Aged Care Plan 2012

July, 2012

Shire of Boddington

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Executive summary

Background

In rural WA many Shires report that older persons are being forced to move from their local communities or are possibly refusing appropriate services for fear of being 'removed' from their local community and 'put into a home'. This, in some instances, means that older persons and their family carers move from Boddington with a loss of social capital within the local community resulting in negative economic impacts into the long term.

For over ten years, the Boddington community and the Shire Council have sought to address the needs of older persons in the community. Steps taken have included exploring the option for a large scale residential development; this was curtailed when it became evident that a development of this scale would not be feasable. Through a process of research and consultation, it became clear that the concept of a smaller scale village of ILUs would be sustainable and therefore this model has been explored. The Shire prepared a Positive Ageing Strategy in 2006 that further emphasised the need for more affordable housing for older people, in close proximity to health services and community facilities. The Shire has undertaken an ongoing series of consultations with older community members since 2007/8. Addressing the needs of older people is becoming increasingly important as the ageing demographic is increasing demand for services and tailored aged persons' housing.

The concept developed by the Shire and the community seeks to integrate an ILU development into the existing community fabric by including features such as a public park. The Shire is now actively seeking a partnership and capital funding to realise an integrated aged care and aged housing strategy.

This Report's Objective

This Aged Care Plan was commissioned by the Shire of Boddington to provide an evidence-based, planning framework that will facilitate the development of aged care services, facilities and older persons housing that will address current and future demand.

Through the provision of evidence of needs for aged care services as compared to Commonwealth planning ratios, there is the potential to facilitate the achievement of benchmarked care levels to the Boddington Community into the future. A comparative analysis of current service levels and planning parameters will support access to funding for capital and service development for the benefit of the local community.

Through the provision of appropriate aged care services and older persons housing the Shire seeks to support the needs and aspirations of aged persons and their family/carers to remain in their community, thus facilitating 'ageing in place'. The Shire also recognises that older persons and their family carers are significant contributors to the social and economic capital of the community.

Service Demand and Drivers

The demand for aged care in Boddington is driven by:

- The ageing demographic;

- The significant gap in aged care services offered in Perth leading to greater demand pressure on rural communities;
- The presence of hospital and medical services in Boddington;
- The West Australian Country Health Service (WACHS) policy direction of not applying for any additional Commonwealth funded aged care funding and to divest themselves of aged care responsibilities where possible.

The Ageing Demographic

The following data for the following aged categories have been reviewed as follows:

- Age 55+ which is the threshold at which people are able to enter a retirement village;
- Age 70+ which is the population benchmark used by the Commonwealth to plan and allocate aged care services;
- Age 85+ which signals high demand for residential high care and higher level packaged care; this population will include at least 1 in 4 persons with dementia and about 50% will require assistance due to profound limitations with the core activities of daily living.

Ageing Population 2006

LGA	55+	% Pop	70+	% Pop	85+	% Pop	Total Pop
Boddington	307	22.2%	81	5.9%	10	0.7%	1,380
Wandering	118	33.1%	36	10.1%	0	0.0%	356
Williams	221	25.6%	66	7.6%	3	0.3%	864
Catchment	**646**	**25.7%**	**183**	**8.7%**	**13**	**1.6%**	**2,600**
Wheatbelt	18,998	27.3%	6,290	9.0%	952	1.4%	69513
WA	448,882	22.9%	164,541	8.4%	27,481	1.4%	1,959,083
ABS Census 2006							

Ageing Population 2011

LGA	55+	% Pop	70+	% Pop	85+	% Pop	Total Pop
Boddington	463	20.8%	108	4.9%	18	0.8%	2,226
Wandering	168	38.4%	45	10.3%	3	0.7%	438
Williams	346	37.9%	84	9.2%	6	0.7%	913
Catchment	**977**	**27.3**	**237**	**6.6%**	**27**	**0.8%**	**3,577**
ABS Census 2011							

A comparison between 2006 and 2011 Census figures shows:

- The overall population of Boddington has grown by a very significant 61.3%;
- The overall population of the catchment (for this study) has grown by 37.6%;
- The proportion of the total population who may require aged care services (aged 70+) has decreased from 8.7% to 6.6%. However, the actual numbers of older persons have increased by 54 persons or +29.5% with Boddington having an additional 27 persons aged 70+ during this 5 year period.

Additional aged care services need to be developed to meet current needs and support a projected 80% increase in the 70+ population through to 2027. Given the lead-time involved in planning for and developing residential aged care facilities,

consideration should be given to commencing planning for these services in the immediate short term. The planning process includes securing the capital for building/fitout in the vicinity of $240,000 per bed.

Gaps in Perth based services

There is a current shortfall of 819 residential aged care beds across the Metro South West and South East regions in Perth that will continue to fuel demand for services particularly on the suburban fringes. The suburban fringes are poorly serviced in terms of residential, commonwealth community care[1], and HACC[2].

These service gaps have particular implications in the current aged care environment now and into the future. People seeking to relocate from Boddington to access aged care services in Perth are unlikely to be able to access the services they need without long waits reducing outward migration and creating a further pressure of demand in rural areas. People on the suburban fringes who may have sought to have their aged care needs accommodated closer to Perth may now look to migrate to regional/rural centres such as Boddington instead.

The Hospital in Boddington

An important factor in attracting and retaining older people in a rural community is access to appropriate medical services that are able to support the needs of older persons as they age. As detailed in this section there are a range of health and aged care services offered to the community through the Boddington District Hospital. These services are crucial as the numbers of older people in Boddington increases. The development of additional aged persons' housing and other aged care services will be impacted by the retention and/or expansion of these health care services.

West Australian Country Health Service (WACHS) Policy

It is the current planning approach of the West Australian Country Health Service to not apply for any additional Commonwealth funded Aged Care including allocations through Aged Care Approvals Round (ACAR) processes. WACHS are divesting themselves of Aged Care service provision where possible.

This has particular implications on the provision of aged care services to the community because the real needs in the community for aged care have outstripped the capacity of the MPS model. Consequently, DoHA funding allocations have not fully kept pace with the growth in the ageing population of rural WA including the Shire of Boddington.

Community Characteristics

The township of Boddington is located 123 km from Perth. Boddington Shire has a population of 2,226 (2011). It has grown by 61% over the past 5 years. Mining development is a considerable driver of this population growth.

A relatively low proportion of 70+ persons in Boddington compared to the 55+ population indicates that over 100 persons 70 + may have migrated out of Boddington to have their aged care needs met or to retire elsewhere.

Other catchment characteristics include:

- Lower Aboriginal population (2.1%) than the State (3.0%);

[1] Verso Consultations with service providers
[2] HACC triennial plan 2008-2011

- A high proportion of the older population who provide unpaid assistance to a person with a disability (this includes older people who need assistance due to age related support needs);
- Boddington is relatively disadvantaged, while Wandering and Williams are comparatively advantaged, indicated that Boddington based aged persons housing should be developed with a capacity to accommodate older persons with a wide range of financial means;
- The median weekly income for the 55+ population in Boddington is 8% lower than the State average reinforcing the need for social housing within an aged persons housing strategy. This may be even more important as the population continues to grow as a result of ongoing mining development and the attendant affect on rentals and property prices.

Services

Community Aged Care Packages (CACP)

WACHS provides 8 CACP delivered through the Boddington District Hospital and 5 delivered from Williams. Consultations indicate that there are no other packages offered by other providers within the catchment area for this plan.

Residential Aged Care

Boddington District Hospital provides 5 low and 5 high care residential beds. It should be noted that these services are not listed on the Department of Health and Ageing (DoHA) Aged Care Servicers List (as at June 2011) and may be provided by WACHS from an allocation made to another area.

Dementia Care

Consultations have shown that dementia care services are lacking. Based on the current dementia rates it can be expected that about 16 persons aged 70+ in the catchment currently have dementia (2012). Within 15 years (2027) that figure will have increased by more than 80%. Current residential care services cannot manage the challenging behaviours or physiological symptoms associated with dementia.

Respite

It is apparent from community consultations that acute beds in the hospital are being used for emergency respite care for older people. This is not an ideal situation for the older person as they are not being provided with a respite experience that reduces stress for families and maintains functional capability for older persons.

Aged Care Planning Benchmarks

Current service levels in the catchment for this plan are below the DoHA aged care planning benchmarks. By 2017 the gap will have increased.

Aged Housing Needs

There is a demonstrated need for a small scale retirement village. Demographic data indicates that there is a requirement for a mix of options to support the diverse financial capacity of older persons in Boddington or migrating to Boddington townships from nearby areas. It is recommended that the proposed village should be operated with a mix of lease-for-life, rental homes and pension level options.

Immediate demand has been estimated to be sufficient for 7 lease-for-life and 4 rental/pension level homes with a completion date of 2016. By no later than 2020 it is estimated that the village development should encompass 25 lease-for-life dwellings and 15 rental /pension level units in order to meet projected demand.

Policy and Planning Context

RDL Policy/Objectives

The Western Australian Department of Regional Development and Lands (RDL) is seeking to build capacity, retain benefits (particularly where there are mining developments) and improve services in regional communities. The policy of the Department is also to attain sustainability, expand opportunity and grow prosperity. This Aged Care Plan proposes the development of older persons housing and the further development of aged care services. To realise the policies of RDL, it is recommend that aged care and older persons housing developments should be guided by these principles

Principle 1: **The importance of place** – ageing in the community where the older person lives and calls home;

Principle 2: **Community Life** – convenient access for families and friends and being retained as a valued member of their community;

Principle 3: **Community's sense of ownership** – the residential aged care facility is considered part of the economic and social assets of the community and assist the community retain and build confidence in its integrity as a community;

Principle 4: **Focus on the person** – provides the individual care recipient with respect and dignifies 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 encompassing all cultures, sexual preferences, religious choices and observations;

Principle 7: **Practicality** – choice and options which are balanced against the reasonable limitations of funding, population density and health/safety considerations;

Principle 8: **Viability and Sustainability** – capacity to create an operational surplus to reinvest into future service development that include: training, staff development, innovations and building, ensuring security of tenure for residents the capacity to maintain staff and organisational learning and intelligence;

Economic Impacts

The retention of older persons, their carers and families in Boddington will significantly impact on the local economy particularly in the consumption of goods and services. The findings of this study undertaken in this planning process have demonstrated that as many as 100 older people may have exited the Boddington community when their aged care needs could no longer be met. As the numbers of older persons in Boddington and its service catchments increases so too will the rate of outward migration unless plans are actioned that arrest this trend. Older persons, their carers and families also make a significant contribution to the social capital of Boddington.

Major Reforms

There are significant changes taking place in policy and programs for health and aged care these include:

- National and State level Health Reforms;
- WA HACC Reforms;
- National Aged Care Reforms.

These reforms provide Boddington Shire with opportunities to develop leading practice responses and to work with funding bodies and suitable aged care providers to redevelop aged care housing and aged care services while integrating these services with health and wider community initiatives.

Recommendations

- Support the development of older persons' housing that includes a sustainable mix of social (pension level), full rental, and 'lease-for-life' rental options for older people through the provision of land and other support e.g. capital grant applications;
- Advocate for and support the development of residential and community aged care services based in Boddington that will also serve Wandering and Williams. This expansion should aim to secure benchmark service levels. Services should be managed with an integrated approach encompassing community options linked to positive ageing initiatives and health care services. This approach is needed to ensure sustainability for the aged care provider. Sustainability can be maximised when the older persons' housing, residential care, community care and HACC services are delivered by a single provider. This approach should also include ageing in place for residents of the older persons' housing units.
- That the Shire advocate for the development of a plan for aged related health services that includes telehealth innovations.

Contents

1 Introduction

1.1 Background

Older persons are being forced to move from their local communities or are possibly refusing appropriate services for fear of being 'removed' from their local community 'home'. This in some instances means that older persons, families and carers move from Boddington with a loss of social capital and with significant economic impacts.

The building of older persons housing and a state of the art age care facility by Global Care Group in York has demonstrated that options other than current arrangements and service levels are possible. The model being offered by Global Care Group has been referenced in some part to work undertaken by Verso Consulting and detailed in the report 'A sustainable model for Regional and Rural Aged Care Services (Sept 2010). This work was funded by DoHA and managed at a local level by the Tasmanian Aged Care Collective. As the name suggests the research and model development were developed with reference rural remote and very remote locations in North West Tasmania.

The 2006 Boddington Positive Ageing Strategy[3] identified that the needs of older people are changing. Families used to care for older retired people until they need high care support. The Strategy showed that as people live longer, they are now interested in a different range of services. Older people are interested in smaller dwellings, allied health services that assist them to remain as mobile and active as possible for longer. The Positive Ageing Strategy also stated that; 'Boddington is a welcoming place for active older people. Boddington has much to attract older people. It is attractively situated close to National Forest, yet is less than two hours from the metropolitan area. This means that older people can enjoy a quiet lifestyle with a reasonable cost of living yet still be close to services and facilities. Most older people in Boddington are active and remain in their own homes. There is likelihood that increased care services will be required to respond to the increasing numbers of older people.

For over ten years, the Boddington community and Shire have sought to address the need for older persons housing. The initial concept on attracting a large scale residential development were curtailed when it was evident that a development of this scale would not be successful. It became clear that the concept of a smaller scale village would be sustainable and therefore this model has been explored. The initial concept for the village was as a traditional retirement facility including a community centre. However, based on community feedback and the example of the Global Care Group's facility in York the design has evolved to improve linkages with existing health and recreation facilities and services.

Community and Stakeholder Consultation

The Shire of Boddington has undertaken a series of consultation with its older community members since 2007/8. The project has been consistently prioritised by older members of the community. The Shire prepared a Positive Ageing Strategy in 2006 that further emphasised the need for more affordable housing for older people, close to services.

[3] Positive ageing in the shire of Boddington; Sustainable Development Facilitation June 1st

The Shire has completed two surveys of demand with the last being in 2009. Another updated, signed expression of interest by interested residents was completed in July 2011. This shows that current demand is standing at 14 dwellings, with a potential seven others who are as yet not fully decided. Regional Development Australia and Peel Development Commission have also been consulted on an ongoing basis and show their support for the development as it targets issues in both Agency's strategic plans.

The Shire has consistently worked with the community in development of the concepts for the Boddington lifestyle village and the broader "Living for Life in Boddington" project, including the public park facility and the integrated planning. The older community formed a Boddington Retirement Village community group to carry out the early planning. The group has been instrumental in progressing the concept although the Shire has lead the legal institutional and statutory planning processes. The Expressions of Interest for relocation demonstrate this group of older people's support for the initiative.

The Shire has also been cognizant of the wider development priorities of the community and has worked with community members to assess the level of importance placed on this project in relation to other development priorities in the Shire. A suitable operator of retirement living and possibly related aged care services will be sought to realise the project.

1.2 Project Objective

This aged care plan was commissioned by the Shire of Boddington to provide evidence based, planning framework to facilitate the development of aged care services, facilities and older persons housing that can meet current and future demand.

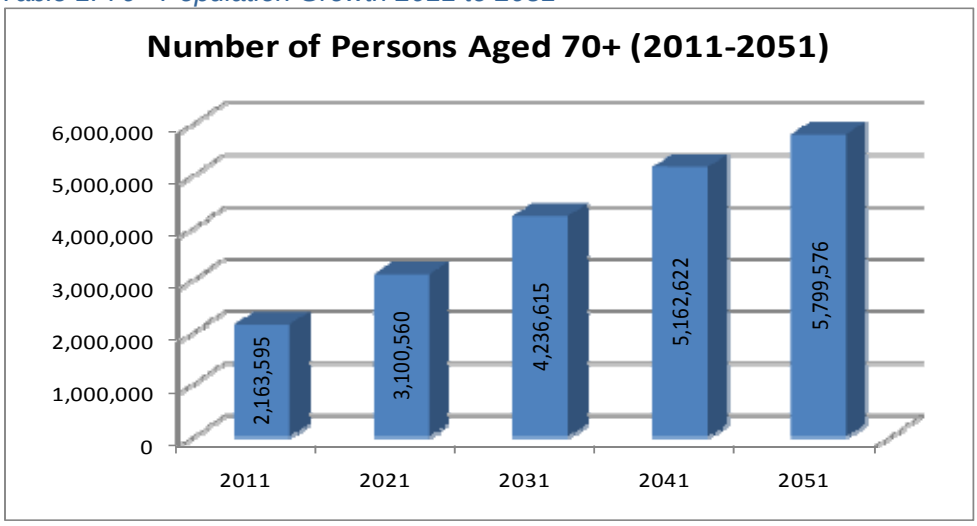
Through the provision of evidence for aged care services ensure that benchmarked levels are available to the Boddington Community and ensure funding sources for capital and operations are maximised for the benefit of the local community.

Through the provision of appropriate aged care services and older persons housing the Shire seeks to support the needs and aspirations of aged persons and their family/carers to remain in their community thus facilitating ‘ageing in place’. The Shire also recognises that older persons and their family carers are significant contributors to the social and economic capital of the community.

1.3 Ageing Population in Australia

Australia's population is ageing and will increase significantly from 2011 to 2051 as can be seen in the following graph. This increase in the population and the changing aspirations of ageing Australians will result in significant pressure for reform.

Table 1: 70+ Population Growth 2011 to 2051



Source: Population Projections Australia - Series B, Australian Bureau of Statistics, 2008

The National Strategy for an Ageing Australia[4] has indicated that the 'baby boomer' generation will enter older age with different aspirations and expectations than previous generations. Baby boomers are likely to demand a greater range and higher quality services and experiment with ways of experiencing older age. The future demand for innovative housing options for an ageing baby boomer population will increase over the lifetime of an ILU village developed as a result of this report. Therefore, this factor should be considered in the design, features and location of the village.

[4] The National Strategy for an Ageing Australia, DoHA February 2002 Publication Approval Number: 2940

2 Service Demand and Drivers

The demand for aged care in Boddington will be driven by:

- the ageing demographic
- the significant gap in services offered in Perth
- the presence of hospital and medical services in Boddington
- WACHS practice to not apply for any additional Commonwealth funded Aged Care and to divest themselves of Aged Care where possible

2.1 The Ageing Demographic

The demand for aged care services and housing will be driven by population growth. The following tables detail population growth for:

- 55+ which is the age at which people are able to enter a retirement village
- 70+ which is the population used by the Commonwealth to plan and allocate services
- 85+ which indicate high demand for residential aged care and higher level packaged care; this population will have at least 1 in 4 with dementia and about ½ will require assistance due to profound limitations with the core activities of daily living

The tables also refer to three local Government areas as it is likely that Boddington township based services will be able to support aged care needs across these areas. The tables refer to these areas as the 'Catchment Area'. Within Commonwealth Aged Care planning frameworks Boddington is in the Wheatbelt. Community places allocated to service providers to deliver in the Wheatbelt can be offered to the package to any resident of the Wheatbelt assessed as eligible. Residential Aged Care however can be offered to anybody assessed as eligible regardless of which planning region they live in. Identifying the catchment for Boddington based services enables a rationale to be developed regarding the identification of unmet needs and service gaps based on Commonwealth benchmarks.

Ageing population 2006

LGA	55+	% Pop	70+	% Pop	85+	% Pop	Total Pop
Boddington	307	22.2%	81	5.9%	10	0.7%	1,380
Wandering	118	33.1%	36	10.1%	0	0.0%	356
Williams	221	25.6%	66	7.6%	3	0.3%	864
Catchment	**646**	**25.7%**	**183**	**8.7%**	**13**	**1.6%**	**2,600**
Wheatbelt	18,998	27.3%	6,290	9.0%	952	1.4%	69513
WA	448,882	22.9%	164,541	8.4%	27,481	1.4%	1,959,083
ABS 2006							

Ageing Population 2011

LGA	55+	% Pop	70+	% Pop	85+	% Pop	Total Pop
Boddington	463	20.8%	108	4.9%	18	0.8%	2,226
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Williams	346	37.9%	84	9.2%	6	0.7%	913
Catchment	**977**	**27.3**	**237**	**6.6%**	**27**	**0.8%**	**3,577**
ABS 2011							

The first and limited release of data sets from the 2011 census has been included in this study. Given the range of variations between the 2011 census, the 2006 census and the customised population projections (that are based on the 2006 census) developed by the ABS for DoHA in 2008, the study has continued to use the ABS projections to support estimations of future demand. Planners/funders will require data from the ABS in any business case developed as a result of this study and therefore it is important that data sets that are accepted by the funding bodies are included in the study.

