbeing;
* Prevent elder abuse and neglect, and in doing so, move older people from a position of vulnerability to one of resilience;
* Maximise the independence and enhance the ability of older people to meet the challenges of their changing needs, and in doing so, move older people from a position of vulnerability to one of resilience;
* Promote positive ageing strategies so all people can age in place and maintain our quality of life as we get older;
* Inform local bodies and organisations on issues of concern for older people so they are represented in our communities.

Age Concern services across Auckland
**Accredited Visiting Service (AVS) –** provides companionship and support for older people by matching them with a regular, volunteer visitor.

**Elder Abuse and Neglect Prevention (EANP) Service –** aims to improve the quality of life of older people in abusive situations and to prevent abuse by providing information, education programmes, advocacy and support.

**Health Promotion –** delivers a range of quality programmes and activities that are fun, sociable and interactive promoting healthy living. Health promotion and education both aim at improving access to health related information and services to give people more control over their health and wellbeing.

**Information and advice –** we provide information, advice and resources for people aged 65 years and older. To receive this information, people either phone us or visit our offices. We also have some information available on the website.

**Total Mobility Scheme –** assesses and provides Total Mobility Cards to eligible people.

Additional services available in Central and West Auckland

**Financial Management Service –** manages the financial resources of an older person when they are no longer able to do so, themselves.

**Minibus Service –** takes people living in residential care for outings out in the community.

**Field Social Worker –** social workers are available to support and assist people aged 65+ with any social needs and health or wellbeing issues.

Additional services available in Counties Manukau

**Handyman Fieldworker service –** attends to small jobs like changing smoke alarm batteries when they are no longer able to do these jobs themselves as well as providing links to services, information and resources

**Counsellor –** provides counselling to older adults around age related issues such as transitioning to residential care, change in family relationships, grief and loss and anxiety.

### Healthy ageing

* The draft strategy takes a preventative approach to illness and disability associated with the ageing process. It says it focuses on older people who have had long-term disabilities, (reference page 1) and priority populations - Maori, Pacific peoples, people on low incomes and people with disabilities. ‘We will prioritise reducing health inequalities ….’ Despite this there are no action points, during the first two years, which reflect these priorities.
* Wellbeing, community and support are the stand out words in the Minister’s Foreword on page 3, these are not reflected in the goals and actions.
* Working older people are not included in the strategy. The ageing workforce and provision of healthcare is mentioned (page 10) but not working older people in general. There needs to be changes similar to those which were put in place for working mothers returning to the workforce. Emphasis needs to be placed on creating a flexible working environment to suit the changing needs of an older workforce, to maintain more older people economically active for longer.
* In the strategic framework vision infographic prevention and wellness is not mentioned, also individual and collective cultural needs are absent.
* Point 2 - resilience is more than physical. All the actions about physical resilience, mental health and overall social connectedness are missing from this section.
* Affordable, accessible housing is a huge priority and needs to take precedence. If people don’t have a safe, healthy home and the ability to cover the cost of living then their health is subsequently affected. See actions 2b and 4c.
* Point 3e is a priority to implement in the first two years. This reads, ‘also contribute to regional economic and social development,’ and should be reworded to be, ‘contribute to community wellbeing’.
* Point 4b re-word to include, ‘understand the changing nutritional needs of ageing people,’ which is different to healthy ageing.
* We must acknowledge the difficulties faced by older couples where they and their long-term partner cannot be accommodated together in the same care facility. The impact of this cannot be under-estimated. More provision of double-rooms in Rest Homes is necessary.
* There is no mention of sight and hearing loss under healthy ageing these difficulties should be made a priority in the same way that oral health is.

Social isolation is a major risk factor for physical and mental well-being and elder abuse and neglect

Social isolation is a major risk factor in the lives of many older people. The HOP Strategy as presented does not show enough emphasis of this.

* Social isolation does not need to be a normal part of ageing. In fact, isolation and the increasing physical and mental challenges associated with ageing, is one of the biggest risk factors for older people who are victims of elder abuse and neglect.
* Social isolation can be caused by a wide range of factors including mobility issues, inappropriate transport provision and significant life-changes (leading to a collapse in personal confidence).
* These are major issues for our community that must be addressed in the Health of Older People Strategy.
* How big are these issues in Auckland? Research suggests that up to 16,000 older people living in Auckland are victims of elder abuse and neglect (10% of the population). And in a recent survey, 32% of Age Concern Auckland members identified social isolation as one of the key challenges facing older people living in Auckland today.

