

Canterbury

District Health Board

Te Poari Hauora o Waitaha

Submission on Health of Older People Strategy

To: Ministry of Health

Submitter: Canterbury District Health Board

Attn: Jane Murray
Community and Public Health
C/- Canterbury District Health Board
PO Box 1475
Christchurch 8140

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

SUBMISSION ON HEALTH OF OLDER PEOPLE STRATEGY

Details of submitter

1. Canterbury District Health Board (CDHB).

Details of submission

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

General comments

4. The use of the five key themes along with the life course approach to healthy ageing makes the document easy to read and clear. The document encourages society to recognise and value the contribution of older people.
5. The CDHB thanks the Ministry of Health for holding the recent consultation workshop in Christchurch. Participants at this forum, including consumers, geriatricians and health service providers from across the system expressed their views and suggestions.
6. This submission adds to those views expressed by CDHB clinicians at the recent forum. The CDHB looks forward to working with the Ministry of Health on consideration of the resource implications. Some initiatives may require an investment approach across government agencies. Other prioritised actions might require a funding stream if current cost barriers are to be overcome.
7. **Oral Health:** It is encouraging to see that the oral health of older people is recognised in the draft HOP strategy as an aspect of general health and in healthy ageing. An increasing proportion of older people are retaining their natural teeth and they have high oral health care needs. For some, cost is cited as a barrier to accessing dental services.

8. **Healthy environments and age – friendly communities:** The CDHB supports the Associate Minister’s direction to the Ministry to consider the National Ethics Advisory Committee (NEAC) report to the Associate Minister of Health (5 May 2016). We suggest that a decision should be made as to whether dementia initiatives are integrated into the HOP Strategy Action Plan, whether there is a defined dementia action plan (as recommended by NEAC), or a mixed model. On page 6, “HOPS in its government context” diagram, a reference to NEAC Recommendations could be added to the lowest box.
9. **Improving workforce recruitment and retention in Aged Care:** All Western countries are struggling with addressing this workforce challenge. Care work needs to be made a more attractive and credible career option¹; this means improving the status of working in aged care. Consideration should be given to enabling trained, experienced care staff to progress through to other healthcare roles such as support workers, nursing, physiotherapy and other careers in health. This needs investment, and the Kaiāwahina Action Plan is a bridge to make it happen. Employees can see a serious, professional future that is worth working towards; employers get more applicants, and more motivated staff; and older people and patients get more committed, longer-term relationships with people who have a genuine stake in caring¹.

Specific comments

Healthy ageing

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

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

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

¹ <https://www.theguardian.com/social-care-network/2015/mar/05/vicious-circle-homecare-care-work> Retrieved 25 August 2016.

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

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

Action 1a is supported. The CDHB supports initiatives to encourage implementation of the Dementia-Friendly communities model. Canterbury has local evidence of need and potential benefit in Karen Smith's Christchurch 2015 research².

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

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

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

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

² Smith K. Developing a Dementia-Friendly Christchurch: Perspectives of people with dementia. URL: http://ageconcerncan.org.nz/media/files/Developing_a_Dementia-Friendly_Christchurch.pdf

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

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

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

The CDHB would encourage the Ministry of Health to include local authorities as one of the lead agencies for Action 3e *“Support initiatives that maximise healthy ageing through supported housing and age-friendly communities where this will also contribute to regional economic and social development.”* The programmes, infrastructure and services that local authorities provide have a great influence on people’s ability to age in place and the quality of their lives within their communities. Action point 5c *“Disseminate updated information and advice on dental care to older people, family, and carers in communities, and aged care organisations”* seems to be an achievable goal that could be met quite quickly. Improved dental care improves quality of life. There are older people who are limited to a soft diet where they do not need to be as a result of a lack of dental care.

Commentary on other Actions:

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

The action point 5a to *“develop referral pathways for optimal dental care throughout ageing...”* reflects the need for early intervention and a life-course approach. This can be achieved by working with others in the aged care sector, GPs, and medical

specialties to ensure oral health is identified as part of overall health, and that oral health care is considered when developing care plans. This is consistent with the requirement set out in the NZ Health Strategy for a smart system that works as one team.

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

Acute and restorative care

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

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

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

Meeting restorative care goals is enabled in the community by sharing clinical goals and information across the healthcare team, including home based support providers. Workforce stability in the home care sector helps with the provision of

continuity of care, and continuity in the care team fosters effective working relationships. (See general comment about workforce development in aged care on page 3.)

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

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

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

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

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

Living well with long-term conditions

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

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

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

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

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

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

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

Support for people with high and complex needs

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

At the Ministry of Health forum on 15 August, there was discussion about a model in the report from the Productivity Commission³ on social services in New Zealand. This is the four quadrant model on page 53. The report notes “many clients have multiple, complex and inter-dependent needs. For these clients, a model segmenting service users according to the complexity of their needs and their own capacity to navigate the services they need”. Quadrant D service users have high needs and less capacity to navigate the system. These older adults identified in Quadrant D would need a response encompassing both health and social systems.

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

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

³ <http://www.productivity.govt.nz/sites/default/files/social-services-final-report-main.pdf>

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

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

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

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

Respectful end of life

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

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

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

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

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

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

Implementation, measurement and review

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

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

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

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

Person making the submission



Evon Currie

Date: 5/09/2016

General Manager
Community & Public Health
Canterbury District Health Board

Contact details

Jane Murray
For and on behalf of
Community and Public Health
C/- Canterbury District Health Board
PO Box 1475
Christchurch 8140

P +64 3 364 1777

F +64 3 379 6488

jane.murray@cdhb.health.nz