Future of Ageing Well service and funding model review

Sector and public engagement summary and themes

May and June 2024

Health New Zealand
Te Whatu Ora

Contents

Executive summary

In July 2023, Health NZ began a review of funding and service models for aged care services. Its purpose is to provide recommendations that will, over time, improve the sustainability of services and ensure equity of access and outcomes for older people across New Zealand.

Our future aspiration is for an aged care sector that balances the need for a cost-effective system with a high-quality continuum of care. Feedback suggests that the model of care and system for Aged Care Services needs to be:

- person and whānau centred
- financially sustainable
- effective at reducing avoidable hospital admissions and bed days
- Supports people to live as independently as they can
- nationally consistent while meeting the needs of local communities; and
- delivered by a competent workforce that is valued and supported.

As part of that review, throughout May and June 2024, we heard from over 2000 people and received over 10,000 pieces of feedback from a range of stakeholders including aged care services, people who use aged care services and other partners and organisations.

This feedback has helped us understand the barriers, opportunities and potential solutions that will improve the health outcomes and experience for older people supported by aged care services.

Our engagement included:

- Eight workshops (two across the region working with Health NZ regional leads)
- Two online webinars
- A lived experience engagement approach including a public survey and a webinar with the New Zealand Dementia Foundation Lived Experience Advisory Board (including 8 people living with dementia and/or their carers).
- Tailored engagement sessions with specific groups, such as Ngati Whatua Orakei Aged Concern, Whaikaha and Health and Home and Community Health Association.
- Various meetings and workshops we attended

The feedback we heard through this engagement has built on and confirmed the findings of an initial review of our aged care system by Sapere independent research group published in April, and initial feedback from aged care providers, professionals, partners and older people and their whānau.

This document outlines the key themes and feedback we received from that engagement activity.

Purpose

Health New Zealand | Te Whatu Ora (Health NZ) began a review of funding and service models for aged care services in July 2023. Its purpose is to provide recommendations that will, over time, improve sustainability of services and ensure equity of access and outcomes for older people across New Zealand.

The implementation of the recommendations from this review aims to create a more sustainable, integrated, and high-quality aged care system in New Zealand. Our goals include reducing demand on public hospitals, delivering holistic and culturally appropriate care, and ensuring financial sustainability. By focusing on person and whānau-centered care, we aim to improve outcomes for older people, particularly Māori and Pacific peoples, and ensure equitable access to services.

Phase one of the programme identified significant challenges such as an ageing population, financial pressures, workforce shortages, and outdated funding and service models. In response, phase two is focused on solutions to these issues. Key priorities include incentivising ARC providers to increase care bed capacity, adopting restorative care models to reduce hospital stays, integrating care services across different settings, and addressing the specific needs of Māori and other priority communities.

The intent of our engagement programme is to place the voices of older people, their carers, and service providers at the center of our decision-making process. Through extensive consultation, we have gathered valuable insights to inform our strategies for a more effective aged care system. This engagement ensures that our approaches are informed by those who are most affected, promoting a system that is responsive to the needs of diverse populations and supports the well-being of older New Zealanders.

Objectives

The primary aim of our engagement programme was to foster a collaborative dialogue with stakeholders in the aged care sector to envision and shape the future of aged care services in New Zealand. We intended to transition from merely collecting and cataloguing challenges to actively exploring and co-creating potential solutions. This engagement was framed with a forward-looking perspective, emphasising the development of a sustainable, equitable, and responsive aged care system.

Over the past decade, numerous interactions with the aged care sector have left many stakeholders feeling unheard and underrepresented. Recognising this sentiment, our programme sought to create a meaningful platform for stakeholders to voice their insights and collaboratively work towards tangible improvements.

With the sector, we examined an ideal future of aged care through four lenses in a workshop format:

1. **Support to Stay at Home and Return Home**: Ensuring that older people can live independently and safely in their homes, with robust support systems in place for their return home from hospital stays or other care settings.
2. **Aged Residential Care**: Enhancing the quality and accessibility of residential care facilities to meet the diverse needs of older adults.
3. **Supporting Our Carers**: Providing adequate support, resources, and recognition for carers who play a vital role in the wellbeing of older individuals.

4. **Enhanced General Practice and Pharmacy**: Improving the integration and effectiveness of general practice and pharmacy services in delivering comprehensive care to the elderly.

This allowed us to tease out what and how much need to change from our current state to deliver on this ideal future, focussing on in on systemic challenges and where things were working well already (and how to scale them).

With the wider public, we asked older people to and their carers to share their experiences of not only their challenges with the aged care system, but also experiences that made their lives better. In conversations, we focused on the journey of ageing, reflecting on key moments where circumstances changed. To gather this information, we facilitated a public survey, spoke with targeted groups, reviewed lived experience stories from the sector, and conducted 1:1 interviews.

Through this range of engagement activities, we aimed to gather diverse perspectives, identify what is currently working well, and pinpoint areas needing improvement. This approach was designed to ensure that the future aged care model is inclusive, meets local needs, and upholds equity for Māori and Pacific people and their whānau.

Engagement

In May and June 2024, we conducted 8 in-person workshops across the motu, as well as two webinars. We also conducted a series of tailored engagement sessions with specific groups, such as Ngati Whatua Orakei Aged Concern, Whaikaha and Health and Home and Community Health Association, among others.

The workshops were supported by an online activity for those who could not attend an in person or online session, or who had extra feedback to contribute. We received **300 responses**.

Alongside the sector engagement, we also conducted a lived experience engagement with the public. This included a public survey and a webinar with the New Zealand Dementia Foundation Lived Experience Advisory Board (including 8 people living with dementia and/or their carers). We received **861 responses** to the survey and have the option to follow up a number of them if we need further information.