It should be explicitly recognized that social isolation is a major detrimental factor in the lives of many older people and a balanced approach needs to be taken to ensure that not only those who are able to ‘positively’ engage or those that have reached crisis point be catered for but that the hidden who suffer at the margins of our communities are also supported.

### Acute and restorative care

* There is no mention of sight and hearing loss under healthy ageing these difficulties should be made a priority in the same way that oral health is.

### Living well with long-term conditions

* Living with long term conditions; we need to see the person as the expert of their condition, within the goals we need to stress that these be fully person-centred.

### Support for people with high and complex needs

* There needs to be a sense of meaning of personhood, especially for people with Dementia, and also a way of understanding that some people lack the ability to set their own goals due to diminished capacity.
* An action is required, in the support of people with complex needs, to rationalise medication.
* Dementia is not mentioned frequently enough throughout the plan.

### Respectful end of life

* Enduring Power of Attorney - no mention is made of the increasing issue of people not having anyone they can nominate as a personal welfare attorney when they need to establish an Enduring Power of Attorney. This issue is quite prevalent when people have no whanau, friends or faith based organisations they connect with.
* End of Life actions - establishing well connected and coordinated end of life service providers so it is not the ‘luck of the draw’ when people are dealing with end of life instead a true pathway/coordinated process.
* Look at a type of 2000 last days, similar to the 2000 first days for the baby targets. That way there is a real plan about meeting the health needs of older people, during their final years, which will be much later than previously experienced in history. Many people born now may live to 100+ years.
* Providing older people and/or their whanau with a booklet, like that available from funeral directors, as a beginning point for discussions in regard to death and any preferences the older person has in regard to a celebration of their life. Religious/non-religious theme, burial/cremation, important songs/readings, etc.

### Implementation, measurement and review

* Getting information to older people, empowering them with knowledge and using a strength based approach.
* Ongoing support for technology-based solutions.
* Research needs to be a priority so we know what works and what doesn’t work, what is the difference that enables older people to thrive?
* Stakeholders to be included in decision making processes.

### Other comments

* Communication across the whole area - building relationships and sharing information needs to be a priority across all the goals. Missing from them all is the role of the carer, whanau and how to meet their needs, training and respite.
* Carer Strategy linking to the Health of Older People Strategy.

**The Number One Priority for the Health Of Older People Strategy should be having a safe affordable accessible home where people can connect with their community!**

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| **Submission 103** |

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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| It’s a good start. Feel that there is less in the document about “growing age friendly communities” – this needs to link in with local authority planning resources and all players in the aged care sector. |

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, but see above. It is more than an “office for seniors” task to identify age friendly communities – local authorities etc need to be involved. It is a big task and needs to have a higher profile.  |

**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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| Important to look at models of care that are evidence based, support prevention, less time in hospital settings and effective discharge. This needs to have a raised profile across the whole sector – we can’t continue to do thing the way they are done now.  |

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 – already work taking place in prevention/treatment spaces (e.g. fractures). I’d say “7b” (using falls data) also should be a priority |

**Living well with long-term conditions**

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

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| There needs to be closer links with other health strategies – not just around older people, but what people do in their lives that do/do’ set them up for long term conditions. Where is the strategy for influencing social media etc.? (What will “grab” people and help them consider change earlier?) |

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

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| They are OK – but feels overwhelming as they are mainly focused on what goes wrong with older people and long term conditions. One big gap is to do with mood/motivation, including psychological support needed for people. There is a risk of trying to assist people who are confused/depressed, have “given up” due to the impact of their long term condition – and these factors are not addressed.  |

**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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| Missing: addressing the capacity to make decisions – EPOA etc, what happens when families take control in a situation (for good or ill). What are the barriers for EPOA/advanced care planning? Technology is still a potential barrier in terms of the risk that it can fall down with the cognitively impaired. Joined up Health information is more available and is improving – should we be promoting InterRai as the way to gather this- what about single shared assessment models that have al the information in one place? Also, oral health needs of elderly people only feature in 5b in relation to residential care  |

