



# Central East Wheatbelt Aged Support and Care Regional Solution/s

Element 8

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Prepared for:

Central East Aged Care Alliance



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We also acknowledge the time and input of the community members from the local government areas of: Bruce Rock, Kellerberrin, Koorda, Merredin, Mt Marshall, Mukinbudin, Nungarin, Trayning, Westonia, Wyalkatchem and Yilgarn.

The leadership and vision of the Central East Wheatbelt Alliance members (the local governments as listed above, the Wheatbelt Development Commission, Regional Development Australia Wheatbelt, Southern Inland Health Initiative, South West WA Medicare Local and Western Australia Country Health Service) made this project possible, and provided significant input into all stages and processes. The commitment of this group is to be commended.

We also recognise other stakeholders who contributed to the project and the particular support and input we received from WACHS.

## About the authors

### *Doug Faircloth, Director*

Doug has been the Lead Consultant for this project.

Doug has many years of experience in customer service and organisational development in commercial and not-for-profit settings. He has worked with Verso Consulting for over 8 years and has been a Director of the practice for seven years. As a Senior Consultant with Verso, his capabilities contribute strongly to the provision of community consultations, market research, service reviews and learning programs for Verso clients, as well as expertise in program and service evaluation.

Doug has worked with governments at all levels, peak bodies, community service organisations, private providers and independent research organisations.

### *Jodie McNair, Research Manager*

Jodie has been a key contributor in relation to data analysis and report writing, as well as undertaking a key liaison role for this project.

Jodie has over six years consulting and service planning experience with Verso Consulting. Prior to commencing with Verso, Jodie held a number of key positions with a major international not-for-profit organisation where she enacted key communication roles and was involved in policy development and quality control.

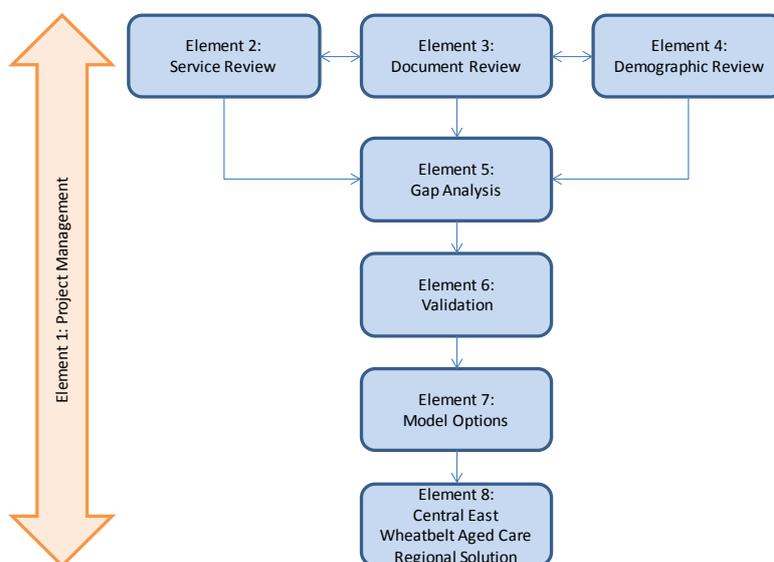
During her time with Verso, Jodie has undertaken a diverse range of feasibility and community profile analyses. Her capacity to identify detailed insights

within population needs has been utilised by many organisations, including analysis of existing service provision options in order to inform business case development for service establishment/expansion.

## About the report

This report comprises Element 8, the final report, and is based upon a staged approach as detailed in the project diagram below:

Figure 1: Project Diagram



The report builds on the findings of the research activities, which have been tested and validated by a broad range of stakeholders. Further detail regarding research activities and the outcomes are available in the Central East Wheatbelt Aged Care Needs Study, September 2012.

# Executive summary

## Context

### *Project Brief*

Central East Wheatbelt Aged Care Regional Solution was commissioned to develop clear direction to develop and implement infrastructure and service level solutions to address the urgent need for aged care accommodation, services and facilities in the region.

### *Critical Assumptions impacting on the project*

The consultants bring the following critical assumptions to the Central East Wheatbelt Aged Care Solution. These assumptions have been identified as broad issues and insights that apply to the delivery of aged care services, with some insights particularly focused on rural aged care. They are:

- All people have the right to choose where they age, including the right to age in their own home
- A functional aged care system reduces avoidable hospitalisation of older people
- The social and physical inclusion of older people in rural communities will add to individual wellbeing and community sustainability
- Sustainable rural/remote aged care models can be adapted for the Wheatbelt
- “Aged care” includes appropriate dementia care

### *Dementia Care Deficit*

The support of older persons living with dementia has been identified as a particular deficit in the Central East Wheatbelt. The needs study includes data relating to the future estimates of dementia within the Central East Wheatbelt. The estimates are that by 2022, 131 persons will be living with dementia. The needs study also identifies that 78.2% of care recipients in residential aged care across Australia have dementia or a mental illness. It can be concluded that addressing dementia in the sub region is a critical element of the plan.

### *Sustainability*

The ‘ideal’ arrangements for the delivery of a sustainable alternate model of aged care in the sub region will be difficult to achieve in the short term as:

- Multiple models are operating to deliver HACC, Community Aged Care and Residential Aged Care
- Restructuring will impact on the MPS model and require a restructuring of the hospital to occur to redirect funding and services for older people
- Restructuring the MPS model at most sites would not facilitate sufficient mass to support an alternate sustainable model

- Communities are strongly committed to the retention of their hospitals many of which are reliant on aged care for ongoing viability thus changes to aged care in the hospital may result in the hospital being reclassified

The current models of service provision - MPS and mainstream service provision (Baptist Care and Dryandra Lodge) and the funding inequities (as detailed in the needs study) require all parties involved to work together to develop a platform that will deliver the quality and quantity of services required by the Central East Wheatbelt. The Solution addresses the rationale for reform and provides clear targets.

## The Integrated Aged Care Solution (s)

The integrated solution draws on the research phases of the project and reflects the aspirations of community members to remain in their local community as they age and to maintain independence for as long as possible. The solution has been developed with direct reference to contemporary policy, leading practice and considers the practical issues of funding, workforce and infrastructure requirements. The solution has been directly referenced to sustainability principles. The solution builds up from the four strategies;

- The continued development of age friendly communities,
- The further development of older persons housing,
- Broadening community aged care
- Reshaping residential aged care.

The solution conceptually considers the interface with the health system and in particular the reform agenda of The Southern Inland Health Initiative (SIHI). The solution also builds on and makes best use of existing community capacity and infrastructure.

Each strategy of the solution could be instituted without the other; however by layering each strategy, one upon another, each strategy supports the next with ever increasing impact and inherent synergies.

### *Age Friendly Community*

An Age Friendly community builds on the Social Determinates of Health. This approach to population health is also an important and foundational idea proposed in SIHI models. This may be expressed in health promotion. An example would be actions/programs that support greater opportunities and education regarding the benefits of moving around - particularly walking. In the age friendly community strategy this same idea may include creating pathways, reducing tripping hazards in public places and improving access to shops and essential services.

Areas of focus in developing the Age Friendly Strategy include:

Areas of focus include:

- Walking and cycling routes
- Streets
- Local destinations
- Open space
- Public and other transport

- Supporting infrastructure
- Fostering community spirit

A significant deficit has been identified as discussed in the Needs Study relating to transport options for older people. An action detailed in the recommendations is the development of an integrated transport plan for CEACA.

### *Aged Persons Housing*

The aged persons housing strategy builds on the age friendly community strategy. The optimum outcomes from this strategy will occur when both the age friendly community strategy and when 'ageing in place' in the housing have been enacted. Recent studies<sup>1</sup> in the rural WA consultation conducted across the CEACA area have identified the critical role that older persons housing plays in supporting older people to remain in the community of their choice. This includes the capacity of older persons to move from a rural property to their local town and for older people living in unsuitable housing in town to move to more suitable housing matched to their needs, choice and aspirations. The availability of suitable aged person's housing in the Central East Wheatbelt townships will provide an alternative to people who may have moved away and options for people seeking to move into communities. By ensuring older persons housing is developed in each township a platform will be created that directly links community aged care to the community through the ageing in place strategy. Key elements of the strategy include:

- 'Ageing in place' in the context of aged persons housing describes the capacity to receive the full range of community aged care services commonly available to older Australian's;
- Design elements that support the possibility that older people may become progressively more disabled (universal design).

Particular design features identified through current studies<sup>2</sup> into housing preferences include:

- 2 bedrooms
- Study/activity room
- Ensuite
- Small Garden
- 1 or 2 Car bays/garage
- Garden and home maintenance

A range of ownership options have been proposed in response to issues identified through the consultations, demographics and other research activities these include: Lease For Life, Resident funded units, Rental arrangements and social housing. To provide the full menu of ownership options the housing provider will need to operate under the Retirement Living Act. Most current older persons housing providers in CEACA operate a social housing model.

<sup>1</sup> Aged Care Plans for Beverly, Quairading, Wyalkatchem, Boddington Verso Consulting (2012)

<sup>2</sup> Verso reports and studies developed for the Shires Quairading, Beverly and Carnarvon 2012

### *Community Aged Care Strategy*

Within the full range of community aged care options, as articulated in the Living Longer Living Better Aged Care Reforms, there is significant scope to imagine a future aged care landscape in the Central East Wheatbelt where older persons are regularly receiving up to and including nursing home levels of support in the community. Within this vision it is imagined that older persons will be able to enter a system that supports a continuum of care from the most basic HACC service through to palliative care in the home. The Commonwealth's design of community aged care and respite services will support the provision of dementia care in a community setting.

The community aged care strategy sits within a broader integrated strategy that includes:

- Age Friendly Communities - for each Local Government Area
- Appropriate older persons housing (with ageing in place strategy)- located in each Local Government Area
- Community aged care, respite and palliative care - delivered in each Local Government Area
- Health services that integrate with the community aged care programs and enhance the effectiveness of services delivered - accessible to residents of each Local Government Area

Well developed community aged care services have the potential to:

- Delay or reduce the need for entry into residential aged care
- Reduce the fear of older persons in the community regarding being 'made to go to residential aged care' and also increase the likelihood that older persons will engage with aged care services earlier and when they can be more effective
- Increase the health of older persons and reduce their need to access health services

The Community Aged Care Strategy is focused on delivering aged care in the manner that most people choose; that is to receive aged care at home. At any point of time 37% of the older persons across the community will be receiving community aged care compared to 8.6% who will be admitted into residential aged care. The strategy focuses on: benchmark service levels, quality, geographic coverage, and achieving the structure of community aged care detailed in Living Longer Living Better.

### *Residential Aged Care Strategy*

The vision for the Central East Wheatbelt is to provide Residential aged care services that are consistent with the Commonwealth's plan for Residential Aged Care as detailed in Living Longer Living Better. In the Central East Wheatbelt this may include services delivered by WACHS through the MPSs and services provided by a private provider(s). A critical element of the Central Eastern Wheatbelt solution is the integration of four strategies; Age Friendly Communities, Older Person's Housing, Community Aged Care and Residential Aged Care. The four strategies when integrated and coordinated will deliver high quality, equitable and the expected/required levels of care. Residential aged care has been the major, and for some community members, the single focus of attention regarding service shortfalls in 'aged care'. The needs study demonstrates that responding to the needs of the sub region requires a more comprehensive and integrated approach. The vision for the residential aged

care component of the strategy incorporates the principles as detailed in Section 1 of this report and summarized as follows:

- Principle 1: The importance of place
- Principle 2: Community life
- Principle 3: Community's sense of ownership
- Principle 4: Focus on the Person
- Principle 5: Choice
- Principle 6: Equitable Access
- Principle 7: Practicality
- Principle 8: Viability

The Residential Aged Care vision, regardless of who the provider is, includes these elements:

- The provision of dementia care; secure indoor and outdoor areas and features in the built form that reduce anxiety and maximise the quality of life for residents in at least one location in the sub region - this strategy is linked with support to improved dementia diagnosis as detailed in the community care strategy
- The provision primary health and many secondary health services to residents within the aged care facilities
- Integration with telehealth - increasing access to specialist diagnosis, treatment (e.g. geriatric assessments as developed by Prof. Len Gray)
- The delivery of the expected range of lifestyle/recreational services
- The capacity to support palliative care in the facility
- Reasonable access to all residents (care recipients, carers, family and friends) of the Central East Wheatbelt (this may also be aided by the proposed integrated transport strategy)
- Capacity to support the special needs of all persons in the designated special needs groups.
- Ageing in place (the capacity to receiving increasingly higher levels of care as required without moving)
- Appropriately trained and sufficient staff **e.g.** Personal Care Assistants with Cert III and Cert IV in aged care with specific competencies in dementia and medication administration
- A built form that meets contemporary standards for residential aged care
- That is integrated as part of an 'end on end' system; Home support (inc. HACC) → Community Care Packages → Residential Aged Care

There are challenges related to achieving the vision which include the current arrangements for residential care. The models are:

- MPSs, the predominate mode of residential aged care (61 beds Eastern Wheatbelt and 8 Bruce Rock)
- Dryandra Lodge (26 beds)

Dryandra Lodge provide residential aged care under mainstream funding, reporting and quality requirements that are significantly different to the

provision of residential care delivered through the MPS. This arrangement is an anomaly to the normal arrangement in an area served by MPSs. The normal arrangement is an ALL IN model; all health funding and aged care (including HACC) funding bundled together to achieve a single pool from which services are flexibly provided according to the needs of the community. Dryandra Lodge's independent status was acknowledged and accepted when the MPS arrangement were first negotiated. When the ALL IN arrangement is compromised it would normally require an MPS status to be reassessed leading to the hospital being reclassified (an MPS can not retain that status unless it provides residential aged care). It is probable that Dryandra Lodge could expand its services without compromising the current MPS arrangement. If an alternate Approved Provider to WACHS (MPS model) was to establish a new residential facility in the CEACA region this would impact on the MPS model and possibly on the ongoing viability of some hospitals.