Workshop attendees by location

Workshop location	Workshop date	Number of attendees (RSVPs)
Christchurch	Mon 6 May, 2024	35
Dunedin	Tue 7 May, 2024	26
Whangarei	Wed 15 May, 2024	41
Auckland	Thu 16 May, 2024	83
Palmerston North	Tue 21 May, 2024	51
Porirua	Wed 22 May, 2024	58

Gisborne	Tue 28 May, 2024	25
Hamilton	Wed 29 May, 2024	48
Online Webinar	Thu 30 May, 2024	55

Workshop participants by organisation type

Organisation Type	**Number of participants (across all workshops)**
Academic Institution	8
Aged Residential Care Facility	186
Allied Health	9
Day Care Provider	5
Government	20
Health New Zealand Services	139
Home and Community Support Service	121
Hospice provider	20
Hospital	12
Iwi	11
Non-Government Organisation (NGO)	138
Pharmacy	5
Primary Care	70
Service user	7
Union	27
Not specified	3
Other	2

For a full list of organisations who engaged, please see the Appendix A.

Public survey respondents

District	Total number of responders
Auckland / Tāmaki-makau-rau	106
Bay of Plenty / Te Moana-a-Toi	24
Canterbury /Waitaha	101
Gisborne / Te Tairāwhiti	13
Hawke's Bay / Te Matau-a-Māui	64
Manawatū-Whanganui	37
Marlborough / Te Tauihu-o-te-waka	11
Nelson / Whakatū	40
Northland / Te Tai Tokerau	29
Otago / Ōtākou	99
Southland / Murihiku	32
Taranaki	23
Tasman / Te Tai-o-Aorere	29
Waikato	63
Wellington / Te Whanga-nui-a-Tara	119
West Coast / Te Tai Pautini	12
Declined to answer	59
TOTAL	**861**

Older persons locality	Number of responses
In a retirement village	77
In an aged residential facility	21
In an independent home	589
Rental property	18
Declined to answer	156

Responder type – Carer, Older person	Number of Responses
Both	77
Carer	120
Neither	49
Older person (age 65+)	557
Declined to answer	58

Additional engagement sessions

Workshop location	Workshop date	Number of participants
Funded Sector Tripartite Group	Late April, 2024	25+
Age Concern Conference	Thu 18 April, 2024	75+
NZ Dementia Foundation Webinar	Thu 2 May, 2024	100+
NZ Dementia Lived Experience Advisory Board	Tue 7 May, 2024	8 people living with dementia and/or carer of people living with dementia
Te Whatu Ora Public Stakeholders briefing session	Tue 7 May, 2024	250+
NZ Dementia Leadership Group	Thu 23 May, 2024	15
Directors of Allied Health (Te Whatu Ora)	Wed 29 May, 2024	20
Commissioning Leadership Team	Wed 29 May, 2024	15
Ngati Whatua Orakei (Marae campus)	Fri 31 May, 2024	10 people, including Kaumatua/koroua and kuia and service providers
Primary and Community Health Aotearoa	Fri 31 May, 2024	25
NZ Association of Gerontology	Fri 31 May, 2024	2
Home and Community Health Association	Tue 11 June, 2024	10
Whaikaha - Ministry for Disabled People	Fri 21 June, 2025	10

Synthesis – Public engagement

Through the public engagement channels, most ideas and feedback fit into one of three "front of house" categories: improving access to care and support, increasing the quality of care or support received and allowing for more flexibility in care and support options. This was true of both positive and negative feedback. Positive feedback was usually a result of one of these aspects were being done particularly well; negative feedback were challenges with these aspects.

Each of the following themes were also echoed strongly in the sector feedback as well.

Access to care and support

- *Equitable Access*: I have equal access to aged care services regardless of my location, socio-economic status, or cultural background.
- *Accessible from Anywhere*: I can access care services and support regardless of where I am, including rural and remote areas.
- *Intuitive to Navigate*: The care system is easy to understand and navigate, with clear information and guidance available to me and my family.
- *Affordable Care*: The cost of my care is manageable and does not cause financial hardship for me or my family.
- *Clear Information*: I have clear information about the available services, how to access them, how much they cost and any financial support available to me.
- *Accessible Technology*: Technological solutions are easy to use and accessible to all, regardless of my tech-savviness or resources.
- *Community-Based Services*: Local community services are available to support my needs and keep me engaged with my surroundings.

Quality of care and support

- *Reliability*: I can count on my care services to be dependable and consistent, ensuring I receive the support I need when I need it.
- *Individualised Care Plans*: My care plan is tailored to my specific needs, preferences, and goals. It evolves as my needs change.
- *Professional Standards*: The staff providing my care are well-trained, qualified, and adhere to high professional standards.
- *Social Engagement*: I am supported to stay connected with my community, family, and friends, which is vital for my emotional well-being.
- *Safe Environment*: My safety is a priority, with measures in place to prevent falls, medication errors, and other risks.
- *Prompt Response*: Any concerns or issues I have are addressed promptly, ensuring I receive timely care.
- *Seamless Transitions*: My transitions between different care settings (home, hospital, ARC) are smooth and well-coordinated, preventing any gaps in my care.
- *Collaborative Care Teams*: All my care providers work together as a team, sharing information and coordinating my care effectively.

Flexibility of care and support

- *Respect for Dignity and Autonomy*: My preferences, choices, and values are respected. I am treated with dignity and my autonomy is supported.
- *Culturally Competent Care*: Services are designed to be culturally appropriate, respecting my heritage and traditions, especially for Māori and Pacific peoples.
- *Adaptable to Changing Needs*: My care services can adjust to any changes in my health or circumstances without delays.
- *Use of Technology*: Technology is used to enhance my care, such as telehealth for remote consultations and digital health records for seamless information sharing.
- *Support for Independence*: Technology helps me to live independently for as long as possible, through tools like home monitoring and assistive devices
- *Holistic Care*: My physical, mental, and emotional health are all considered in my care plan.
- *Preventive Services*: I have access to preventive health services that help maintain my health and prevent deterioration.

Pillars of person-centered care

As we move through the system design process, we will ensure that these three pillars—access, quality, and flexibility—are embedded into the foundational design principles of the new aged care system. These principles will guide the system's development at every step, ensuring that we're keeping the values of our older people front and center. We'll look to develop both qualitative and quantitative ways to measure each aspect to evaluate our new model of care.