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

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| Frailty identification tool – a good idea, could be promoted/worked on at a regional level e.g. via HOPSLA in South Island). Suggest making 19B a priority & integrating long term care management, advanced care planning, acute care). This is not just about acting in older people space. Medicines management – good call to have this in here.  |

**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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| --- |
| No |

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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| EOPA – mentioned here, should be flagged much earlier i.e. when people are in their 50s, especially for those without immediate family support (potentially increasing numbers?). 22A – advanced care planning, “yes”, but needs to be closer partnership with primary and secondary health. They are the ones who will often beginning to have these significant conversations – what do we need to do to provide other opportunities for these in the wider community? What is the DHB role in this? |

**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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| There is good information and direction in the draft strategy – but concerned that It may be “lost” in some of the health silos that can be around. For example, there is a lot in the strategy that applies in acute health settings, public health, mental health – how high is awareness of this strategy in these areas?  |

**Other comments**

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| **Submission 104** |

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| --- | --- |
| This submission was completed by: (name) | Zonta Club of Mana |

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

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

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

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

[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training provider [ ]  Local government

[ ]  Service provider [ ]  Government

[ ] xxx **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?

|  |
| --- |
| The vision outlined is comprehensive and all the points made are important. Investing in healthy ageing makes economic sense for the nation. Older people can manage their lives, are a potential source of manpower, care providers for younger generations, and the keepers of societal knowledge and history. It is also noted that age-friendly communities need roads and footpaths in good condition. An intergenerational focus is needed to support age-friendly communities. |

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

|  |
| --- |
| The actions marked \* are all important. We also added 1b as the strong partnerships between DHBs and Healthy Families NZ will be needed and an intergenerational focus. However, as the Office for Seniors is named as a lead agency it will be essential that it is adequately resourced. 4e and f are important as the ‘digital divide’ can isolate older people. Access to information in a form that can be understood is essential. One suggestion is the establishment of an “Elderline” – a landline which older people can contact for information and assistance. Many older people have not taken up new technology and their landline is their key communication method. |

### Acute and restorative care

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

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| --- |
| The vision on page 19 is about rehabilitation and support for older people. There is a need for overall coordination between the bodies listed. Information should be shared and all should be working together with “lead agency” responsibility in specific cases according to the needs of the older person. While the vision is comprehensive, there could be problems through the lack of trained support people and adequate funding.  |

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

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| --- |
| 7a is the obvious place to begin. Again the lead agencies quoted need to be working together. Overall coordination is essential. Some health professionals need better communication skills. There should be an age set for individuals to be assessed. Rehabilitation is important to get people mobile again. If not done well the injury can persist and recovery becomes more difficult.  |

### Living well with long-term conditions

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

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| There needs to be a better awareness of what needs to be done. Social assistance is important with services available close to home. Strengthening home and community support services is essential – but this requires support people and funding.  |

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 14 \* actions shown are all essential to maintaining living standards. We thought that 9a was the most important as the trained kaiawhina workforce is essential. However, while the Ministry of Health is named as the lead agency, it will need the cooperation and support of education and training providers and the DHBs. And while the training of the workforce is very important, to attract good people to train and work in this area they need to be paid a living wage.  |

### Support for people with high and complex needs

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

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| --- |
| The vision covers the key aspects to be addressed to support those with high and complex needs. The involvement of families and whanau is important. Better communication between the providers of services is also needed. There is a need to coordinate flexible home and residential care and the technology required. Mobile phones and Medic Alerts are needed to maintain contact.  |

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

|  |
| --- |
| The \* actions are all important. Reducing frailty is but a start and building responsiveness to frailty in primary health care settings will be important.  Better integration of the services for people in residential care is another key area. Another point made in our group was that people should have choices as to who can touch their bodies. And concern was expressed that there is a need to streamline waiting room times so that the elderly do not have to spend long times in big waiting rooms with many noisy and active children.  |

### 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 suggestions regarding the vision for a respectful end of life covered the situation well. It was thought that end of life is something that needs to be talked about more. And medical disciplines need to be in contact so that planning can be done in advance. The needs and practices of different cultures should be understood too. These days many people prepare their funeral arrangements in their lifetime. This can be important for the older person and their family.  |