The other barrier affecting the MPS is operational and funding inequities. Key findings are:

- Current funding provided by the Commonwealth to support the mixed aged care services in the MPS is significantly lower than the mixed funding available to mainstream residential aged care providers such as Dryandra Lodge;
- While the demographically driven demand for new residential and community aged care services has increased significantly and it will grow at an increasing rate over the next five years, growth funding from the Commonwealth to MPSs in WA has not; therefore there is an increasing gap between funding and demand.

The implications of the funding gap means that it is unlikely that the MPS will be able to increase the volume of services required to meet the growing demand in the Central eastern Wheatbelt unless the issues are robustly addressed by DoHA and WACHS.

The solution for Aged Care in the Central East Wheatbelt through the instrument of the other 3 strategies will result in entry to residential aged care being delayed or not being required at all for a greater portion of the population than is the current experience.

By 2022 the CEACA area will require 121 residential aged care beds in total which will be comprised of an additional 26 beds all of which will need to be ageing in place beds. Within the next 10 years the following is likely to be required in relation to residential beds in the CEACA area:

- All residential beds will be ageing in place
- Ageing in place will require that most existing beds in the 'lodges' to be decommissioned
- A significant dementia care focus and capacity will be required - this will mean that existing facilities will need to be rebuilt/altered and suitable secure outdoor areas will also be required (this may render a number of hospital/facilities obsolete)
- An estimated 60 new beds will be required by 2022 to achieve the vision as described in this section - 26 to replace decommissioned low care 'lodge beds'<sup>3</sup>, 8 to replace decommissioned hospital beds that cannot be

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<sup>3</sup> Needs Study CEACA Section 4.1.1 Assessment for Entry into Aged Care through the MPS

appropriately upgraded and 26 new beds to respond to the increased aged population

- At current costs \$15 to \$20 million will required to construct the new beds

The vision for residential aged care will not be achieved without a commitment of the major stakeholders to reshaping residential aged care in the CEACA area including the implications and or opportunities to reshape the hospitals. Key stakeholders include: WACHS, DoHA, Dryandra Lodge, and possibly other approved providers.

### *Integration with Health*

The integrated aged care strategy has been developed to facilitate and integrate with leading practice in health services, potential service changes being delivered through SIHI and the existing health services delivered through the MPSs.

## Governance

Governance can simply be defined as ‘decision making and accountability mechanisms’<sup>4</sup>.

Significant parts of the Aged Care Solution are operated under governance arrangements that are regulated by funding bodies and the various Act’s under which they operate. A summary of the broad range of governance applicable to the solution are identified in the decision making and accountability mechanisms matrix for each of the strategies that include:

### *Age Friendly Community*

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
Audit of community for all elements of age friendly community	Common tools and approach	Local Government	Community clubs/ orgs	Local Government
Development of plans or refinement of existing plan	Peer review	Local Government	Services (Medical, Health/SIHI, Aged Government)	Public Transport HACC Volunteer Drivers
Development of governance for planning for and then operating shared facilities, equipment or services	Template Agreements Peer Support Coordinated approaches	Local Government	Commercial services	Community clubs/ orgs WDC RDA Services (Medical, Health, Aged Government)
Implementation of plans	Common approach to grants for capital funding Advocacy	Local Government		Commercial services St John’s RFDS
Monitor Implementation	Information	Local Government		

<sup>4</sup> Trade Training Centres in Schools - Governance and Financial Models, Department of Education and Early Childhood Development, March 2009, p11

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
of Age Friendly Community Plan excluding transport plan	Peer support			
Improve and redevelop plan	Common approach to grants for capital funding Advocacy Information Peer support	Local Government		
Development of a regional integrated transport plan	Coordinate Plan development and Implementation Advocate Common approach to grants for capital funding	CEACA Public Transport St John's Local Government (own buses etc.) HACC/WACHS Volunteer Transport	Each Local Government Member of CEACA Public Transport HACC Volunteer Drivers St John's RFDS	As Above
Monitor Implementation of transport plan and Improve				

#### *Older persons Housing*

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
Review current stock - demand - and priority areas based on Aged Care Solution findings and plan	Identify the degree to which stock meets current requirements Current and future plans of current Housing Orgs Wait lists Covenants on current stock Pricing Undertake a common community survey	CEACA	Each Local Government that makes up CEACA WDC RDA WA Dept of Housing	Residents of current stock Existing older persons Housing Orgs Aged care Service providers Local Government WDC RDA WA Dept of Housing The community 55+ years
Development of ageing in place, multiple ownership options, quality older persons housing plan including the	Develop a coordinated approach to common development, ownership and integration	CEACA	Existing older persons housing owners: Trusts, Foundations, Community Organisations, Local Government,	Potential residents Residents of current stock Existing older persons Housing Orgs

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
business case	Common approach to marketing		Dept of Housing Possible new Housing provider	Aged care Service providers Local Government WDC RDA WA Dept of Housing Royalties for Regions
Identify and allocate/ acquire land and capital funding	Develop a common approach land and capital  Advocate  Acquire capital commitments  Manage Royalties or other Capital applications	Local Government	RDL (crown land)  Royalties for Regions  Dept of Housing	Potential residents Residents of current stock Existing older persons Housing Orgs Aged care Service providers Local Government WDC RDA WA Dept of Housing Royalties for Regions
Development of older persons housing across CEACA: with ownership options, ageing in place, with a quality required by the community  This development includes staged planning	Manage coordinated approach  Form a legal entity to deliver older persons housing vision  <i>or</i>  appoint a regional housing provider to develop/ operate as required  Manage relationships and approach with existing providers as required  Coordinate new arrangements with existing providers are required/ invited	CEACA Housing Provider	Each Local Government Entity  Funder	Potential residents Residents of current stock Existing older persons Housing Orgs Aged care Service providers Local Government WDC RDA WA Dept of Housing Royalties for Regions

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
Management of older persons housing across CEACA and ongoing staged development: with ownership options, ageing in place, with a quality required by the community	Monitor Progress and performance against agreements with provider	Housing provider	Local Government Funder	Potential residents Aged care Service providers Local Government WDC RDA WA Dept of Housing Royalties for Regions

#### *Community Aged Care*

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
Ensure Community Packaged Care Program is delivered according to the Living Longer Living Better architecture and consistent with benchmarks levels applicable to the CEACA sub region.	<p>Advocate using the findings of this report</p> <p>Ascertain how the MPSs will deliver the Living Longer Living Better Community Aged Care Approach</p> <p>Form agreements MOUs to ensure future planning and operations align with the Housing and Aged Friendly Community Strategy</p>	<p>Aged Care Providers</p> <p>WACHS</p> <p>DoHA</p>	<p>Housing Provider (s)</p> <p>Residential Care Provider (s)</p> <p>Local Government</p>	<p>Local Governments</p> <p>WDC</p> <p>RDA</p> <p>Aged Care Providers</p> <p>WACHS</p> <p>DoHA</p> <p>Housing Provider (s)</p> <p>Community Members</p>
Ensure Home Support Program is delivered according to the Living Longer Living Better architecture and consistent with benchmarks levels applicable to the CEACA sub region - currently part of bundled funding through the MPS	<p>Advocate using the findings of this report</p> <p>Ascertain how the MPSs will deliver the Living Longer Living Better the Home Support Program</p> <p>Form agreements MOUs to ensure future planning and operations align with the Housing and Aged Friendly</p>	<p>WA Health (HACC)</p> <p>WACHS</p>	<p>DoHA</p> <p>Housing Provider (s)</p> <p>Residential Care Provider (s)</p> <p>Local Government</p>	<p>Local Governments</p> <p>WDC</p> <p>RDA</p> <p>Aged Care Providers</p> <p>WACHS</p> <p>DoHA</p> <p>Housing Provider (s)</p> <p>Transport Providers</p> <p>Community members</p>

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
	Community Strategy			
Ensure that the Community Aged Care Strategy is integrated with health services	Facilitate connections/ links with the other elements of the Solution and the providers	Aged Care Providers WACHS Local Councils	Housing Provider (s) Residential Care Provider (s)	As Above

#### *Residential Aged Care*

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
Ensure that Residential Aged Care is delivered according to the Living Longer Living Better structure and the benchmark levels are delivered in the CEACA sub region.	<p>CEACA facilitate a joint working party with RDA and WDC with WACHS, DoHA, WA HACC and Dryandra Lodge</p> <p>Advocate using the findings of this report</p> <p>Ascertain how the MPSs will deliver the Living Longer Living Better</p> <p>Facilitate agreements with key stakeholders</p> <p>Ascertain what arrangements and approaches will be used in regard to restructuring aged care in MPSs, for beds that become redundant and growth arrangements</p>	Aged Care Providers WACHS DoHA	Housing Provider (s) Residential Care Provider (s) Community Care Providers Local Government Community Reference Group	Local Governments WDC RDA Aged Care Providers WACHS DoHA Housing Provider (s) Community Members
Develop alternate and creative options	Work with the joint working party with reference to the report and innovations already tested in other locations and developing new approaches	Aged Care Providers WACHS DoHA	As above	As above
Ensuring workforce development strategies are implemented	Work with the joint working party with reference to the report and	Aged Care Providers WACHS	As above	As above

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
that facilitate the community aged care, housing and aged friendly strategy	innovation already tested in other locations	DoHA		
Supporting approaches that contribute to Dryandra Lodge's viability and capacity to respond to a portion of the identified need for additional residential aged care and dementia care	Work with the joint working party and Dryandra Lodge	Dryandra Lodge WACHS DoHA	Housing Provider (s) Community Care Providers Local Government Community Reference Group	Local Governments WDC RDA Aged Care Providers WACHS DoHA Housing Provider (s) Community Members
Facilitate the context for the Residential Aged Care Strategy to be integrated with health services particularly maximizing the benefits of reforms initiated through SIHI including the capacity to make best use of telehealth and increased primary health care	Work with the joint working party and particularly SIHI and local HSMs	WACHS including; Management, SIHI and local HSMs.	Housing Provider (s) Residential Care Provider (s) Community Care Providers Local Government Community Reference Group	As Above
Develop of local boards for each MPS	Work with WACHS to develop local Boards to increase involvement of community and key stakeholders in the planning and performance assessment of the MPS	WACHS	WA Health HACC	Local Governments WACHS DoHA Community Members

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## Recommendations

There are five primary recommendations; they are:

Recommendation 1: Accept the findings and implications of this report

Recommendation 2: Implement an Age Friendly Community Strategy

Recommendation 3: Realise an Older Persons Housing Strategy

Recommendation 4: Realise the Community Aged Care strategy

Recommendation 5: Realise the Residential Aged Care strategy

The recommendations have been developed giving consideration to; the needs study and complex governance issues. The recommendations have also been developed after consultation throughout the project with the key decision and policy makers to determine what approaches that are likely to be supported and the steps that may be required to realise the full vision of an integrated aged care solution.

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# 1 Context

## 1.1 Project Brief

Regional forums conducted with 43 local Governments in the Wheatbelt in 2010 highlight Housing and Aged Care as issues being of regional significance. Other issues identified were telecommunications, transport and health; all of which impact the delivery of quality aged care services.

The 11 LGAs in the Central East Wheatbelt who participated in the forums identified the urgent need to address current issues surrounding aged care and the problems their individual communities face. They are seeking to develop a holistic regional solution to allow aging residents to remain in the region for as long as possible.

To this end a project to develop the Central East Wheatbelt Aged Care Regional Solution was commissioned. The final report is to provide the Central East LGAs clear direction to develop and implement infrastructure and service level solutions to address the urgent need for aged care accommodation, services and facilities in the region.

The solution is to be developed with specific reference to the Living Longer Living Better Aged Care reforms. The solution is also to be referenced to and to consider the opportunities and impact of the Southern Inland Health Initiative.

## 1.2 Aged Care Context

### 1.2.1 Critical Assumptions impacting on the project

The consultants bring the following critical assumptions to the Central East Wheatbelt Aged Care Solution. These assumptions have been identified as broad issues and insights that apply to the delivery aged care services, with some insights particularly focused on rural aged care. They are:

- All people have the right to choose where they age, including the right to age in their own home
- A functional aged care system reduces avoidable hospitalisation of older people
- The social and physical inclusion of older people in rural communities will add to individual wellbeing and community sustainability
- Sustainable rural/remote aged care models can be adapted for the Wheatbelt
- “Aged care” includes appropriate dementia care

The support of older persons living with dementia has been identified as a particular deficit in the Central East Wheatbelt. The needs study includes data relating to the future estimates of dementia within the Central East Wheatbelt. The estimates are that by 2022, 131 persons will be living with dementia. The needs study also identifies that 78.2% of care recipients in residential aged care across Australia have dementia or a mental illness. It can be concluded that addressing dementia in the sub region is a critical element of the plan.

### 1.2.2 Guiding Principles

A series of guiding principles were suggested by the consultants to support decisions and the priorities of the Central East Wheatbelt Aged Care Solution. These principles were tested in forums with community members and were found to reflect their aspirations and outlook. The principles are:

Principle 1: The importance of place - ageing in the community where the older person has lived all their life; place may be very specific e.g. Wyalkatchem, Bruce Rock

Principle 2: Community life - convenient access for family and friends, strong community within the facility/service, familiar staff builds confidence for the older person and for their family/friends, maintenance of community connections and being a valued member of their local community

Principle 3: Community's sense of ownership - builds trust, builds community capacity (economic/social assets), community cohesion, social capital, iconic, provides point of access to information, the role of facility as a hub

Principle 4: Focus on the Person - honouring their own sense of time/values/history/choice/worldview, dignifying their personhood

Principle 5: Choice - older persons must be provided with options that maximise their capacity for independence and self determination

Principle 6: Equitable Access - inclusiveness includes elements such as: cultures; sexual preferences; religious choices and observances

Principle 7: Practicality - choice and options must be balanced against practicality. Filters to balance choice may include: health/safety considerations; reasonable limitations of funding; population density

Principle 8: Viability - Capacity to create an operational surplus to reinvest into future service development; training/staff/innovations/ buildings; security of tenure; capacity to maintain staff and retain organisation learning and intelligence

### 1.2.3 Principle of Residential aged Care Sustainability

The consultants have also considered the development of the plan giving reference to sustainability principles drawn from previous work; published as 'A Sustainable Model of Care. A Framework for Action'<sup>5</sup>. The sustainability principles use findings from an evaluation of residential aged care services that were financially viable and those that were not in rural and remote Nth West Tasmania. The key findings have been summarised and now constitute the sustainability principles. These relevant principles are:

- Multiple services delivered from one organisation (supporting losses or marginal results in residential care)
- Maintaining high occupancy levels (supported through providing multiple services over the continuum of care from social supports, HACC and community aged care)
- Retaining qualified and expert staff
- Having personnel skilled in securing bonds and discussing financial arrangements with clients and their families (this includes the structure of farming enterprises)
- Good leadership and sound Governance

Ideally delivering sustainable aged care in the Central East Wheatbelt would be achieved if just one or two providers delivered; older persons housing, Home and

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<sup>5</sup> A Sustainable Model of Care. A Framework for Action May 2011; Verso Consulting

Community Care (and other service types foreshadowed in Living Longer Living Better), Community Care Packages and Residential Aged Care. This approach provides the opportunity for an aged care provider to achieve sustainability by achieving critical mass without the need to build large numbers of residential beds. The model also enables an aged care provider the opportunity to better manage the flow of older people into the residential aged care facility made possible by relationships with older people across the continuum of care needs. This capacity tends to mitigate the high costs associated with vacancies. Vacancy rates typically increase as the remoteness increases, therefore this is likely to be a significant challenge to sustainability in the Central East Wheatbelt.