Where it's working well

The survey responses also reflect a wide range of positive experiences and services that have made a significant difference in the lives of respondents. We wanted to highlight a few themes that came through around things that are working well (and we should aim to maintain and expand):

- *Responsive and Compassionate Care*: Many respondents highlighted the compassionate and responsive care received from GPs, hospital staff, and specific health professionals like physiotherapists, oncologists, and surgeons. The quality of interpersonal interactions and the feeling of being genuinely cared for were frequently mentioned as crucial factors in positive experiences.
- *Specialized Medical Services:* Services such as colonoscopies, heart surgeries, and cancer treatments were frequently mentioned. The skill and dedication of specialists contributed to improved health outcomes and overall satisfaction.
- *In-Home Assistance:* Regular home help, including cleaning, showering assistance, and meal preparation, was a major factor in allowing respondents to maintain independence and quality of life. This also included the provision of mobility aids such as walkers, wheelchairs, and handrails significantly improved the quality of life for respondents. Home modifications, including the installation of ramps and raised toilet seats, were also valued. The availability of equipment like electric wheelchairs and assistive devices for showering and daily activities made it easier for respondents to live independently and safely.

- *Local, Community-Based Programs:* Programs offered by organizations like Age Concern, Dementia support groups, and local hospices were frequently mentioned as valuable. These services provided social interaction, mental health support, and respite care, enhancing the well-being of both patients and caregivers. Engaging in community activities, social programs, and group exercises provided not only physical benefits but also crucial social interactions that helped combat loneliness and isolation.
- *Respite Care and Support Groups:* For those who have access, caregivers highly valued respite services, which provided them with necessary breaks from their duties. Support groups and regular visits from community health workers were also essential in reducing caregiver stress and burnout.

While many praised the dedication of healthcare workers, there was a recurring concern about under-resourcing and understaffing, leading to overworked staff and sometimes inconsistent service delivery. Several respondents mentioned challenges with the consistency of care and communication within healthcare services. Missed appointments, lack of follow-up, and difficulties in contacting service providers were common concerns.

Overall, the survey responses highlight the critical importance of compassionate, responsive care, the value of in-home support services, and the positive impact of community-based programs. However, they also underscore the ongoing challenges related to resource constraints, communication issues, and the need for more consistent service delivery.

Synthesis – Sector engagement

In the sector engagement, we explored an ideal future aged care system through four key topics:

1. Support to stay at home and return home
2. Aged Residential Care
3. Supporting our carers
4. Enhanced General Practice and pharmacy.

For each key topic, we had three aspects of what the ideal future state would entail. In this section, we have summarised the key challenges we'd need to solve to achieve a better future, and opportunities and ideas shared with us for how to do so. We've also highlighted any regional differences that emerged as well as included indicative verbatim responses where appropriate.

Across all topics, there was a strong appetite for significant change. We should capitalise on this momentum. Some regions had programs in place that already come closer to the ideal future state, however significant work would need to be done to scale these programs to enable them nationally.

1. Support to stay at home and return home

1.1 Technology and self-determination

Ideal future state

System perspective	Person perspective

Our health system uses integrated and emerging technology to enable self-determination and deliver high quality service. I can use technology to connect with my support people	This allows me choice and control in my care. I can easily share information with my carers, as they can with me.

In the ideal future state, technology empowers older individuals to take charge of their health and wellbeing, allowing them to live independently and with dignity. Accessible and user-friendly technological solutions, such as telehealth services, wearable health monitors, and personalised digital health platforms, provide continuous and proactive health management.

Older people have easy access to their health records and can communicate seamlessly with their healthcare providers, receiving real-time support and advice. This technological ecosystem is inclusive, catering to diverse needs and abilities, ensuring that everyone, including Māori and Pacific elders, can utilise these tools effectively.

Key aspects:

- **Empowerment through information**: Individuals have control over their health information, can easily access their medical history, and understand their health status through intuitive digital platforms.
- **Proactive health management**: Wearable devices and telehealth services offer continuous monitoring, early detection of potential health issues, and timely interventions, reducing the need for hospital visits.
- **Inclusivity and accessibility**: Technology solutions are designed to be inclusive, with features that accommodate different languages, cultural contexts, and levels of digital literacy, ensuring equitable access for all, including Māori and Pacific communities.
- **Seamless communication**: Older people can communicate easily with healthcare providers through multiple channels, including video calls, messaging, and online portals, enhancing their engagement and satisfaction with the care they receive.
- **Support for self-management**: Digital tools and applications provide personalised health advice, reminders for medication, and lifestyle tips, empowering individuals to manage their health proactively.

Summary of themes

The key challenges in achieving an ideal future state where the health system uses integrated and emerging technology to enable self-determination and deliver high-quality service include significant gaps in digital literacy among older adults, especially within Māori and Pacific communities, prohibitive costs associated with technology, and physical and cognitive impairments that hinder technology use.

Additionally, there are issues with data privacy, lack of integrated systems, and poor internet coverage in rural areas. However, there are notable opportunities to address these challenges through education and training programs for older adults and their families, developing national and integrated patient management systems, investing in internet connectivity for rural areas, and implementing wearable health monitoring devices. Ensuring culturally sensitive and accessible technology solutions, providing funding for technology adoption, and fostering trust through transparent communication are also critical steps in promoting equity and inclusion in the use of technology in aged care.