Particular comparisons between the 2006 census and the 2011 census include:

- The overall population of Boddington has grown by a very significant 61.3%
- The overall population of the catchment (for this study) has grown by 37.6%
- Proportionately the persons who may require aged care services (70+) has declined from 8.7% for the catchment to 6.6% however the number has increased by 54 persons or +29.5% with Boddington having an additional 27 persons 70+ since 2006

Comparisons between the 2011 census data and the 2012 projections include:

- The 55+ population is numerically higher than projected in the catchment (+8.8%)
- The 70+ population is lower than projected in the catchment (-12%)
- The 85+ population is similar to the projection (given rounding used in the census)

Projection 2012 (based on ABS 2006)

LGA	55+	% Pop	70+	% Pop	85+	% Pop	Total Pop
Boddington	487	30.7	143	9.0	12	0.7	1,585
Wandering	115	29.3	35	8.9	9	2.3	392
Williams	296	31.3	92	9.7	9	0.9	946
Catchment	**898**	**30.7**	**270**	**9.2**	**30**	**1.0**	**2,923**
WA	576,065	30.5	205,827	10.9	38,120	2.0	1,888,292
ABS Customised population projections developed for DoHA							

Projection 2017 (based on ABS 2006)

LGA	55+	% Pop	70+	% Pop	85+	% Pop	Total Pop
Boddington	605	36.7	201	12.2	15	0.9	1,648
Wandering	115	29.3	35	8.9	9	2.3	392
Williams	331	34.5	112	11.7	15	1.6	959
Catchment	**1,051**	**35.0**	**348**	**11.6**	**39**	**1.3**	**2,999**
WA	677,942	26.3	254,344	9.9	46,788	1.8	2,574,454
ABS Customised population projections developed for DoHA							

Projection 2022 (based on ABS 2006)

LGA	55+	% Pop	70+	% Pop	85+	% Pop	Total Pop
Boddington	695	40.8	253	14.8	19	1.1	1,704
Wandering	115	29.3	35	8.9	9	2.3	392
Williams	363	37.6	130	13.5	19	1.9	965
Catchment	**1,173**	**38.3**	**418**	**13.6**	**47**	**1.5**	**3,061**
WA	780,421	27.7	318,033	11.3	54,885	1.9	2,811,972
ABS Customised population projections developed for DoHA							

Projection 2027 (based on ABS 2006)

LGA	55+	% Pop	70+	% Pop	85+	% Pop	Total Pop
Boddington	749	42.7	297	16.9	25	1.4	1,755
Wandering	115	29.3	35	8.9	9	2.3	392
Williams	392	40.5	154	15.9	18	1.8	967
Catchment	**1,256**	**40.3**	**486**	**15.6**	**52**	**1.7**	**3,114**
WA	888,312	29.1	385,316	12.6	67,796	2.2	3,047,128
ABS Customised population projections developed for DoHA							

Given the very significant increase in the overall number of persons living in Boddington it is difficult to estimate how the longer-term overall population estimates will be affected. However a comparison of the 2011 census and 2012 estimates supports the longer-term assertions regarding aged care demand with the 55+ data being higher than estimated using the 2011 data and the 70+ data being lower than estimated.

The implication is that additional aged care services will need to be developed to support an 80% increase in the 70+ population from 2012 to 2027. Given the lead-time involved in planning for and developing residential aged care including securing the capital required ($240,000 per bed including land) consideration should be given to commence planning for these services in the immediate short term.

2.2 The significant gap in services offered in Perth

There is a current shortfall of 819 residential beds across the Perth Metro South West and Metro South East will continue to fuel demand for services particularly on the suburban fringes where services are not being developed in concert with population growth. The suburban fringes are poorly serviced with Residential Aged Care, Commonwealth Community care[5], and HACC[6]

Consultations with Boddington District Hospital reveal that people are moving into the area and bringing their elderly parents with them to maintain close access to the hospital and medical centre. Population growth is expected to increase due to; mining in the LGA, population growth in Perth and 'tree changers' particularly older people.

Consultations showed that "CACP are well used and often "topped up" by staff so people do not need to move away". There are no EACH in area so people who need

[5] Verso Consultations with service providers
[6] HACC triennial plan 2008-2011

more than the CACP often must go to a residential care facility which may be as far away as Albany.

This has particular implications in the current aged care environment now and into the future. People seeking to relocate from Boddington to access aged care services in Perth are unlikely to be able to access the services they need without long waits reducing this instances of outward migration to access Perth based residential aged care services. People on the suburban fringes who may have sought to have their aged care needs accommodated closer to Perth may now look to migrate to centres such as Boddington instead.

2.3 The presence of hospital and medical services in Boddington

The health services within Boddington consist of the Boddington District Hospital which provides a wide range of inpatient services including general medicine, post surgical supports, paediatric services, aged care, palliative care and respite care. Outpatient services are also provided to the community: 24 hour accident and emergency, x-ray (Monday-Friday), pathology (Monday-Friday), Physiotherapy (Tuesday), Occupational Therapy (as required), Speech Pathology (as required), Dietitian (as required), Diabetic clinic, Podiatry, Health Promotion, and Patient Assistance transport.

The Boddington Medical Centre is staffed by a GP and provides general practitioner services. The Medical Centre provides a Child Health Clinic and School Health services. There is also a visiting dental service who operates in Boddington on a fortnightly basis.

Pharmaceutical services are provided through the local pharmacy in town.

HACC services are provided by Boddington District Hospital. Services offered include: Assessment, Care coordination, Personal care, Respite, Meals on Wheels, Domiciliary Nursing, Domiciliary Assistance, Local Transport, Social Support, Home Maintenance, Centre based Daycare (Tuesday and Friday), and Chiropractor (weekly on Thursdays).

Community Care services are provided through the WACHS and 8 CACP general packages are administered through the Boddington District Hospital. The Hospital also provides 5 high care beds.

Aside from these beds, the nearest aged care residential facilities are: Pam Corker House (Waroona, 59km away), Beddingfeld Lodge (Pinjarra, 68km), Valleyview Residence (Collie, 68km), Hocart Lodge Aged Centre (Harvey, 70km), Pingelly Hostel (Pingelly, 77km), Kalkarni Residency (Brookton, 78km) and Narrogin Nursing Home (Narrogin 82km away).

An important factor in attracting or retaining and aged community is access to appropriate medical services that are able to support the needs of older persons as they age. As detailed in this section there are a range of health and aged care services offered to the community through the Boddington District Hospital. These services are crucial as the numbers of older people in Boddington increases. The development of additional aged persons housing and other aged care services will be impacted by the retention and/or expansion of these services.

2.4 WACHS practice

It has been the practice of the West Australian Country Health Service to not apply for any additional Commonwealth funded Aged Care including allocations through the Aged Care Approvals Round (ACAR). WACHS are divesting themselves of Aged Care service provision where possible.

This has particular implications impacting on the provision of aged care services to the community. By not applying for funding WACHS will not be able to respond to the demographically driven demand for additional services. Their position is likely to signal to the Department of Health and Ageing (DoHA), the funder of residential and community aged care, that there is no additional demand for aged care services in Boddington resulting in no allocations of additional places being made through the ACAR to any organisation. This position will in effect reduce the likelihood of an alternate aged care providers being able to respond to the unmet need in Boddington.

3 Community Characteristics

The township of Boddington is located 123 km from Perth. The Shire has a population of 2,226 (2011) and has grown by 61% over the intervening census periods; 2006 to 2011. Mining development is a considerable driver of this population growth. The Shire of Boddington is 1900 square km of which almost 50 percent is state forest.

3.1 Area and population Characteristics

ARIA

The Accessibility/Remoteness Index of Australia (ARIA) ranks all Australian areas by their relative accessibility to goods, services and opportunities for social interaction. The ARIA is derived from the road distance of 11,338 populated localities to 201 service centres across Australia. For each locality distances are converted to a

continuous measure from 0 (high accessibility) to 12 (high remoteness). The definitions of ARIA ratings are as follows:

- Highly Accessible (HA: ARIA score less than 1.84) – relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction
- Accessible (A: ARIA score 1.84 to 3.51) – some restrictions to accessibility of some goods, services and opportunities for social interaction
- Moderately Accessible (MA: ARIA score 3.52 to 5.80) – significantly restricted accessibility of goods, services and opportunities for social interaction
- Remote (R: ARIA score 5.81 to 9.08) – very restricted accessibility of goods, services and opportunities for social interaction
- Very Remote (VR: ARIA score 9.08 or more) – locally disadvantaged, with very little accessibility of goods, services and opportunities for social interaction

All areas of the catchment region are considered as Accessible, meaning that they may experience "some restrictions on accessibility of some goods, services and opportunities for social interaction"

LGA	Score
Boddington	2.4571
Wandering	2.8752
Williams	2.3194

Source: Accessibility/Remoteness Index of Australia (ARIA): Search Facility http://www9.health.gov.au/aria/ariainpt.cfm accessed 02.03.12

The findings are that while there are some restrictions to services these are not sufficient to qualify for subsidies from the Commonwealth to respond to the added costs of providing Aged care services in Boddington. The subsidy levels commence at an ARIA score of 3.52.

Aged Population

Aged population for Boddington referenced to the ABS 2006 Census and the ABS 2011 population census. The catchment area for Aged Care services currently located in the township of Boddington is detailed in the following table.

Catchment area for Boddington Township based aged care services

LGA	55+	% Pop	70+	% Pop	85+	% Pop	Total Pop
Boddington	463	20.8%	108	4.9%	18	0.8%	2,226
Wandering	168	38.4%	45	10.3%	3	0.7%	438
Williams	346	37.9%	84	9.2%	6	0.7%	913
Catchment	**977**	**27.3**	**237**	**6.6%**	**27**	**0.8%**	**3,577**
State (estimate)	556,776	24.3%	198,251	8.6%	36,265	1.6%	2,292,008
ABS Census 2011 and Customised projections developed by the ABS for DoHA (2008)							

The 70+ population of Boddington is significantly lower that the State average (4.9% compared to an estimated 8.6%). The other local Government areas that make up the

catchment for Boddington based services demonstrate similar (while elevated) aged person's profiles to the State estimates. These figures are significantly distorted by the increase of the younger working age population who are associated with mining developments. The proportional relationship between the 55+ population and the 70+ population is lower in Boddington catchment than demonstrated in the State data supporting the assertion detailed through the consultations that 'older persons are moving out of Boddington when their aged care needs can no longer be met' e.g. the State figures demonstrate that the 70+ population is about 36% of the 55+ population, while across the Boddington catchment this figure is 24%. Based on an analysis of the data in the table there may be over 100 persons no longer living in Boddington catchment due to shortages in suitable aged persons housing and aged care services. Other factors may include retirement to the coast or relocation to be close to family members who left the district.

The lower proportion of 70+ persons in the Boddington catchment compared to the 55+ population indicates that over 100 persons 70 + may have migrated out of Boddington to have their aged care needs met or to retire elsewhere. Some of these persons will be persons who are older carers.

ATSI

The populations of persons who Aboriginal and Torres Strait Islanders needs to be analysed as ATSI persons are described as a special needs group under the Aged Care Act 1997. DoHA recognises persons from special needs groups as persons may experience barriers to service access and who may specific and targeted services to respond to their special needs. ATSI persons 50+ are included into the planning ratios when DoHA determines service benchmarks. ATSI persons, as young as 45+, may be able to access aged care services if their need for a service is a result of conditions that are related to premature ageing. The value 3 may represent between one and three people. The ABS does not report data of less than 3 to maintain individual privacy.

It is widely recognised that the ABS statistics may underestimate the ATSI population and therefore this may need to be taken into account when analysing the data.

Aged ATSI population

Area	45+	% Pop	55+	% Pop	65+	% Pop	Total Pop	Total Aged
Boddington	3	9.1	3	9.1	0	0.0	33	3
Wandering	0	0.0	0	0.0	0	0.0	8	0
Williams	0	0.0	0	0.0	0	0.0	15	0
Catchment	**3**	**5.4**	**3**	**5.4**	**0**	**0.0**	56	**3**
Wheatbelt	**581**	**9.7**	**286**	**6.3**	**95**	**3.1**	3056	**581**
WA	9,862	16.8	4,604	7.8	1,915	3.3	58710	9,862

ABS 2006

Need for assistance

The table 'need for assistance' details the number and age of persons who require support due to severe or profound limitations with the core activities of daily living. An analysis of the catchment indicates that there are less people 70+ than the State averages with 'need for assistance'. If the State averages were reflected in the

Catchment there would be an additional 15 people in the catchment require support due to severe or profound limitations with the core activities of daily living.

Need for assistance

Area	# 55+	% of Age	# 70+	% of Age	# 85+	% of Age
Boddington	25	8.1	16	**19.8**	4	40.0
Wandering	0	0.0	0	0.0	0	0.0
Williams	13	5.9	6	**9.1**	3	**100.0**
Catchment	38	**5.8**	22	**12.0**	7	53.9
Wheatbelt	**1,698**	**8.9**	**1,088**	**17.3**	**445**	**46.4**
WA	42,627	10.2	32,871	20.0	13,099	47.7

ABS 2006

Unpaid assistance for a person with a disability

The table unpaid assistance for a person with a disability demonstrates that number of persons older than 55+ who are acting as unpaid carers for person with a disability. A person with a disability may include older persons who are disabled due to age related conditions or younger people with a disability.

It may be hypothesised, from an analysis of the table that older carers (85+) in the Wheatbelt and in the catchment, that they are older persons (85+) moving away from the area as they or the person they are caring for may have to leave the area when higher level of need cannot be supported by local aged care services. It could be suggested that 7 additional persons 85+ could be living in the area given a similar profile to WA as a whole.

Unpaid assistance for a person with a disability

Area	# 55+	% of Age	# 70+	% of Age	# 85+	% of Age
Boddington	39	12.7	9	11.1	0	0.0
Wandering	17	14.4	0	0.0	0	0.0
Williams	29	13.1	13	19.7	0	0.0
Catchment	**85**	**13.1**	**22**	**12.2**	**0**	**0.0**
Wheatbelt	**1,961**	**10.3**	**433**	**6.9**	**35**	**3.7**
WA	42,647	9.5	12,742	7.7	5,135	18.7

ABS 2006

The finding is that there are no unpaid carers 85+ living in the catchment; this may point to a lack of services that support aged carers.

3.2 Characteristics that impact on Older Persons Housing

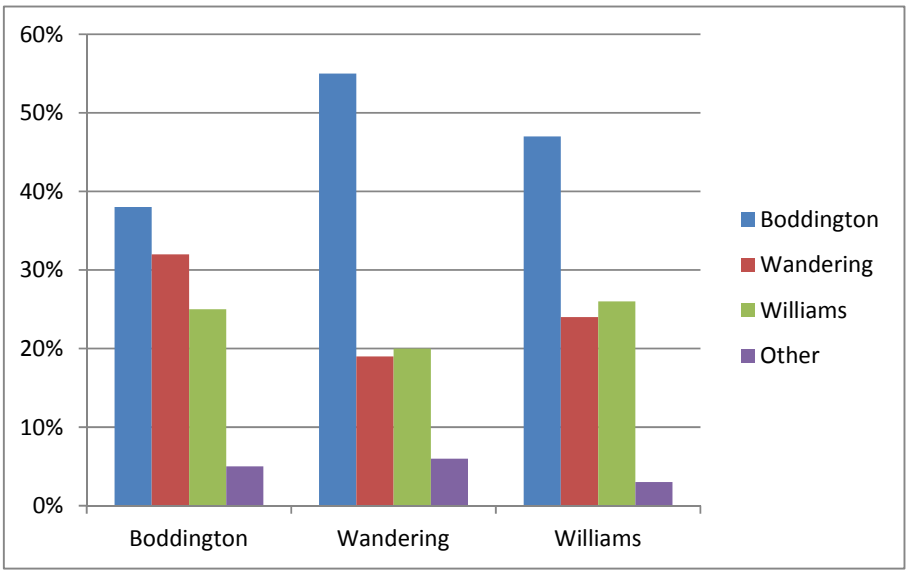
To consider the issues that affect older persons housing the following tables have been prepared; Tenure, SEIFA and Median Weekly Income. It was noted in

consultations that rentals are high, associated with high incomes of mining personnel living in Boddington. It was considered that this may be restricting the capacity of some older persons to relocate to Boddington when they require more direct access to services afforded by such a move. A search for rentals properties suggests that there rentals are limited 6 properties were detailed on REIWA.com[7]. Prices vary from $290 to $500 per week.

Within the Boddington District, the majority of residents (of all ages) own their own house with at least 70% owner occupied in each of the three Shires that make up the catchment, and with approximately 25% renting in Boddington. The following table details the home ownership structure for the catchment highlighting the lower figures for 'fully owned'.

Simon Marmion and Co[8] found that; Housing is considered affordable when mortgage repayments or rental costs are up to 30% of household income. Simon Marmion compared the gross weekly household income with rental payments at 2006; their evidence demonstrated that on the whole housing is generally affordable in Boddington, Wandering and Williams. It should however be noted that anecdotal reports reveal that housing affordability has declined since the reopening of the NBG in 2009. Verso argues that with further population growth there will be upward pressure on rental prices in Boddington with attendant impacts on older persons.

Home Ownership Structure (General population)



Source ABS 2006

Tenure 70+

The 70+ data demonstrates that there are 28 persons 70+ in the catchment area with 'other responses'; this may be associated with alternate arrangements on rural properties akin to lifetime tenure. The data suggests that there are high levels of security of tenure for the 70+ population in the catchment.

[7] Accessed March 5th 2012
[8] Simon Marmion and Co, Boddington Economic Development Strategy 2012

Tenure 70+

Central South Sub-Region	Fully Owned		Being Purchased		Lifetime Tenure		Rented		Rent-free		Other Responses	
	#	%	#	%	#	%	#	%	#	%	#	%
Boddington	53	68	0	0	0	0	7	9	3	4	15	19
Wandering	22	76	0	0	0	0	0	0	0	0	7	24
Williams	54	76	0	0	0	0	6	9	5	7	6	9
Catchment	**129**	**73**	**0**	**0**	**0**	**0**	**13**	**7**	**8**	**4**	**28**	**16**
Wheatbelt	**3,706**	**64**	**264**	**5**	**42**	**1**	**622**	**11**	**164**	**3**	**1,027**	**18**
WA	94,450	57	7,876	5	4,718	3	18,717	11	1,525	1	27,860	17

Source ABS 2006

SEIFA

SEIFA stands for Socio-economic Indexes for Areas. This suite of indexes ranks geographic areas across Australia in terms of their socio-economic characteristics. The SEIFA indexes are created by combining information collected in the five-yearly Census of Population and Housing (called the Census throughout this paper). There are four different indexes, each representing a slightly different concept. These concepts are abstract and difficult to measure, so the indexes aim to capture these abstract concepts by combining information that is related to the concept. For example, the Index of Relative Socio-economic Disadvantage uses information such as low income and low education as markers of relative socio-economic disadvantage.

The table below details relative advantage and disadvantage over the whole population of Boddington; disadvantage is scored as below 1,000 and advantage as a score above 1,000. The finding is that within the catchment Boddington LGA is disadvantaged. The differential between the high and low ratings is greater in Boddington than in the other LGAs in the catchment.

SEIFA

LGA	Score	Rank	Min	Max
Boddington	989	407	909	1037
Wandering	1018	533	996	1065
Williams	1007	500	945	1069
ABS Census 2006				

Median Weekly Income

The table below details the median income for older persons living in the catchment confirming the relative disadvantage of Boddington identified through the SEIFA compared to the Wandering, Williams, Wheatbelt and the State.

Median Weekly Income (aged 55 and 70+)

LGA	55+	70+
Boddington	285	267
Wandering	313	274
Williams	417	325
Wheatbelt	**317**	**272**
WA	309	283
ABS Census 2006		

The relative disadvantage of Boddington coupled with comparatively high rents and limited choice is impacting on the capacity of Boddington to support the aged care housing needs of older persons in the catchment. In particular the capacity to provide aged housing (ILUs) and options for older persons with limited income and assets.