#### **1.2.4 Barriers to achieving optimum Sustainability**

The current models in the Central East Wheatbelt include a community based aged care provider delivering residential aged care (Dryandra Lodge), a not for profit church based organisation (Baptist Care) delivering community aged care and WACHS delivering aged care, according to need, capacity and the prioritisation of services that include: HACC, Community Aged Care and residential aged care. There are a range of organisations and governance models involved in delivering housing options targeted to older persons with most housing being focused on pension level arrangements for the residents. These mixed arrangements significantly limit the opportunity to develop the ideal model to create sustainability.

#### **1.2.5 Changes to Aged Care - Impacts the Hospital**

Another important dynamic that has been considered in the process of developing the solution is the relationship between the hospital and aged care and the degree to which the continued delivery of aged care through the MPSs impacts on the overall viability of the MPS (hospital). The common arrangement for service delivery in an area served by an MPS is 'ALL IN'; that is all aged care and health funding in a single bundle of funding. In this approach services are arranged, prioritised and delivered in a flexible manner calculated by the local MPS staff to respond to the needs of the whole community that the MPS serves. The Central East Wheatbelt does not fully align to this practice. Services delivered through the approved providers, Baptist Care and Dryandra Lodge, are provided under different governance, funding, quality and reporting arrangements than those services delivered through the MPS. These services are not part of an 'ALL IN' approach. These practice anomalies and differing funding and administrative arrangements, limit the opportunity to develop and deliver a single alternate model of aged care based on the sustainability principles in the immediate short term.

The current departure from the normal 'ALL IN' practice described in the previous paragraph also produces some uncertainty regarding the future approach that the primary funder of aged care (DoHA) might take in relation to growth funding and service development in the sub region. To be an MPS the service must provide residential aged care. If alternate providers commence delivery of residential aged care in an area served by an MPS, under these arrangements, it would be normal for the MPS aged care services to cease in that area. On that basis a local hospital designated as an MPS would cease to be an MPS and therefore the hospital would need to be restructured and reclassified although this did not happen in Kellerberrin however in York this restructuring and reclassification is to be addressed by the end of the financial year. In some locations aged care may be the core activity of the existing MPS. The current SIHI strategies propose options to ensure that an alternate approach to sustainability and better targeting of the health service. This will be showcased in the primary health demonstration sites.

### 1.2.6 Restructuring Issues

Restructuring residential aged care delivered through an MPS in a distinct community will not, in and of itself, create sufficient scope to achieve sustainability for an alternate residential provider as the number of aged care beds at any one site is quite small e.g. the MPS in Yilgarn is nominally funded to deliver 4 high care and 2 low care residential beds. If the bundled aged care funding in any given MPS was provided to an alternate provider from a practical point of view this could be easily converted to community aged care, but it would be extremely difficult to convert the funding to residential aged care. For a situation to be created where an alternate provider would have sufficient mass to develop a new/alternate residential aged care facility, as discussed in this section as 'ideal', a number of sites would have to restructure their residential aged care beds to create sufficient mass (26 to 30 beds).

It is clear from the consultations and stakeholder interviews that the maintenance of the existing hospitals is of great importance. Many of the people consulted concede that this may require restructuring. It is also apparent that improving the options and arrangements for older people needs to occur.

It would be possible for the existing community based residential aged care provider in the Central East Wheatbelt, Dryandra Lodge, to achieve greater sustainability through:

- Increasing the number residential aged care beds
- Delivering community aged care
- Delivery of HACC
- Becoming an aged housing provider

This commentary regarding Dryandra Lodge is offered as this Provider can be differentiated from an alternate new provider because they already have an ageing in place residential aged care facility of 26 beds and are currently operating as an exception to the 'ALL IN' rule. Dryandra Lodge serves an area that is also served by an MPS. Any redirecting of aged care funds (even small bundles) to Dryandra Lodge will support greater sustainability as discussed in the 'ideal' arrangements.

### 1.2.7 Summary

The 'ideal' arrangements for the delivery of a sustainable alternate model of aged care in the sub region will be difficult to achieve in the short term as:

- Multiple models are operating to deliver HACC, Community Aged Care and Residential Aged Care
- Restructuring will impact on the MPS model and require a restructuring of the hospital to occur to redirect funding and services for older people
- Restructuring the MPS model at most sites would not facilitate sufficient mass to support an alternate sustainable model
- Communities are strongly committed to the retention of their hospitals many of which are reliant on aged care for ongoing viability

Given the current structure of aged care services in the Central East Wheatbelt and the issues discussed in this section, it is necessary in the Solution to identify the quantity and quality of community aged care and residential aged care that will be required over the next 10 years. The Solution also identifies the interplay between various elements of the Solution. The current models of service provision - MPS and mainstream service provision (Baptist Care and Dryandra Lodge) and the funding inequities (as detailed in the needs study) require all parties involved to work

together to develop a platform that will deliver the quality and quantity of services required by the Central East Wheatbelt. The Solution addresses the rationale for reform and provides clear targets.

## 2 The Integrated Aged Care Solutions

### 2.1 Solutions Overview

The integrated solution draws on the research phases of the project and reflects the aspirations of community members to remain in their local community as they age and to maintain independence for as long as possible. The solution has been developed with direct reference to contemporary policy, leading practice and considers the practical issues of funding, workforce and infrastructure requirements. The solution has been directly referenced to sustainability principles. The solution builds up from the four strategies; the continued development of age friendly communities, the further development of older persons housing, broadening community aged care and reshaping residential aged care. The solution conceptually considers the interface with the health system and in particular the reform agenda of The Southern Inland Health Initiative (SIHI). The solution also builds on and makes best use of existing community capacity and infrastructure.

Each strategy of the solution could be instituted without the other; however by layering each strategy, one upon another, each strategy supports the next with ever increasing impact and inherent synergies. The solution is illustrated as follows:



There is potential for even the smallest community to participate in this solution without the costs and complications of providing residential aged care. The solution will facilitate aged care in each community in the Central Eastern Wheatbelt for the majority of older people. It is anticipated that each strategy will integrate with the major themes and underlying approaches that are embedded into the Southern Inland Health Initiative.

An Age Friendly community builds on the Social Determinates of Health. This approach to population health<sup>6</sup> is also an important and foundational idea proposed in SIHI models. This may be expressed in health promotion. An example would be actions/programs that support greater opportunities and education regarding the benefits of moving around - particularly walking. In the age friendly community strategy this same idea may include creating pathways, reducing tripping hazards in public places and improving access to shops and essential services.

In the next sections the individual strategies are discussed in relation to the elements or dynamics that are being proposed.

## 2.2 Age Friendly Community

Many shires across WA are actively engaged in developing aged friendly communities including local governments in the Central East Wheatbelt. Age Friendly Communities provide a platform upon which the other strategies can be built. The WA Department of Communities state, “As the ageing population increases, there is a greater priority for local communities to accommodate the lifestyles of seniors in the community. To support the needs of every WA senior, whether they are 60 or 90, a community must be age-friendly. The Department for Communities is encouraging local government authorities to embrace the World Health Organisation’s Age-friendly Communities concept which is part of an international effort to prepare for the ageing of our community”<sup>7</sup>.

### 2.2.1 Elements of an Age Friendly Community

It also anticipated that communities that fully embrace all of the elements of an aged friendly community will be more successful in attracting further inward migration of older people who are ‘returning home’ and/or retiring. As identified in the needs study there is evidence that there are opportunities for all communities in the study to increase the inward migration and to stem the outward migration of older people from the townships in the study.

An age friendly community encourages active ageing by optimising opportunities for health, participation and security in order to enhance quality of life as people age. In practical terms, an age friendly city adapts its structures and services to be accessible to and inclusive of older people with varying needs and capabilities’. Areas of focus include:

- Walking and cycling routes
- Streets
- Local destinations
- Open space
- Public and other transport
- Supporting infrastructure
- Fostering community spirit

<sup>6</sup> “The art and science of preventing disease, prolonging life and promoting health through organised efforts and informed choices of society, organisations, public and private; communities and individuals.”  
[http://www.health.qld.gov.au/phcareers/documents/background\\_paper.pdf](http://www.health.qld.gov.au/phcareers/documents/background_paper.pdf)

<sup>7</sup> <http://www.communities.wa.gov.au/serviceareas/seniors/Pages/AgeFriendlyWA.aspx>

The age friendly community’s strategies in the Central East Wheatbelt have the added advantage of being able to build on significant social capital within the communities. The World Bank States<sup>8</sup> that “Social capital refers to the institutions, relationships, and norms that shape the quality and quantity of a society’s social interactions. Increasing evidence shows that social cohesion is critical for societies to prosper economically and for development to be sustainable. Social capital is not just the sum of the institutions which underpin a society - it is the glue that holds them together.” Another definition is that social capital is about the value of social networks, bonding similar people and bridging between diverse people, with norms of reciprocity.<sup>9</sup>

The consultants have observed that each of the local communities have significant civic participation and vibrant social organisations. The Age Friendly Community strategy should focus on engaging clubs and community leaders to maximise the existing social capital.

### 2.2.2 Transport

The greatest deficit in the elements of an Aged Friendly Community identified in the needs study is transport. This element is more difficult to address as transport solutions may include: individuals, volunteers, organisations, funding from programs, the Shire’s and State Government.

The focus of transport needs for an ageing community relates to the capacity to support older persons to maintain the instrumental activities of daily living ability thus assisting the maintenance of independence. The instrumental activities of daily living include a series of life functions necessary for maintaining a person’s immediate environment - e.g. obtaining food, cooking, laundering, housecleaning, managing one’s medications and phone use. In addition the maintenance of financial management (bill paying) and social and spiritual connections, practices and relationships is considered vital. In addition the maintenance of the health of older persons includes the need to access GPs and medical specialist.

The following extract supports insight into the impact of distance on older persons.

**Extract from the needs study: ‘The experience of distance’**

The respondents in Merredin provided the following helpful observations: “Merredin is the centre of a sub-region, but is isolated from Perth and its metropolitan services. The statistical measure of road kilometres, etc., does not make up for the fact that more sophisticated services are resident in Perth and are physically out of range of the ageing population. Public transport connections (train) will not allow a specialist to visit in the metro area without staying overnight. ARIA looks like an objective measure but does not reflect the problems of real life for the ageing population. Statistical plausibility of connectivity is one thing; the experience of distance is another”.

Within the Central East Wheatbelt there are particular challenges identified in the needs study related to transport these are summarised as:

- Over reliance on voluntary ambulance services;
- Disengagement from services if transport is not available;

<sup>8</sup> <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALDEVELOPMENT/EXTSOCIALCAPITAL/0,,contentMDK:20185164-menuPK:418217-pagePK:148956-piPK:216618-theSitePK:401015,00.html>  
<sup>9</sup> [www.socialcapitalresearch.com/definition.html](http://www.socialcapitalresearch.com/definition.html)

- Limited public transport;
- Overnight stays are often necessary if travelling to Perth;
- Underutilised Shire buses.

As a result of the findings of the study it is recommended that the Central East Wheatbelt Alliance develop an integrated transport strategy.

### 2.2.3 Governance

The Shire has the primary remit for developing the strategy and implementing the elements. It may be useful to consider drawing together key local stakeholders on a Shire by Shire basis to action the plan.

The recommendation related to transport will require an alternate approach that includes all transport providers as stakeholders.

## 2.3 Aged Persons' Housing

The aged persons housing strategy builds on the age friendly community strategy. The optimum outcomes from this strategy will occur when both the age friendly community strategy and when 'ageing in place' in the housing have been enacted. Recent studies<sup>10</sup> in the rural WA consultation conducted across the CEACA area have identified the critical role that older persons housing plays in supporting older people to remain in the community of their choice. This includes the capacity of older persons to move from a rural property to their local town and for older people living in unsuitable housing in town to move to more suitable housing matched to their needs, choice and aspirations. The availability of suitable aged person's housing in the Central East Wheatbelt townships will provide an alternative to people who may have moved away and options for people seeking to move into communities.

In effect by ensuring older persons housing is developed in each township a platform will be created that directly links community aged care to the community through the ageing in place strategy. This will ensure that each community is equitably treated and in the longer-term the services will remain anchored to the local infrastructure according to assessed needs of the residents. It is important to note that this strategy does not preclude other persons who live in their own homes from also receiving community aged care as required.

The strategy also supports clustering of community aged care services to multiple persons in older person's housing developments leading to the creation of greater efficiencies for community care service provision (minimising the cost and time required for travel when delivering services). It is envisaged that the older person's housing developments will be modest in size and in some instances may only 2 or 3 independent living units while in other larger townships there may to 30 independent living units over time. This strategy would be enacted giving due consideration to existing housing stock and the extent to which the stock meets 'ageing place' requirements and to which the stock meets the requirements of potential residents as outlined in the needs study and summarised in 'built form'. Due the scale and dispersed geography and mix of options commercial providers are unlikely to be interested in developing and managing the new housing. To develop a sustainable model a provider would require capital support for the social housing component and land and possibly the headworks to make the overall project viable.