Key challenges

1. **Technology literacy and accessibility**
    - Significant gaps in digital literacy, especially among older adults and specific ethnic groups (e.g., Māori, Pacific).
    - High costs associated with technology (devices, internet connectivity).
    - Physical and cognitive impairments (e.g., dementia, aphasia) that hinder the use of technology.
    - Need for technology solutions to be simple, user-friendly, and accessible to all, including those with disabilities.
2. **Trust and privacy concerns**
    - Resistance to technology due to mistrust or fear among older adults.
    - Concerns about data privacy and sovereignty.
    - Ensuring that personal health information is secure and shared only with authorised individuals.
3. **Infrastructure and interoperability**
    - Lack of integrated systems that can seamlessly share information across different care providers (e.g., PHOs, HCSS, hospitals).
    - Inconsistent technology platforms and lack of a single, unified patient management system.
    - Poor internet coverage in rural and remote areas.
    - High costs of emerging technology and infrastructure investments.

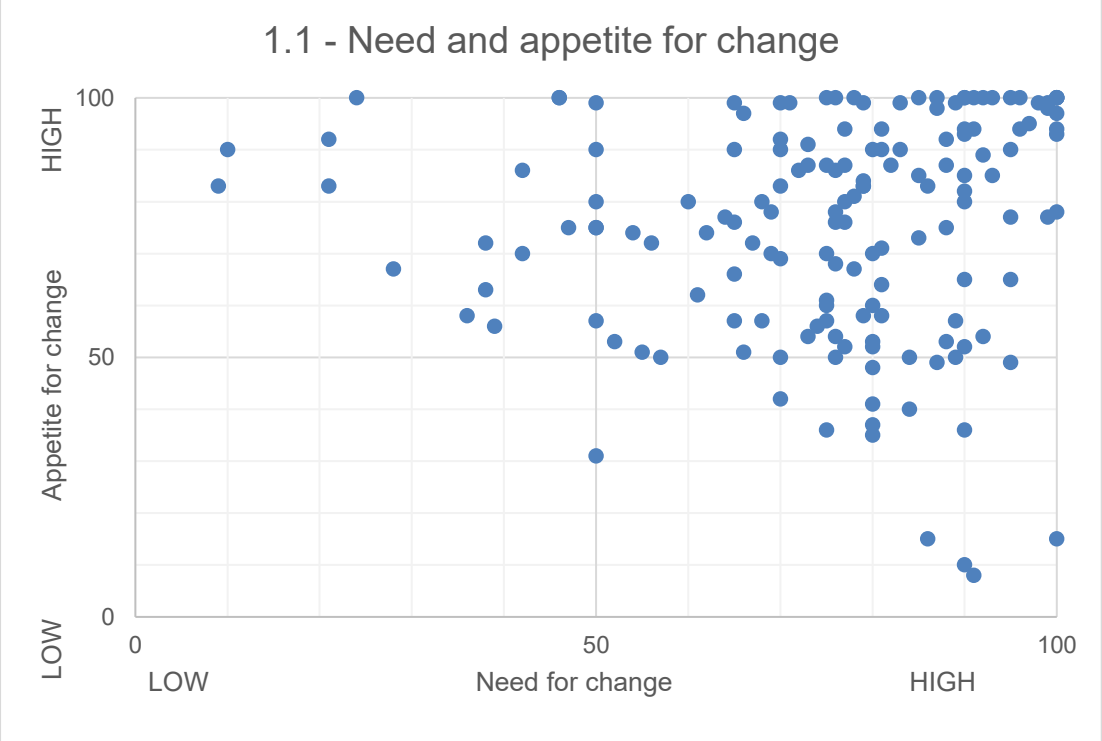
Opportunities and Ideas

1. **Enhance digital literacy**
    - Provide education and training programs for older adults and their families on using technology.
    - Develop community hubs (e.g., marae, churches) for digital literacy training.
    - Utilise younger generations as technology coaches for older adults.
2. **Build trust and ensure privacy**
    - Implement robust privacy measures and clear guidelines on data sharing.
    - Foster trust through transparent communication and involvement of older adults in technology design and implementation.
    - Offer options for both digital and face-to-face interactions to accommodate preferences and build trust.
3. **Improve infrastructure and integration**
    - Develop a national patient management system accessible to all health providers and patients.
    - Invest in technologies to improve internet connectivity in rural areas.
    - Implement integrated care plans and shared platforms to ensure seamless information sharing.

4. **Utilise emerging technologies**
    - Explore the use of AI for translating health information and supporting clinical monitoring.
    - Implement wearable devices for monitoring vital signs and health conditions remotely.
    - Use telehealth and mobile health technologies to extend care to rural and remote areas.
5. **Promote equity and inclusion**
    - Ensure technology solutions are designed to be culturally sensitive and accessible.
    - Provide funding and resources to lower-income households for acquiring necessary technology.
    - Develop multilingual and easy-to-use technology interfaces.

Appetite for change

The sector generally believes there is a strong need for change and have a high appetite for it.



Regional differences

- **Te Manawa Taki Region (Hamilton and Gisborne)** Hamilton focused on funding, privacy, data sovereignty, and balancing technology with face-to-face interactions. Gisborne emphasised funding, culturally sensitive technology, and early health literacy education.

- **Central Region (Porirua and Palmerston North)** Porirua stressed integrated, whānau-centric systems, digital monitoring, and rural connectivity solutions. Palmerston North highlight3e client choice, privacy, technology accessibility, and integrated platforms.
- **Te Waipounamu Region (Dunedin and Christchurch)** Dunedin focused on a national patient system, health literacy, and tech innovation funding. Christchurch valued a funded patient management system, predictive technology, and professional training.
- **Northern Region (Whangarei):** Whangarei struggled with technology coverage, funding pathways, and simple, accessible tech solutions.
- **Auckland Metro** emphasised integrated communication platforms, wearable health monitoring, digital literacy, and cultural inclusivity.

1.2 Consistent home and community support

Ideal future state

System perspective	Person perspective
Home and Community Support is nationally consistent based on restorative support and case-mix funding.	I am as independent as I can be at home. Support is there when I need it, and I know how to ask for it.