4 Aged Care Services

4.1 Home and Community Care

The Home and Community Care program (HACC) is a joint initiative of the Commonwealth and State Governments. The program is primarily focused on early intervention supporting the maintenance of older person independence providing support for the instruments of daily living such as; managing money, shopping, telephone use, travel in community, housekeeping, preparing meals, and taking medications correctly. The program may also support persons who require short term support or low levels of support with; Personal hygiene and grooming, dressing and undressing, self feeding, functional transfers (getting into and out of bed or wheelchair, getting onto or off toilet, etc.), bowel and bladder management and ambulation (walking without use of use of an assistive device (walker, cane, or crutches or using a wheelchair). The HACC program also supports community nursing often facilitating wound management, post acute care, monitoring of health conditions and medication administration. Eligibility assessments are currently managed by the HACC care staff based at the Boddington Hospital.

The National Program Guidelines 2007 describe the target population as:

- People in the Australian community who, without basic maintenance and support services provided under the scope of the National Program, would be at risk of premature or inappropriate long term residential care, including:
    - older and frail people with moderate, severe or profound disabilities
    - younger people with moderate, severe or profound disabilities
    - such other classes of people as are agreed upon, from time to time by the Commonwealth Minister and the State Minister
    - the unpaid carers of people assessed as being within the National Program's 'target population'

Significant changes to the assessment processes are being progressively rolled out across Western Australia. The HACC program will refocus services through the reform process with an emphasis a wellness and/or a capacity building approach. The WA HACC Manual (2.2) states; "Wellness is based on the principles that people want to retain autonomy and build capacity, which in turn has a positive impact on their self esteem and ability to manage day to day life and where independence is not limited to physical functioning but extends to social and psychological functioning. It is an important philosophical change in the thinking behind and delivery of HACC services in WA. The WA HACC service sector will be supported to develop and implement service models that build capacity by actively working with the client to:

- Prevent loss of independence by focusing on the retention of existing skills; and
- Focus on regaining skills and a subsequent increased level of independence and well-being"

The significance of these reforms is that within the next 12 months the assessment processes for HACC in Boddington will change. As a result of the process of reforms the local HACC program is unlikely to provide higher levels of service commonly provided across rural WA through the HACC program. HACC programs are more likely to provide lower level services and in some cases time limited services after the

reforms have been instituted. The services under the reforms will be focus on regaining skills to facilitate self care or informal supports. This may result in persons who currently receiving high levels of support on HACC requiring alternate aged support increasing the demand for Commonwealth funded services. In consultations conducted with the HACC program staff in WACHS, metropolitan based service providers (where the reforms have already been instituted) and by Paul Gevers who has overseen the HACC reform process they have identified a significant number of situations where HACC clients have received services that exceed the program design and do not appear to align with the guidelines.

The WA HACC Triennial Plan 2008 – 2011 States that In the rural regions there is more variety in service type priorities, probably as a reflection of the greater heterogeneity of these regions. The strongest priorities represented across all rural regions, CBDC and Transport, were however also common to metropolitan regions. These support services were consistently identified through needs analysis and, more particularly, through rural consultation processes. The other strong priorities indicated in the metropolitan regions, i.e. Social Support, Domestic Assistance and Home Maintenance will also be significant rural priorities, although not represented in all regions. Personal Care and Nursing Care will be the other significant priorities in the rural regions. In a couple of rural regions, Respite Care will also be a priority.

The findings are that broadly speaking HACC reforms are likely to highlight areas of 'over servicing' and equally gaps in service coverage across the Wheatbelt. This is likely to result in more Commonwealth funded community care packages being required in Boddington.

4.2 Commonwealth Funded Services

Aged Care Assessment Teams

The Aged Care Assessment Teams (ACATs) assess persons for eligibility for Commonwealth Funded Aged Care programs which are high and low care residential, residential respite, and community care packages (Community Aged Care Packages [CACP], Extended Aged Care in the Home [EACH] and Extended Aged Care in the Home Dementia [EACHD]). Other forms of respite funded directly by the Commonwealth are funded through the National Respite for Cares Program (NRCP) but these programs do not require an ACAT assessment.

Multi Purpose Services

Multi Purpose Service (MPS) is a joint initiative of WACHS and the Commonwealth to flexibly deliver aged, community and health services. Nancy Bineham, Manager Planning, Planning & Infrastructure Team, WA Country Health Service (WACHS), states: "The design of the Multi Purpose Service (MPS) program allows rural communities to pool Commonwealth and State health and aged care funds within a designated geographical area, creating opportunities to coordinate and appropriately target community health and aged care needs". The MPS model is a major platform for the delivery of Aged Care across the Wheatbelt.

Boddington is not listed as having coverage from the MPS model; however there is no evidence that beds used for aged care in the hospital are funded under an alternate funding scheme. Consultations with hospital have provided no further clarity regarding the arrangements or the funding.

The implication of this is that Approved Providers of Aged Care (Approved under the Aged Care Act 1997) seeking to establish services in Boddington can do so based on

the planning benchmarks and evidence demonstrating need if the area is not part of an MPS area. Alternately if the area is part of an MPS area the by convention approved providers other than WACHS are not invited to apply for residential or community care places. Current administrative arrangements for the distribution of aged care places and planning to meet future need are complicated in Boddington due the role of the hospital as the primary provider of aged care services.

Community Aged Care Packages (CACP)[9]

CACPs are designed for frail older people aged 70+ and 50+ for Aboriginal and Torres Strait Islander (ATSI) people living in the community who have been assessed by an Aged Care Assessment Team (ACAT) as eligible to receive the equivalent of low level residential aged care and who have:

- Complex care needs arising from physical, social and psychological needs
- A need for comprehensive management of care services
- A preference to remain living in the community with appropriate supports
- A need for ongoing monitoring and review of changing care needs
- The ability to live in the community with appropriate community care

The aim of the CACP program is to assist residents to remain at home by providing coordinated, flexible care services that promote personal choice, independence, dignity and safety.[10]

Case management provides support and advice to coordinate care, advocacy to assist residents to access support to meet their care needs, information and education about available services and the service system and encourage residents to feel empowered to make decisions about their needs.

Case managers work closely with residents and their carers, families and health professionals, to plan and coordinate support and to encourage independence.

There are no citizenship or residency restrictions on accessing a CACP, however the intention of CACPs is ongoing care and not temporary care. This includes residents of Retirement Villages.

The CACP Program is a Commonwealth funded program. Subsidy rates for organisations providing CACPs are $36.73/day (up to the 30th June 2012).

CACP providers are able to provide packages to any resident of the planning region unless special conditions apply to the Providers funding agreement with DoHA. CACP on offer in the Wheatbelt are detailed by the table below.

Location	#	Provider
Boddington (S)	8	WA Country Health Service
Narrogin (T)	19	Town of Narrogin
Northam (T)	33	Share & Care Community Services Group Incorporated
Wagin (S)	4	Shire Of Wagin
Narrogin (T)	6	Silver Chain Nursing Association Incorporated
Northam (T)	5	Silver Chain Nursing Association Incorporated

[9] www.health.gov.au/internet/main/publishing.nsf/Content/ageing-publicat-brochure-ccp.htm-copy3
[10] http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/CACP-1

Toodyay (S)	31	Silver Chain Nursing Association Incorporated
Northam (T)	10	Uniting Church Homes
Wickepin (S)	2	WA Country Health Service
Williams (S)	5	WA Country Health Service

Within the catchment WACHS is the provider of 13 CACPs. The benchmark service levels for the catchment reveal that the number CACP on offer exceed the benchmarks. The hospital reports "CACP are well used and often "topped up" by staff so people do not need to move away." The topped up may refer to the use of funds from HACC or other sources of funding to provide services beyond what is available from the package.

Extended Aged Care at Home (EACH)[11]

The EACH program provides the equivalent of high level residential care to frail older people with complex care needs, who wish to remain living in their own homes, and are able to do so with the assistance of a care package. This includes residents of Retirement Villages.

EACH packages are individually planned and coordinated packages of community aged care services provided to approved clients and managed by an approved provider. EACH differs from CACP in that it is specifically targeted at frail older people living in the community who would otherwise be eligible for high level residential aged care.

The packages are flexible in content, however the expectation is that a package would include qualified nursing input, particularly in the design and ongoing management of the package and also where there are high level complex care needs. To access an EACH package a person must first be assessed as eligible by an ACAT.

EACH packages are very flexible and are designed to help with individual care needs. Generally a person who requires high level care could be eligible for an EACH package, and the types of services that may be provided as part of an EACH package include:

- Care planning and management
- Clinical care
- Support with Activities of Daily Living, Nutrition and Hydration, Management of Skin Integrity, Continence management, Mobility and dexterity
- Emotional support and leisure, interests and activities
- Support to access Allied Health and Clinics
- Home safety, modifications and maintenance[12]

The EACH Program is a Commonwealth funded program. Current subsidy rates for EACH are $122.79/day.

EACH providers are able to provide packages to any resident of the planning region unless special conditions apply to the Providers funding agreement with DoHA. The table below details the number, location and providers of EACH in the Wheatbelt.

[11] www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/EACH
[12] http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-commcare-comcprov-eachdex.htm

Office	#	Provider
Toodyay (S)	15	Regional Home Care Services EACH/Silver Chain
Northam (T)	19	Uniting Community Care - EACH Northam

DoHA Aged Services List

The benchmark levels for the catchment are less than 1 package (see 4.5 Aged Care Planning Benchmarks). Consultations with the Hospital reveal that the lack of access to EACH has resulted in persons requiring high care in the community having to go to residential care "sometimes they have to go as far away as Albany".

EACH Dementia (EACHD)[13]

EACHD packages are individually planned and coordinated packages of care tailored to help older Australians who experience difficulties in their daily life because of behavioural and psychological symptoms associated with their dementia.

EACHD packages are very flexible and are designed to help with individual care needs. The packages provide the same full range of services that EACH packages provide with an emphasis on the management of "behaviours of concern" and dementia.

EACHD packages also offer service approaches and strategies to meet the specific needs of care recipients with dementia experiencing "behaviours of concern" which may impact their daily quality of life.

To receive an EACHD package, a prospective service user must be assessed by an ACAT as requiring high level care and:

- Experience behaviours and psychological symptoms associated with dementia that is significantly impacting upon service users ability to live independently in the community
- Require a high level of residential care
- Prefer to receive an EACHD package
- Are able to live at home with the support of an EACHD package

The EACHD Program is a Commonwealth funded program. Current subsidy rates for EACHD are $135.41/day.

There are no EACHD providers in the Wheatbelt.

The benchmark levels for the catchment are less than 1 package (see 4.5 Aged Care Planning Benchmarks). Consultations with the Hospital indicate that there are limited options for people with dementia.

Residential Care[14]

Residential care services provide accommodation and support for people who can no longer live at home. These links provide more information.

[13] http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-commcare-eachd.htm-copy3
[14] http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-index.htm

To enter a residential care service, an ACAT assessment is required. Two levels of residential care are provided in Australia. These are low level (hostel) services, and high level (nursing home) services.

Low level hostel services may suit people who are unable to remain living at home and who have:

- Complex care needs arising from physical, social and psychological needs
- A need for comprehensive management of care services
- A preference to remain living in the community with appropriate supports
- A need for ongoing monitoring and review of changing care needs

High level nursing home care may suit frail older people who require support with Activities of Daily Living, Nutrition and Hydration, Management of Skin Integrity, Continence management, Mobility and dexterity and Clinical support.

Residential Respite care services are also available in residential care facilities.

All Residential Care Facilities must be accredited under the Aged Care Standards and Accreditation Agency. This process is undertaken on a three year cycle of accreditation against 44 outcome standards.

The provision of either low care or high care residential services is funded through the Commonwealth Department of Health and Ageing. The funding structure for residential beds is based on the ACFI (Aged Care Funding Instrument) which takes a number of factors into account, such as Residential Care Scale (RCS) level, as well as oxygen or enteral feeding supplements.

Residential Aged Care buildings must comply with the 9c building code. Aged Care Audits will reveal that Class 9c buildings are 'aged care buildings', which are defined by the Building Code of Australia as being a 'building for residential accommodation of aged persons', who generally require personalised care. Residents of class 9c buildings generally have varying degrees of incapacity and as a result, 24 hour personal care services provided by staff to assist residents in an emergency evacuation, aged care audits must allow for these provisions.

Transition Care Program[15]

The Transition Care Program is designed to improve older people's independence and confidence after a hospital stay.

The Transition Care Program was established in 2004-05 as a jointly funded initiative between the Commonwealth and states and territories. Since 2005 the Commonwealth has provided 2,000 transition care places to all states and territories broadly based on the proportion of non-Indigenous people aged 70 and over and Indigenous people aged 50 and over. In 2007-08 the Government made a budget announcement to provide an additional 2,000 transition care places by 2011-12. The recurrent costs to governments of these places are fully funded by the Commonwealth.

The Transition Care Program aims to help older people leaving hospital to return home rather than prematurely enter residential care.

Transition care is goal-orientated, time-limited and therapy-focussed. It provides older people after a hospital stay with a package of services that includes low intensity therapy (such as physiotherapy, occupational therapy and social work) and nursing support and/or personal care. It helps older people complete their restorative

[15] http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-policy-transition.htm

process and optimise their functional capacity, while assisting them and their family or carer to make long-term care arrangements.

The Transition Care Program is for older people who would otherwise be eligible for residential aged care. To enter the Program, clients must be assessed by an ACAT while they are still an in-patient of the hospital. This can be organised through the hospital where the client has received their acute/sub-acute care. A transition care client can only enter transition care directly upon discharge from hospital.

Transition care can be provided in either a home-like residential setting or in the community. The average duration of care is 7 weeks, with a maximum duration of 12 weeks that may in some circumstances be extended by a further 6 weeks.

States and territories represented by their health departments are the Approved Providers for transition care under the Aged Care Act 1997. This arrangement allows state and territory governments to develop their own service delivery models for transition care that best respond to local circumstances.

National Respite for Carers Program (NRCP)[16]

The NRCP is a community-based program that offers flexible respite for carers of older people and people with a disability. Respite aims to maintain the primary carer/client relationship so that the carer can continue caring for longer and relieve pressure on more formal sources of care. The main targets of the NRCP are unpaid carers who need assistance and someone to look after their loved one while they run errands, have a night off or even clean the house.

The NRCP is funded through the Commonwealth Department of Health and Ageing under the Community Aged Care Program.

Veterans Home Care (VHC)[17]

VHC is very similar to the HACC program except that it is targeted specifically to Veterans and War Widows. Organisations providing VHC will work closely with the Department of Veterans' Affairs who may pay for equipment and other work required.

The VHC is a Commonwealth Department of Veterans' Affairs funded program.

Commonwealth Carelink Centres/Commonwealth Carer Respite Centres[18]

Commonwealth Respite and Carelink Centres are information centres for older people, people with disabilities and those who provide care and services. Centres provide free and confidential information on community aged care, disability and other support services available locally, interstate or anywhere within Australia.

There are a wide range of services to support independent living in the community, but finding out about them or accessing them can be time consuming, difficult and confusing. Commonwealth Respite and Carelink Centres provide a single point of contact for the general public, service providers, general practitioners and other health professionals for information on community, aged and disability services and carer support. The Centres can also assist with information about costs for services, assessment processes and eligibility criteria.

Each Commonwealth Respite and Carelink Centre has extensive regional networks and maintains a comprehensive database containing community aged care, disability and

[16] www.health.gov.au/internet/main/Publishing.nsf/Content/ageing-carers-nrcp.htm
[17] http://factsheets.dva.gov.au/factsheets/documents/HCS01%20About%20Veterans%60%20Home%20Care.pdf
[18] http://www9.health.gov.au/ccsd/

other support services. Shop-fronts are operated by organisations that already provide established services within their region. Their extensive local knowledge ensures they provide a quality service. This regional focus enables each Centre to develop an awareness of the entire range of services available, to establish networks with local providers and ensure information is up to date.

The Centres can also help arrange respite, when carers need to take a break from caring. They do this by acting as a single contact point for information need by carers and by organising, purchasing, or managing respite care assistance packages for carers. Examples of respite care assistance include in-home respite care; care workers who assist carers while they are taking a break away from home; and residential respite care.

4.3 Current Services

Community Aged Care

WACHS provide 8 CACP delivered through the Boddington District Hospital and 5 delivered from Williams. Consultations indicate that there are no other packages offered by other providers in the catchment area

Residential Aged Care

Boddington District Hospital provides an estimated 5 high care beds. It should be noted that these services are not listed on the DoHA Aged care Servicers List (June 2011) and therefore funding for theses beds may be provided by the WACHS from another area or from a funding stream other than Commonwealth Aged Care subsidies. Consultations with the hospital demonstrated that they were unable to give a definitive response regarding the configuration and number of aged care beds being operated by the hospital.

Aside from these beds, the nearest aged care residential facilities are: Pam Corker House (Waroona, 59km away), Beddingfeld Lodge (Pinjarra, 68km), Valleyview Residence (Collie, 68km), Hocart Lodge Aged Centre (Harvey, 70km), Pingelly Hostel (Pingelly, 77km), Kalkarni Residency (Brookton, 78km) and Narrogin Nursing Home (Narrogin 82km away).

Consultations detail that dementia care services are lacking. The observations include: 'Hospital cannot handle wanderers', 'We have to lock the front door at 5.00 because reception staff go home and cannot watch the doors' and "By the time we have found them somewhere to go, that stage (wandering)[19] has passed." Based on the current dementia rates it can be expected that about 16 persons 70+ in the catchment will have dementia (2012). Within 15 years (2027) that figure will have increased by more than 80%. Current residential care cannot manage the challenging behaviours or physiological symptoms associated with dementia.

By virtue of the reported incidents of older persons having to go as far as Albany to find a placement in a suitable aged care facility and hospitals perspective that additional residential aged care beds would be welcomed it can be concluded that there is a need for additional residential aged care in Boddington. This is confirmed by other evidence presented in this report (planning benchmarks, demographic driven demand, shortages of residential aged care on the suburban fringes).

Respite

Residential and community respite services are lacking. Consultations reveal:

[19] It is likely that when the 'stage' (wandering) has passed that the person is bed ridden.

- Respite is not well covered here
- There is no respite day care and people ask for it all the time

It is apparent from the consultations that vacant acute beds in the hospital are being used for emergency respite. This is not an ideal situation for the older person as they are not being provided with a respite experience that reduces stress and or leads to the persons or the family seeing the benefit of residential care. Residential respite is commonly a 'try before you buy' opportunity for the family, the older person and also for the provider. The responses from the hospital include:

- Respite is difficult in the hospital due to 24 hr Emergency Department and acute bed already occupied by old folk
- "I can really only take one at a time or it is hard to staff"
- A local aged care facility would help with respite, they have different staffing arrangements

Service Issues

Transport remains an issue in rural parts of WA. Consultations with Boddington Hospital report that the transport service is well utilised. Transport is mainly used by older people travelling to hospitals in Perth or specialists. A round trip to Perth can take 6-7 hours. The bus service between Perth and Albany is useful, although transport is still required to reach the bus stop on the Albany highway.

Volunteers are also ageing, which impacts on the type of travel that can be provided to older people.

4.4 Aged Care Planning Benchmarks

The Aged Care Planning Benchmarks are based on 88 residential place (44 high care and 44 low care) and 25 community places per 1,000 people 70+ years and ATSI 50+. The planning is referenced planning regions. In the context of Aged Care planning Boddington is in the Wheatbelt Planning Region (There is no DoHA Peel planning Region).

Aged Care Planning Benchmarks 2011

LGA	Pop	Resi High care	Resi Low Care	Com	Total	Current	Difference
Boddington	111	5	5	3	13	18	+5
Wandering	45	2	2	1	5	0	-5
Williams	84	4	4	2	10	5	-5
Total	240	11	11	6	28	23	-5

The DoHA aged care services list and ABS 2011

Aged Care Planning Benchmarks 2017

LGA	Pop	Resi High care	Resi Low Care	Com	Total	Current	Difference
Boddington	204	9	9	5	23	18	-5
Wandering	35	2	2	1	5	0	-5
Williams	112	5	5	3	13	5	-8
Total	273	12	12	9	31	23	-18

The DoHA aged care services list and ABS customised population projections

The findings are that current service levels in catchment are below the DoHA aged care planning benchmarks. By 2017 the gap will have increased. The current data includes unconfirmed numbers of residential aged care beds being operated by the Boddington Hospital; 10 (5 High Care and 5 Low Care). An alternate estimate is 5 high care beds. The lack of clarity creates uncertainty regarding the gap between current service levels and the current DoHA benchmarks.

Consultations with hospital reveal that additional community care packages would be welcomed indicating that there is unmet demand in Boddington.