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<sup>10</sup> Aged Care Plans for Beverly, Quairading, Wyalkatchem, Boddington Verso Consulting (2012)

### 2.3.1 'Ageing in Place'

'Ageing in place' in the context of aged persons housing describes the capacity to receive the full range of community aged care services commonly available to older Australian's whether they are delivered through the local MPS or by an alternate approved provider. This includes HACCC and the low care community aged care through to high care and palliative care if necessary in a community setting.

### 2.3.2 Built form

To facilitate an 'ageing in place' strategy the housing must include design elements that support the possibility that older people may become progressively more disabled. The design elements include:

- Accessibility - Features include items such as: wide doors, sufficient clear floor space for wheelchairs and hoists, capacity to lower bench tops, lever and loop type handles on hardware, capacity to provide seats at bathing fixtures, capacity to provide grab bars in bathrooms/toilets, shower bases on same level as the bathroom floor, capacity to add audible and visual signals, switches and controls in easily reached locations, entrances free of steps and stairs, and an accessible route through the house.
- Adaptability - Adaptable design means readily adjusted. Many of "accessible" features are built into the design and apparent however other elements may be fitted when they are needed e.g. grab handles, adjustments to bench top heights.

For older people living in housing that restricts the capacity to receive community aged care alternate housing options provides a real alternative to residential aged care.

The Needs Study details the contemporary community aspirations for older persons housing that includes the following elements that were consistently rated as highly desirable:

- Housing that afforded low to no maintenance
- A secure environment
- Supportive services and programs for ageing in place
- A place of active social engagement

Other considerations are:

- Older persons are influenced by issues or features separate to, but not excluding size, shape and age of the dwelling
- Additional bedrooms are generally seen as desirable and as multi-functional in use; guest room and hobby room combined
- Some, who presently lived in 'bedsit' housing, enjoyed the size of their dwelling and the multi-use of space
- External appearance of the building is of importance - "Attractive looking with some sort of character"
- Choice and personalisation are an important consideration in designing a dwelling that is uniquely deemed as 'homey'
- Specific areas for men to work on 'outside' hobbies was commonly supported
- Homes that provide older persons with the freedom to choose an 'active' lifestyle are seen of as highly preferable and commensurate with healthy living

- Environmental design features were not at the forefront of respondent's thinking, however among all participants there was a clear social and environmental conscience
- All respondents voiced their unwillingness to invest ALL of their assets into a new home
- While there were a number of older persons consulted who had not moved from their family home it was clear that most had given some consideration to a potential move

Particular design features identified through current studies<sup>11</sup> into housing preferences include:

- 2 bedrooms
- Study/activity room
- Ensuite
- Small Garden
- 1 or 2 Car bays/garage
- Garden and home maintenance

It can be concluded that quality older persons housing options that conform to universal design and mirror contemporary expectations regarding quality and features will provide older persons the option to age in place and will delay or curtail the need to enter residential aged care. It can be calculated that housing developed in a manner that conforms to the above mentioned strategy will reduce outward migration of older people and increase inward migration.

### 2.3.3 Ownership options

A range of ownerships options will need to be developed to accommodate the financial capacity and choice of older people across the Central Eastern Wheatbelt. To facilitate all of the housing options mentioned in this section the housing provider will need to be able to operate under the Retirement Villages Act. When operating under the Act the housing provider will need to have secured ownership of the land. To facilitate the viability of this housing strategy land may need to be ceded by RDL or the Shire to the housing provider. The land ownership and governance arrangements need to be considered within this recommendation.

Ownership options will need to be able to support 'pension level only' (restrictions on the total portion of pension paid as rent). To fund this arrangement capital for building this 'social housing' option will need to be obtained through WA Department of Housing. Early indications from the Department indicate that they are willing to support this option if there is evidence of need and a housing provider is willing to manage and maintain the housing.

Where residents own the units or a rental arrangement is put in place the capital cost will be the responsibility of the housing provider. This arrangement is often facilitated through resident deposits and progress payments.

Regardless of the ownership arrangement with the resident, a weekly operating cost rent is charged.

Resident ownership options can be summarised as:

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<sup>11</sup> Verso reports and studies developed for the Shires Quairading, Beverley and Carnarvon 2012

- Lease-For-Life: These units are funded on a deferred management fee basis. The resident pays an entry contribution (based on the current market value of the unit) when they move in. When they leave, the unit is marketed and the incoming resident pays the market price to the provider. The Provider deducts its Deferred Management Fee and any costs associated with preparing the unit for sale, and pays the balance to the previous resident. The Deferred Management Fee at the time of the sale is calculated as follows: sale price x agreed percentage x number of years the resident lived in the unit (typically this is 3% capped at 10 years).
- Resident funded units: The resident pays an entry contribution negotiated with the resident which consists of two parts; A non refundable portion and a fully refundable portion (without interest). The fully refunded portion is returned to the resident when they leave the village
- Rental Arrangements including pension level
- It is also possible that strata title options could be developed (this arrangement would not operate under the Retirement Villages Act and would not involve deferred management fees)

## 2.4 Community Aged Care, Respite and Palliative Care

### 2.4.1 The Vision

Within the full range of community aged care options, as articulated in the Living Longer Living Better Aged Care Reforms, there is significant scope to imagine a future aged care landscape in the Central East Wheatbelt where older persons are regularly receiving up to and including nursing home levels of support in the community. Within this vision it is imagined that older persons will be able to enter a system that supports a continuum of care from the most basic HACC service through to palliative care in the home. The Commonwealth's design of community aged care and respite services will support the provision of dementia care in a community setting.

The role of the carer will also be recognised with community and residential based respite services being available on a planned and emergency basis. It is intended that such a system will be integrated and coordinated. It is further imagined that the system of aged care will be enhanced by health reforms that emphasise primary care including strategies to better manage chronic disease, reablement, early interventions and geriatric health promotion. Through the Southern Inland Health Initiative the health reforms are being given real momentum and providing new opportunities for WA rural communities. Given the ageing population and the changing demand for services, this is a particular significant reform initiative.

### 2.4.2 Integrating Strategies

The Central East Wheatbelt Communities could enjoy a significant change to aged care that is more effective and is in-step with older person's aspirations and choices. This effectiveness will be enhanced through a strategy secures the following:

- Age Friendly Communities - for each Local Government Area
- Appropriate older persons housing (with ageing in place strategy)- located in each Local Government Area
- Community aged care, respite and palliative care - delivered in each Local Government Area

- Health services that integrate with the community aged care programs and enhance the effectiveness of services delivered - accessible to residents of each Local Government Area

It is important to note that delivering and integrated community aged care strategy will enhance the impact of the Aged Person's Housing Strategy and the Age Friendly Community Initiatives. In effect there will be a synergistic impact that has the potential to deliver aged care services that will; significantly improve care (quality, choice and volume), support the retention of older people within their communities and respond to the demographically driven demand for aged care services. The strategy seeks to integrate all aspects of aged care achieving an 'end on end' system; Home support (inc. HACC) → Community Care Packages → Residential Aged Care.

#### **2.4.3 Impact of Initiatives**

Well developed community aged care services have the potential to:

- Delay or reduce the need for entry into residential aged care
- Reduce the fear of older persons in the community regarding being 'made to go to residential aged care' and also increase the likelihood that older persons will engage with aged care services earlier and when they can be more effective
- Increase the health of older persons and reduce their need to access health services

#### **2.4.4 Background**

The findings from the Needs Study reveal that there is a low level of awareness in the community about the community aged care options and in particular the higher levels of care that may be available. It is also evident that current community aged care options are limited and in some cases sporadic at a local community level; this includes HACC through to arrangements for higher levels of community care. Community members demonstrated almost no awareness or experience of either community respite options and or palliative care in the community.

#### **2.4.5 Community Care**

The community aged care program is wholly funded by the Commonwealth in all States and Territories except in Western Australia and Victoria where the HACC program is jointly funded on a 60% (C'wth), 40% (State) split. It is uncertain as to how long the current arrangements in WA and Vic will continue.

Community Aged Care is provided by the MPS's through 'cashed out' contributing to a total funding pool that can be flexibly used to meet identified health and aged care needs of the community served by the MPS. WACHS have advised; "The MPS is more than an aged care service. An MPS is a health service which pools agreed Commonwealth and State funding to provide a range of health services tailored to the needs of the community it services. The mix of services includes primary care, acute care, community care, aged care and palliative care. So, essentially, a service which provides care across the care continuum. Being flexible and with pooled funding the services/programs can be changed to meet the needs of the community it serves. Provision of aged care services, especially residential places is a crucial component of being an MPS. The 3 yearly service delivery planning helps determine the priorities of the MPS. As residential aged care & CACPs is a Commonwealth responsibility our MPS do not exceed their allocation of places. They do however flexibly apply within the range of places available depending on community need. MPS funding is made up of

State funding, HACC funding, Commonwealth (flexible) funding (residential low, high, respite & Community Aged Care Packages)<sup>12</sup>.”

The broader architecture of the community aged care system detailed by the Commonwealth in Living Longer Living Better can be divided into two broad programs; The Home Support Program and Home Care Packages.

The Home Support program from July 1<sup>st</sup> 2013 will include:

- Home and Community Care (HACC)
- National Respite for Carers Program (NRCP)
- Day Therapy Centres
- Assistance with Care and Housing for the Aged Program

The HACC program provides services to the majority of aged care recipients, 862,000; across Australia in contrast there are 185,500 persons in residential aged care and 59,900 receiving Home Care Packages. The number receiving home care packages will rise to about 140,000 over the next 10 years.

The Home Care Packages program (1<sup>st</sup> of July 2013) will include a gradated range of aged care from low care through to high care. Funding in 2013 will be set at the following levels for each person receiving a package of care.

- Level A \$7,500pa
- Level B \$15,000pa
- Level C \$30,000pa
- Level D \$45,000pa

From the 1<sup>st</sup> of July 2013 packaged the Home Care Packages program will also be delivered with the following subsidies increasing the funding in the packages to provide additional services or offset higher costs in delivering the services:

- Behavioural Supplement
- Rural & Remote Supplement
- Financial & Social Disadvantage Supplement
- Veterans supplement

#### **2.4.6 Delivering Increased Levels of Community Care**

In 2013 the number of packages per 1,000 people 70+ (plus ATSI 50 - 69) is set at 27 by 2022 this figure will be 45 per 1,000 70+ (plus ATSI 50 - 69). In the Central East Wheatbelt the realisation of the benchmark levels would equate to about 30 packages in 2013 and 68 packages in 2022. The current arrangement for the delivery of packaged care is mixed with Baptist Community Care offering 11 CACP (package type B - 2013 onwards) and 23 Extended Aged Care at Home (EACH)/EACH Dementia (package type D 2013 onwards) and flexible arrangements that may equate to packages of care being delivered through the MPS. Due to the bundled funding arrangements in the MPS it is not possible to fix a number to the amount of community care being offered. The nominal or ‘cashed out’ figure for community aged care is 21.

Delivering increased levels of community care (including HACC) is a central strategy in this solution. WACHS have advised; “MPS are not expected to provide EACH level

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<sup>12</sup> Kathy Stack A/Area Director Aged Care WACHS Oct 2012

care in the community even though they sometimes do for limited periods. Private providers can provide EACH within an MPS, however, unless providers already provide other services in a nearby area then providing only EACH within an MPS is a challenge (re staffing, sustainability and viability)<sup>13</sup>. Under the new arrangement (2013 onwards) EACH (Extended Aged Care in the Home) will equate to package D. It is uncertain what other packaged care types will or will not be in the remit of the MPS when these new packages are rolled out.

Current arrangements in the Central Eastern Wheatbelt are an anomaly to these arrangements with DoHA supporting Baptist Community Care to provide 11 CACP (equivalent to level B in the arrangements from 2013 onwards) to this sub region contrary to WACHS advice. Generally the MPS is an ‘ALL IN<sup>14</sup>’ (health and aged care) model. The arrangements with Baptist Care and with Dryandra Lodge (Residential Care) are at odds with the common approach to MPS service provision.

Recommendation
These anomalies and uncertainties regarding who can or will deliver community aged care must be addressed to ensure that the community can benefit from the intent of the Aged Care reforms regardless of the service model employed by WACHS or alternate providers across the Home Support Program and Home Care Packages.

The vision for community aged care as detailed in this section of the report imagines the delivery of 68 community packages in the Central Eastern Wheatbelt by 2022 in a manner that reflects the architecture of the Home Care Packages. It is also envisaged that the program design of the Home Support Program will also be realised. It is imagined that community respite, day therapy services and early low level services through HACC will be available to support up to a third of all persons over 65 years of age in the Central Eastern Wheatbelt (689 persons receiving services by 2022).

To provide these services as envisaged there is a requirement to develop a community care workforce. Alternate strategies to develop the community care workforce have been cited in the Needs Study. Local Government and private providers have both demonstrated particular flexibility regarding their approach to recruiting and training a workforce to deliver community care in small communities and rural locations. In 2022, Verso has estimated that up to 1,200 hours (689 persons) of service may be required in the Home Support Program and 700 hours in the Home Care Packages (68 persons). This will equate to a direct care workforce of 63 Equivalent of Full Time (EFT) and 9 EFT in direct coordination and administration of the programs.