This proposed ideal future state envisages a nationally consistent Home and Community Support Services (HCSS) model. This model needs to ensure that older individuals can maintain their independence at home, receiving timely and appropriate support tailored to their needs. By reviewing the funding approach, the system could provide equitable, high-quality care, enabling older people to access the support they need when they need it, and empowering them to live independently. For this ideal state to be successful, adequate funding and resources needs to be allocated to support the shift to maintained independence with associated care packages where required, along with comprehensive training and workforce development to equip carers and health professionals. Additionally, integrating advanced technologies to enhance care coordination and information sharing is crucial, as is establishing policies and regulations that mandate national consistency in care models and funding.

Key aspects:

- **Independence and Self-Determination**: Support older people to maintain independence at home by providing consistent and high-quality care.
- **National Consistency**: Implement a standardised quality and funded care model across New Zealand to reduce regional disparities.
- **Restorative Care**: Shift from traditional task-based support to a restorative care approach that promotes independence and reduces hospital admissions.
- **Integrated Technology**: Utilise emerging technologies to enhance self-determination, improve care coordination, and ensure seamless information sharing between carers and older people.

Summary of themes

To achieve the ideal future state where HCSS is nationally consistent, several key challenges need to be addressed.

These challenges include significant gaps in training and qualifications for HCSS workers, national inconsistency in funding models and service specifications, pay disparity, and inadequate remuneration for support workers.

Additionally, there are delays in service provision, barriers to accessing services in rural areas, and a lack of awareness about available support services among older adults and their families. Addressing these challenges involves comprehensive education and training programs, establishing consistent national policies and funding models, improving data collection and infrastructure, and enhancing awareness and accessibility of services. Furthermore, developing a robust workforce strategy to create attractive career pathways and ensuring continuous outcome monitoring and evaluation are essential to ensure high-quality and equitable support for all older people across New Zealand.

The need for consistent, high-quality home and community support services (HCSS) is critical. Challenges include variability in service quality, funding inconsistencies, and workforce shortages. Opportunities focus on standardising care models, enhancing training for caregivers, and ensuring equitable access to support services across regions.

Key challenges

1. **Workforce shortages and training**
    - Insufficient numbers of qualified support workers.
    - Limited career progression, professional development and training opportunities for staff
    - High turnover rates due to working conditions.
2. **Inconsistent service delivery**
    - Variability in the quality and availability of home and community support services.
    - Different care models leading to unequal outcomes.
    - Inconsistent care standards and lack of coordination among service providers.
    - Fragmentation in service provision leading to gaps in care.
    - Inconsistent funding models affecting service availability.
3. **Accessibility and equity**
    - Barriers to accessing services for older adults in rural and remote areas.
    - Inequities in service provision for Māori, Pacific, and other marginalised communities.
    - Financial barriers preventing access to necessary support services.
    - Inequities in resource distribution, especially in rural areas.

Opportunities and ideas

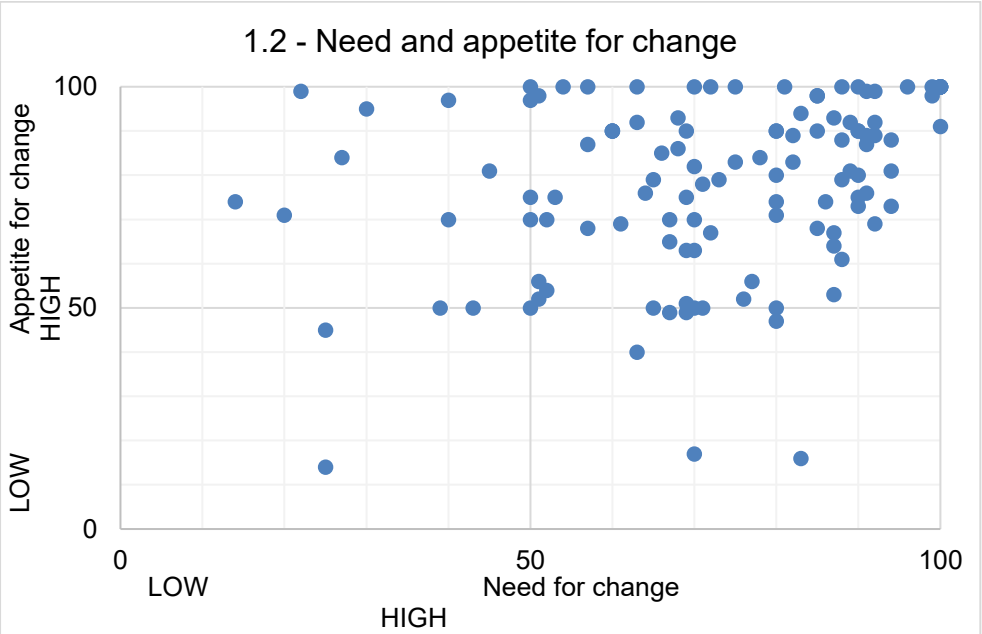
1. **Improve accessibility and equity**
    - Expand outreach and support services in rural and remote areas.
    - Develop culturally appropriate service models to address the needs of Māori, Pacific, and other marginalised communities.
    - Provide financial support or subsidies to ensure equitable access to home and community support services.
2. **Standardised care models**
    - Establish national (evidenced-based) standards, care models and guidelines for home and community support services.
    - Enhance coordination among service providers through integrated care models.
    - Implement consistent (and cost-effective) monitoring and evaluation of service quality.
3. **Enhanced training programs**

- Offer comprehensive training for caregivers.
- Provide ongoing professional development opportunities.
- Align certification programs to enhanced payment schemes.

4. **Transparent and equitable funding models**
    - Explore a bulk, needs-based funding allocation system.
    - Ensure equitable distribution of resources across all regions.
    - Advocate for increased funding to meet demand.
5. **Workforce support and development**
    - Improve working conditions and compensation for caregivers.
    - Develop career pathways and incentives to retain and attract support workers.
    - Enhance support for caregiver well-being and retention.
6. **Integrated community services**
    - Strengthen partnerships with local NGOs and community groups.
    - Provide holistic support that includes social and health services.
    - Facilitate community-based rehabilitation and support programs.

Appetite for change

The sector generally believes there is a strong to moderate need for change and have a healthy appetite for it.