4.5 Sustainable Aged Care Services Development Issues

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 facilitates 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:

Principle 1: Multiple services delivered by one organisation who is the provider of residential aged care

Principle 2: The maintenance of high occupancy levels often facilitated by the integration of community care and residential care

Principle 3: Retaining qualified and expert staff

Principle 4: Prioritising entry into low care for persons who can provide a bond this is supported by the development of ageing in place beds in low care (low care beds built to a high care standard)

Principle 5: Having personnel skilled in securing bonds

Principle 6: Good leadership and sound governance

Planning for sustainable services in rural and remote areas resulted in Nth West Tasmanian Residential Aged Care Providers and hospital personnel to confirm the following principles for aged care service provision. Wider consultations with Residential providers across Australia have confirmed the universality of the following principles:

Principle 1: The importance of place – ageing in the community where the older person lives and calls home.

Principle 2: Community Life – convenient access for families and friends and being retained as a valued member of their community.

Principle 3: Community's sense of ownership – the residential aged care facility is considered part of the economic and social assets of the community and assist the community retain and build confidence in its integrity as a community.

Principle 4: Focus on the person – provides the individual care recipient with respect and dignifies 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 encompassing all cultures, sexual preferences, religious choices and observations.

Principle 7: Practicality – choice and options which are balanced against the reasonable limitations of funding, population density and health/safety considerations.

Principle 8: Viability and Sustainability – capacity to create an operational surplus to reinvest into future service development that include; training, staff development, innovations and building; ensuring security of tenure for residents; the capacity to maintain staff and organisational learning and intelligence

In 4.7 the impact of residential and community care services on the development of aged care housing is cited.

4.6 Aged Housing Needs

Consultations confirm that there is a demand for a small scale retirement village. Demographic data indicates that there is a requirement for a mix of options to support the diverse financial capacity of older persons in Boddington or migrating to Boddington townships from the catchment. An analysis of the findings indicates that the village should be operated on a mix of lease-for-life, rental homes and pension level.

Lease for life operates on the basis of residents investing their capital into a Reserve Fund and also paying an on-going resident's maintenance fee for a share of the capital gain into their estate when the dwelling is sold. Rental units will be based on commercial rental rates and an on-going resident's maintenance fee built into the rental arrangement. Pension level will be based on a fixed % of the older person's income; this arrangement will be means tested.

Immediate demand has been estimated to be sufficient for 5 lease-for-life and 6 rental/pension level homes with a completion date of 2016. By no later than 2020 it estimated that the village will consist of 20 lease-for-life dwellings and 20 rental /pension level units.

In the report 'Positive Ageing in the Shire of Boddington June 2006' demand for aged persons housing was detailed as; "The Boddington Shire owns four independent two-bedroom care units. The units are consistently filled and there is generally a waiting list of 10-12 people. The Shire is in the process of applying for funding to build six more independent living units at the rear of the hospital and a recent survey confirmed that there is sufficient demand also to keep the new units filled."

Consultations[20] undertaken to develop this proposal demonstrate that the rate of sale of retirement units and general confidence of retirees improves with the knowledge that they will have access to residential and community aged care and the expected range of health services when required. RSL WA indicates that in their Jurien Bay development that the average age of retirees is 77 years. Other data sources indicate that residents of retirement villages are in their mid to low 70's.

Consultations also highlighted the following: 'ILUs would mean that people from out of town would be able to move closer and still be independent', 'Rents in town are very high due to the mine' and "You see these old people struggling to find somewhere to live. They often end up in old farm houses close to town which are not ideal. It breaks your heart."

Boddingtons's health services and aged care services will impact on the retirement village (rate of sale, possibly the pricing, stability of the residents and capacity to age in place). The mix of housing types in the retirement village will ensure the needs of seniors across the catchment are met. There is sufficient current and future demand to develop a 40 unit retirement village.

The Housing Needs and Wants Findings

Another way to gauge future demand is by reviewing the findings of 'Housing Needs and Wants of Older People'[21]. Persons interviewed while undertaking this report were asked to describe their current housing arrangement, and any other housing arrangements over the past thirteen years. Information reported in this section was gathered to test whether older persons fiercely held onto their family homes or to test whether they would move if suitable alternate housing was available.

It is interesting to note that the report demonstrates that thirteen years ago, all of the participants were living in their own/the family home, unit or independent living unit. The data indicates that there is a clear continuum of change from larger family homes, to units, to independent living units as issues of mobility and maintenance come in to play.

The report also details that 75% of those interviewed were still living independently, the type of housing most commonly preferred to the family home by respondents was independent living units (35% of respondents). The results support the view that independent living is about features of homeliness and independence not size.

Some respondents provided insights into their motivation for moving, this was typified in this response: "It was hard to move, I had so many memories here but I would do anything that was necessary to maintain my independence. I do not want to go to residential aged care".

The table below demonstrates of those living in their own home in 1997, that 63% of this group has moved from the family home with 18% of the group who moved having also made an intermediary move. This supports the contention that 'the family home' may not be sacrosanct as some commentators have suggested. Those who were in a flat or unit had all moved more than once.

The importance of place: An interesting theme that emerged when older people discussed their housing needs was the importance of 'place' for many of the participants. This importance of 'place' had a slightly different meanings including the desire to closeness to family and or friends, their emotional connection to a

[20] Ken Hamilton RSL WA, Liz Petit Global Care

[21] Housing Needs and Wants a series of three studies undertaken by Verso consulting 2008 to 2010 in SA and Victoria

locality, familiarity with a local area and the desire to stay connected to community groups/churches/civic contribution.

The market for ILUs may be much larger in Beverley than indicated through the consultations already undertaken in the local community. Future demand for an ILU village may increase demand if the following elements are evident; the importance of 'place', pricing, entry options, the built environment, social environment of the village, access to community/community facilities, and the access to aged care and related health services. The research presented in this section assists in understanding the value of these elements.

Longitudinal View of Aged Persons Housing

Living Arrangement	1997 living arrangement	Intermediary Move	Current
Own/Family Home	103	12	38
Flat/Unit	14	14	11
ILU	5	-	43
Retirement Village Unit	-	2	5
Aged Care Facility	-	6	25
Total	122	34	122

Source: Verso Consulting unpublished review of needs and wants in aged persons housing

5 Policy and planning Context

5.1 Alignment with RDL Policy

Regions objectives RDL

The Western Australian Department of Regional Development and Lands are seeking to build capacity, retain benefits (particularly where there are mining developments) and improve services in regional communities. The policy of the department is also to attain sustainability, expanding opportunity and grow prosperity. The aged care plan proposes the development of older persons housing and the further development of aged care services. While it is not in the remit of this plan the development of complementary geriatric health services is necessary to retain older people in Boddington and its service catchments and to encourage the development of Boddington as a retirement destination. Within this section the economic impacts of achieving these objectives is introduced.

The outcome of developing older persons housing is that it will increase the capacity to retain older persons in the community, respond to their needs and promote their wellbeing. This Ageing in-place concept articulated in the Aged Care Act 1997 and is also the choice and preference of older Australians. This concept has also informed a broad range of recommendations in the Productivity Commissions Report (Caring for Older Australians) currently under consideration by the Department of Health Ageing and part of a major reform agenda for aged care.

The development of older persons housing in Boddington will also support the development of Boddington as a retirement destination for residents in surrounding LGAs and possibly from people living in the suburban fringes. The rate of sale and success of this retirement development will impact on the likelihood of other developments into the future.

The current aged care and health service infrastructure in Boddington contributes to the likelihood of the success of the older person's housing development. The lack of these services in other locations including surrounding LGAs will also feed inward migration to Boddington. It will therefore be essential that Boddington based residential and community aged care and related health services are being developed in concert with the development of older persons housing. Aged care, health services and older persons housing are symbiotic.

It should be noted to maintain sustainability and respond to the choice of older person's concepts other than the traditional Residential Aged Care services should also be explored as part of future planning. These options may include cottage respite houses, the provision of packaged care into the retirement units and an application of the principles of 'apartments for life'.

To realise the policies of RDL the consultants recommend that aged care and older persons housing be developed guided by these principles

Principle 1: **The importance of place** – ageing in the community where the older person lives and calls home.

Principle 2: **Community Life** – convenient access for families and friends and being retained as a valued member of their community.

Principle 3: **Community's sense of ownership** – the residential aged care facility is considered part of the economic and social assets of the community and assist the community retain and build confidence in its integrity as a community.

Principle 4: **Focus on the person** – provides the individual care recipient with respect and dignifies 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 encompassing all cultures, sexual preferences, religious choices and observations.

Principle 7: **Practicality** – choice and options which are balanced against the reasonable limitations of funding, population density and health/safety considerations.

Principle 8: **Viability and Sustainability** – capacity to create an operational surplus to reinvest into future service development that include; training, staff development, innovations and building; ensuring security of tenure for residents; the capacity to maintain staff and organisational learning and intelligence

5.2 Economic Impacts

The retention of older persons, their carers and families in Boddington will significantly impact on the local economy particularly in the consumption of goods and services. The findings in this study demonstrate that as many as 100 older people may have exited the community when their aged care needs could no longer be met or they have relocated to retire. As the numbers of older persons in Boddington and its service catchments increases so too will the rate of outward migration unless plans are actioned that arrest this trend. Older persons their carers and families also make a significant contribution to the social capital of Boddington.

The development of additional aged care services and related health services to meet a demand driven by the aged demographic and a demand created by Boddington becoming a retirement destination will create additional employment. For example each additional high care and ageing place low care beds 1.08 full and part-time jobs will be created.

The construction will create the opportunity for additional local employment. The developments that may result from the adoption of the recommendations in this study include: 40 ILUs, 10 additional residential care beds (@ $240,000 per bed – land and 9c certification) and possibly alterations to the hospital. The ABS state[22] that for every $1,000,000 spent in construction in one year 9 direct jobs are created in that year. It could be estimated that staged construction spread over 5 years would amount to 21 people being employed over 5 years. This is based on the projects being valued at $11.7m.

5.3 Other Impacts

The development of the capacity to house and support older persons aged care and health needs will result in Boddington based services being able to leverage additional funding for respite, community aged care and geriatric health services.

The success of the retirement village may attract other developments.

[22] ABS - Yearbook 1301.0.202

5.4 Broad Policy Context

There are significant changes taking place in policy and programs for health and aged care.

5.4.1 Health reforms

The health reforms are supported by a National agreement for funding public hospitals with the objectives of increasing the levels of transparency and accountability and reducing waste and waiting for patients.

Key components of the National Health Reform Agreement (and the related National Partnership Agreement on Improving Public Hospital Services and the National Healthcare Agreement 2011) that are directing the changes to Australia's health system include:

- A new framework for funding public hospitals and an investment of an additional $19.8 billion in public hospital services over this decade;
- A focus on reducing emergency department and elective surgery waiting times;
- Increased transparency and accountability across the health and aged care system;
- A stronger primary care system supported by joint planning with States and Territories and the establishment of Medicare Locals;
- The Australian Government taking full policy and funding responsibility for aged care services, including the transfer to the Australian Government of current resourcing for aged care services from the Home and Community Care (HACC) program, in most states and territories except Victoria and Western Australia (negotiations regarding these arrangements in the light of the Aged Care reforms is continuing).

5.4.2 WA HACC Reforms

The WA HACC reforms are being instated within the National reform agenda. The objective of the reform is to reshape and strengthen the community care system across Australia. The reform work is structured around developing and adopting a set of "common arrangements" – processes, methodologies and tools to simplify and streamline a range of activities.

The reform includes the development of an overarching framework within which all community care programs operate. The framework will seek to achieve consistency across all community care programs in the following key areas:

- Assessment for need and eligibility
- Access to services
- Eligibility criteria
- A common approach to determining fees
- Accountability
- Quality assurance
- Information management and data collection
- Planning

The framework will also include national targeting strategies to ensure an appropriate balance of HACC funding across care needs and will be underpinned by the objective of achieving greater alignment between the HACC Program and other community care programs.

Reform of the WA HACC Program to improve eligibility screening, assessment, coordination and service delivery processes has been underway for a number of years. This reform has been guided by WA and national policy initiatives and projects including:

- the National HACC Framework for Assessment (1995);
- the WA Community Care Classification Project including the development of the WACCC-PAF (1997);
- the WA HACC Assessment Strategy including the development of the WA HACC Needs Identification (HNI) instrument (2003);
- the release of the report entitled A New Strategy for Community Care – The Way Forward (2004);
- the implementation of the Wellness Approach incorporating the key strategy of face to face wellness focused assessment (2006);
- The Model of Care for the Older Person in Western Australia developed by the Aged Care Network (2007).

Building on the reform work undertaken nationally and at a local level, over the past few years the WA HACC Program developed the Assessment Framework – Service Redesign document that is being used to guide the future direction of HACC assessment and service delivery in WA and reform across the broader community care sector.

The WA HACC reforms incorporate a wellness/capacity building approach as the policy position for future growth and development in service delivery for all HACC clients.

Wellness is based on the principles that people want to retain autonomy and build capacity, which in turn has a positive impact on their self esteem and ability to manage day to day life and where independence is not limited to physical functioning but extends to social and psychological functioning.

It is an important philosophical change in the thinking behind and delivery of HACC services in WA. The WA HACC service sector will be supported to develop and implement service models that build capacity by actively working with the client to:

- Prevent loss of independence by focusing on the retention of existing skills; and
- Focus on regaining skills and a subsequent increased level of independence and well-being

This service model is more conducive to the emerging trends in health care and consumer advocacy and is in contrast to a service model focused on continuing or increasing dependence on services.

5.4.3 Aged Care Reforms

The most significant reform in aged care since the establishment of the Aged Care Act 1997 has been announced and has been detailed in the Commonwealth Government's Living Longer, Living Better – Aged Care Reform Package May 2012. Attachment 2 is a summary of the Aged Care Reform package developed by the Aged Care peak body Aged and Community Services Australia (ACSA).

The Commonwealth Government's Living Longer, Living Better – Aged Care Reform Package May 2012 responds to the Productivity Commissions enquiry into Aged Care and involves a package of reform measures. The reforms include[23]:

- Increased user contributions (this does not include the family home)
- Increased supply of aged care services including 2 new community aged care package types
- Increases the opportunity for people to receive care at home
- Maintains a care ratio framework and licences/allocations through the Aged Care Approvals Round (ACAR)
- Embeds consumer direct care principles in community care and will trial this approach in residential care
- Create 'a home support program' by combining HACC and existing Commonwealth community programs such as respite and day therapy programs with the intention of putting a greater emphasis on prevention and reablement and a consistent fee policy after 2015 (WA and Victoria arrangement are under negotiation)
- Increase access to services and information through the creation of a gateway
- Introduce choice of a fully refundable lump sum payment or rent for all residents in residential aged care
- The Commonwealth will increase the accommodation payment for all supported residents (pension level) in new or redeveloped residential aged care facilities (2012>)
- Recalibrations of definitions in the ACFI to reduce the rate of growth in the care subsidies
- Create an independent pricing authority to approve pricing for residential aged care accommodation and charges for extra services
- Create a dementia subsidy across community care services
- Improve the approach to dementia care in hospitals
- Improve the approaches and arrangements for palliative care
- Create a new agency to accredit and monitor residential aged care facilities while DoHA will maintain responsibility for the complaints scheme, compliance and sanctions
- Create an 'Implementation Reform Council' to guide the implementation and further development of the reforms

5.4.4 Broad Aged and Health Service Policy

Aged Care and Health services have a strong evidence base that detail benefits such as:

- Aged friendly communities;
- Geriatric health prevention and promotion;
- Restorative health care.

[23] Living Longer, Living Better – Aged Care Reform Package May 2012; The Commonwealth of Australia

Concepts within this plan have been developed giving due consideration to these factors. An annotated bibliography (attachment 1) provides a summary of key policies and concepts that will impact on the development of health services focused on older persons and on the development of aged care services.

6 Recommendations

6.1 Recommendations

Retirement Village

Support the development older persons housing (small scale retirement village) that includes a sustainable mix of social (pension level), full rental, and lease for life rental options for older people through the provision of land and other appropriate assistance (see section 7). This recommendation is in concert with the research that has already been conducted by the Shire including considerable community consultation and participation in planning.

The recommendation supports the development of an MOU between a suitable retirement living provider and the Shire of Boddington. The village development should relate to developing 40 Independent Living Units between now and 2020. The recommended business model for the village to include the following arrangements:

- Lease for Life
- Part rental and part incoming entrance fee (to satisfy issues with very low property values for the home sold by the resident to enter the village)
- Commercial rentals
- Pension level rentals (means tested) and funded through arrangement with the WA Department of Housing

The actions to realise this development objective are detailed in section 7 of the study.

Expansion of Aged Care Services

Advocate for and support the development of residential and community aged care services based in Boddington that also serves Wandering and Williams. The services include dementia, respite, community packages, HACC and Residential Care. This expansion should aim to secure benchmark service levels and be managed within an integrated approach to aged care to ensure sustainability for the aged care provider. Sustainability can be maximized when the older persons housing, residential care, community care and HACC services are delivered by a single provider. This approach should also include ageing in place for residents of the ILUs.

To ensure sustainable development of aged care services including retirement living the Shire should consider developing an MOU with a provider of an integrated range of services (aged persons housing, ageing in place, respite services, community aged care and other services for older people).

This study details current and future demand and provides evidence to support the expansion of services. This evidence should be used by the Shire of Boddington and a provider to advocate for the appropriate service levels and required aged care programs. This study will support an approved provider to apply in the Aged Care Approval Rounds for additional places and if necessary capital grants.

The evidence in this study should also be used to support enhanced targeting and delivery of HACC services managed and delivered by WACHS. The Shire of Boddington is well positioned to use the findings to advocate for the service mix and service

levels required to respond to the needs of older persons in Boddington. This study should aid long-term planning.

Expansions of age related health services

That the Shire advocate for the development of a plan for aged related health services that includes telehealth. The plan should seek to reduce the number of trips that older persons need to be made to Perth to access services. The development of the plan should be governed by WACHS and the Shire of Boddington in partnership and should consider the population and catchment assumptions, and drivers of demand detailed in this study.

The Shire of Boddington should work with WACHS to secure NBN connectivity to aid the early adoption of telehealth. The Shire may also seek to facilitate cooperation between the intended provider of aged housing and aged care services, the GP and WACHS to explore processes for ensuring the appropriate complementary aged care services are delivered and developed in a manner that maximises the health/aged care workforce e.g. community care workers, case managers, allied health professionals. The workforce may be able to work across services and programs to ensure that all programs and services remain viable and the capacity of the scarce workforce is maximised. This may also facilitate better outcomes in relation to geriatric health promotion and health prevention activities thus reducing the incidents of avoidable hospitalisation.

7 Action Plan

The action plan relates only to the development of a retirement village. This action is the only part of recommendations in the study.