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

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| The early and widespread participation in advance care planning was seen as most important – 22a. We also thought that 23b – encouraging the use of new technologies should be a priority. The implementation of Te Ara Whakapiri was supported.Medically assisted dying is another aspect which has requires some consideration. People die in diverse settings and their spiritual care is important.  |

### Implementation, measurement and review

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

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| The implementation of the Strategy should be the first priority. The Ministry of Health is named as the lead agency. It is to be hoped that there will be key staff and resources available to enable this to proceed. The Implementation Plan needs buy-in and commitment from all the agencies involved in the health sector. Including older people in the service design, development and review would be crucial to implementation. It is also important to involve Maori and Pasifika people in the planning as their life expectancies are shorter than those of European backgrounds. The Health Quality and Safety Commission’s role is important 26dIt was thought that all the items mentioned in this section 25 – 28 were important but to achieve them will require resources and funding and the commitment of all those involved in the health sector who deal with older people.  |

### Other comments

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| The Health of Older People is becoming even more important as life expectancy has lengthened. A variety of lead agencies has been designated responsibility for the 28 initiatives outlined in the Report. The Ministry of Health is given overall responsibility for the Implementation Plan and will need to be adequately resourced to do this. The other Lead agencies noted throughout the Consultation Draft will also require resourcing as they will be involved in additional work and support. Adequate funding for DHBs was a concern. The Health of Older People Strategy is an impressive start to address the needs of our ageing population. |

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| **Submission 105** |

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

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

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

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

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

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

[x]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [x]  District health board

[ ]  Education/training provider [ ]  Local government

[x]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Union

[x]  Primary health organisation [ ]  Professional association

[ ]  Academic/researcher [x]  Other *(please specify)*:
A collection of feedback from DHB, Provider organisations, some consumers, palliative care representatives, general practice teams and local district council input

### Healthy ageing

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

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| This theme is well supported. There is agreement between the links of social isolation and healthy aging, though preference for language that is more positive such as ‘social inclusion’. Recommendations that actions rising from this section are overt in later sections of the document and translate into the implementation plan. Suggest actions that strengthen the volunteer sector.  |

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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| Work towards aged friendly communities has existed for some, some in its infancy, others more advanced. The mandate for actions within the aged friendly communities framework does not go far enough to ensure this translates into environmental changes such as building consents, town and urban environment development and planning. Is this the right office (Office for Seniors) to take the lead on this? District Councils are somewhat involved already in this development and need to take lead roles. 1.c – escalate this to a more timely intervention. Social inclusion link to other determinants. The area of oral health is welcomed but concern that other equally importance aspects are being overlooked such as continence, vision and hearing for older people. These other issues link to improved social inclusion.  |

### 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 section discusses three different areas, delayed or premature discharge, a “do with not do for” philosophy and over assessment (numerous assessment tools). Will the actions described on page 33 link to support better discharge and remove over-assessing?  |

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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| Currently over assessment occurs between allied health disciplines (social work, PT/OT, nursing and NASC. Competing professional opinions on discharge and service models for intervention are widespread. Consider gaining national agreement on supported discharge models which reduce over assessment and streamline using efficient resources to return people back to their communities. Suggest work towards models of primary care ‘pulling people from hospital’ not people being pushed out of hospital.Consider intervention actions that ensure the right tools are plentiful for supporting older people to feel safe on discharge and in their own homes. Timely ‘in home’ rehabilitation outside the ACC model which covers other non ACC users of services. Consider wider application of the interRAI suite of tools such as the acute care tool for use in inpatient and rehabilitation wards.Consider actions that interface with Ministry of Justice for timely interim or personal orders to facilitate discharge/placement support for those who cannot speak for themselves. Low numbers might infer the issue is not significant, but this is not the case when average length of stay is impacted, individuals are exposed to hospital environments unnecessarily for protracted periods and these time delays add burden of cost on DHBs. Pathways that are sensitive to older people and are consistent nationally provide greater clarity for families, clinicians and services on a way forward. #6.a This action is not considered comprehensive enough to give context to meaning – thoughts to tease this out more? The document is silent of models for acute care for older people with conditions that have a predilection for delirium and how they get better managed.  |