Within the Central Eastern Wheatbelt it has been estimated that 131 people will be living with dementia by 2022. A number of these people will at differing stages in the progress of their condition require assistance through the Home Support Program, the Home Care Packages and Residential Care. A large portion of these persons will require palliative care that may be provided in a community, residential aged care or acute setting. The vision for community care imagines that dementia and mental health care for older persons will be provided with a particular focus on:

- Trained and qualified staff
- Models of community Based Dementia care that reflects contemporary practice and is continually updated to embrace current research
- Making best use of technologies and building design thereby maximising older persons capacity to maintain independence and remain in their community

<sup>13</sup> Kathy Stack A/Area Director Aged Care WACHS Oct 2012

<sup>14</sup> Shane Matthews Chief Operating Officer WACHS Sept 2012 (consultation)

- Integrate service clinical services with Telehealth initiatives (SIHI)
- Supporting up to and including nursing home levels of care in the community for persons with dementia
- Early interventions and programs that enable older persons to access care and clinical approaches that increase their capacity to remain independent and living in the community
- Reablement for persons with stroke related dementia
- Supporting therapeutic responses to persons with underlying mental health issues either as a dual diagnosis with dementia or producing behaviours of concern
- Supporting better and earlier diagnosis of dementia by GPs in the sub region including but not limited to:
  - conditions that commonly aggravate dementia such as alcohol, thyroid disorders, depression, infections, renal failure, and malnutrition
  - an understanding of the differing forms of dementia (Alzheimer’s Disease, Vascular Dementia, Lewy Body, Parkinson’s Disease, Picks Disease, Alcohol-related)
  - particular, associated care requirements and differing approaches to care in a community based setting
- Enhanced access to dementia specialists, services and psycho-geriatric services

Additional programs, incentives and grants are likely to be made available through tenders to provide support for training, dementia care initiatives, and community palliative care. To maximise these opportunities for the Central Eastern Wheatbelt proactive planning and leadership is essential.

## 2.5 Residential Aged Care, Respite and Palliative Care

### 2.5.1 The Vision

The vision for the Central East Wheatbelt is to provide Residential aged care services that are consistent with the Commonwealth’s plan for Residential Aged Care as detailed in Living Longer Living Better. In the Central East Wheatbelt this may include services delivered by WACHS through the MPSs and services provided by a private provider(s). A critical element of the Central Eastern Wheatbelt solution is the integration of four strategies; Age Friendly Communities, Older Person’s Housing, Community Aged Care and Residential Aged Care. The four strategies when integrated and coordinated will deliver high quality, equitable and the expected/required levels of care. Residential aged care has been the major, and for some community members, the single focus of attention regarding service shortfalls in ‘aged care’. The needs study demonstrates that responding to the needs of the sub region requires a more comprehensive and integrated approach. The vision for the residential aged care component of the strategy incorporates the principles as detailed in Section 1 of this report and summarized as follows:

- Principle 1:     The importance of place
- Principle 2:     Community life
- Principle 3:     Community’s sense of ownership
- Principle 4:     Focus on the Person
- Principle 5:     Choice

Principle 6: Equitable Access

Principle 7: Practicality

Principle 8: Viability

The Residential Aged Care vision, regardless of who the provider is, includes these elements:

- The provision of dementia care; secure indoor and outdoor areas and features in the built form that reduce anxiety and maximise the quality of life for residents in at least one location in the sub region - this strategy is linked with support to improved dementia diagnosis as detailed in the community care strategy
- The provision primary health and many secondary health services to residents within the aged care facilities
- Integration with telehealth - increasing access to specialist diagnosis, treatment (e.g. geriatric assessments as developed by Prof. Len Gray)
- The delivery of the expected range of lifestyle/recreational services
- The capacity to support palliative care in the facility
- Reasonable access to all residents (care recipients, carers, family and friends) of the Central East Wheatbelt (this may also be aided by the proposed integrated transport strategy)
- Capacity to support the special needs of all persons in the designated special needs groups;
  - Financially and socially disadvantaged
  - Rural and remote,
  - Veterans
  - Cultural and Linguistically Diverse (CALD)
  - Aboriginal and Torres Islanders (ATSI)
  - Homeless or at risk of homelessness
  - Lesbian Gay Bi sexual Transsexual Intersex (LGBTI)
  - Careleavers
- Ageing in place (the capacity to receiving increasingly higher levels of care as required without moving)
- Appropriately trained and sufficient staff e.g. Personal Care Assistants with Cert III and Cert IV in aged care with specific competencies in dementia and medication administration
- A built form that meets contemporary standards for residential aged care
- That is integrated as part of an 'end on end' system; Home support (inc. HACC) → Community Care Packages → Residential Aged Care

### 2.5.2 Challenges to Delivering the Vision

The needs study details residential aged care in the Central East Wheatbelt is currently delivered by WACHS through the MPS's and by a Community Based Organisation; Dryandra Lodge. Dryandra Lodge provides services in a facility that conforms to the building standards for residential aged care required by DoHA. The Residential Aged Care services delivered through the MPS model are not required to

conform to these standards. Residential Aged Care delivered through the MPSs in the Central East Wheatbelt is varied depending on the age and configuration of the local hospitals and hostels that deliver the residential aged care.

The variation in building design is a limiting factor in achieving the vision for residential aged care and in particular dementia care. Delivering dementia care in a residential setting is an essential element of this residential aged care strategy. 78.2% of residents of Aged Care Facilities in Australia have dementia or a mental health condition. As detailed in the community aged care section it is expected that by 2022 there will be 131 persons 70+ in the sub region living with dementia.

MPS residential aged care currently has a varying capacity to support the expected lifestyle and recreational activities required in the broader residential aged care services across Australia. Dryandra Lodge is required by DoHA to deliver these services to the required standard. The varied service provision of lifestyle and recreational options through the MPS are a product of building design and staffing arrangements in the MPS.

A particular strategy of WACHS has been to encourage alternate aged care providers to consider delivering residential aged in rural WA; SIHI stream 5 providers financial incentives to achieve this. A challenge for residential providers is that the business model for residential aged care is marginal even under optimal conditions (90+ beds and an urban location). The framework for sustainable aged care in rural and remote Australia details that a provider of a small scale (<50) residential facility will need to also deliver a range of other integrated services to achieve financial and operational viability. To deliver residential aged care to the required standards an alternate provider would also need capital grants to cover the high building costs (\$230,000 to \$250,000 per bed).

Findings from the ‘Sustainable Model of Aged Care Regional and Rural (including remote) Australia	
<p>Across regional, rural and remote Australia there are significant viability issues impacting on provision of Residential Aged Care. Many providers report losses or marginal results in residential services. The conditions or facilities that have the most significant viability issues are facilities of less than 30 beds with those between 30 and 60 also being vulnerable. Other factors include the degree of rurality and remoteness and the lack of multiple programs being operated by the provider. When the following principles were present in rural providers in Tasmania the providers of varying sizes were viable:</p>	
<b>Principle 1:</b>	Multiple services delivered by one organisation who is the provider of residential aged care;
<b>Principle 2:</b>	The maintenance of high occupancy levels often facilitated by the integration of community care and residential care;
<b>Principle 3:</b>	Retaining qualified and expert staff;
<b>Principle 4:</b>	Having personnel skilled in securing bonds;
<b>Principle 5:</b>	Good leadership and sound governance.

The range of conditions required to achieve optimum sustainability for a new alternate residential aged care provider will be difficult to achieve in the Central Eastern Wheatbelt e.g. multiple services such as providing housing and community care options. The factors that reduce the likelihood that a sustainable model can be replicated in the Central East Wheatbelt include the elements discussed in this section. Baptist Community Care is offering community packaged care across the sub region slightly in excess of current benchmark levels; they have also only recently

begun to offer these packages (June 2012). Therefore an alternate provider will be unlikely to be able to deliver additional community aged care. The only alternate strategy for delivering community aged care would be to redirect HACC contracts currently delivered through the MPS. This approach would be contrary to the 'ALL IN' protocol in place across MPS areas.

Older persons housing provision is also currently supported across the sub region by a variety of providers with differing capacities and differing visions for service provision. These factors suggest that attracting new providers in the sub region to deliver residential aged care (that conforms to the sustainability principles) is unlikely to be achieved without very significant change. This type of change would require the agreement and collaboration of multiple stakeholders.

The other significant barrier affecting the achievement of the vision for residential aged care in the sub region is operational and funding inequities that impact the capacity of the MPS to respond to rapidly increasing population of older people in the sub region. The needs study provides a detailed discussion on this issue. Key findings are:

- Current funding provided by the Commonwealth to support the mixed aged care services in the MPS is significantly lower than the mixed funding available to mainstream residential aged care providers such as Dryandra Lodge
- While the demographically driven demand for new residential and community aged care services has increased significantly and it will grow at an increasing rate over the next five years growth funding from the Commonwealth to MPSs in WA has not; therefore there is an increasing gap between funding and demand

The Commonwealth has accepted that this dynamic exists and have announced a suite of measures to address funding inequities and to improve viability in rural and remote areas such as the Central Eastern Wheatbelt; as detailed in the text box.

Response to the Productivity Commission; Australian Government - Rural and Remote <sup>15</sup>
Productivity Commission Recommendation:
<p>The Australian Government should ensure that rural and remote, and Indigenous aged care services be actively supported before remedial intervention is required.</p> <p>This support would include but not be limited to:</p> <ul style="list-style-type: none"> <li>• the construction, replacement and maintenance of appropriate building stock</li> <li>• meeting quality standards for service delivery</li> <li>• clinical and managerial staff development, including locally delivered programs and enhanced use of technology assisted training</li> <li>• applying funding models that ensure service sustainability and support the development of service capabilities at a local level.</li> </ul>
The Australian Government Response:
<p>The Australian Government supports these recommendations in principle. The aged care reform package supports a number of measures to improve the access of older people living in rural and remote areas and Indigenous Australians to aged care services:</p> <ul style="list-style-type: none"> <li>• The maximum level of the accommodation supplement the Australian</li> </ul>

<sup>15</sup> <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-techdoc-htmlversion.htm> Section 11.4.

Response to the Productivity Commission; Australian Government - Rural and Remote<sup>15</sup>

Government pays in respect of care recipients who cannot meet their own accommodations costs will be significantly increased, for aged care homes that are built or significantly refurbished after the date that the aged care reform package was announced;

- Better targeting of capital grants funding to services caring for special needs groups, including rural and remote and Indigenous communities, whose capital needs may not be adequately met through mainstream aged care financing arrangements;
- The expansion of the ACHA program will target support to regional and remote areas where the incidence of older people who are homeless is highest;
- The new Aged Care Financing Authority will take into account the higher costs of delivering aged care services in rural and remote areas and to Indigenous Australians when making recommendations to the Government on appropriate subsidy levels in relation to these services. For example, the additional funding could be paid through the viability supplement arrangements;
- The Aged Care Financing Authority will also undertake a review of the funding basis for Multi-purpose Services (MPS), with a view to bringing these programs into closer alignment with mainstream pricing arrangements;
- The aged care reform package also includes increased funding to address workforce pressures, which will include a strong focus on better responding to the needs of rural and remote and Indigenous communities.

The implications of the funding gap means that it is unlikely that the MPS will be able to increase the volume of services required to meet the growing demand in the Central eastern Wheatbelt unless the issues are robustly addressed by DoHA and WACHS. There is an opportunity for these issues to be addressed ahead of the renegotiation of the MPS triennial agreement between WACHS and DoHA (to come into effect from July 2013).

Due to the bundled funding arrangements in the MPS it is not possible for WACHS to accurately fix a number to the quantity and type of residential aged care beds being offered through the MPS's in the Central Eastern Wheatbelt. However DoHA definitively reports the funding levels and service types in the Aged Care services list. This data is used by DoHA to identify the extent to which the benchmark service levels are being provided. The Needs study provides detailed information in regard to the benchmarks and the degree to which service levels are being provided and projections into the future. For additional residential aged care places to be allocated to the sub region evidence as detailed in the service list will be one of the factors used by DoHA to ascertain if there is a case to provide the additional recurrent funding (bed licences) for an Approved Provider or growth funding for additional residential aged care in the MPSs. While this will not be the only factor used by DoHA in their decision to allocate places there will be an added burden on the Approved Provider to prove their case.

Approved Providers such as Dryandra Lodge are significantly impacted by the potential differential between nominally allocated places and operational places. An example is provided in the text box. Urgent attention is required to address these anomalies.

### The Impact of differential between nominally allocated places and operational places

If a residential provider seeks to increase the number of residential aged care beds the current service level will be reviewed by DoHA when considering the application.

Service levels are based on current reported levels in the aged care services list and the population of the 70+ and ATSI 50 to 69 years (2011). The data details that the Central East Wheatbelt is receiving more services than the benchmark requires. On this basis no additional places would be allocated to a residential aged care facility serving the CEACA population.

Area	Pop 70+ & ATSI	Benchmark levels based on population				Current Allocation	Variance
		Resi High care	Resi Low Care	Comm'ty	Total		
CEACA	1,088	47.9	47.9	27.2	123	154	+31
W'belt	8,254	363.2	363.2	206.3	932.7	524	-409
WA	193,852	8,529	8,529	4,846	21,904	22,649	+745

While this data demonstrates that there is no need for additional aged care services the community reports that there are significant unmet needs. A review of the services being actually delivered (as opposed to the services reported on the aged care services list) suggests that the actual level may be 124 places (mixed residential and community). On this basis aged care services are currently at benchmark levels and additional licences or growth funding may be granted to meet future demand (2 to 3 years ahead). Without the recent allocation of 34 places to Baptist Care the situation reported by the community is more easily understood.

The differential between the operations of the MPS and planning framework used by DoHA is a barrier to delivering the vision for aged care in the CEACA because currently there is no certainty regarding what the aged care service levels are being provided through the MPS. WACHS report; “An MPS is a health service which pools agreed Commonwealth and State funding to provide a range of health services tailored to the needs of the community it services. The mix of services includes primary care, acute care, community care, aged care and palliative care . So essentially, a service which provides care across the care continuum. Being flexible and with pooled funding the services/programs can be changed to meet the needs of the community it serves. Provision of aged care services, especially residential places is a crucial component of being an MPS”.

The consultants are of the opinion that the higher cost of delivering residential aged care in MPS's is likely to limit the extent to which WACHS will seek to expand residential aged care over the next 10 years. The higher costs are associated with the structure of the workforce including remuneration levels in a health system<sup>16</sup>. Health systems have also faced greater challenges when it comes to developing more flexible and innovative recruitment and staff retention strategies. It is likely that flexible strategies will be required to deliver residential aged care within the limitations of funding. These cost issues are likely to create increased pressure on WACHS to consolidate residential aged care into fewer sites with more beds. This will challenge the longer term viability of the smaller facilities/MPs particularly if the majority of

<sup>16</sup> Bird Cameron Chartered Accountants identified the differential in care costs in aged care between WACHS and a private provider to be 11.7% higher in a Health Service in WA (analysed Oct 2010)

aged care needs can be responded through more flexible, lower cost and better targeted community aged care options.