Action Plan

Subject	What	When	Who
Land for ILU development	Identification of the need for older persons housing and the volume required	Completed	Shire
	Community consultations and participation to determine the model, demand, site and possible constraints	Completed	Shire
	Identification of land located where ageing in place is facilitated by virtue of access to other services including health services and residential aged care.	Completed	Shire
	Land for the development of an Ageing Place retirement village. The land is Lot 165 Forrest Street Boddington comprising of 1.3776ha. The lot is zoned residential. This zoning supports a retirement village development. This property is owned by the Shire of Boddington.	Completed	Shire
	Identification of experienced retirement living ILU providers willing to develop a retirement village of the modest scale required by the Shire	IP	Shire
	MOU developed with the preferred provider defining location, land transfer arrangements, minimum number of units for the first phase of the development and the number of units for the completed development. The agreement also describes the mutual responsibilities of the parties.	TBD	Shire

Subject	What	When	Who
Land for ILU development	Develop formal legal agreement for land use and transfer including in a manner that allows the village to operate effectively under the Retirement Villages Act	TBD	Shire
	Transfer land to Provider	TBD	Shire
Subject	**What**	**When**	**Who**
Design ILUs, preliminary works	Appoint Architects	31/07/12	Shire
	Develop site plan detailing staged development	31/07/12	Shire
	Develop the model for the village based on identified needs and contemporary experience in rural settings. The model will include a mix of lease for life, mixed entry fee and rental, commercial rental and pension level arrangements. The model also includes an inclusive principle that does not identify the purchase/rent arrangements through differences in the external visual cues.	30/09/12	Shire
	Ascertain options for pension level housing	31/10/12	Shire
	Cost intended design and construction including landscaping and engineering	30/11/12	Shire

Subject	What	When	Who
Design ILUs, preliminary works	Identify capital funding sources to fund the development of the village	31/07/12	Shire
	Agree to site plan and stage 1 development	30/06/12	Shire
	Consolidate all capital sources and develop cash flow process and plan to fund the construction of the village.	31/12/12	Shire
	Undertake soil testing, engineering and statutory planning processes related to the development of the Village.	31/10/12	Shire
	Approve engineering and development plans including public comment and objection processes	31/10/12	Shire
	Develop detailed building plans for the development	30/11/12	Shire
	Cost final building, construction, engineering and landscaping	31/12/12	Shire
	Approve building plans	31/12/12	Shire
	Adjust cash flow plans and capital requirements based on final costing	31/12/12	Shire

Subject	What	When	Who
Construction	Identify builder /landscape contractor	31/12/12	Shire
	Commence Construction Stage 1	Jan 2013	Shire
	Complete Construction Sage 1	Dec 2013	Shire
	Complete additional Stage	TBD	Shire
Subject	**What**	**When**	**Who**
Operations	Form contracts with residents and take deposits where applicable	Oct 2012 onwards	Shire
	Operationalise Stage 1 of the village	Dec 2013	Shire

8 Attachments

Attachment 1

Document	Policy and Planning Context – Key Points
BODDINGTON PLANNING DOCUMENTS	
Positive Ageing in the Shire of Boddington; Sustainable Development and Facilitation June 2006	The Document was developed as part of a larger piece of planning for the peel Region. The Study process has been led by the Peel Community Development Group – a strategic regional not-for-profit organisation that aims to "support a positive sustainable development process for the community in Peel". Funding for the Study was contributed by the Peel Development Commission, local government and interested private sector organisations. The Study process was facilitated and analysed by Sustainable Development Facilitation, a Peel-based international sustainability enterprise. The Positive Ageing in the Shire of Boddington addressed: • an overview of the Boddington Study and its main conclusions and recommendations; • the current community in Boddington; • the likely changes that Boddington faces in future; • some points that can be considered in assisting today's and tomorrow's older people in Boddington. The points have been structured on the key aspects that are considered most important in the overall Peel Study: health and wellbeing; accommodation; income; employment and activity; transport and planning; and governance. • summarises the findings of the Study and proposes a way forward. The report also contains appendices provide more detail and other references.

Document	Policy and Planning Context – Key Points
SuperTowns visioning workshop update (Dec 2011) http://www.boddington.wa.gov.au/documents/stownsupdate	The document was produced to reflect the broad outcomes from community consultations (60 participants). The participants identified impediments relative to aged care and older persons housing as; the relatively high cost of land and an ageing population. Physical and Social Infrastructure Gaps and Requirement relative to aged care and older persons housing where: Retirement accommodation and Residential Aged Care
Shire of Boddington SuperTown Economic Development Strategy Shire of Boddington February 2012	The plan identifies seven core industrial/business focus areas that can support community economic growth. Included are population and personal services related to health care, aged care and wellbeing. The plan also refers to aged care accommodation as a key catalyst capital works project. The plan details the following consideration to aged care, older persons housing and interrelated health services: • The Department of Health is currently considering the implications of SuperTowns growth scenarios and will be formulating an investment program. The Boddington District Shires should be core participants in this process. • In the medium term a new model for a small scale aged care facility may be developed in Boddington, which will provide an additional, much needed service to the aging population. There is likely to be a small job creation element. • It is envisaged that some local health support will be provided through tele-health services. This supports the imperative for the Boddington District to be NBN ready.
Boddington SuperTown Growth Plan March 2012	Aged Care and Retirement living have been identified as 'transformative' projects this also referred to in the plan as catalyst projects. The plan also identifies that there is a "need to meet the needs of an aging population through the provision of independent living units, followed by a residential aged care facility'. It is considered that these projects will assist in retaining existing population (of older persons their carers and their families) and will also support the retention potential residents and their extended families. Relevant stakeholder comments provided by WACHS demonstrates that the Southern Inland Health Initiative is focused on pioneering new and innovative ways of delivering health services, including the introduction of tele-health services which will link smaller health centres higher order centres and specialised services via

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	video technology. The Growth plan also reveals that on the issue of aged care, the Health Department is likely to play a decreasing role – deferring to the Commonwealth, private sector and not-for-profit groups for this service. Aged care is a difficult area to make work commercially and generally 60 beds are required to make a facility work. The plan makes reference to the alternate arrangements that Global Care Group is piloting in York. The plan details that Global Care also intends implement one (the model) in Boddington in the medium to long term. The plan identifies that aged care contributes to community sustainability and aged and health care as one of seven core business/industrial focus areas. The Growth plan also details that over the next 5 years that facilitate retirement living and aged care $11.9m will be sought from Royalties for Region.
International and Federal/Commonwealth Policy	
Global Age-friendly Cities: A Guide, World Health Organisations, 2007 Global Age-friendly Cities.pdf	**The purpose of this Guide is to engage cities to become more age-friendly so as to tap the potential that older people represent for humanity. An age-friendly city encourages active ageing by optimizing 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 capacities.** **In an age-friendly city, policies, services, settings and structures support and enable people to age actively by:** • recognizing the wide range of capacities and resources among older people; • anticipating and responding flexibly to ageing-related needs and preferences; • respecting their decisions and lifestyle choices; protecting those who are most vulnerable; • promoting their inclusion in and contribution to all areas of community life. Active ageing depends on a variety of influences or determinants that surround individuals, families and nations. They include material conditions as well as social factors that affect individual types of behaviour and feelings Age-friendly community and health services checklist:

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	Service Accessibility • Health and social services are well-distributed throughout the city, are conveniently co-located and can be reached readily by all means of transportation. • Residential care facilities, such as retirement homes and nursing homes, are located close to services and residential areas so that residents remain integrated in the larger community. • Service facilities are safely constructed and are fully accessible for people with disabilities. • Clear and accessible information is provided about the health and social services for older people. • Delivery of individual services is coordinated and with a minimum of bureaucracy. • Administrative and service personnel treat older people with respect and sensitivity. • Economic barriers impeding access to health and community support services are minimal. • There is adequate access to designated burial sites. Offer of Services • An adequate range of health and community support services is offered for promoting, maintaining and restoring health. • Home care services are offered that include health services, personal care and housekeeping. • Health and social services offered address the needs and concerns of older people. • Service professionals have appropriate skills and training to communicate with and effectively serve older people. Voluntary Support • Volunteers of all ages are encouraged and supported to assist older people in a wide range of health and community settings. Emergency Planning and Care • Emergency planning includes older people, taking into account their needs and capacities in preparing for and responding to emergencies.
A Healthier Future for All Australians (2009) – Federal Health Reform Commission	Recommendations include: • A goal of fundamental redesign of the Australian health system

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http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/F9985BD254EC75F5CA2575FB0025888A/$File/FinalReportof%20thenhhrcJune2009.pdf	• Embed prevention and early intervention into every aspect of the health system and lives • Establish a National Health Promotion and Prevention Agency • Connect and integrate health and aged services around people • Integrating multidisciplinary primary health care services • Establishment of comprehensive primary health care services and centres • Establishing primary health care organisations • The Commonwealth having full policy and funding responsibility for primary health care
Building a 21st Century Primary Health Care System (Draft National Primary Health Care Strategy) (2009) http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draft-report-toc/$FILE/NPHC-Draft.pdf	Contains four (4) key Priority Areas and Directions for Change: Improving access and reducing inequity via delivery through an integrated service system Better management of chronic conditions via a practice or provider who becomes responsible for managing care Increasing the focus on prevention via regular risk assessments available at multiple points of service, which are actively linked to community-based supports and activities Improving quality, safety, performance and accountability by giving individuals information to make informed choices and improving patient information at handover
Primary Health Care Reform in Australia – Report to Support Australia's First National Primary Health Care Strategy (2009) http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draftreportsupp-toc/$FILE/NPHC-supp.pdf	The report supports and expands on the issues which have determined the Key Priority Areas in the Draft Strategy above.
Close the Gap – Statement of Intent from Indigenous Health Equity Summit (2008) http://www.hreoc.gov.au/Social_Jus	The Statement of Intent notes the challenge to embrace a new partnership between Indigenous and Non-Indigenous Australians, and that the core of the partnership is to close the gap on life expectancy, educational achievements and employment opportunities. The statement notes a shared commitment to achieving concrete targets relating to literacy, numeracy and

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tice/health/statement_intent.html	employment, to halving the gap in infant mortality and life expectancy. The parties to the statement are the Australian Government, ATSI people, supported by non-Indigenous Australians and health organisations. The statement includes commitments to: • A long term flow of action to address inequities in health services • Ensure primary health care services and health infrastructure are capable of bridging the gap in health standards by 2018 • Ensure full participation in all aspects of health need • Work collectively and systematically to address the social determinants which impact on health equality • Measure, monitor and report on joint efforts in accordance with benchmarks and targets
Healthy By Design: A Planner's Guide to Environments for Active, Healthy Living (2004) http://www.heartfoundation.org.au/search/healthybydesign	This guide provides design objectives and considerations for planners, consultants, developers, engineers, architects and community organisations. The guide covers the aspects of: • Walking and cycling routes • Streets • Local destinations • Open space • Public transport • Supporting infrastructure • Fostering community spirit The guide also provides design prompts (Objectives and Considerations) for all of these.
Who Cares ...? - Report on the inquiry into better support for carers (2009) **(also Document Review by Natalie Appleby)** http://www.aph.gov.au/house/committee/fchy/carers/report/fullreport.pdf	Recommendations relevant to Municipal Health include: • Promote a better understanding of the role and needs of carers (Recommendation 2) • Prioritise locally-based peer support groups (Recommendation 8) • Provide a preventative health care program targeted at carers (Recommendation 46) • Nominate carers as an early priority for social inclusion in the social inclusion system (Recommendation 50)

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Australia: The Healthiest Country by 2020 – National Preventative Health Strategy – Overview (2009) http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/AEC223A781D64FF0CA2575FD00075DD0/$File/nphs-overview.pdf	Strategies are: • Shared responsibility – developing strategic partnerships • Act early and throughout life • Engage communities • Influence markets and develop coherent policies • Reduce inequity • "Close the gap" for Indigenous Australians • Refocus primary healthcare towards prevention
National Action Plan on Mental Health 2006 – 2011 (2006) http://www.coag.gov.au/coag_meeting_outcomes/2006-07-14/docs/nap_mental_health.pdf	This joint Commonwealth and States Plan has five (5) action areas with attendant specific policy directions. The action areas are: • Promotion, prevention and early intervention • Integrating and improving the care system • Participating in the Community and Employment • Co-ordinating care • Increasing workforce capacity
National Framework for Action on Dementia 2006 – 2010 http://www.healthyactive.gov.au/internet/main/publishing.nsf/Content/D64BD892C6FDD167CA2572180007E717/$File/nfad.pdf	The framework incorporates the following principles: • People with dementia are valued and respected • Carers and families are valued and supported • People with dementia, their carers and families are central to choices about care • Service responses recognise individuals • People with dementia, carers and families receive services that respond to the social, cultural and economic background, location and needs • A well-trained workforce delivers quality care • Communities play an important role
Social Housing Initiative - Guidelines (2009)	No apparent long term policy implications in document and no mention of local government role. However there may be specific outcomes from particular new or refurbished social housing projects in Hume.

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http://www.fahcsia.gov.au/sa/housing/pubs/housing/socialhousing/social_housing_init_guidelines/Documents/Social_Housing_Initiative.pdf	
The Australian Unity Wellbeing Index - Survey 1, Report 1 (2001) http://acqol.deakin.edu.au/index_wellbeing/Survey1_1.pdf	Quality of life is subjective as well as objective, a matter of how people feel about life as well as the material conditions in which they live. Interestingly, however, these two kinds of measurement are normally poorly related. So we need both. There are a plethora of objective measures that relate to quality of life and wellbeing. There is, however, a lack of subjective measures that are rigorous, comprehensive and systematic. The Australian Unity Wellbeing Index is designed to fill this niche. It has the aim of promoting greater public and political awareness of the social factors underpinning wellbeing, as well as enhancing scientific understanding of subjective wellbeing. Nineteen surveys have been conducted since 2001 and a number of Special Reports are available including data on differences between towns/cities.
Western Australian Policy	
A Healthy Future for West Australians, Report of the Health Reform Committee, March 2004 A Healthy Future for Western Australians Final_Report.pdf http://www.health.wa.gov.au/hrit/docs/publications/Final_Report.pdf	The document states that the need for change is accepted by all but incremental reform is no longer the pathway to a financially sustainable vision for WA. A fundamental reprioritisation of the public health system. An increased focus on health promotion, improved interface between general practice and the public health system and enhanced community-based aged care, mental health, Aboriginal health services will not only improve the health status of Western Australians, but will reduce the growth in demand for hospital emergency care and beds. Investments s needed to help people navigate the health system. This includes both technology to facilitate the movement of information through the health system, such as electronic health records and unique patient identifiers, and in clinical guidelines to bring greater consistency to clinical practice. Significant reconfiguration of hospital services in WA is proposed. This is necessary to rectify historically poor planning decision, to reflect rapidly changing demographics, to improve access to hospital care and to ease the burden and reduce the dependency on tertiary hospitals.
State Planning Strategy, West	The State Planning Strategy is a land use planning strategy for Western Australia's development up to our

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Australian Planning Commission, Final report, December 1997 State Planning Strategy Report 1997.pdf	bicentenary in 2029. The Strategy prepares for significant population growth, an expanding economy, a changing and vibrant community and a sustainable future. It provides a vision to assist strategic decision-making and a set of principles by which coordinated, sustainable development will be implemented. It is a plan to meet community needs and aspirations, and facilitate wealth creation, the provision of public infrastructure and the protection and improvement of the environment. Environmental principle: To protect and enhance the key natural and cultural assets of the State and deliver to all Western Australians a high quality of life which is based on sound environmentally sustainable principles. Community principle: To respond to social changes and facilitate the creation of vibrant, accessible, safe and self-reliant communities. Economic principle: To actively assist in the creation of regional wealth, support the development of new industries and encourage economic activity in accordance with sustainable development principles. Infrastructure principle: To facilitate strategic development by ensuring land use, transport and public utilities are mutually supportive. Regional principle: To assist the development of regional Western Australia by taking account of the region's special assets and accommodating the individual requirements of each region.
The Western Australian Chief Health Officer's Report 2010, Department of Health, Western Australia, March 2010 WA_chief_health_officers_report_2010.pdf	
Aged Care Policy	
Health and Quality of Life for Older West Australians, discussion Paper, Health Department of Western Australia Quality_of_Life_for_West	Part of the report deals with health promotion and prevention interventions. The report identifies that a substantial amount of chronic disabling conditions associated with ageing are potentially preventable and not an inevitable accompaniment of growing old. The report considers a number of risks factors that impact on good health and notes that a lifestyle approach needs to be developed encouraging healthy habits from an early age but also recognises that benefits can be obtained from changing habits. The report details

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Australians.pdf	strategies that can support improved wellbeing. Other themes in the report include the continuing move for greater integration of GPs and other parts of the health system. The report also discusses the aged care system and the role of community care.
State Aged Care Plan for Western Australia 2003-2008, WA Aged Care Advisory Council, 2003 http://www.health.wa.gov.au/publications/documents/sacp0308.pdf	In early 2002, the Minister for Health established the WA Aged Care Advisory Council to provide ongoing advice to government on health and related aged care services for older people in Western Australia. As a priority term of reference, the Advisory Council was required to "develop a State Aged Care Plan, including an action plan for dementia care, for the State's ongoing involvement in the provision of health and related aged care services to the older population of Western Australia".
Leadership in Aged Care Plan for Western Australia 2004-2008, WA Aged Care Advisory Council, 2004 http://www.health.wa.gov.au/publications/documents/Leadership_Action_Plan_12pp.pdf	This plan is the Advisory Council's response to the first goal of the State Aged Care Plan which states the critical importance of strong leadership to envision, create and shape change for the benefit of older Western Australians. Vision: Independence, well-being and quality of life for older people through responsive health and aged care services and supports Goals: 1. Strong leadership to envision, create and shape change for the benefit of older Western Australians 2. Transformed systems to ensure integrated and coordinated services and supports 3. Continuous improvement so that services and supports focus on the individual and recognise diversity 4. The people who provide services and supports are valued, mentored, skilled and resourced Values: • Aged care is about the person, both the individual and their family (of origin, or choice) and carers and is built on participation and respect • Aged care is positive and enabling with service delivery based on flexibility and choice • Equity and inclusion are fundamental • Quality systems are fundamental Leadership -Aim to champion a shared vision of an environment of care and support for older people Strategies The aged care sector - Aim to support and shape an integrated and responsive aged care sector Communities of interest - Aim to support community involvement in shaping the responsiveness of health and aged care services.

Document	Policy and Planning Context – Key Points
Aged Care Network, Discussion Paper **Model Of Care For The Older Person In Western Australia, Department of Health, 2007** **Discussion_Paper_Model_of_Care.pdf**	"Independence, well-being and quality of life for each older person in Western Australia through responsive health and aged care services and supports across the continuum of care The key findings centred on refinement of the draft model of care in terms of: • a greater emphasis on the phases of the ageing process • the need to promote healthy ageing as an important part of the continuum of care • the nature of the continuum of care in relation to the care needs of an aged person • recognition of the difficulties that an older person and/or a carer may face as they move through the continuum of care • addition of a further principle relating to "carers" in respect to the support they provide and their role as an important member of the team that provides care • inclusion of the "Age-friendly principles and practices" as the foundation for the model of care • the values espoused in the State Aged Care Plan for Western Australia 2003-2008 should also act as a foundation for the model. These findings have subsequently been applied to the development of the Model of Care for the Older Person.
Model of Care for the Older Person in Western Australia, Aged Care Network Department of Health, 2007 Older_Person_Model_of_Care.pdf	In line with the ongoing reform agenda occurring across the WA health system, WA Health Networks identified the need to provide "a structure for outlining system change and redesign that incorporates the shared principles originally outlined in A Healthy Future for Western Australians: Report of the Health Reform Committee".2 The model of care approach developed by WA Health Networks has provided the framework to assist in completing this task. This document describes the broad policy approaches for the Model of Care for the Older Person that relates to the continuum of care service delivery for older persons across the WA Health system and beyond.
Active Ageing Strategy, Generations Together: 2004 – 2008 Report, Department for Communities, Government of Western Australia, 2008 **ActiveAgeingStrategy_Report20042008.pdf**	**The World Health Organisation (WHO) argues that if nations, societies and communities actively plan and respond now, we will be prepared to meet this challenge successfully. They articulate the active ageing process as a way of thinking and working to "optimise opportunities for health, participation and security in order to enhance quality of life as people age" (World Health Organisation 2002).**

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Models of Care Overview and Guidelines, WA Health Networks http://www.healthnetworks.health.wa.gov.au/publications/docs/070626_WA_Health_Model_of_Care-overview_and_guidelines.pdf	*Key Focus Areas:* The development and implementation of new or redesigned Models of Care retain a focus on the following four key areas. These are based on the National Chronic Disease Action Areas (National Health Priority Action Council 2006). Prevention & Promotion - A key focus of the WA Health reform agenda is the adoption of prevention programs and the promotion of healthy lifestyles and the modification of risky behaviours. All health care interactions across the continuum of care identified in models of care should include education about risky behaviours and support for instigating or maintaining behavioural changes. Early Detection & Intervention - Models of care will have a strong focus on the need for early detection and early intervention to prevent or slow progression of a condition and subsequently improve patient outcomes. Significant activity can occur within the primary care setting and this should be encouraged in new models of care. Integration & Continuity of Care - Partnerships between government agencies, non government and private organisations, primary, specialist and multi disciplinary professionals and home, community and hospital settings should be explored and fostered in the development of new models of care.Collaboration and commitment between these partnerships and a desire to place the patient at the centre of all activities ensuring continuity of care will support the delivery of more effective and efficient prevention, detection and management services. Self Management - There is an accepted recognition of the importance of enhancing an individuals ability to self manage, from prevention of risk factors or risky behaviour to the various stages of management of their care. The current health system is ill equipped to educate and support individuals to self manage. A shift in the culture of the workforce is required. Health professionals need the skills to routinely teach self-management principles and to believe that people are capable of preventing and managing their own conditions.
Western Australian Home and Community Care Program, Triennial Plan 2008–2011, Aged Care Policy Directorate, Department of Health, March 2008 HACC_Western_Australian_Triennial_Plan_2008-2011.pdf	The 2008/2011 Western Australian (WA) Home and Community Care (HACC) Triennial Plan is provided to the Australian Department of Health and Ageing, as required by the Review Agreement under Clause 5(1) that provides for three year planning cycles, supported by annual processes. The Triennial Plan provides the strategic direction, priorities and allocation of funds for the Home and Community Care Program in WA over the triennium.
Foundations for Country Health Services *The WA Country Health Service Strategic Plan*	Residential Aged Care Program, the the Australian Government's Healthy Horizons report and a recent report by the Royal Australasian College of Physicians demonstrate that people in rural and remote areas of Australia have poorer health status than their