### 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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| Contributors generally agree with this section. There is a general disregard in primary care for modifying the CAPs (clinical assessment protocols) within the interRAI tool due to time capacity constraints. For example, unmanaged pain for living with long term conditions etc. Would like to see some direction linking other assessment tool data and requirement to support, subject to resourcing to enable more rigour in health planning for the individual. Integration of assessment tools with leadership nationally to support DHBs. Consideration of discharge planning and reduction of multiple assessment tools where this is able. Nationally led guidance on this preferred.  |

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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| Action (e) “better utilise the allied health workforce…” needs escalating to within two years. Significant loss of workforce including social work, OT, PT is impacting on primary care supports to the wider general practice team. 13.a regards to health apps, we would like to see expanded options not just reliance on technology as this group may not succeed in the uptake of health apps. Frail older people may not engage in the smartphone technology (the platform for the apps) therefore usage may be variable and not system integrated. Need to ensure frailty is seen as a ‘long term condition’.  |

### 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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| There is a need for more choice in living accommodation for older people that does not limit to just living at home at one end of a spectrum and aged residential care at the other. ‘Custodial type care’, shared care, flatting, and other types of support need consideration to provide choice and enable other aspects important to well being to continue such as improving on social inclusion, efficient and affordable living for older folk and sensible supports from a wider community. Policies and actions that do not penalise varying living arrangements may need consideration (led by MSD).  |

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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| General agreement exists for these actions. Lacks actions to bring EPOA/ACP further up the lifespan when chronic conditions are present. These items should not be limited to palliative care and end of life. Actions that provide a consistent model across NZ and support IT platforms for data to be accessed are put forward for consideration. 14.(b) does not have an asterisk – suggest this is given some priority in support of older people with frailty now rather than later in the strategic roll-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?

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| Generally supported by the MDHB palliative care district group. Bereavement support is somewhat subtle and needs to be more overt.  |

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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| Feedback supports all the outcomes noted in the document but makes the comment that education needs to line across undergraduate and postgraduate educations and be realistic regarding the availability and accessibility of educational opportunities. The secondary care clinicians share a view/caution, that the sector needs to be realistic regarding what level of palliative care need can be safely supported in primary care. Support for the last days of life care plan when dying is identified. Feedback from our hospital clinicians refers to the high in hospital mortality which indicates the need for appropriately supportive spaces for people dying the acute care space. This links to physical environments that are appropriate for care.  |

### Implementation, measurement and review

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

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| --- |
| Extend the link (page 41) 26 (d) that this work feeds to District Health Board Funding and Planning divisions as well as hospitals and primary care. There is strong support for the aging consumer as part of design and implementation of the actions. 27(b) Ensure the methodology for the indicators is balanced. Contributory measures are selected by DHBs and are not mandatory. It is unclear if there are specific age-related measures relevant to service level measures that could target older people beyond what occurs for other ages. Widespread concern at the DHBs capacity and capability for implementation and data collection, without placing additional burden on DHBs without sufficient support, including technology, people, linkages and in the context of benefit and cost.  |