### 2.5.3 Delivering Residential Care

The solution for Aged Care in the Central East Wheatbelt considers the capacity of a comprehensive and coordinated plan (age friendly community, older persons housing, community aged care and residential aged care) that is integrated with primary health. This approach will result in entry to residential aged care being delayed or not being required at all for a greater portion of the population than is the current experience.

The integrated plan is also likely to increase the age at which people first enter residential care and reduce the length of stay. This approach will result in residential aged care being provided to people requiring higher levels of care (almost 80%); this is consistent with broader trends in mainstream residential aged care. The current ratio is 32% low care beds to 68% high care or ageing in place in the CEACA area. Restructuring over time will be required to reflect the higher needs of recipients. Over time the proportion of beds per 1,000 70+ will reduce. This dynamic is consistent with broader planning as detailed in Living Longer Living Better that states that the planning ratio for residential aged care will be reduced from 88 person per 1,000 70+ in 2011 to 80 beds per 1,000 70+ by 2022. This will not result in a loss of beds but a reduction in the rate of growth of residential aged care in the CEACA area. By 2022 the CEACA area will require 121 residential aged care beds in total which will be comprised of an additional 26 beds all of which will need to be ageing in place beds.

Within the next 10 years the following is likely to be required in relation to residential beds in the CEACA area:

- All residential beds will be ageing in place
- Ageing in place will require that most existing beds in the ‘lodges’ to be decommissioned
- A significant dementia care focus and capacity will be required - this will mean that existing facilities will need to be rebuilt/altered and suitable secure outdoor areas will also be required (this may render a number of hospital/facilities obsolete)
- An estimated 60 new beds will be required by 2022 to achieve the vision as described in this section - 26 to replace decommissioned low care ‘lodge beds’<sup>17</sup>, 8 to replace decommissioned hospital beds that cannot be appropriately upgraded and 26 new beds to respond to the increased aged population
- At current costs \$15 to \$20 million will required to construct the new beds

The vision for residential aged care will not be achieved without a commitment of the major stakeholders to reshaping residential aged care in the CEACA area. Key stakeholders include: WACHS, DoHA, Dryandra Lodge, and possibly other approved providers. The Alliance in cooperation with the Wheatbelt Development Commission and RDL Wheatbelt has the opportunity to provide leadership, community collaboration/liaison and to advocate for the change. It is likely that the change process required will take 4 to 6 years to realise.

### 2.5.4 Inevitable Drivers of Change

The issues that are driving the inevitable need for change in the CEACA LGAs include:

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<sup>17</sup> Needs Study CEACA Section 4.1.1 Assessment for Entry into Aged Care through the MPS

- The growth of the 70+ population; 2012 to 2022 +32%;
- Increasing prevalence of dementia 131 persons by 2022;
- Reduced incidence of persons with a low care assessment entering residential care <20%;
- Need to develop ageing in place;
- Increasing pressure on the high cost of providing residential aged care in the MPS model;
- A requirement to improve the quality of care including lifestyle and dementia care in MPS residential aged care;
- The increasing challenge of recruiting and retaining appropriately qualified and experienced staff;
- Increasing vacancies and the accompanying impact on sustainability in low care hostels as they can no longer support the care needs of the ageing community.

The status quo will cannot be maintained as these issues will force change; the issue for the CEACA group is, will the process be managed to achieve improved outcomes or will the change be crisis led. The consultants consider the opportunity to manage the change will maximise opportunities for the community.

## 2.6 Integration with Health

The integrated aged care strategy has been developed to facilitate and integrate with leading practice in health services, potential service changes being delivered through SIHI and the existing health services delivered through the MPSs. The concepts are detailed in the needs study and the annotated bibliography. Key impacts/ approaches include:

- Age Friendly Community - health promotion and population health strategies
- Aged Persons' Housing - capacity to support reablement and post acute care
- Community Aged Care, Respite & Palliative Care Options - improved monitoring, tailored care planning, improved access and use of allied health services, improved medication administration, maintenance or reestablishment of social relationships, enhanced dementia care management, reduced unnecessary hospitalisation, improved health and wellbeing of carers etc.
- Residential Aged Care, Respite & Palliative Care Options - better access to primary care in the residential units including allied health and GPs, improved dementia care options and continued socialisation and recreation with the accompanying health benefits. Telehealth provides the potential to deliver some of the diagnostic and monitoring services without the need to move residents from the facility. The approach also supports better access for families, partners and carers to remain connected to residents with accompanying health and wellbeing benefits.

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## 2.7 Summary of Aged Care Solutions

### *Age Friendly Community*

Each community will develop and implement an age friendly strategy and measure how effective the strategy is in producing the required outcomes. The strategy will ensure that:

- There are walking and cycling routes that connect local destinations and there are open spaces that are attractive and conducive to recreational use;
- Streets, parking, public buildings, services and shops are accessible to older people particularly those using mobility aids;
- Transport services and arrangements are well coordinated and able to support an ageing population to maintain independence, to access health services and the GP and maintain social and civic connections;
- Values, respects and includes older people in civic, sporting and social structures and activities of the community;
- The older persons housing strategy and community aged care strategy are able to achieve the optimal impact - the support of older persons capacity to age in the CEACA area local communities living independently for as long as possible thus delaying or removing the need for these people to enter residential aged care.

It is envisaged that a CEACA integrated transport strategy will be developed, implemented and monitored as part of this strategy; transport has been identified as the greatest deficit in current arrangements that support an aged friendly community.

Governance options for the implementation of this element of the solution are covered in section 2.7.

### *Older Persons Housing*

The strategy supports:

- Synergy when coupled with the age friendly community strategy and the community aged care strategy
- When coupled with the community aged care strategy ageing in place is facilitated as is the capacity and occasion for geographically anchoring community aged care in each participating community
- Supports an identified need to deliver housing options that can assist older people to down size or to move to more appropriate housing that facilitates the maintenance of independence
- Supports changing support needs, facilitating independent living as the resident's mobility is reduced and frailty increases utilising universal design as detailed in the needs study
- Improves options for social connections and safety
- Reduces the need for older people to move from their community when their current housing arrangements become untenable and increases the option for older people moving into the community
- Varying financial capacities of potential residents
- The aspirations of older persons in terms of quality and the features of the home

- A staged approach to building the homes in line with deposits received, against local community interest and arrangements with the Department of Housing

Governance options for this element of the strategy are dealt with in section 2.7.

### *Community Care*

The Community Aged Care Strategy is focused on delivering aged care in the manner that most people choose; that is to receive aged care at home. At any point of time 37% of the older persons across the community will be receiving community aged care compared to 8.6% who will be admitted into residential aged care. The strategy focuses on: benchmark service levels, quality, geographic coverage, and achieving the structure of community aged care detailed in Living Longer Living Better particularly:

- Community Packaged Care (4 levels and dementia care)
- Home Support Program (National Respite for Carers, HACC, Day Therapy Centres and Assistance with Care and Housing for the Aged)
- Community palliative Care
- Provides a continuum of care

When coupled with the age friendly community and an older persons housing strategy delivers significant capacity for older people to remain in their community.

Governance options for this element of the strategy are dealt with in section 2.7.

### *Residential Care*

The Residential Aged Care Strategy is focused on ensuring that additional Residential Aged Care Beds are constructed to meet demographically driven demand, to replace aged care beds that will no longer be functional in the CEACA region and ensure that there are Residential Aged Care beds that can support people living with dementia and built as ageing in place.

Residential aged care will be delivered in a manner that aligns with a quality of care that is consistent with mainstream Residential Aged Care. Residential Aged Care sits within an integrated strategy that will delay or reduce the occasions for which older people will need to enter residential aged care. Residential care will be part of an end on end system that when coupled with the age friendly community, community aged care and an older persons housing strategy delivers significant capacity for older people to remain in their community.

## 3 Governance

Governance can simply be defined as ‘decision making and accountability mechanisms’<sup>18</sup>.

### 3.1 Background of issues that impact on Governance

#### *Residential Aged Care and Community Aged Care*

The needs study identifies the complex issues of the aged care environment in the CEACA area. Key issues identified in the study include:

- The mixed aged care delivery modes that operate in the CEACA area (contrary to the normal MPS protocols) - (1) A residential aged care provider operating under the mainstream service arrangements, (2) A community aged care provider operating under mainstream arrangements, (3) the MPS’s (the main mode of service delivery of HACC, Residential Aged Care, some Community Aged care and Health Services) delivering a flexible range of services under bundled funding through the MPS administrative arrangements;
- Uncertainty regarding the actual service levels delivered in the CEACA area through the MPS making the identification of service gaps and options for service growth difficult to identify and to plan for;
- Uncertainty regarding how the Living Longer Living Better Aged Care Reforms will impact and be outworked through the MPS model;
- Recognition that if an alternate provider of aged care provides residential aged care as a substitute to a current MPS then the MPS will lose its designation as an MPS requiring the hospital to be reclassified and the requirement to develop new funding arrangements. This type of change may result in the hospital no longer being viable;
- Recognition that the local communities are strongly opposed to any of the rural hospitals closing down (a possible outcome of devolving aged care from the hospital/MPS);
- There are significant inequities in the operational and capital funding arrangements for MPS when compared to the more favourable arrangements applied to mainstream aged care service provision. The consultants consider that these inequities will, over time, create significant pressures that will result in a retraction of the numbers of people receiving services in areas supported by an MPS, while the number of people requiring services will sharply increase;
- By virtue of protocols that generally preclude other providers delivering the aged care in the area supported by an MPS, it is likely that significant shortages in aged care service, will increase into the future resulting in the reported incidence of outward migration of older people from the CEACA LGAs continuing and increasing;
- Alternate arrangements for health services and aged care are being proposed by WACHS SIHI.

<sup>18</sup> Trade Training Centres in Schools - Governance and Financial Models, Department of Education and Early Childhood Development, March 2009, p11

These factors are interconnected and complex. Addressing these issues requires the parties involved in funding, in setting administrative arrangements, and policy to recognise the impact of the current arrangements on services and to work together to provide the quality and volume of services that are required in a sustainable manner. The CEACA group's role will need to be that of advocates in these core issues. The consultants have been cognisant of the issues that are sometimes competing and incongruent; these issues are producing challenges to delivering high quality residential and community aged care across the CEACA LGAs now and into the future. The consultants have engaged DoHA and WACHS in the process of undertaking the needs study and in developing solutions. DoHA and WACHS will have to take the major carriage of changes required to deliver the vision of residential and community aged care in the CEACA area.

The restrictive administrative and funding arrangements have impacted on the way the consultants have addressed the development of residential and community care model options. Rather than providing more concrete options and methodology we have developed a vision for community aged care and residential aged care. The vision for community and residential aged care is consistent with policy and leading practice. When the vision is realised, the aged care needs of the CEACA area will be responded to appropriately. By approaching the solution in this manner we have proposed options that are likely to be responded to in a constructive, creative and positive manner by the responsible bodies DoHA and WACHS. The engagement of these bodies in the implementation of the findings and recommendations of this project is a critical success factor.

### *Age Friendly Communities and Older Persons Housing*

The continued development of aged friendly communities including an integrated transport strategy and the further development of older persons housing will be in and of itself a set of initiatives that will positively support the ageing communities. This approach will also support enhanced community aged care and encourage the community aged care to be delivered according to need across all CEACA LGAs. These initiatives will support all older people and the majority of persons requiring any forms of aged care. The residential aged care will ultimately only support less than 9% of the population.

Local Governments in the CEACA LGAs will have the primary responsibility for the development, implementation, ongoing monitoring and service improvements of age friendly communities. Local Governments will also have a significant role of attracting housing providers and supporting the development to realise the older persons housing strategy detailed in the Aged Care Solution. In regard to Governance arrangements these CEACA local government members will have significant governance responsibilities. The current work being undertaken by the Wheatbelt Development Commission regarding alternate structures may be employed to good effect in this strategy.

#### **3.1.1 Governance Arrangements, Residential and Community Aged Care**

##### *Operating a Commonwealth funded Aged Care Service*

Commonwealth funded aged care services and approved provider categories currently operated in the CEACA area are:

- Flexible care - MPS funding stream WACHS
- Flexible care - EACH and EACHD Baptist Care
- Community care - CACP Baptist Care
- Residential care - Dryandra Lodge

The Aged Care Act 1997 stipulates the governance arrangements including the accreditation as an approved provider to facilitate the administrative and operational management and delivery of aged care service types being delivered in CEACA LGAs. Accredited Health services, state and local governments are deemed to have met the requirements of being an approved provider.

For private providers to receive Australian Government subsidies for providing aged care, an aged care service must be operated by an organisation that has been approved by the Australian Government (an “approved provider”) and has an allocation of “places” in respect of care recipients occupying those places in a service. If providing residential aged care the facility must also be accredited by the Aged Care Standards and Accreditation Agency (the Agency). For the approved provider to be eligible to receive a payment, the care recipient must be assessed by an Aged Care Assessment Team (ACAT) to be eligible to receive that type of care.

The primary requirements to become an approved provider are:

- That the applicant is an incorporated body;
- That the applicant is suitable to provide aged care;
- That none of the applicant’s proposed key personnel is a disqualified individual (i.e. convicted of an indictable offence, insolvent or of unsound mind);

To be an Approved Provider the provider has satisfied DoHA of its:

- Ability to provide care;
- Record of financial management;
- Ability to meet relevant standards for aged care;
- Commitment to the rights of aged care recipients.

Within these governance arrangements the organisation must have ‘key personnel’ who meet the Departments test for experience in management positions and their record as key personnel in the provision of aged care or other similar activities. Key personnel are defined as:

- People responsible for the executive decisions (this includes directors and board members);
- People having authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the provider;
- Any person responsible for nursing services provided, or to be provided, by the provider, whether or not the person is employed by the provider;
- Any person who is, or likely to be, responsible for the day-to-day operation of an aged care service conducted by the provider, whether or not the person is employed by the provider.