Document	Policy and Planning Context – Key Points
2007 – 2010, Department of Health, 2007 Foundations for Country Health Services 2007-10.pdf	metropolitan counterparts. Analysis of health data indicates that many health conditions suffered by the country community are avoidable or can be managed in the community, reducing the need for hospitalisation. Examples include diabetes, chronic obstructive pulmonary disease, asthma and congestive cardiac failure. The health of the community depends on a complex range of factors including lifestyle, housing, employment, education, occupational and environmental factors such as access to good drinking water and healthy food. Responsibility for good health is shared among individuals, families, communities and the government. Lifestyle factors can promote good health or place people at increased risk of disease. Country residents are more likely than their metropolitan counterparts to smoke tobacco, drink alcohol in hazardous amounts, be overweight and be physically inactive. Young males have higher suicide rates than their metropolitan counterparts. The health system alone cannot address all of the health issues of country communities, as there are social, family and environmental factors that impact on the health of people and populations. A range of government and non-government agencies and the community must work together to address the factors that affect community health. Building the ability of the community to improve the health and well-being of its members is vitally important. Community development and capacity-building strategies include engaging and involving all sections of country communities, including people from Aboriginal and other diverse cultural backgrounds and people with disabilities, and relevant agencies in setting priorities and planning services, educating the community through health promotion, undertaking early intervention and prevention programs, upgrading transport services and improving environmental health. The WA Country Health Service has identified the following four priorities for future investment and effort: 1. Focusing on, and re-investing in, primary and community health activities that can be demonstrated to improve the health of the country population 2. Improving the health of Aboriginal people 3. Building capacity to respond to mental health issues within all services so as to provide a broader base of services to protect, maintain and improve the mental health of regional communities 4. Supporting healthy ageing in the community through services that maintain health and independence. Key actions that WACHS will take to achieve significant improvements in these areas over the next three years. *Maintaining the Health and Independence of Older People* WACHS will strive to redesign the way services are provided to the elderly. In partnership with GPs, we will place greater emphasis on services that maintain the health and independence of older people and on improving the efficiency and quality of our residential aged

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	care services. Our Aged Care Services WACHS is a significant provider of community-based aged care, residential aged care and hospitalbased respite care for older people. Currently WACHS provides care to over 440 aged care residents in 48 of its 74 hospitals and multi-purpose centres. Thirty-five of these facilities receive funding through the Multi-Purpose Service Program (MPS). WACHS also manages Australian Government funded nursing home beds in Derby, Port Hedland and Kununurra and is the provider of Carelink in the Pilbara, Kimberley and Midwest. Aged care services are principally funded by the Australian Government through MPS, the Home and Community Care Program (HACC), the Long Stay Older Patients Program and Carelink. It is estimated that over 14,000 country residents (31% of the population in the HACC target age group) receive HACC services each year. Only 6% of aged people in Australia live in residential aged care. Most elderly people prefer and expect to remain living in the community, where they are often supported by family, friends and neighbours. Support for carers is a critical component of successful aged care services. In many areas of WA, WACHS has to consider the transient older tourist population who present with demands for medication and equipment on their travels around Australia. *Future Directions* A key aim of WA Health reform is to prevent avoidable admissions to acute hospital care. While comprising 11% of the population, those 65 years and over account for 29% of hospital admissions and 43% of total bed days13. Working in partnership with other aged care providers will be a key strategy in our endeavours to strengthen rural and regional aged care services in a manner that is consistent with the vision in the State Aged Care Plan of 'Independence, well-being and quality of life for older people' through responsive health and aged care services. WACHS will establish an aged care management function in each regional network in order to better coordinate the planning and delivery of aged care services, minimise duplication of processes (as in the case of multiple assessments) and better up-skill and support staff. This will help to integrate aged care staff, including staff in HACC, Aged Care Assessment Teams (ACAT) and residential aged care providers, and create links with other providers such as Silver Chain Nursing Association, local government, church-based agencies and the private sector. In collaboration with our aged care partners, WACHS will develop coordinated programs for chronic disease management, rehabilitation, preventive services (e.g. prevention of falls) and community-based alternatives (e.g. 'hospital in the home') to reduce unnecessary hospitalisations.

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	Many small country hospitals have become the default residential care providers, with and without MPS funding support. This residential aged care model, whereby small numbers of beds are spread across a large number of small country hospitals does not necessarily make the best use of limited health funding and resources. Through regional services planning we will designate sites to be the future providers of aged care services. In addition, WACHS recognises that many of the older low-care facilities were designed for acute inpatient care, do not meet contemporary residential aged care standards and are not appropriate for the increasingly complex needs of older residents. Factors that contribute to this complexity include the residents' need to access care while maintaining their connection to family, and the providers need to attract good staff and to renew and revitalise facilities. The skill set of hospital staff can often be under-utilised in aged care or may not meet the increasingly specialised needs of the elderly. WACHS will provide support for hospital staff and GPs to access geriatric expertise and up-skilling. In seeking accreditation under the Australian Council of Healthcare Standards, We will benchmark aged care services against relevant national Residential Aged Care Standards and HACC National Service Standards. In order to keep older people well, maintain them in the community and prevent hospital admissions, investment in aged care services must be realigned to better respond to the need for community-based and restorative services. While the provision of locally based services demands a balance between accessibility and affordability, the importance of these services to the community means that we must develop solutions that will meet community needs in a more sustainable manner. <u>Objective 21: Increase the focus on services that maintain the health and independence of older people.</u> Key Reform Actions: • Develop community based services that maximise the independence of older people • Expand early discharge and community rehabilitation services for older people • Introduce the Residential Care Line to provide residential aged care services with telephone advice and support that will enable them to manage sick patients who do not require transfer to an acute service. <u>Objective 22: A coordinated, integrated and efficient network of community and residential aged care services in each region.</u> Key Reform Actions: • Appoint aged care coordinators in all regions • Strengthen aged care services and skills by utilising the expertise of visiting geriatricians and telehealth

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	• Review the current arrangements for residential aged care services to improve efficiency and quality of care • Make better use of the skills of registered nurses by increasing the number of patient care assistants employed for non-nursing duties • Meet relevant national standards for community and residential aged care service
WA Country Health Service Annual Report, 2010–11, WA Country Health Service, September 2011 WACHS_Annual_Report_2010-11.pdf	Aged Care In 2010-11 WACHS continued to implement a number of programs operating across the Area Health Service to improve access to aged care services and services for younger people with disabilities including: • Increasing Friend In Need Emergency (FINE) complex care coordination across all seven regions. The program is attached to larger emergency departments to coordinate care for „at risk" older patients who attend the emergency department. • Providing a 10 bed Inpatient Rehabilitation Unit Day Therapy service and community rehabilitation program in Bunbury commencing April 2011 and a full time geriatrician to the South West was appointed in March 2011. • Expansion of inpatient and outpatient rehabilitation programs in Albany and Geraldton. • Commencement of community physiotherapy and expansion of the Day Therapy Program in Northam. • Creation of older adult mental health positions in Goldfields, Wheatbelt and South West regions. • An allocation of $1 million for continued growth in Home and Community Care programs across country regions. • Full implementation of the National Job Creation Package Program across 16 remote communities in the Pilbara and Kimberley for the provision of community aged care services. • Review and improvement of all multipurpose service residential care documentation incorporating aged care friendly principles and best practice standards.
WA Health Clinical Services Framework 2010–2020, Department of Health, 2009 CLINICAL_SERVICES_FRAMEWORK_WEB.pdf	
Subacute Care Plan – Western Australia 2009-	The combination of a relatively low population base compared to eastern seaboard states, the vast size of WA and geographically

Document	Policy and Planning Context – Key Points
2013, National Health Partnership Agreement Schedule C, Innovation and Health System Reform Division, Aged Care Policy Directorate, Department of Health, April 2009 SUBACUTE_CARE_PLAN_2009-13.pdf	remote regional communities has led to the historical concentration of health care and hospital resources in the metropolitan area. In addition, within the WA metropolitan area, there has been a historical tendency to concentrate on services provided by tertiary hospital sites, with the main focus on acute service provision with linked clinical specialist services. The aim of the WA Subacute Care Plan is to expand the provision of subacute services in line with targets, employing approaches agreed to by the National Subacute Care Working Group in alignment with WA local needs, priorities, circumstances and opportunities. Specifically, the Plan will provide increased services in the ambulatory care setting, move services to secondary hospital sites closer to where people live and will assist hospitals to be more efficient and sustainable. It is envisaged that the anticipated outcomes from the Plan will support the implementation of the Taking Pressure Off Public Hospital Plan and in particular the State "Four Hour Rule Program" in WA. The key strategies of the WA Plan are to: • build and strengthen existing services based on evidence based outcomes; • provide new services where there are identified gaps based on evidence based outcomes; • strengthen both the allied health and clinical workforce to drive increased service delivery and improve outcomes; and • concentrate effort on robust data collections that support increase levels of activity across subacute care services. Key opportunities for WA Country Health Service (WACHS) Regional Areas: • Strengthening of the visiting consultant geriatrician service to WA Country Health Service (WACHS) regional resource centres with formal links to specific metropolitan aged care and stroke departments. • To provide a visiting consultant psycho-geriatrician service to WA Country Health Services (WACHS) regional resource centres aligned with the geriatrician visiting service. • The clinical platform of specialist clinician services will provide the "imprimatur" for a best practice comprehensive, multi-disciplinary approach to rehabilitation and geriatric evaluation and management (GEM). Downstream benefits will accrue in respect to the development of a stronger rural and regional allied health workforce. • Sub-acute secondary rehabilitation units in major regional resource centres where population projections indicate demand. • Establishment of rehabilitation in the home (RITH) in key WACHS regional resource centres. • Establishment of "Day Therapy" services in key WACHS regional resource centres.

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	• Enhanced utilisation of tele health centres in regional areas.
Liveable Neighbourhoods, A West Australian Government Sustainable Cities Initiative, West Australian Planning Commission, January 2009, Update 02 Liveable Neighborhoods a WA Govt sustainable cities initiative.pdf	Liveable Neighbourhoods is an operational policy for the design and assessment of structure plans and subdivision for new urban areas in the metropolitan area and country centres. Liveable Neighbourhoods has been adopted by the WAPC as operational policy, and is to be followed in the design and approval of urban development. Liveable Neighbourhoods applies to structure planning and subdivision for greenfield sites and for the redevelopment of large brownfield and urban infill sites.
Website, Office of Seniors http://www.communities.wa.gov.au/serviceareas/seniors/Pages/AgeFriendlyWA.aspx	The Department for Communities (DfC) is committed to building strong, vibrant communities. One of the most effective ways to create a strong community is to adopt an age-friendly approach to planning at the local government level. 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. An age-friendly community is one which: • Recognises the great diversity among older people; • Promotes their inclusion and contribution in all areas of community life; • Respects their decisions and lifestyle choices; • Anticipates and responds to ageing-related needs and preferences. An age-friendly community benefits everyone in the community, not only older people as it creates a culture of inclusion enjoyed by people of all ages and abilities. Grants to support local government planning As local government authorities are best placed to explore the issues faced by seniors as they age, the Department is providing grant funding to WA local government authorities to assist them in adopting an age-friendly approach to their strategic planning .The grants program was established following an age-friendly community pilot program with the Cities of Melville, Rockingham, and Mandurah, and the Shire of Augusta-Margaret River.

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	In May 2010 15 applicants covering 23 Local Governments were awarded grants of $8,000 each to undertake research, facilitate workshops and conduct other information-gathering exercises.
Disability Policies	
Disability Services Commission Strategic Plan 2011-2015 Disability strategic plan 101015.pdf	Our vision for the future is that: • All people live in welcoming communities that facilitate citizenship, friendship, mutual support and a fair go for everyone. In achieving this vision the rights of people with disability are recognised, their families and carers are supported, their involvement in all levels of decision-making is encouraged, and their life choices are respected. • There is increased availability and choice of personalised supports and services • The disability services sector fosters the best blend of supports and services • There are integrated responses to disability issues at national, state and local levels • Communities are welcoming of people with disability, their families and carers We will: • Create a better understanding of what it is like living with a disability, the contribution people with disability make to their communities, and the challenges they face when participating in community life • Deliver services in ways that create more opportunities for community living, participation and contribution • Support community networks, advocacy groups, individuals, families and carers to build inclusive communities • Promote well-planned and accessible communities • Pursue options for improving housing availability, access and design to meet emerging needs.
Count Me In – Disability Future Directions, A Better Future for Everyone, Disability Services Commisssion, ? count_me_in_disability_future_directions.pdf	Priority Areas: Economic security Well-planned and accessible communities: *Pathway 1* – Develop well-planned and accessible communities by: • extending planning initiatives which currently integrate town planning, housing and transport including Livable Neighbourhoods, the Model Scheme Text and Directions 2031;

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	• involving people with disabilities,families and carers in planning and development; • creating a common vision for town planners, developers and architects. *Pathway 2* – Establish, promote and enforce stronger town planning codes and zoning classifications including the Residential Design Codes: • to support the development of accessible communities and universally-designed housing; and • to enable greater scope for developers to make innovative use of land to achieve more accessible communities. *Pathway 3* – Create greater access to buildings and facilities by promoting widespread understanding of and compliance with the Access to Premises Standards. *Pathway 4* – Harness the growing numbers of senior Western Australians, who have a personal investment in ageing services, to advocate for wellplanned and accessible communities. Universally designed housing Welcoming communities Life-long learning in inclusive settings Secure employment in meaningful work Access to health and mainstream services: *Pathway 1* – Ensure that mainstream services increasingly respond to the needs of people with disabilities, families and carers through strengthening Disability Access and Inclusion Plans, and by working with the Human Rights Commission and the West Australian Equal Opportunity Commission *Pathway 2* – Improve the access of people with disabilities to quality health, allied health, dental and related care by: • providing improved information, education, training and ongoing support to health care professionals; • arranging ways to share and transfer information about people with disabilities across departments and jurisdictions; • providing practical and advocacy support for people with disabilities, families and carers who want assistance to access mainstream health and related services; • improving service portability between States and Territories; and • ensuring culturally responsive services are available to people from Aboriginal and culturally diverse backgrounds.

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	Pathway 3 – Collaborate with government agencies to develop effective service responses to acquired disabilities including: • Foetal Alcohol Syndrome, in particular for Aboriginal children; • Acquired Brain Injury through motor vehicle accidents and drug and alcohol use; and • other conditions that are likely to develop in people with disabilities as they live longer, such as Alzheimer's disease. *Pathway 4* – Coordinate effective and timely service responses between disability services and mainstream agencies for people with disabilities who also have: • challenging personal or aggressive social behaviours; • mental health disabilities; • involvement with the justice system; and • ongoing and intensive medical needs. Enabling information and technologies Innovative and responsive supports Life-long security for people with complex and high needs for support Strong, supportive partnerships with families and carers Collaborative responses to people with disabilities who are ageing: Pathway 1 – Develop effective interfaces between disability services, community aged care services, and residential aged care services for older people with disabilities who live independently, with family or carers, or in supported accommodation. Pathway 2 – Develop aged care facilities that cater effectively for people with all types of disabilities and that provide home-like environments and good opportunities for community access. Pathway 3 – Ensure that services for older people with disabilities are culturally responsive to people from Aboriginal and culturally diverse backgrounds, for example, by acknowledging and assisting those Aboriginal people who wish to return to, or visit, country as they age, and by providing additional support to families of people with disabilities from culturally diverse backgrounds who wish to continue caring. Pathway 4 – Promote active, healthy ageing and ageing-in-place by: • ensuring that preventive health funding, health programs and life-style planning for ageing Australians are also accessed by older people with disabilities;

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	• ensuring that older people with disabilities receive services that enable them to remain at home where this is a preferred option,for example in-home support, aids and equipment, and 'change of support' assessments (home may be a range of settings including independent living, living with family or carers or living in supported accommodation); • educating disability workers in ways to foster active, healthy ageing; • anticipating and responding to the needs of people with disabilities who are living longer lives and that are likely to acquire other conditions as they age, for example Alzheimer's disease; and • emphasising opportunities for community contribution and participation for people with disabilities during senior years. Pathway 5 – Ensure that people with disabilities, families and carers receive specialised help to coordinate, plan and address the many separation issues that arise when older people with disabilities leave their family home. Responsive approaches for people living in rural and remote areas: Pathway 1 – Develop flexible, innovative solutions to unique rural and remote issues using a range of strategies, for example: • investigate and promote the adoption of effective disability related approaches in rural and remote areas, such as the therapy assistant program developed in the Wheatbelt; • develop partnerships between private, corporate and government bodies to improve housing, health, family support, disability and other services; and • facilitate local 'think-tanks' and other forums for people in rural and remote areas to create local and regional solutions. Pathway 2 – Ensure disability services are culturally responsive to the diverse needs of Aboriginal people, for example, by providing cultural awareness training to staff, by employing Aboriginal staff and by encouraging Aboriginal-controlled agencies to provide services or partner disability organisations. Pathway 3 – Develop strategies that recognise and address the additional cost of goods, supports and services in rural and remote areas, for example: • by increasing access to transport by people with disabilities, families and carers, for example by petrol subsidies, financial assistance to purchase appropriate vehicles, increased community transport schemes and expansion of accessible and subsidised taxi schemes; and • by acknowledging and funding more disability-related travel to Perth or other service areas for people with disabilities, families, carers, and service providers. Pathway 4 – Extend the reach of metropolitan-based information, supports and services to country areas by:

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	• developing additional out-reach capacity within Commission, funded and unfunded services; and • utilising communication and webbased technology to complement direct service provision, for example by developing an interactive web facility on disability use of technology, by using videos to demonstrate therapy and by video-conferencing to share information and training. Pathway 5 – Promote exchange of expertise between metropolitan, rural and remote areas through: • encouraging partnerships between rural and remote agencies and metropolitan-based agencies; • resourcing metropolitan-based service providers to deliver supports and services in rural and remote areas; • facilitating collaboration between metropolitan and country organisations in relation to providing information and training for direct care workers, people with disabilities, families and carers; and • encouraging sharing of information and expertise between different rural and remote areas. Pathway 6 – Increase the attraction and retention of qualified workers in rural and remote areas by: • ensuring that tertiary training of therapists and human service workers includes rural and remote work experience including service delivery to Aboriginal communities; • developing strategies to retain experienced human service and disability staff; and • promoting jobs and career pathways in disability services, including for Aboriginal people
Disability Access and Inclusion Plan, Mental Health Commission, 1 July 2011 – 30 June 2016, 2011 Disabilities+Access+and+Inclusion+Plan+(external).pdf	Western Australia's first Mental Health Commission came into effect on 8 March 2010. There are more than 405,500 people living in Western Australia who have a disability, which equates to one in every five Western Australians. It is anticipated that in 2026, there will be 646,000 Western Australians with disability. Almost three-quarters of this increase is attributable to the increase in the prevalence of disability in people aged 65 years and older. Most Western Australians with disabilities (95 percent) live in the community either independently or with family or friends. A disability may have minimal or significant impact on a person's capacity for communication, social interaction, learning or mobility. Nearly 30 percent of Western Australians with disability need personal assistance with self care, mobility or communication. Families and friends, otherwise known as carers, provide a large majority of the assistance to people with disability and provide this in a freely given way. Over 208,000 Western Australians are carers for people with disability, and more than one-third of carers have a disability themselves. In addition: The Mental Health Commission through its Disability Access and Inclusion Plan aims to identify and implement strategies that result in people with disability having the same opportunities as everyone else to access the Commission's services, facilities, and information,