### Other comments

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| 1. Omitted areas include growth in the interface between people with an intellectual disability and aging needs.
2. Our Maori Health lens has put forth their support for the strategy overall. Particularly the active inclusion of He Korowai Oranga and the Treaty Relationship – however there needs to be further detail around how the Older Persons Strategy will practically;
* build Maori capacity to actively contribute to their own iwi, hapu and whanau;
* improve Maori participation and decision making in the health and disability sector;
* ensure that health and disability services are effective for Maori as well as all New Zealanders; and
* ensure that we think beyond narrow definitions of health and work across sectors to achieve a wider vision of good health for everybody...would be useful to ensure a consistent planning process and factor analysis for areas.
* We are very supporting and committed to action 2b Expand the provision of targeted health promotion activities and services to increase resilience among Maori and other vulnerable older populations who have poorer health status and finally we are supportive of the respectful end of life and in particular bullet point 3 on page 27 Making sure that people in the last stages of life are in control of all aspects of care as much as they are able - from deciding their clinical treatment to fulfilling their cultural needs. This is a key action that will effectively support our kaumatua to remain active and well as long as possible.
1. Ensure the strategy carries a strong equity focus and health priorities are articulated specifically for Maori. Recognising elder Maori and kaumatua needs, finding out what they think is most important to them. Ensuring we have quality ethnicity data and information more broadly. Improvement in access rates – policies that drive this.
2. The EPOA/ACP involvement is linked to end of life care rather than up front when people are still retiring. Suggest that there is a continuum that identifies ‘planning for retirement/aging’ which incorporates other actions such as health promotion, physical activity, environment and housing planning.
3. The interface between people with active mental health needs and aging needs but are not elderly is not overt and is a growing dimension for suitable community and accommodation options.
4. A consumer contribution to this feedback suggests that the HOP strategy document does not ‘speak simple language’ and would benefit from a lens that considers removing “*health speak*”.
5. Overall positive feedback for the document, in some instances though to be aspirational and in other groups it is thought not to go far enough. Other groups within the DHB will provide their own perspective from their respective disciplines.
6. The current housing stock in New Zealand is likely to be the housing many NZers will use as they age over the next two decades. Thinking about environmental access and suitable changes to existing housing stock links to the health and wellbeing of all New Zealanders. Are their opportunities to add activity on this front?
7. Social inclusion: linkages to well being and better health are multifaceted including calls for volunteers and engaged in community and other work sectors. Removing unnecessary barriers around Health & Safety and ensuring older folk are valued and available for contributions to the workforce are value added opportunities. Suggest building on opportunities within this space.
8. Infrastructure around sustainable and suitable transport options to support aging living is inferred under ‘age friendly communities’ but does not get specific action. Suggest more overt connections in this space.
9. Consideration of future homelessness/custodial care and models of living which will impact and drive residential care in part. Suggest any model of care work considers emerging trends/needs.
10. Dementia from some groups is thought not to be mentioned enough in the actions. Consider actions to progress the early diagnosis of dementia and discussions with family/whanau including end of life care for people with dementia.
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| **Submission 106** |

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| --- | --- |
| Organisation (if applicable): | Hospice New Zealand |
| Position (if applicable): | CEO |

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

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

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

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[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [x]  District health board

[ ]  Education/training provider [ ]  Local government

[ ]  Service provider [ ]  Government

[x]  Non-governmental organisation [ ]  Union

[ ]  Primary health organisation [ ]  Professional association

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

### Healthy ageing

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

|  |
| --- |
| We support the vison and goals in this section.  |

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

|  |
| --- |
| We would like to see Advance Care Planning included in this section. This supports the vision and goals of building resilience, ability to make informed choices and supported in ways appropriate to their needs.  |

### Acute and restorative care

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

|  |
| --- |
| We support the vison and goals 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?

|  |
| --- |
| We would like to see Advance Care Planning included in this section. This supports the vision and goals of working with people, maintaining and adapting, setting restoration outcomes, ensuring appropriate support is in place, and looking for ways in involving the family and whānau and wider community. A person’s wishes need to be known before planning response and support.  |

### Living well with long-term conditions

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

|  |
| --- |
| We support the vison and goals in this section.  |

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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| Please see comments about Advance Care Planning in earlier sections. It plays a very significant role in this section. People with a long-term condition need to control, plan and articulate choices about their current and future care, treatment and setting early rather than at a time of complexity and/or crisis later in their trajectory and possibly when they are no longer able to make critical choices. Plans need to be revisited when a person is diagnosed with a long-term condition. We believe Action **9g** is a priority – family carers carry a considerable burden of care that requires training and support to ensure and maintain their wellness; physically and emotionally.  |

### Support for people with high and complex needs

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

|  |
| --- |
| We support the vison and goals in this section.  |

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

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| --- |
| Please see previous comments about Advance Care Planning. We see **19** as a priority**.** Integration is critical for people with complex needs potentially accessing many services across a number of settings. The sharing of information and plans ensure people have timely access to appropriate (and chosen) care and treatment, including palliative and end-of-life care.  |