Regional differences

- **Te Waipounamu Region (Dunedin and Christchurch)** Emphasised the need to address service variability in rural areas and supported the use of telehealth to improve accessibility and standardise care protocols.
- **Central (Porirua and Palmerston North)** Highlighted inconsistencies in service availability and communication issues, with a focus on creating a unified service framework and leveraging digital monitoring tools.
- **Northern (Whangarei)** highlighted poor accessibility and variability in service quality, and the need for culturally sensitive and inclusive services. They were also concerned about high turnover rates and insufficient training for HCSS workers, advocating for increased investment in workforce development and training programs.
- **Auckland Metro** Pointed out fragmented care due to poor communication between providers, suggesting enhanced integration and standardised service delivery across the region. They reported better service integration but highlighted workforce shortages as a critical issue.
- **Te Manawa Taki (Hamilton and Gisborne)** focused on addressing rural accessibility and investment in primary care, identified the lack of coordination between care providers, and recommending integrated care models and improved communication channels for cohesive service delivery. Cultural sensitivity in support services was also a strong theme.

1.3 Coordinated continuum of care

Ideal future state

System perspective	Person perspective
The continuum of care across our system is timely, coordinated and reflects the changing needs of the older person	My needs change and I need different services at different times. My journey from home to hospital and maybe to ARC (if I need it) makes sense to me and feels comfortable. If I get better, I can return home as soon as possible.

In the ideal future state, the aged care system offers a seamless and well-coordinated continuum of care for older individuals, ensuring they receive the right support at the right time, regardless of their care setting. This model prioritises smooth transitions between home, hospital, and aged residential care (ARC), minimising disruptions and enhancing the overall care experience. A robust care coordination framework supports integrated services across different care providers, resulting in timely and personalised care that adapts to the changing needs of older adults.

Older people benefit from a cohesive care plan that is managed and monitored by a multidisciplinary team (MDT), ensuring continuity and consistency in care delivery. The care pathway is designed to be patient-centered, with a strong focus on enabling older individuals to maintain their independence and quality of life.

Key aspects:

- **Seamless transitions:** Processes and protocols to ensure smooth transitions between home care, hospital care, and ARC, minimising disruptions and confusion

for patients. Care pathways clearly outline steps and responsibilities during transitions to ensure no aspect of a patient's care is overlooked.

- **Integrated services:** Effective communication and collaboration among healthcare providers is facilitated, ensuring that all team members have access to up-to-date patient information. Technology could support real-time information sharing and coordination among different care settings.
- **Personalised care plans:** individualised care plans adapt to the changing needs of older adults, ensuring that they receive appropriate and timely interventions. Patients and their families are involved in care planning and decision-making to ensure that care aligns with their preferences and goals.
- **Preventative and proactive care:** Preventive care measures are emphasised to manage chronic conditions and avoid hospital admissions. Care teams are proactively identifying potential health issues and addressing them early to maintain the health and independence of older adults.
- **Holistic support systems:** Comprehensive support services, including home and community support, are integrated into the care continuum to provide holistic care. Older people receive the necessary assistance to manage daily activities and maintain their health and well-being at home.

Summary of themes

A coordinated continuum of care is crucial for meeting the evolving needs of older adults, yet challenges such as fragmented transitions, poor communication, and inadequate discharge planning persist.

To overcome these, we need to consider integrated service offerings, enhance communication, and provide continuous support. This requires well-trained staff supported by improved career paths and pay equity, along with policy changes to break system silos and implement flexible funding models.

Investments in technology and infrastructure will enhance service integration, while targeted information campaigns and community co-ordination hubs will aid navigation of the system. Addressing high workforce turnover, ensuring equitable access to services, and providing culturally appropriate care are essential for meeting the diverse needs of Māori, Pacific, and other ethnic communities.

Key challenges

1. **Inconsistent models of care and funding**:
    - The models of care vary significantly across New Zealand. Some regions employ a "restorative" model that includes input from allied health and nursing, while others rely on traditional task-based home support which does not promote independence.
    - There is a mixture of funding models across the regions, which adds complexity and increases transaction costs for suppliers. The amount of access to in-home assessment and support services can depend heavily on geographical location.
2. **Coordination of care transitions**:
    - The transition process between different care settings (e.g., from home to hospital, then to ARC or back home) can be confusing and poorly

coordinated. This leads to delays and gaps in care which impact the wellbeing of older people.

3. **Workforce pressures**:
    - The aged care sector, similar to other parts of the health system, continues to face significant workforce challenges, affecting the quality and consistency of care.
4. **Equity of access**:
    - Access to aged care and related community services is inequitable across different regions and population groups, particularly affecting priority populations and those in rural areas.