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	and to be fully inclusive of people with disability. Key reform directions for the MHC are: • Person centred supports and services – the unique strengths and needs of the person experiencing mental health problems are the key focus of individualised planning, supports and services. • Connected approaches – strong connections between public and private mental health services, primary health services, mainstream services, businesses, communities, individuals, families and carers help achieve the best outcome for Western Australians living with mental illness. • Balanced investment – a comprehensive and contemporary mental health system provides a full range of support and services, ranging from mental health promotion and prevention activities, through to early intervention, treatment and recovery. The six desired DAIP strategy outcomes are: 1. People with disabilities have the same opportunities as other people to access the services of, and any events organised by, the Mental Health Commission. 2. People with disabilities have the same opportunities as other people to access the buildings and other facilities of the Mental Health Commission. 3. People with disabilities receive information from the Mental Health Commission in a format that will enable them to access the information as readily as other people are able to access it. 4. People with disabilities receive the same level and quality of service from the staff of the Mental Health Commission. 5. People with disabilities have the same opportunity as other people to make complaints to the Mental Health Commission. 6. People with disabilities have the same access as other people to participate in any public consultation by the MHC.
Mental Health 2020: Making it personal and everybody's business, Reforming Western Australia's mental health system, Mental Health Commission, 20?? Mental+Health+Commission+strategic+plan+2020.pdf	Respect and participation -People with mental health problems and/or mental illness, their families and carers are treated with dignity and respect, and their participation across all aspects of life is acknowledged and encouraged as fundamental to building good mental health and to enriching community life. Engagement - People with mental health problems and/or mental illness, their families and carers are engaged as genuine partners in advising and leading mental health developments at individual, community and service system levels across Western Australia. Diversity - The unique needs and circumstances of people from diverse backgrounds are acknowledged,

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	including people from Aboriginal or from culturally and linguistically diverse (CaLD) backgrounds, people with disability and people of diverse sexual and gender orientation, and responsive approaches developed to meet their needs. Quality of life - By developing personal resilience and optimism, maintaining meaningful relationships, having access to housing and employment, opportunities to contribute and engage within the community and access to high quality mental health services when needed, individuals can build a good and satisfying life despite experiencing mental health problems and/or mental illness. Quality and best practice - Mental health programs and services are statewide, based on contemporary best practice, easily accessed and delivered in a timely and collaborative way. Three key Reform Directions underpin the future of supports and services for people living in Western Australia who are affected by mental health problems and/or mental illness. Person centred supports and services - The unique strengths and needs of the person experiencing mental health problems and/or mental illness are the key focus of individualised planning, supports and services. Connected approaches -Strong connections between public and private mental health services, primary health services, mainstream services, businesses, communities, individuals, families and carers help achieve the best outcomes for Western Australians living with mental health problems and/or mental illness. Balanced investment - A comprehensive and contemporary mental health system provides a full range of support and services, ranging from mental health promotion and prevention activities, through to early intervention, treatment and recovery. The World Health Organisation has developed a framework to provide guidance to countries on how to organise services for mental health. The framework, known as the optimal mix of services pyramid, aligns closely with the balanced investment reform being undertaken by Mental Health 2020. The pyramid shows that the majority of mental health care can be self managed by an individual, their families, carers and friends, or managed by informal community supports. The World Health Organisation recommends a balanced approach whereby investment in mental health hospitals is capped and complemented by investment in all other levels of the pyramid. This includes an emphasis on prevention and early intervention initiatives, in addition to treatment and recovery services. The integration of mental health services into local primary health services is a good investment to increase

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	access, treat health and mental health issues holistically and reduce stigma. Likewise, the investment into the important roles of teachers, police and community sector organisations to prevent people with mental health problems entering the specialist system and to support people who are discharged from hospital, clinics or leaving prison represents a focus on investment in prevention initiatives. Self care is encouraged as the most substantial form of support. People are encouraged and supported to manage their own mental health problems with help from family or friends. This involves learning to monitor their own mental health, maintain a preventive lifestyle, manage emotional problems as they arise and know when and where to seek help. Different forms of collaboration are needed to support people in different circumstances and with different needs. People living in rural and remote areas use tele and video conferencing to enhance collaboration between metropolitan based and country based services and practitioners. People from Aboriginal and CaLD backgrounds require mainstream services, mental health services and Aboriginal or multicultural services and organisations to work together. People who have a disability require a coordinated approach between mental health services and disability specialist services. People who experience coexisting problems arising from alcohol and drug use, having a disability or living with chronic or physical health issues have a particular need for the development of appropriate policies, programs and protocols developed across responsible agencies. People who experience mental health problems and/or a mental illness, frequently have poorer physical health outcomes than the general population. It is recognised that improving physical health enhances recovery from mental illness and that access to smoking cessation, nutrition and physical activity programs need to be integrated into the services and supports available as part of recovery. In addition, mental health service providers require a more holistic approach in identifying and addressing coexisting physical health risks and problems and in working collaboratively with primary care providers to improve physical health outcomes. Mental health issues have a unique impact upon certain groups of people within the Western Australian population and require specialised responses. Although it is acknowledged that there are many groups with specific needs, Mental Health 2020 focuses on the following specific populations: • Aboriginal people; • People from culturally and linguistically diverse backgrounds (CaLD); • People living in rural and remote regions;

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	• Fly-in/Fly-out workers and their families; • Infants and children; • Youth; • Older adults; and • People who experience a range of co-occurring problems. Rural Health Issues - Recent consultation,for example, highlighted the reduced opportunities for mental health interventions due to limited availability of primary health care services, private psychologists and psychiatrists. Technology is increasing access to mental health services, particularly in rural and remote communities. The new and expanding area of telepsychiatry offers video-conferencing between people in rural sites and metropolitan based psychiatrists. A confidential telephone service, Rurallink, offers a single point of contact for people in rural and remote areas to obtain information and advice from experienced community mental health staff. Fly-in Fly-out workers - The mining industry in Western Australia requires a large number of people to fly from their hometown to mine sites or other remote locations on a cyclical basis. While these jobs pay well, they require long shifts and separation from family and friends, often for weeks at a time. This lifestyle impacts not only on workers but also on families who are left without one parent on a regular basis. Both workers and their spouses are considered at risk of developing mental health problems. Fly-in Fly-out workers are also considered to be at risk of misusing drugs and alcohol.
Our children our future - A framework for Child and Youth Health Services in Western Australia 2008–2012, 2008 WA_Child_&_Youth_Framework_2008-2012.pdf	The Framework identifies five key objectives for improving the health and wellbeing of Western Australia's children and young people: Improve the health and wellbeing of all children and youth through perinatal and early childhood intervention and prevention strategies which address the determinants of health Improve child and youth health and wellbeing through the early diagnosis, acute care and ongoing treatment of current key health issues Improve child and youth health and wellbeing by encouraging self-management and addressing key health-related and risk-taking behaviours Improve the health and wellbeing of specific population groups through improved access and cultural sensitivity

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	Improve child and youth health and wellbeing by improving child and youth health service provision.
Indigenous/ Aboriginal Policies	
Western Australian Aboriginal Health Strategy - A Strategic Approach to Improving the Health of Aboriginal People in Western Australia, Text as endorsed by Joint Planning Forum on 3 February 2000 West Australian Aboriginal Health strategy.pdf	Aboriginal people have the right to good health. Aboriginal people must have the freedom, capacity and opportunity to enjoy their cultural, spiritual and physical potential. 'Health' to Aboriginal peoples is a matter of determining all aspects of life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity. The Aboriginal view of wellbeing is socially determined, not just biologically or pathologically determined, and is closely linked to the land and all its inhabitants. This view links the individual with their family, kinship networks, country and culture as an indivisible whole. It is a whole of life view including the cyclical concept of life-death-life. Clearly Aboriginal expectations are that health providers and planners will frame their efforts to improve Aboriginal health within this context. Thinking about, describing and responding to ill health in this manner will indicate a way forward to a healthier future that ensures optimal Aboriginal ownership and participation. Aboriginal people have long sought a level of health and wellbeing that allows them to freely and fully participate in their family's, community's and culture's way of life. Despite gains in recent years, substantial gaps between current health status and this goal remain. Closing these gaps and delivering gain in a manner mindful of Aboriginal peoples' vision of health in Western Australia will require political commitment, sustained action and Aboriginal participation that is focussed, timely and co-ordinated. The vision will be achieved when - Aboriginal Western Australians: • Are free of preventable and premature death, disease and disability; • Have access to adequate health resources; • Have cultural needs respected within all health services; • Have the capacity to action decisions about their individual, family and community lives; and • Play an appropriate role in the health system's decision making on matters that might affect their health and wellbeing, their culture or their capacity to be self-determining. And when non-Aboriginal Western Australians:

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	• Acknowledge the effects of Australia's history on the health and well-being of Aboriginal people; • Reconcile Australia's history with the impact on Aboriginal people and work in partnership to overcome this history and improve Aboriginal health; and • Acknowledge and respect Aboriginal people's living culture and find ways of growing with it. The WAAHS aims to secure the greatest possible improvement in the health and well being of Aboriginal Western Australians by progressively and systematically building a health system that: • Recognises its responsibility to develop and organise the delivery of health services in a manner that allows all Aboriginal people to have the opportunity to attain their full health potential; • Reflects the differing cultural and health needs of Aboriginal people and engages them in making informed choices about health gain; • Encourages and supports Aboriginal individuals, families and communities to take responsibility for their health; • Provides adequate and appropriate finances and resources; and • Secures the greatest gain for Aboriginal health from the available human and financial resources.
A Best Practice Model for Health Promotion Programs in Aboriginal Communities, Department of Health and Office of Aboriginal Health 1887 BestPracticeModel19402.pdf	
Western Australian Aboriginal Primary Care Resource Kit - Health Reform Implementation Taskforce, Department of Health, May 2007 10307ABORIGINAL_HEALTH_web_version.pdf	Currently, a complex network of responsibilities for Aboriginal health exists making integration of health projects difficult. Fragmentation of the health system has also contributed to inequity, duplication and inefficiency. The diverse range of health service providers and the shared funding arrangement between Commonwealth and State, together present substantial challenges for the delivery of an efficient and coordinated system in WA. WA Health is committed to developing partnerships to create a more workable system that provides integrated primary health care and directly addresses priority health issues. The WA primary care sector should be focused on health outcomes and their direct improvement to quality of life. WA Health's role is to

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	ensure that at a minimum, core primary care services are being delivered and to identify service capacity to deliver services locally and to prioritise and direct funding to gaps in service delivery. Finding new ways to provide these local primary care services is a direction WA Health will support and promote, along with the concept of Life Coaches who will assist with healthy pathway planning through the use of local community services directories that provide medical as well as non-medical services such as physical fitness activities, local support groups and healthy lifestyle schemes. Healthier planning requires clinical staff to plot patient pathways integrating local services both medical and non-medical, linking into support groups and other community-based services that assist patients to reach the target goals of their pathway plan.
Access to health services for Aboriginal and Torres Strait Islander people, Australian Institute of Health and Welfare Canberra, May 2011 Access to Health Services for ATSI - AIHW.pdf	Aboriginal and Torres Strait Islander people (Indigenous Australians) typically die at much younger ages than other Australians and are more likely to experience disability and reduced quality of life because of ill health. One important contributor to health and wellbeing is access to health services. This paper examines Indigenous Australians' use of a range of health services, including those that provide preventive, primary and community health, hospital or specialised care. Preventive health services • In December 2009, Indigenous children were less likely than their non-Indigenous counterparts to be fully immunised at 1, 2 and 5 years of age. • The number of Indigenous-specific health checks delivered to Indigenous children aged less than 15 years, and reimbursed by Medicare, more than doubled between September 2006 and September 2009. • Indigenous women aged 50–69 years were less likely than all women in this target age group to have received a breast cancer screen from BreastScreen Australia programs in 2007 and 2008. Primary and community health services • In 2009–10, general practice-type service use, reimbursed by Medicare, was similar for Indigenous Australians and non-Indigenous Australians. • The rate of potentially preventable hospitalisations for Indigenous people was 4.9 times the rate for other Australians in 2008–09. Hospital services • Compared with other Australians, Aboriginal and Torres Strait Islander people were more than two times as likely to be hospitalised than other Australians although less likely to undergo a procedure while in hospital.

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	• Indigenous Australians had longer waiting times than other Australians for a range of public elective surgeries, including cataract extraction, septoplasty and total hip replacement. Specialised services • In 2009–10, Indigenous Australians had slightly lower usage rates of Medicare-reimbursed specialist services than non-Indigenous Australians. • In 2008–09, around 17,000 treatment episodes for alcohol and/or other drugs were provided to clients of Aboriginal and/or Torres Strait Islander origin, accounting for 12% of all treatment episodes. • Between 2003–04 and 2008–09, the number of hearing services provided to Indigenous clients under the Community Service Obligations program more than tripled.
A Comparative Overview of Aboriginal Health in Western Australia, Department of Health, Western Australia, December 2001. comparative_overview_of_aboriginal_health_in_western_australia.pdf	The five conditions reported on in this study account for 75% of all Aboriginal deaths in Western Australia. Analysis of other conditions is difficult due to the very low numbers of deaths, even when 10 years of data are aggregated. The largest cause of Aboriginal mortality and third-highest reason for hospitalisation was due to circulatory disease. Statewide, Aboriginals dying of cardiovascular disease died approximately six years younger than non-Aboriginals dying of cardiovascular disease. The highest rates of hospitalisation occurred in the Midwest and Great Southern Health Regions. Injury and poisoning was the second most common cause of death and the second most common reason for hospitalisation. Three-quarters of deaths occurred in males. Although rates of mortality and hospitalisation were more that three times higher than for non-Aboriginals, the potential years of life lost per death were similar. Areas of the State with the highest injury and poisoning rates for mortality and hospitalisation for Aboriginal people were the Kimberley, Pilbara, Midwest and Goldfields. Respiratory disease is a major cause of Aboriginal death and the most common cause of hospitalisation for Aboriginal people. The gap in potential years of life lost between Aboriginal and non-Aboriginal people is largest (13.4 years) for this condition, suggesting this is the area most affected, hospitalisation for respiratory disease is generally higher in all northern and eastern regions of the State. Although a significant cause of death for Aboriginal people, cancer is one condition that showed the least variation with non-Aboriginal people. There has been no change in cancer mortality rates during the past 10 years and little to no variation between metropolitan and country areas. Higher rates of hospitalisation due

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	to cancer were seen in the Pilbara and Great Southern Regions. Although diabetes only affects a small number of Aboriginal people, diabetes–related mortality and morbidity rates are more than ten times those of the non-Aboriginal population. In recent years, some reduction in mortality rates has occurred but this was not statistically significant. Rates of hospitalisation have increased, perhaps reflecting better awareness and access to treatment. Aboriginal people in country areas appear to be at highest risk although elevated rates of hospitalisation occur in the Midwest, Pilbara, Goldfields and Great Southern Regions.
Department for Communities Strategic Plan 2011-2015, Government of Western Australia, July 2011. Dept of Communities Strategic Plan Web.pdf	• Identify and address the unique issues faced by women • Enrich the lives of children and families • Recognise and support the valued contribution of carers • Strengthen parenting across all communities • Support volunteering in the community • Encourage and support young people to engage in community life • Encourage and support older people to live full and active lives • Support the development of age-friendly communities, programs and services to better respond to the needs of people as they age • Provide information and support to assist seniors to plan for their later years, participate fully in the community, and maintain their independence and healthy lifestyles.
Maintaining an Effective Procedural Workforce in Rural Western Australia, Healthfix Consulting: Kim Snowball, June 2007 Maintaining-a-Procedural-Workforce-in-WA-Jun 2007.pdf	This project was commissioned by the Western Australian General Practice Education and Training Ltd (WAGPET). It arose out of concerns expressed by rural doctors in Western Australia (Engaging Rural Doctors Final Report 2007) over the fragility o f the procedural workforce and the lack of succession planning and training to ensure a future ongoing supply of Australian trained procedural doctors into the system. The current reliance on overseas trained doctors was not seen as sustainable and, while there will always be a need to seek overseas recruits, it was not seen as a preferred source of doctors. Current trends indicate that, unless measures to address the supply of Australian trained procedural doctors are implemented, the decline in the availability of procedural doctors in rural WA will accelerate with the ageing of the workforce and require increased recruitment from overseas into the future.

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	The projected replacement rate of rural procedural doctors stands at more than 30 per annum. This number is required simply to replace those expected to leave the workforce each year. The rate of replacement of rural procedural GPs by doctors sourced from overseas is already very high at more than 70% in 2005 and 60% in 2006 and exceeds the percentage of OTDs in the overall rural GP workforce (46%) and is higher than annual arrivals into the overall workforce (44%). The future for the procedural specialist workforce is even more problematic. Of the 79 rural procedural specialists 43 (54%) are practising in Bunbury. There are only two specialist Anaesthetists and three specialist Obstetrician and Gynaecologists (one of whom is part-time) practicing in rural areas outside Perth and Bunbury. Most of the procedural specialists work as solo practitioners and receive little or no support from metropolitan hospitals. They receive little or no support sourcing locums and have no clear back up or succession plan for their replacement. The exception to this is the Obstetricians who receive locum support through the Royal College of Obstetricians and Gynaecologists (RANZOG). Large numbers of procedural specialists are nearing retirement or have indicated their intention to cease or leave over the next five years. This will create a major problem for maintaining effective procedural cover in their communities. Many also work in shared-care arrangements with General Practitioners and their absence will restrict the capacity of GPs to provide loc al services. While GPs have a number of programs to support them, including the General Practice Networks and dedicated workforce agencies, specialists do not have any similar support programs. There is no workforce planning that considers specialists as a group and this has led to a "pot luck" approach to maintaining an adequate rural workforce.
Adult Population Profile, Health and Wellbeing Surveillance System, Department of Health, WA, 2010 All Health Regions HWSS Adult Profile 2010.pdf	The information contained in this report was taken from the WA Health and Wellbeing Surveillance System (HWSS) from 1st January 2010 to 31st December 2010 for persons aged 16 years and over. The HWSS is an ongoing data collection interviewing over 6000 people each year by a Computer Assisted Telephone Interview (CATI). Information presented is based on self-report from the respondents. The HWSS was developed to monitor the health and wellbeing of Western Australians. People are asked a range of questions on a range of indicators related to health and wellbeing, including chronic health conditions, lifestyle risk factors, protective factors and socio-demographics. The data can be considered representative of the population but will not be representative of small or specific groups such as Aboriginal people or people from non English speaking backgrounds. All conditions are self-reported.
Wheatbelt Policy and Planning	

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Documents and Central Coast Wheatbelt GP Network Rural Palliative Care Project	
Wheatbelt Health Planning Initiative, Report Of Consultations, MMT Consulting Services, For the Wheatbelt Health MOU Group, Western Australia, August 2009 Wheatbelt Health Planning Initiative.pdf	This Report is the outcome of stage one of the Wheatbelt Health Planning Initiative Project, which is being led by an inter-agency group comprising, the Wheatbelt Development Commission, WA Country Health Services, Local Government and the Wheatbelt General Practice Network. The Report is a summary of consultations conducted by MMT Consultancy Services that were held with community members and other stakeholders across the Wheatbelt Region during June and early July 2009. The aim of the consultations was to gather information on the future health needs of the community and to provide the community with an opportunity to identify solutions that would contribute to the development of a sustainable health system for the Wheatbelt in the future. In summary, the community identified health needs across the whole population and the entire spectrum of health. That is, from health promotion and prevention through to acute care and high level residential aged care, including secure dementia care. A recurring theme for the communities across the Wheatbelt was the need to maintain current services. In addition, the communities identified the need for an increase in the range and level of services across the Region to better meet the increasing needs of their communities (particularly older people) and the growing population. Access to emergency response services and medical care were very important to the community as well as access to nursing care. The community also identified child, youth women's and men's health, Aboriginal health, mental health and allied health as key areas of need. Furthermore, access to transport was identified in every area as a major issue. A considerable number and variety of solutions were identified by the community and other stakeholders. These included solutions relating to: • Improving health planning, coordination and the sharing of resources; • Addressing service boundaries to improve access to services; • Ensuring access to sustainable emergency care and transport; • Ensuring access to a well-coordinated and affordable transport system;

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	• Attracting and retaining health workers and GPs; • Ensuring access to a wide range of services for older people; • Making better use of existing facilities; • Increasing funding; • Increasing support for volunteers and developing new roles for volunteers; • Increasing access to health promotion and prevention; and • Increasing the use of technology, particularly to reduce the need to travel to access health care.
Wheatbelt Strategic Framework Wheatbelt Region Strategic Framework.pdf	Abridged version July 2011 – 3 pages
Wheatbelt Health Care Profile, Final January 7, 2011 wheatbelt_health_care_profile_final1.pdf	The following areas will need to be considered in the planning of primary health services within the Wheatbelt region. Population The population of the region is spread over the whole area which has contributed to there being no designated regional resource centre. Determinants of health • The region has areas with low SEIFA scores. Wheatbelt adults had a significantly higher prevalence of insufficient physical activity, high blood pressure and obesity compared with the State. • Lifestyle behaviours will need to be monitored, particularly those relating to smoking, alcohol use, diet, exercise and body mass index. Mortality • Diseases of the circulatory system and neoplasms accounted for three in every five deaths in the region. • Around two-thirds of deaths of Wheatbelt residents under the age of 75 could potentially be avoided. Of these more than half could be avoided through the use of primary intervention. Emergency Departments • The ED attendance rate has increased among Wheatbelt residents. · Three-quarters of attendances to hospitals within the region are for semi-urgent or non-urgent cases.