The provider and their key personnel are responsible for their:

- Obligations of being an approved provider;
- Certification of residential care services;
- Quality of care;
- User rights;
- Accountability;
- Prudential requirements;

- Record keeping.

As detailed the governance arrangements are prescriptive. Dryandra Lodge and Baptist Care are both private providers who are approved providers under the Act. WACHS by virtue of its accreditation as a health service is deemed, under the Act, to have met the requirements of being an approved provider.

The MPS services operated by WACHS do not have the same governance and accreditation requirements as providers delivering mainstream services. WACHS by virtue of its own governance arrangements has put in place a number of initiatives to maintain and improve the quality of aged care services they include:

- Quality Review process conducted by CommunityWest for Residential Aged Care which is combined with the existing community care review process and review cycle. The review process results in improvement plans and accompanying action;
- ACAT assessments for entry into the MPS (although this is not a requirement under the Aged Care Act);
- SIHI has also conducted building audits that provide insight into the capacity of the buildings to support aged care and the impact of the built form on the quality of care.

WACHS have operational policies that address key issues relevant aged care delivered through MPSs and small hospitals that include:

- Security of Tenure of Residents of Aged Care Facilities
- Compulsory Reporting of Allegations of Assault in Residential Aged Care and Protection for Staff who report Assault
- Restraint Minimisation
- Animals in Health Care Settings
- Prevention of Elder Abuse
- Policy for Respite Approval in Multi Purpose Services

#### *Operating a HACC Service*

WA Health - Community Services forms contracts with applicant organisations that meet their requirements. These requirements include the capacity and commitment to conform to the Community Care Common Standards (CCCS). These standards were developed jointly by the Commonwealth Government and State and Territory Governments as part of broader community care reforms. The contract guides operational and organisational performance. The contracts are normally in place for three years.

HACC services in the MPS areas are part of the 'ALL IN' arrangement and therefore the contracts are bundled with the other funding streams to deliver aged care and health services in a flexible manner. The governance arrangements for this element are linked to the parties to the contract (primarily WA Health and WACHS)

#### *Alternate Model Options*

The following discussion offers insight into model options that may allow alternate aged care implementation strategies to be achieved and place responsibility for delivering the expected structure, quality and service levels back in the hands of the local community. These models also allow health service to continue to operate although this may require significant reorganisation. These options are not recommendations they provide guidance to support community, WACHS and DoHA

discussions regarding how services will need to be reorganised to deliver the expected services in the CEACA LGAs.

**Model Variation 1:** If alternate models were developed it would be possible under the legislation for providers other than WACHS to be the operators of an MPS. The alternate arrangements (other than WACHS) for delivering an MPS include the requirement that the provider operates residential aged care and at least one of the following services:

- a home and community care service;
- dental or other health care;
- transport services;
- community care under the Aged Care Act 1997;
- a service for which a medicare benefit is payable under the Health Insurance Act 1973;
- the provision of a pharmaceutical benefit under the National Health Act 1953;
- a service that the Minister nominates, in an agreement with the responsible Minister of the State, as an appropriate service.

This model would allow local governments, or GP service, or a community aged care provider to become the operator of an MPS providing a range of services to respond to community needs using the sustainability principles detailed in section 1.2.3. If this model was enacted it would likely result in existing health services and the accompanying administrative arrangements at the site ceasing. New arrangements and classifications would be required for these or alternate health services.

**Model Variation 2:** Develop local boards for each MPS to:

- to increase involvement of community and key stakeholders in the planning and performance assessment of the MPS
- establish a clearer separation of roles and responsibilities for the planning and delivery of health services
- align with reforms negotiated between the States and the Commonwealth Government under the National Health Reform Agreement.

Within this model variation the community would be offered the opportunity to realise the potential of operating as a community-driven health service. The greater transparency achieved through this approach would enable local communities to appreciate how funding is prioritised and what the impact and deficits are relative to the differing priorities. This approach is considered by Australian College of Health Service Executives and Australian Healthcare & Hospitals Association to be a simple way of ensuring greater transparency regarding funding arrangements. This approach may increase the opportunity for innovation and flexibility and increase the use of volunteers. It is noted by Australian College of Health Service Executives and Australian Healthcare & Hospitals Association that WA MPSs do not make significant use of volunteers and “In Western Australia, all funds are pooled centrally and then allocated to regions, where the WA Country Health Service’s regional management teams determine specific Multi-purpose Service sites<sup>19</sup>”.

This approach would align the operations of the MPSs in the CEACA LGAs with the original spirit of the MPS; a partnership between communities, the State Health authority and the Commonwealth Government. This approach broadly aligns with the

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<sup>19</sup> ACHSE/AHHA Issues Paper - Multi-purpose Services to respond to the Productivity Commissions Enquiry into Aged Care

WA Minister for Health's August 2011 announcement regarding a major overhaul of WA Health's governance arrangements<sup>20</sup>.

### 3.2 Governance Aged Friendly Communities and Older Persons Housing

A variety of approaches may be required to realise the vision for age friendly communities and increasing the range, volume and ownership option for aged persons housing. Depending on the ownership and delivery model a range of governance options may be considered. While it is recognised that the local governments are central to the planning and leadership a variety of factors may require local council to participate or support the development of entities required to deliver the vision. These factors may include:

- The need to establish a project team e.g. at local Government or CEACA level e.g. to develop an integrated transport plan and then to implement that plan
- The need to develop a new shared facility
- The establishment of a housing cooperative able to operate under the Retirement Living Act in the event that established housing providers are not able or willing to realise the CEACA vision for older persons housing (such a Coop could be at CEACA or LGA level)
- Shared planning, monitoring and service development approaches for age friendly communities across CECA

The organisations and agencies that may be involved along with Council in governance arrangements may operate as a range of legal entities. The development of shared governance models may require the development of new legal entities such as:

- Partnership with a Lead Agency
- Incorporated Association
- Single Joint Venture - Two Operational Committees - Assets and Operations
- Two Joint Ventures - Assets and Operations with complementary Board Membership
- Limited Liability Company
- Statutory Body - Local Government Act 1995
- Section 86 Committee
- Committee of Management - Crown Land
- Body Corporate or Statutory Body - through a specific Act relating to the establishment and operation of a not-for-profit, Non-Government Organisation

Understanding the attributes, advantages and disadvantages of these legal entity types will help Council make more informed decisions about how the different legal entities should relate to one another and what will be the best type or most appropriate legal entity for activities, services, projects and infrastructure required to achieve the vision. A greater understanding of these alternatives may be gained from the current work WDC and Local Governments are undertaking together.

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<sup>20</sup> Health Service Governing Councils Handbook WA Health 2011

### 3.2.1 Aged Friendly Community

The main responsibility for planning, implementation, monitoring and ongoing development of the age friendly strategy is the local government. It must also be recognised that an age friendly strategy, at its core, is a community development approach. A community development approach must harness a range of groups and organisations with often disparate capacity, membership, governance structures, objects and financial capacity e.g. the development of an integrated transport response. Therefore the local government approach may require the flexible capacity to support the development of or participate in a variety of community or project based groups.

The scope of governance for shared facilities, services and projects include two distinct but inter-related areas:

- Project Planning and Delivery
- Operational Governance Model

Two areas that need to be managed are:

- Governance that relates to the legal entity/ies and risk management with clear legal and financial responsibilities
- Governance that relates to operational matters, the co-location and integration of services and activities and the development of community partnerships and community building

Elements that contribute to ‘good’ community facilities, services and projects include but are not limited to:

- Sound Land Use Planning
- Good Design
- Clear Service and Community Planning
- Sustainable Funding
- Strong Partnerships
- Good Governance
- Capacity and Competencies

#### *Decision making and accountability mechanisms matrix: Age Friendly Community*

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
Audit of community for all elements of age friendly community	Common tools and approach	Local Government	Community clubs/ orgs Services (Medical, Health/SIHI, Aged Government)	Local Government Public Transport HACC Volunteer Drivers
Development of plans or refinement of existing plan	Peer review	Local Government	Commercial services	Community clubs/ orgs WDC RDA
Development of governance for planning for and then operating shared facilities,	Template Agreements Peer Support Coordinated	Local Government		Services (Medical, Health, Aged)

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
equipment or services	approaches			Government)
Implementation of plans	Common approach to grants for capital funding Advocacy	Local Government		Commercial services St John's RFDS
Monitor Implementation of Age Friendly Community Plan excluding transport plan	Information Peer support	Local Government		
Improve and redevelop plan	Common approach to grants for capital funding Advocacy Information Peer support	Local Government		
Development of a regional integrated transport plan	Coordinate Plan development and Implementation Advocate Common approach to grants for capital funding	CEACA Public Transport St John's Local Government (own buses etc.) HACC/WACHS Volunteer Transport	Each Local Government Member of CEACA Public Transport HACC Volunteer Drivers St John's RFDS	As Above
Monitor Implementation of transport plan and Improve				

### 3.2.2 Older Persons Housing

Key elements of the older persons housing strategy is to:

- Deliver the range of ownership options,
- Deliver housing that meets current and future expectations of community members (design, exterior look, quality of finishes, location and layout),
- Ensure that within the mix of housing pension level entry is available
- Ensure that housing is available across all CEACA LGAs with an accompanying ageing in place strategy and capacity (universal design)

It is expected that to achieve this vision the developments will require capital support, land and head-works gifted to the project and the housing will need to be able to operate under the Retirement Villages Act. The social housing component will need to comply with the requirements of the Department of Housing.

To achieve this vision for older persons housing a range of stakeholders will be involved and may stipulate governance arrangements. These may include:

- WA Department of Housing

- RDL
- Royalties for Regions
- A Housing Provider
- Local Government
- Existing Housing Trusts/Boards

The range of options for governance will depend on the capacity and willingness of a housing provider to take ownership of the vision. An alternate approach would be for the CEACA group to establish a housing coop to deliver the vision across the sub region.

*Decision making and accountability mechanisms matrix: Older Persons Housing*

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
Review current stock - demand - and priority areas based on Aged Care Solution findings and plan	Identify the degree to which stock meets current requirements  Current and future plans of current Housing Orgs  Wait lists  Covenants on current stock  Pricing  Undertake a common community survey	CEACA	Each Local Government that makes up CEACA  WDC  RDA  WA Dept of Housing	Residents of current stock  Existing older persons Housing Orgs  Aged care Service providers  Local Government  WDC  RDA  WA Dept of Housing  The community 55+ years
Development of ageing in place, multiple ownership options, quality older persons housing plan including the business case	Develop a coordinated approach to common development, ownership and design and integration  Common approach to marketing	CEACA	Existing older persons housing owners: Trusts, Foundations, Community Organisations, Local Government, Dept of Housing  Possible new Housing provider	Potential residents  Residents of current stock  Existing older persons Housing Orgs  Aged care Service providers  Local Government  WDC  RDA  WA Dept of Housing  Royalties for Regions
Identify and allocate/ acquire land and capital funding	Develop a common approach land and capital  Advocate  Acquire capital commitments	Local Government	RDL (crown land)  Royalties for Regions  Dept of Housing	Potential residents  Residents of current stock  Existing older persons Housing Orgs

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
	Manage Royalties or other Capital applications			Aged care Service providers Local Government WDC RDA WA Dept of Housing Royalties for Regions
Development of older persons housing across CEACA: with ownership options, ageing in place, with a quality required by the community  This development includes staged planning	Manage coordinated approach  Form a legal entity to deliver older persons housing vision  <i>or</i> appoint a regional housing provider to develop/ operate as required  Manage relationships and approach with existing providers as required  Coordinate new arrangements with existing providers as required/ invited	CEACA  Housing Provider	Each Local Government Entity  Funder	Potential residents Residents of current stock Existing older persons Housing Orgs Aged care Service providers Local Government WDC RDA WA Dept of Housing Royalties for Regions
Management of older persons housing across CEACA and ongoing staged development: with ownership options, ageing in place, with a quality required by the community	Monitor Progress and performance against agreements with provider	Housing provider	Local Government  Funder	Potential residents Aged care Service providers Local Government WDC RDA WA Dept of Housing Royalties for Regions

### 3.2.3 Community Aged Care

Key elements of the community aged care strategy are:

- Achieve the delivery of the full range of community packaged care types as detailed in Living Longer Living Better in the CEACA region at least to the benchmark service levels, services will include dementia care to the equivalent of high care;

- Achieve the delivery of HACC within the full range of services as detailed in the Home Support Program outlined in Living Longer Living Better - service levels are to be consistent with wider Australian benchmarks for the services in the Home Support Program (HACC, Reablement, Community Respite and housing support);
- Achieve the delivery of Home Support Program services and Community Packaged Care into older persons housing to realise the Ageing in Place Strategy;
- Seek a commitment and partnership approach with existing community care provider to deliver the required geographic coverage, ageing in place and mix of packaged types facilitated by leading practice in workforce development;

Alternately

CEACA form an entity to apply for and deliver the community aged care services in line with the vision;

Alternately

CEACA work with WACHS and/or Dryandra lodge to deliver community aged care services in line with the vision;

- Develop the Housing and Age Friendly Strategies with the Community Aged Care Provider participating in the development as a key stakeholder;
- Facilitate integrated and partnership approaches that deliver the synergies with the age friendly community (including transport) and ageing in place housing strategy through MOUs or similar instruments with the prescribed providers;
- Through delivering the integrated strategy delay or remove the need for entry into residential aged care thus reducing the demand and at the same time increasing the instances where older people will remain living independently within the community of their choice.