### Respectful end of life

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

|  |
| --- |
| General comments We welcome the highlight and recognition of this important phase of the life course. Bereavement care needs to be included in this section – the care for family and whānau is imperative for on-going well-being. Please see previous comments. Advance Care Planning needs to be started early when a person is “well” and continued as a conversation at all stages of a person’s life. i.e. this is an important part of healthy ageing and a proactive/preventative approach. “Technology improves end-of-life care” - this statement could be misleading and confused with medical technology – suggest “Technology as a communication tool… “ It is important that the aged residential care sector is highlighted and acknowledged as a key provider for palliative and end of life care. This Is based on the work of Heather McLeod – e.g. more than 33% of deaths occur in aged residential care. Page 28 – we believe the term “require a sufficient” is too loose and subjective – suggest remove “sufficient”.  |

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** – this is a priority so that all new health care graduates start out in practice with a knowledge of palliative and end-of-life care needs which they will potentially meet in all/most of their practice settings. A national training and education programme is required to prepare all staff providing palliative and end of life care – regulated and unregulated. Engagement in foundation national programmes to be required and evidenced e.g. the HNZ Fundamentals of Palliative Care programme and the HNZ Syringe Driver Competency programme e.g. the Careerforce Unit Standard 4 that is being developed. This should be started earlier than end-of-life as palliative care is an important consideration for people with long-term conditions and complex needs – e.g. knowledge of a palliative care approach and when to make timely referrals for specialist input. We would be happy to provide more information. **24a** – this is a priority as it provides the framework, expectation and required outcomes. Note: the HNZ Standards for Palliative Care and Quality Review programme were implemented in the hospice sector in 2012. The intention was they could be used and applied across all settings. An evaluation of these Standards has been completed in 2016 and Hospice NZ would welcome the opportunity to collaborate and support a wider sector pilot with organisations interested in using the Standards in their setting (e.g. aged residential care).  |

### Implementation, measurement and review

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

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| The implementation of the strategy will be critical to its success. We believe it will require centralised contracting and monitoring to ensure the DHBs and providers meet the agreed action requirements and priorities consistently. This will require robust reporting and monitoring. Funding models need to be flexible and reflect the complexity and overlap of the key areas – i.e. we need to avoid silos and services should be responsive and wrap around a person’s changing needs and setting. There will be a need for an inter-sectoral and inter-agency approach which will need to be reflected in the contracting and provision of care. The alignment with other key work and strategies needs to be clearly presented and understood. Setting the priorities for the first two years is challenging without more information – they need to be dynamic as needs change and emerge.  |

### Other comments

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| Thank you for the opportunity to provide feedback on this important draft strategy that will direct and lead the health and wellbeing of older people for the next 10 years. We have focused our feedback on three key areas and the guiding questions but we would like to offer some general comments. Overall, we fully support the draft and the proposed vision, goals, implementation and action plan. We have been impressed with the consultative and inclusive approach and the process followed to achieve this comprehensive work to date. We believe the format of the document has a logical flow making it easy to read and apply. We particularly like the life course approach, the alignment with the themes and strategic framework of the Health Strategy and the proactive preventative focus. We welcome the focus and inclusion of end-of-life. It is essential that the work and outcome of the review of adult palliative care services informs and closely aligns with this strategy. The strong linkage between palliative care and care of older people needs to be reflected and articulated in the respective goals and actions. We do note that palliative care has not been included as an approach that aligns with other areas, such as long-term conditions and complex conditions. Palliative care is relevant before end-of-life care and needs to be considered early to guide appropriate care and treatment, advance planning and timely referrals. It is important that the role of aged residential care sector is acknowledged as a key provider for palliative and end of life care. The psychosocial team and member’s contribution to the wellbeing of people and their family and whānau needs to be acknowledged more strongly throughout the report. We suggest that ‘Allied Health’ explicitly includes psychosocial, spiritual and cultural workforce and expertise e.g. social work and counsellors. Question - we note that the term holistic care is not used in the draft and do not believe this is entirely covered within person-centred care. Would this be seen as a model of care? We would be very happy to be contacted if you require further information.  |

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| **Submission 107 withheld at submitter’s request** |

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| **Submission 108** |

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| Organisation (if applicable): | Enliven Service Presbyterian Support Upper South Island |

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.