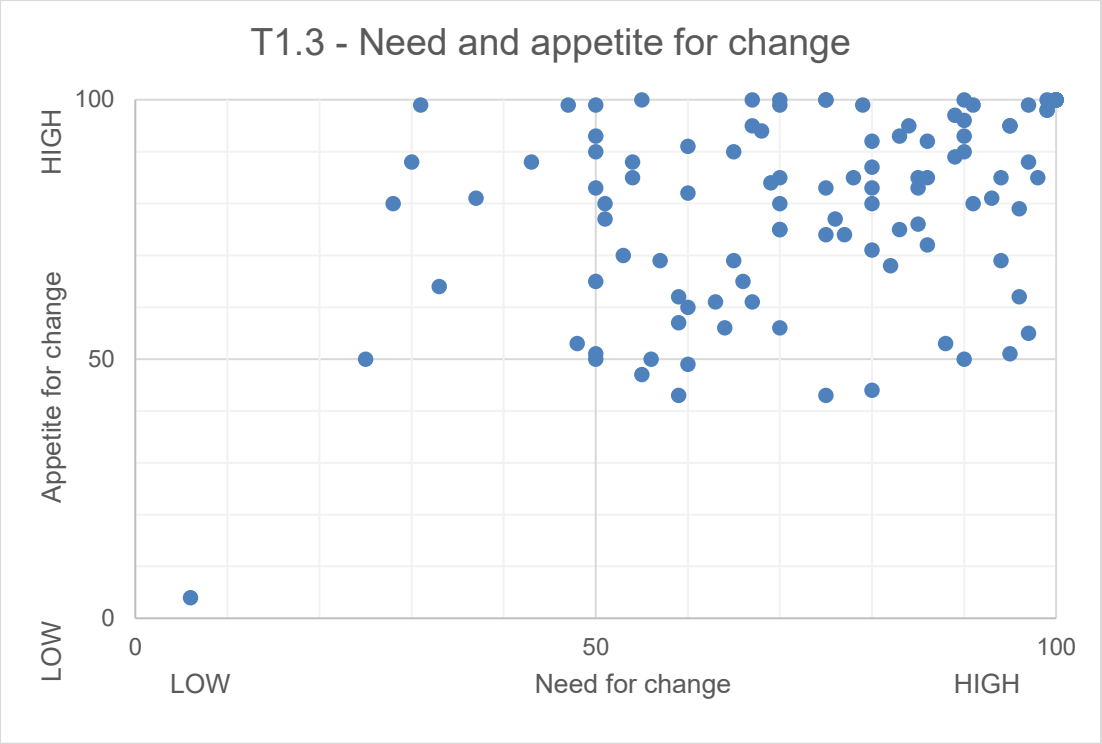
Opportunities and ideas

1. **National restorative care model**
    - Implementing a nationally consistent restorative care service and bulk-funded model could standardise care and reduce hospital admissions. Restorative models focus on enhancing the independence and recovery of older people.
    - Revising funding models to reflect assessed needs derived from comprehensive tools like the interRAI Home Care (HC). This can ensure that care providers are funded appropriately based on the level of need, allowing for a more equitable distribution of resources.
2. **Leverage emerging technologies**:
    - Utilising emerging technologies can improve data use to enhance efficiency and support self-determined care coordination. Technologies such as telehealth and data-sharing platforms allow older people more choice and control over their care, facilitating seamless communication between carers and patients.
3. **Improve care transition processes**:
    - Developing more coordinated and timely care transitions between home, hospital, and ARC. This would involve better collaboration between HCSS, General Practice, ARC, and allied health services to ensure older people receive the right support at the right time.
    - Implement protocols and collaboration frameworks to ensure seamless transitions between home, hospital, and ARC, minimising disruptions and improving continuity of care.
4. **Integrate Primary Care**:
    - Integrating primary care teams, including pharmacy services, into the wider aged care system. This can help older people stay healthy at home for longer and reduce the need for hospital admissions. Enhanced primary care support and medication management are critical areas of focus.
5. **Target funding to address equity**
    - Develop targeted strategies to ensure priority populations, including Māori and Pacific peoples, have equitable access to aged care services. This includes supporting services delivered by iwi and community organisations.

6. **Strengthen workforce support**:
    - Address workforce pressures by implementing strategies for recruitment, retention, and training of aged care professionals, ensuring a robust and capable workforce to meet future demands

Appetite for change

The sector generally believes there is a strong to moderate need for change and have a healthy appetite for it.



Regional differences

- **Te Manawa Taki Region (Hamilton and Gisborne)**: stressed the importance of holistic and culturally appropriate care models. There is a need for services that respect and incorporate the cultural values and practices of Māori and Pacific peoples. Participants emphasised the significance of community-based care models that are designed and delivered in partnership with iwi and local communities.
- **Central Region (Porirua and Palmerston North)**: In the Central region, there was positive feedback on the implementation of restorative care models, which are seen as effective in reducing hospital admissions and promoting independence. However, the challenge remains in scaling these models to ensure they are available uniformly across the region. They also highlighted gaps in communication between hospital and community services.
- **Te Waipounamu Region (Dunedin and Christchurch)**: Participants in the Te Waipounamu Region expressed concerns about the inequitable access to services and resources. Rural areas, in particular, face significant challenges in accessing timely and appropriate care, leading to delays and fragmented care experiences. They also highlighted the challenges of coordinating care in rural areas and suggested a navigator role and funding flexibility to prevent unnecessary hospitalisation.

- **Northern Region (Whangarei)**: Participants in the Northern region emphasised the inconsistencies in HCSS. They pointed out that while some areas have a restorative care model, others still use a traditional task-based approach. The need for a consistent standard for HCSS was a common theme. They also wanted to ensure holistic end-of-life, hospice and palliative care was included in the model.
- **Auckland Metro:** underscored the importance of social worker support, culturally appropriate care, and better transitions between care settings. They reported better coordination but still faced challenges with communication among providers – there is still a need for better integration of services to ensure smooth transitions from home to hospital and back. There is a strong desire for a more coordinated approach involving general practice, allied health, and ARC services to make discharges sustainable and prevent re-admissions.

2. Aged Residential Care

2.1 Integrated Primary Care and ARC

Ideal future state

System perspective	Person perspective
Our health system, including primary care, pharmacy, and specialist services, enables a flexible and responsive ARC service and promotes continuity of care.	I receive the right support at the right time and in the right place. The health services involved in delivering support can share information so the support I receive meets my needs.

In the ideal future state, primary care and aged residential care (ARC) services are fully integrated to provide holistic, continuous, and high-quality care for older individuals. This model ensures that older people residing in ARC facilities or living independently at home have seamless access to primary healthcare services, fostering a collaborative approach that enhances their overall health and well-being.

Healthcare providers, including General Practitioners (GPs), Nurse Practitioners (NPs), Registered Nurses (RNs), and other allied health professionals, work closely with ARC staff to deliver coordinated and comprehensive care. This integrated system reduces the need for hospital admissions and supports older individuals in managing chronic conditions, promoting preventive care, and maintaining a high quality of life.