**Decision making and accountability mechanisms matrix: Community Aged Care**

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
Ensure Community Packaged Care Program is delivered according to the Living Longer Living Better architecture and consistent with benchmarks levels applicable to the CEACA sub region.	<p>Advocate using the findings of this report</p> <p>Ascertain how the MPSs will deliver the Living Longer Living Better Community Aged Care Approach</p> <p>Form agreements MOUs to ensure future planning and operations align with the Housing and Aged Friendly Community Strategy</p>	<p>Aged Care Providers</p> <p>WACHS</p> <p>DoHA</p>	<p>Housing Provider (s)</p> <p>Residential Care Provider (s)</p> <p>Local Government</p>	<p>Local Governments</p> <p>WDC</p> <p>RDA</p> <p>Aged Care Providers</p> <p>WACHS</p> <p>DoHA</p> <p>Housing Provider (s)</p> <p>Community Members</p>
Ensure Home Support Program is delivered according to the Living Longer Living Better	<p>Advocate using the findings of this report</p> <p>Ascertain how the MPSs will deliver the Living Longer</p>	<p>WA Health (HACC)</p> <p>WACHS</p>	<p>DoHA</p> <p>Housing Provider (s)</p> <p>Residential Care</p>	<p>Local Governments</p> <p>WDC</p> <p>RDA</p> <p>Aged Care</p>

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
architecture and consistent with benchmarks levels applicable to the CEACA sub region - currently part of bundled funding through the MPS	Living Better the Home Support Program  Form agreements MOUs to ensure future planning and operations align with the Housing and Aged Friendly Community Strategy		Provider (s)  Local Government	Providers  WACHS  DoHA  Housing Provider (s)  Transport Providers  Community members
Ensure that the Community Aged Care Strategy is integrated with health services	Facilitate connections/ links with the other elements of the Solution and the providers	Aged Care Providers  WACHS  Local Councils	Housing Provider (s)  Residential Care Provider (s)	As Above

### 3.2.4 Residential Aged Care

Key elements of the community aged care strategy are:

- Achieve the delivery of ageing in place residential aged care consistent with Living Longer Living Better in the CEACA including dementia care to the expected high care levels;
- Achieve the delivery of residential aged care to the benchmark for beds
- Within the full range of services as detailed in the Home Support Program outlined in Living Longer Living Better - service levels are to be consistent with wider Australian benchmarks for the services in the Home Support Program (HACC, Reablement, Community Respite and housing support);
- Achieve the delivery of Home Support Program services and Community Packaged Care into older persons housing to realise the Ageing in Place Strategy;
- Seek a commitment and partnership approach with existing community care provider to deliver the required geographic coverage, ageing in place and mix of packaged types facilitated by leading practice in workforce development;

Alternately

CEACA form an entity to apply for and deliver the community aged care services in line with the vision;

Alternately

CEACA work with WACHS and/or Dryandra lodge to deliver community aged care services in line with the vision;

- Develop the Housing and Age Friendly Strategies with the Community Aged Care Provider participating in the development as a key stakeholder;
- Facilitate integrated and partnership approaches that deliver the synergies with the age friendly community (including transport) and ageing in place housing strategy through MOUs or similar instruments with the prescribed providers;
- Through delivering the integrated strategy delay or remove the need for entry into residential aged care thus reducing the demand and at the same time

increasing the instances where older people will remain living independently within the community of their choice.

**Decision making and accountability mechanisms matrix: Residential Aged Care**

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
Ensure that Residential Aged Care is delivered according to the Living Longer Living Better structure and the benchmark levels are delivered in the CEACA sub region.	<p>CEACA facilitate a joint working party with RDA and WDC with WACHS, DoHA, WA HACC and Dryandra Lodge</p> <p>Advocate using the findings of this report</p> <p>Ascertain how the MPSs will deliver the Living Longer Living Better</p> <p>Facilitate agreements with key stakeholders</p> <p>Ascertain what arrangements and approaches will be used in regard to restructuring aged care in MPSs, for beds that become redundant and growth arrangements</p>	<p>Aged Care Providers</p> <p>WACHS</p> <p>DoHA</p>	<p>Housing Provider (s)</p> <p>Residential Care Provider (s)</p> <p>Community Care Providers</p> <p>Local Government</p> <p>Community Reference Group</p>	<p>Local Governments</p> <p>WDC</p> <p>RDA</p> <p>Aged Care Providers</p> <p>WACHS</p> <p>DoHA</p> <p>Housing Provider (s)</p> <p>Community Members</p>
Develop alternate and creative options	Work with the joint working party with reference to the report and innovations already tested in other locations and developing new approaches	<p>Aged Care Providers</p> <p>WACHS</p> <p>DoHA</p>	As above	As above
Ensuring workforce development strategies are implemented that facilitate the community aged care, housing and aged friendly strategy	Work with the joint working party with reference to the report and innovation already tested in other locations	<p>Aged Care Providers</p> <p>WACHS</p> <p>DoHA</p>	As above	As above
Supporting approaches that contribute to Dryandra Lodge's viability and capacity to respond to a portion of the identified need for additional	Work with the joint working party and Dryandra Lodge	<p>Dryandra Lodge</p> <p>WACHS</p> <p>DoHA</p>	<p>Housing Provider (s)</p> <p>Community Care Providers</p> <p>Local Government</p> <p>Community Reference Group</p>	<p>Local Governments</p> <p>WDC</p> <p>RDA</p> <p>Aged Care Providers</p> <p>WACHS</p>

Identified Area of Action	CEACA Role	Primary Responsibility	Other Responsible Bodies	Stakeholders
residential aged care and dementia care				DoHA Housing Provider (s) Community Members
Facilitate the context for the Residential Aged Care Strategy to be integrated with health services particularly maximizing the benefits of reforms initiated through SIHI including the capacity to make best use of telehealth and increased primary health care	Work with the joint working party and particularly SIHI and local HSMS	WACHS including; Management, SIHI and local HSMS.	Housing Provider (s) Residential Care Provider (s) Community Care Providers Local Government Community Reference Group	As Above
Develop of local boards for each MPS	Work with WACHS to develop local Boards to increase involvement of community and key stakeholders in the planning and performance assessment of the MPS	WACHS	WA Health HACC	Local Governments WACHS DoHA Community Members

## 4 Recommendations

This section includes 5 primary recommendations. The broad recommendations and more detailed elements have been developed giving consideration to; the needs study and complex governance issues. The recommendations have also been developed after consultation throughout the project with the key decision and policy makers to determine what approaches that are likely to be supported and the steps that may be required to realize the full vision of an integrated aged care solution.

### Recommendation 1: Accept the findings and implications of this report

It is recommended that:

CEACA and the local councils that make up the CEACA LGAs review the needs study and the Aged Care solution report and substantially accept the findings and implications; [Dec 2012]

CEACA and the local Governments that make up the CEACA LGAs consider the proposed actions and allocate resources to support progress toward the actions including grant applications; [Feb 2013]

CEACA develop an implementation plan (based on the report and its recommendations) and continue to meet as a group to deliver the outcomes. Important roles will include advocacy, leadership and facilitation; [Feb, March 2013]

RDA and WDC review the needs study and the Aged Care solution report and substantially accept the findings and implications; [Dec 2012]

RDA and WDC support the leadership and role of CEACA in implementing the strategy including support to access grants; [Ongoing]

RDA and WDC support CEACA by facilitating connections and relationships with DoHA, WA Health, the Department of Housing, Department of Transport, WACHS and other Key external Stakeholders as required (particularly as it is imagined that similar themes will emerge from other studies being undertaken in the Wheatbelt; [In accordance with implementation plan March 2013 onwards]

WACHS and DoHA review the needs study and the Aged Care solution report and substantially accept the findings and implications paying particular attention to the issues that are within their purview (Chap 3). [Jan, Feb 2013]

Local governments establish a community reference group for the ongoing implementation of the plan in its entirety [May 2013]

## Recommendation 2: Implement an Age Friendly Community Strategy

It is recommended that:

Each Local Government audit all elements of age friendly community within each LGA (in collaboration with stakeholders) using a common tool agreed to by CEACA [March, Apr 2013]

Each Local Government Develop plans or refine existing plans that respond to deficiencies identified through the audit process including cost estimates. As CEACA, consider what common elements would benefit from a shared approach to grant applications, advocacy etc. [March, June 2013]

Development of governance arrangements at each Local Government level for planning and then operating shared facilities, equipment and/or services using common tools sourced/agreed to by CEACA [July onwards 2013]

Each Local Government Implement plans facilitated by grant funds and community actions

CEACA continues to meet to provide peer review and support of the plans

Each Local Government monitor the implementation of Age Friendly Community Plan and improve and redevelop plan as required

Develop a CEACA integrated community transport plan focused on older persons that includes; all transport option required to facilitate the goals of an aged friendly community and is responsive to the particular needs of older people in regard to their care - CEACA in collaboration with RDA and WDC [Feb to Aug 2013]

CEACA and its local government members jointly and severally implement, monitor and improve the transport plan [Sept 2013 onward]

### Recommendation 3: Realise an Older Persons Housing Strategy

It is recommended that:

Each Local Government audit the current housing stock and the degree to which it aligns to the aspiration and needs of current and future residents based on the findings of the report. Other audit considerations should include, current rental arrangements, wait lists and turnover of residents and the current and future planning of the existing housing providers [March 2013];

CEACA develop a common community survey building on surveys already undertaken e.g. Wyalkatchem, to determine immediate demand for housing to be actioned by each local government [Feb to March 2013];

Create a consolidated plan for the development of housing stock including allocations for a social housing component across CEACA. The common plan will need to consider how existing stock and providers fit into the plan and how the services will be integrated into a plan [May to June 2013];

Develop a shared plan to engage a housing provider(s) and or forming an entity to deliver housing in the manner described in this report through CEACA. The common approach will deliver ageing in place, quality as per the findings, ownership options and integration with the overall aged care solution. The plan will consider the principles and innovation detailed in the [July to Aug 2013]:

- Need Study 6.4.13 Dutch Alternate Housing and Care Options
- Needs Study 6.4.14 Dutch Aged Care Housing Options
- Needs Study 6.4.12 Humanitas - Apartments for Life
- Needs Study 6.4.9 Tasmanian Residential Aged Care Collective related model innovations
- Needs Study 6.4.3 Balladong Lodge

The housing provider(s) develop a business plan that identifies the support required at each local government level that may include land and capital funding and processes be established to facilitate the support required [Sept to Oct 2013];

Local Government and or CEACA apply for capital funding and manage and or support arrangements to deliver the social component with the Department of Housing (WDC and RDA will support this process) [Nov to Dec 2013];

The housing provider engage a builder/developer to construct housing in a modest and on a needs basis across the CEACA maximising efficiencies through common design and geographically scattered construction plan that is part of a higher volume proposition achieved through a CEACA wide and demand approach [Feb to March 2014], Operationalise [March 2015>];

Ongoing staged development be managed as detailed based on demand [April 2015>];

CEACA and its local government members jointly and severally monitor and improve the plan in conjunction with all key stakeholders including the community reference group [Dec 2015>].

#### Recommendation 4: Realise the Community Aged Care strategy

It is recommended that:

CEACA facilitate a joint working party with the support and engagement of RDA and WDC with WACHS, DoHA, WA HACC and Baptist Care to put a process in place that ensures that program and policy approaches are in place and are effective in:

- Ensuring the Home Support Program is delivered according to the Living Longer Living Better architecture and consistent with benchmarks levels applicable to the CEACA sub region
- Ensuring the Community Packaged Care Program is delivered according to the Living Longer Living Better architecture and consistent with benchmarks levels applicable to the CEACA sub region
- Ensuring that the Community Aged Care Strategy is integrated with health services particularly maximizing the benefits of reforms initiated through SIHI
- Ensuring flexible, integrated and creative options are developed to respond to the needs even the smallest communities e.g. Needs study 6.4.1 Yetman Community Service Model
- Ensuring workforce development strategies are implemented that are consistent with:
  - Needs Study 6.4.4 Mallee Track
  - Needs Study 6.4.16 Tasmanian Workforce Development [Feb 2013 to Feb 2015]

CEACA ensure that the policy and program responses and protocols are developed in a manner that, aligns with, and makes optimal use of, the housing and age friendly strategies detailed in this plan [March 2013>]

CEACA support a process that results in the development of local boards for each MPS to:

- to increase involvement of community and key stakeholders in the planning and performance assessment of the MPS
- establish a clearer separation of roles and responsibilities for the planning and delivery of health services
- align with reforms negotiated between the States and the Commonwealth Government under the National Health Reform Agreement [April 2013]

### Recommendation 5: Realise the Residential Aged Care strategy

It is recommended that:

CEACA facilitate a joint working party with the support and engagement of RDA and WDC with WACHS, DoHA, WA HACC and Dryandra Lodge to put a process in place that ensures that program and policy approaches are in place and are effective in:

- Ensuring that Residential Aged Care is delivered according to the Living Longer Living Better structure and the benchmark levels are delivered in the CEACA sub region.
- Planning for and making decisions related to the impact on MPS (health services and community aged care services) of alternate arrangements and the options that respond to quality of care issues, dementia care and the redundancy of the hostels. This approach will jointly consider strategies and actions that align with SIHI initiatives
- Enables alternate options to be developed such as:
  - Needs study 6.4.3 Balladong Lodge
  - Need study 6.4.9 Tasmanian Residential Aged Care Collective Related Model Innovations
  - Needs study 6.4.13 Dutch Alternate Housing and Care Options particularly with reference to dementia care
- Ensuring workforce development strategies are implemented that are consistent with:
  - Needs Study 6.4.4 Mallee Track
  - Needs Study 6.4.16 Tasmanian Workforce Development
- Supporting approaches that contribute to Dryandra Lodge's viability and capacity to respond to a portion of the identified need for additional residential aged care and dementia care
- CEACA ensures that the policy and program responses and protocols are developed in a manner that, aligns with, and makes optimal use of, the housing, community aged care and age friendly strategies detailed in this plan
- Ensuring the that the Residential Aged Care Strategy is integrated with health services particularly maximizing the benefits of reforms initiated through SIHI including the capacity to make best use of telehealth and increased primary health care [Feb 2013 to Feb 2015]

CEACA support a process that results in the development of local boards for each MPS to:

- to increase involvement of community and key stakeholders in the planning and performance assessment of the MPS
- establish a clearer separation of roles and responsibilities for the planning and delivery of health services
- align with reforms negotiated between the States and the Commonwealth Government under the National Health Reform Agreement [April 2013]

## 5 Attachments

- Central East Wheatbelt Aged Care Needs Study, October 2012
- Next Steps Presentation, 16 November 2012