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	Hospitalisations • The hospitalisation rate of Wheatbelt residents is significantly lower than that of the State. • The hospitalisation rate for alcohol-related conditions was significantly higher than that of the State. • A greater proportion of hospitalisations of Wheatbelt residents were potentially preventable compared with the State, particularly for Aboriginal residents. Chronic conditions accounted for three in five of these hospitalisations. Aged Care • A significantly lower proportion of older Wheatbelt residents reported receiving their annual flu vaccinations compared with the State. Maternal Health • In 2008 one in eight Aboriginal Wheatbelt women who gave birth were aged less than 20 years. • More than half of Aboriginal Wheatbelt women smoked during pregnancy. Child and Adolescent • Less than 90% of Wheatbelt children were fully vaccinated at 60 months.
Wheatbelt Palliative Care Directory, Wheatbelt GP Network, Rural Palliative Care Project Palliative Care Directory final for printing.pdf	Help for people with life-threatening disease to live more comfortably. Service listing of health and support services in the Wheatbelt.
Wheatbelt Land Use Planning Strategy, Draft for Public Comment, West Australian Planning Commission, April 2011 Wheatbelt_land_use_planning_strategy_web.pdf	Regional planning principles In the context of land use planning, the Western Australian Planning Commission (WAPC) will: • Environment: Identify and protect the Wheatbelt's natural assets and deliver enhanced environmental outcomes, recognising the region's fragmented landscape and international biodiversity values. • Community: Enable land supply that supports the lifestyle values of the region by recognising the cultural significance of the land and the unique character and identity of Wheatbelt communities. • Economic: Provide for a strong, diverse economy by protecting and enhancing primary production and create opportunities for new business and innovation. • Infrastructure: Promote prioritisation of investment in physical and social infrastructure throughout the

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	region, responding to community needs and the dispersed population. • Regional development: Support robust and resilient communities that are open to opportunities and prepared for challenges. • Governance: Support a policy and planning framework that anticipates and responds to the Wheatbelt's attributes and assets, and provides for innovation and participation to: support the development of healthy, vibrant communities able to respond to social and economic opportunities and change; support diversity and difference across the region and provide for a variety of community experiences and lifestyles; promote a settlement hierarchy based on economic opportunities and existing and planned services (including suitable water supplies), that are capable of sustaining future growth; achieve a sustainable and consolidated settlement pattern in the Wheatbelt; support urban development in places in the identified settlement hierarchy; ensure an adequate balance is achieved between the supply of urban, industrial and commercial land; embrace heritage and culture in planning for the people of the Wheatbelt.

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RDA Wheatbelt Inc. Strategic Regional Plan 2010 – 2015, (2011 Revision - Draft), Regional Development Australia, 2011 Revision RDA_Wheatbelt_Strategic_Regional_Plan_2011_Revision_Draft(1).pdf	There are approximately 490 high and low care beds available throughout the Wheatbelt region (refer to table 6). ABS statistics indicated that there were 2,357 people aged 80 years and over living in the Wheatbelt in 2008. Assuming that this is the age group most likely to access aged care facilities, at present the number of beds available will only service approximately 21% of the aged population of our region. Social • Differential growth across the region, with the population growing steadily in some areas whilst others have more stable or declining populations. • Centralised decision making and fragmentation of service delivery across the region resulting in duplication and inequitable access • Ageing of the population and the required infrastructure and services to meet the needs of this demographic • Out-migration of young people • Strategic investment in sport and recreation in the region is required • Providing infrastructure and services to a relatively small and geographically dispersed population • Limited diversity of housing stock • Providing greater variety and flexibility in public transportation syste Liveable Communities Innovative, safe, healthy and resilient communities where services and infrastructure reflect the needs and aspirations of residents and compliment unique Wheatbelt characteristics Objectives 1) A collaborative strategy ensures health, education, aged and youth/children's services reflect the needs of current and future Wheatbelt residents 2) Communities innovate, co-operate and value diversity 3) Diverse cultural, sport and recreational activities contribute to community well being 4) Community amenity is well designed to enhance employment, lifestyle opportunities and community safety.
Towards a Wheatbelt Infrastructure Plan, Report by Morrison Low Consultants, October 2010 Towards a Wheatbelt Infrastructure Plan.pdf	The report purpose is to identify infrastructure priorities for the 2010/11 Country Local Government fund (CLGF) Regional component and to begin development of a Wheatbelt Plan.

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Age –Friendly Communities Study, Final Report, The Shire of Moora, June 2011 Moora Age Friedly report.pdf	The Shire of Moora has partnered with the Department of Communities to integrate the World Health Organisation's Age Friendly Cities Guide. The Guide identifies that there are 8 key aspects of the makeup of an Age Friendly Community: Outdoor Spaces and Buildings Transportation Housing Respect and inclusion Social participation Communication and information Civic participation and employment Community support and health services The main findings from the consultation phase indicate there are issues concerning: Parking and Pedestrian Crossing at IGA - 100% of participants indicated that they feel this is a major issue that needs addressing urgently Housing and Accommodation – lack thereof Travel to Specialists – many do not drive and find it difficult to attend Perth appointments Crime and Safety Travel to Shops – very popular suggestion to have a community bus run once a week to help elderly people do their shopping, etc. Public Transport - No public transport is available within the town i.e. no Taxis or buses. A community bus is owned by the Shire which is available for community groups to hire although, apart from one participant, most considered this was too expensive for most community groups to utilize. It was suggested within the Service Providers Group that the Community Bus could be utilized on a set day to cover a set route to collect older people and take them to the major shops and home again at either low or no cost. This was also raised within the Older People and Carers' Group as a vital service which needs to be made available, especially to the elderly who are not currently receiving HACC services Another popular suggestion was that funding should be sort to purchase a vehicle, to be driven by

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	volunteers, to provide transport for the elderly to attend specialist appointments etc in Perth. Some participants indicted that finding the volunteer drivers would present a bigger problem than funding the vehicle however others indicated that several community groups such as Lions and Rotary would be happy to help out in that way if they were asked and maybe there were others around also who do not realise that this is required. It was suggested that an advertising campaign may be helpful to raise awareness within the community of the need for these types of volunteers. Aged Housing - Currently there are at least 35 people on the waiting list for Aged housing (as quoted by R.Stephens, Secretary of Moora Homes for the Aged Committee) which is considered a clear indication that there are not enough independent living units to meet the demand. Each participant was able to prioritise 3 issues they considered to be most important and of the 27 attendees in the Older People and Carers Group, 22 indicated that this was one of those areas urgently needing attention.Service providers indicated that wheelchair access is limited in some houses, included some purpose-built housing (particularly bathrooms). They also indicated that many older homes within the community don't meet the current needs of the elderly. Health and Community Services - It was agreed by all participants in both groups that our community has excellent medical services available. It was noted that there does seem to be a difficulty in retaining some health professionals in the town. In particular Physiotherapists, who are in high demand, seem to have a high turnover and often, there is not one available at all. There is also concern that the mental health services within the community are very limited. More respite care is needed along with the need for more housing as discussed in earlier topics. Many indicated that they felt people were unaware of the types of health services available within our community and that perhaps a list could be added to the Shire "Welcome Packs". The Older People and Carers Group indicated that although they felt HACC was affordable, there needs to be more HACC workers available to service the needs of the elderly. Both groups indicated that the Gym facilities that are available are very good but that a heated pool would be very beneficial for the elderly, especially for those recovering from operations. It was pointed out by many of the participants within the Older People and Carers Group that our community has excellent Occupational Therapist Services available. There is great concern amongst the elderly females that the Breastscreen van no longer notifies them of their upcoming visits once they turn 70. Once the van arrives in town and they try and make appointments it is already full. One participant who attended the Older People

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	and Carers Focus group advised that Red Cross Carers attend Moora once a month to support people within our community who are carers and this is thought to be a very valuable exercise. There are many volunteer organisations such as church groups, CWA, Lions, Meals on Wheels, sporting clubs etc who provide social and some volunteer support services to older people. Interestingly most of these organisations are run by older people themselves. They participated in the focus groups as individual older people and raised issues relating to volunteering at these forums. The information gathered as part of the Age Friendly Communities Study has been utilised to generate 4 strategies: Strategy 1: Aged Friendly Access Audit Strategy 2: Aged Friendly Accommodation Needs Assessment Strategy 3: Aged Friendly Services Audit Strategy 4: Community Health Services Audit
Wheatbelt Region – The Population & Health Status, Department of Health, 2009 WHEATBELT_REGION_Needs_Analysis_V2_2010.pdf	
Towards a Wheatbelt regional strategy - directions paper for public comment, August 2009 Wheatbelt_web.pdf	
Other	
Ten principles for geriatric health promotion, Meredith Minkler, Barry Checkoway 10 Principles of Geriatric Healt6h Promotion - Minkler 1988.pdf	By stressing empowerment, the strengths and not merely the needs of aged people, community participation and the role of public policy, geriatric health promotion is seen as embracing the World Health Organization approach to health promotion as a broad, enabling process. Similarly, in its attention to functional health status, the needs of informal caregivers and the social as well as the health needs of elderly people, it complements and draws upon recent trends in the fields of geriatrics and gerontological health. 10 principles are as follows:

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	GHPs should stress the special strengths, not only the special needs, of the elderly; GHPs should meet the social as well as the health needs of elderly people and their families; the needs of people who give informal care should receive high priority; health promotion for the elderly should stress functional health status; the empowerment of old people should be a goal of health promotion for the elderly; GHPs should begin by addressing the needs that elderly people feel are the most important; older women should be a focus for special concern; the community is a key unit of practice for geriatric health promotion; public participation would have multiple benefits for health and the aged; public policy can contribute to geriatric health promotion at the local level.
South West Active Ageing Research Project, South West Development Commission, 2010 http://www.swdc.wa.gov.au/media/68943/active%20ageing_web_2.pdf active ageing_web_2.pdf	A critical element of planning for population ageing is the creation of age-friendly, liveable communities and built environments. Affordable housing, carefully planned housing and neighborhoods, accessible transport, accessible public spaces and amenities, opportunities for participation and involvement in community and economic life and accessible health and community services are required for older people to live fulfilling lives. This project is unique in that it shows how the wellbeing of older people can be addressed through action across a wide range of public policy areas such as land use planning, urban design and urban planning, planning of the built environment, transport services, housing design and provision, design of public space, outdoor places and buildings, economic and labour market planning, human services planning, social and civic participation and recreational and cultural planning. Services and infrastructure for the ageing population need to be clustered in places where older people live.
Creating Healthy Neighbourhoods, Consumer preferences for healthy development, National Heart Foundation of Australia, 2011. creating-healthy-neighbourhoods.pdf	Neighbourhood design plays an important role in providing opportunities for incidental and recreational physical activity. Providing safe places for people to walk and cycle, destinations within walking distance and easy access to public transport all contribute to developing a neighbourhood that supports physical activity and community interaction. The Heart Foundation calls this a “healthy neighbourhood” and we have a long history of collaborating with built environment professionals to encourage this type of development. Quality open space -The community values being within close proximity to attractive and useable park land

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	with Heart Foundation research indicating that over 45% of people regard being within walking distance to a local park extremely or very important when deciding where to live. Integrating a well-connected network of footpaths, trails, shared paths and on and off road cycle lanes allows people to travel and exercise safely and easily. Developing connected, safe and legible street networks. Having more people on streets contributes to active and lively communities where people meet and interact, a neighbourhood characteristic which is becoming increasingly valuable. Compact neighbourhoods ensure the viability of destinations - Heart Foundation research indicates that 64% of people say that being within easy walking distance to a range of local services would be extremely or very important to them when deciding where to live. Creating a community heart - Community spirit is about people having a sense of ownership and belonging in their local area. Recent studies have demonstrated that people are willing to pay more to live in communities that feel connected. Active communities increase community spirit and connectivity in a local area because people are out and about, meeting their neighbours and contributing to the local economy. Involve the existing community surrounding new development in planning activities through meaningful consultation. This will help residents of your new community to embrace existing community life. Avoid 'fortress' or gated residential developments where residents are not encouraged to connect with the public realm. Create opportunities for informal community interaction such as well maintained open spaces, walking trails, community gardens and other destinations.
Older persons and Health Promotion – An Overview of the Literature, Sally Savage, Susan Bailey, City of Greater Geelong, Live Well a Strategy for Health, Mature Communities, October 2004 Older persons and health promotion - An	Social and Cultural Involvement • There are strong links between participation in social and other activities and enhanced physical and mental health • Appropriate leisure activities for older people enhance their overall satisfaction with life • Examples are presented of programs that enhance social and cultural involvement • Formal clubs and organisations play an important role in facilitating participation

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overview of the lite.pdf	• Specific interventions to facilitate the involvement of older people have been received positively by participants • Intergenerational programs offer benefits to older people and to the younger people they become involved with, and the important contribution older people can make is acknowledged • Volunteering should be promoted as it is beneficial to the volunteer as well as to the community as a whole The Role of Health Professionals • General practice is an ideal place to promote a range promoting behaviours to older persons, given that the majority will visit a doctor regularly • Difficulties are experienced in obtaining the necessary time and commitment from GPs due to some systemic barriers that are difficult to overcome • Alternative approaches such as nurse practitioners or practice nurses having a health promotion role in general practices may be more feasible.
Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions, Mima Cattan, Martin White, John Bond and Alison Learmouth, Ageing & Society 25, 2005, 41–67* Preventing social isoloation and lonliness among older people.pdf	Preventing and alleviating social isolation and loneliness among older people is an important area for policy and practice, but the effectiveness of many interventions has been questioned because of the lack of evidence. A systematic review was conducted to determine the effectiveness of health promotion interventions that target social isolation and loneliness among older people. Quantitative outcome studies between 1970 and 2002 in any language were included. Articles were identified by searching electronic databases, journals and abstracts, and contacting key informants. Information was extracted and synthesised using a standard form. Thirty studies were identified and categorised as 'group' (n=17) ; 'one-toone' (n=10) ; ' service provision' (n=3) ; and 'community development ' (n=1).Most were conducted in the USA and Canada, and their design, methods, qualityand transferability varied considerably. Nine of the 10 effective interventions were group activities with an educational or support input. Six of the eight ineffective interventions provided one-to-one social support, advice and information, or health-needs assessment. The review suggests that educational and social activity group interventions that target specific groups can alleviate social isolation and loneliness among older people. The effectiveness of home visiting and befriending schemes remains unclear. The findings provide clear evidence that a few interventions are effective, namely group interventions

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	involving some form of educational or training input, and social activities that targeted specific groups of people. Of importance to both policy and practice, it appears that programmes that enable older people to be involved in planning, developing and delivering activities are most likely to be effective. It is, however, less clear what other interventions might be effective.
Karratha City Of The North, Implementation Plan, Volume 1, Shire of Roebourne, ?? http://www.roebourne.wa.gov.au/Assets/documents/karratha2020/karratha%20implementation%20plan%20vol%201%20reduced.pdf karratha implementation plan vol 1 reduced.pdf	Royalties for Regions VISION FOR KARRATHA - CITY OF THE NORTH - A liveable, compact, Regional demographic balance, affordability, high quality amenity, and infrastructure. It is a place of choice, to work, visit, grow up, raise families and age gracefully. City of 50,000+ people, with a diversified economy and a healthy local community. It provides a sustainable growth plan to guide Karratha on its journey from a town with a permanent population of approx. 18,000 through to a city in excess of 50,000. The City Growth Plan, which covers the entire Karratha town site, provides the necessary information and direction to allow the Shire of Roebourne to prepare a new local planning strategy and planning scheme, both of which will be necessary to provide the right administrative instruments to accommodate Karratha's new direction.
Targeting in Community Care: A Review of Recent Literature and Analysis of the Aged Care Assessment Program Minimum Data Set, Anna Howe1, Colleen Doyle2 and Yvonne Wells2, April 2006 Targeting in Community Care & Literature Review and Analysis of ACAP MDS.pdf	The main objective of this review was to identify and appraise the evidence accumulated since 1999 for the efficacy of low to medium levels of community care services in maintaining the independence of a significant proportion of the HACC target population in their own homes. This focus derived from the HACC Targeting Study that analysed 1995 ACAP data and reported in 1998. The main findings from the 1998 HACC Targeting study can be summarised in terms of three main effects: • a 'protective effect' whereby highly dependent clients using one service at the time of assessment protected against a recommendation for nursing home care compared to using no services • a 'diminishing returns effect' whereby use of additional services did not increase this protective effect; that is, additional services after the initial did not achieve a further reduction in risk of admission for high dependency clients • 'floor effects' arose for lower dependency clients; while the ACAP assessed a substantial number of low dependency clients, the great majority of these clients were (a) using either no or only one service, and (b) highly unlikely to be recommended for nursing home care. There was thus no real margin for community care to reduce admission to residential care among this group

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	as it was so low (a floor effect), and there was no evidence of low dependency clients using high-levels of services that could be taken as evidence of "mis-targeting". There is clear evidence for the positive effect of providing small amounts of community care for people at a range of dependencies, including high dependency clients. The benefits of receiving some services compared to none, and experiencing unmet need, were especially evident. The clearest evidence of effectiveness was found when a particular service was directed to a particular need. The first implication of these findings is that targeting should aim to facilitate access to services rather than restrict it, and provide a basic response to assessed needs for as many clients as possible. The second implication is that intake assessment, as set out in the tiered model, should focus on finding the most appropriate response to the client's needs. Intake assessment can thus be characterized as careful selection from a wide array of services rather than providing less discriminating access to more services. The evidence was more mixed in relation to the outcomes realized by provision of additional levels of services, including case management, and two related reasons explained these mixed findings. The implications for targeting are that access to higher levels of service or packages of services for people with complex needs should continue to be managed, and managed with greater consistency than is currently the case, to ensure that clients with like needs receive like levels of support. The implications of these findings for targeting in community care in Australia are that packaged care needs close monitoring in order to maximise the effectiveness of extra resources for case management vis-à-vis direct service provision. Guidelines are needed to provide careful definitions of what case management or care coordination comprises, the proportion of cost allowable for coordination as opposed to service provision, and the type of client who can benefit most. In the situation where Aged Care Assessment Teams (ACATs) currently recommend far more clients for CACPs than are likely to receive them, there is a need for greater clarity about the type of clients who will benefit from packaged care, and the nature of the benefits, as distinct from the services they would otherwise receive, and indeed will continue to receive for want of a package. Three main conclusions are drawn from the Literature Review and the analyses of the ACAP MDS with reference to the further development of targeting in community care. They are: (i) Targeting in community care should focus on provision of small amounts of services to a large number of clients and extend the coverage of moderately and highly dependent clients who currently receive none of

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	the services recorded in the ACAP MDS. This targeting will not only maximise the protective effective of use of community care service against entry to residential care but also realise a wide range of other outcomes for clients and carers in terms of independence and quality of life, including reduction of unmet need and its associated adverse outcomes. (ii)Access to higher levels of service needs to be managed more selectively than appears to be the case at present so that access to higher levels of services and more costly services, including case management, is more clearly related to the outcomes being sought. This targeting needs to be based on assessment of dependency and care needs; targeting on the basis of the level and kinds of services available through various packages appears to have a considerable distorting effect at the boundary between HACC and CACPs. (iii) An ongoing plan of analysis of the ACAP MDS together with the HACC MDS and other databases needs to be developed to inform the ongoing development of assessment and community care and to monitor outcomes of changes that are implemented. One means to this end would be to expand the scope of the current evaluation of the Aged Care Assessment Program to include other databases and so cover the whole of the aged and community care system.