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

[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [x]  District health board

[ ]  Education/training provider [ ]  Local government

[ ]  Service provider [ ]  Government

[x]  Non-governmental organisation [ ]  Union

[ ]  Primary health organisation [ ]  Professional association

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

### Healthy ageing

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

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| We support the MOH draft strategy for health & wellbeing of older people. The identified vision and the five objectives form a clear pathway to supporting healthy ageing with a holistic perspective. We like the fact that the strategy will be reviewed early (after 2 years). We support community engagement, person centred care & support that enables a person the opportunity to live their lives well, informed and participating in their life course.  |

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 for Q1 Could NGO’s be included in b,c & d
* Q2 I we think b is the starting point as there has been a lot of work on Falls Prevention in the past 5 +years with very good results
* Q3 Yes for\*
* Q4 all are vital nutrition is vital to wellbeing?? more of a focus
* Q5 affordable oral health care is vital to wellbeing
* Support with pilot technology for this age group
 |

### 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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| Discharge Planning and a period??6 weeks (similar to CREST model) of post discharge community support & follow up under Restorative Model is important for this age group to ensure planned health outcomes are maintained. People living alone follow up. Enliven service well placed to support this process. Shared client care plans will support this process.  |

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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| \* starting at 6a Discharge Planning including GP, Pharmacy, Family District Nursing ,Restorative, Allied Health & NGO’s \*for 8 also While 7a continues to be vital ongoing it has been a focus now with data showing reduction in numbers of admissions from falls related injury  |

### 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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| 1. Health pathways working well, Health info provides supporting evidence based information for general population 2. Models of Care 3. Access to shared care plans 4. Investment in navigation of health service, Social supports working together with health for wrap around support 5. Early detection of cognitive issues & dementia friendly communities 6. Carer support & respite options 7. Prevention and living well ongoing programmes develop within communities 8. Support for emotional and Mental Health issues  |

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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| All Vital add 11 i \* 10c\*  |

### 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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| Client centred care Consumer consultation Information to client in a form that is understand clear & consistent Rural locations have access to specialty support?? increase in Nurse Practitioners, Specialist Assessment and Review Ethnic groups supported Maori & Pacific Communities engagement & consultation Ongoing training - investment in for carers Data linked to NHI would give knowledge of who and how many people are providing support for clients  |

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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| 16 c vital \* include NGO’s 19c ,b & C \* 21a\*  |

### Respectful end of life

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

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| We support the identified goals. ?? Include Hospice NZ  |

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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| Include 23 a\* Agree with 25\* 7 27\* 28(b)\* and 28(c)\* All \* areas good to focus on  |

### 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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| Age friendly communities vital with consumer consultation. Continued support for Day Programmes such as Home share in communities and Day Care Centres. Affordable Social Housing. Increase in NASC Assessors.  |

### Other comments

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| Opportunity for Health \*& Social Services to continue to work together.  |

1. http://www.health.govt.nz/system/files/documents/publications/olderplebb.pdf [↑](#footnote-ref-1)
2. Hanger HC et al. NZ Med J 2005 URL: <http://www.nzma.org.nz/journal/118-1214/1439/> [↑](#footnote-ref-2)
3. From Sylvia Beale’s speech on SDGs: <http://www.helpage.org/blogs/sylvia-beales-199/i-am-here-to-speak-about-ageing-and-older-persons-947/> [↑](#footnote-ref-3)
4. <https://sustainabledevelopment.un.org/post2015/transformingourworld> [↑](#footnote-ref-4)
5. <http://who.int/ageing/events/world-report-2015-launch/en/> (World Report on Ageing and Health) Page 7. [↑](#footnote-ref-5)
6. <http://www.un.org/disabilities/convention/conventionfull.shtml> [↑](#footnote-ref-6)
7. <http://apps.who.int/iris/bitstream/10665/67215/1/WHO_NMH_NPH_02.8.pdf> [↑](#footnote-ref-7)
8. <http://apps.who.int/iris/bitstream/10665/67215/1/WHO_NMH_NPH_02.8.pdf> page 12. [↑](#footnote-ref-8)
9. <https://www.health.govt.nz/system/files/documents/publications/health-of-new-zealand-adults-2011-12-section7.pdf> [↑](#footnote-ref-9)
10. <https://www.health.govt.nz/system/files/documents/publications/costbarrierstohealth.pdf> [↑](#footnote-ref-10)
11. A list of areas without coverage of services can be provided. [↑](#footnote-ref-11)