Key aspects:

- **Seamless integration of services:** Primary care services are embedded within ARC facilities, ensuring residents have immediate access to medical care. Regular on-site visits by primary care providers to ARC facilities enhance the monitoring and management of residents' health conditions.
- **Collaborative care teams:** Multidisciplinary teams, including primary care, pharmacists, and allied health professionals, collaborate to develop and implement individualised care plans. Care teams work together to provide comprehensive assessments, treatments, and follow-up care, ensuring all aspects of an older person's health are addressed.
- **Enhanced access to primary care:** Older individuals living independently have improved access to primary care services through community outreach, telehealth,

and mobile clinics. Primary care providers are trained to address the specific needs of older adults, ensuring age-appropriate and sensitive care.

- **Proactive health management:** Focus on preventive care and early intervention to manage chronic conditions and prevent acute health issues. Regular health check-ups, screenings, and immunizations are provided to maintain and improve the health of older individuals.
- **Effective communication and coordination:** Integrated electronic health records facilitate real-time information sharing between primary care providers and ARC staff, ensuring continuity of care. Communication protocols are established to keep all members of the care team informed about the patient's health status and care needs.
- **Patient-centred care planning:** Individualised care plans reflect the unique needs, preferences, and goals of each older adult, with an emphasis on promoting independence and enhancing quality of life. Families and whānau are involved in the decision-making process.

Summary of themes

Participants highlighted the need for better integration between primary care and ARC facilities to provide seamless, high-quality care for older adults. Key challenges include fragmented communication, inconsistent care pathways, and inadequate funding models. Opportunities focus on creating integrated care networks, enhancing communication systems, and developing a more flexible funding structure to ensure that care is responsive to the individual needs of residents.

Key challenges

1. **Siloed communication**
    - Poor communication between primary care providers and ARC facilities.
    - Limited sharing of patient information, leading to fragmented care.
    - Inconsistent care coordination among different healthcare providers.
2. **Inconsistent care pathways**
    - Disjointed transitions from hospital to ARC and vice versa.
    - Lack of standardised protocols for managing patient transitions.
    - Patients and families often find care pathways confusing and difficult to navigate.
3. **Inadequate funding models**
    - Current funding models do not reflect the complexity and diversity of patient needs.
    - Insufficient financial incentives for ARC facilities to invest in comprehensive care services.
    - Funding disparities between regions, affecting the quality and availability of care.

Opportunities and ideas

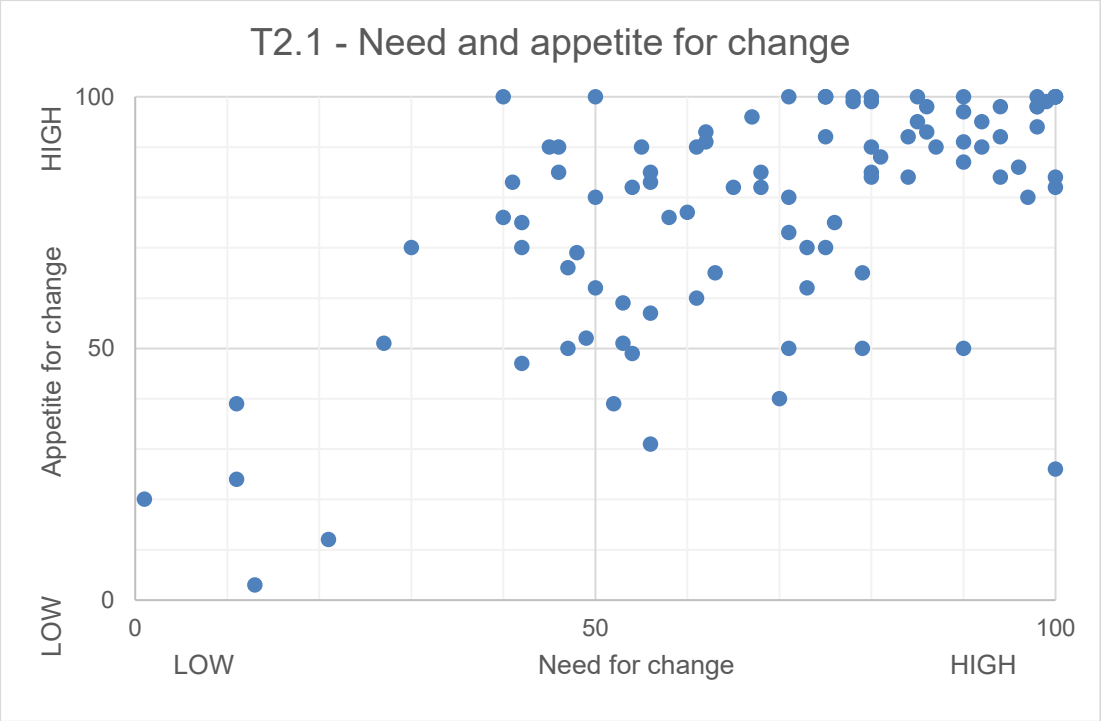
1. **Establish integrated care networks**

- Facilitate multidisciplinary teams that include primary care, ARC staff, and other healthcare providers.
- Develop shared care plans that are accessible to all relevant providers.
- Implement care coordinators to manage transitions and ensure continuity of care.

2. **Enhance communication systems**
    - Use technology to facilitate real-time information sharing between primary care and ARC.
    - Standardise communication protocols to ensure all providers have access to up-to-date patient information.
    - Provide training for effective communication among healthcare providers.
3. **Flexible funding models**
    - Develop a flexible funding model based on comprehensive assessments like the interRAI LTCF.
    - Ensure funding models reflect the specific care needs of each patient.
    - Advocate for increased funding to address the growing demand for aged care services.
4. **Standardise care pathways**
    - Create clear, standardised protocols for patient transitions between hospital, home, and ARC.
    - Provide comprehensive discharge planning that involves patients and their families.
    - Develop tools and resources to help patients and families understand and navigate care pathways.
5. **Culturally competent care**
    - Ensure that care services that are culturally appropriate and meet the needs of Māori and Pacific peoples are available and accessible.
    - Partner with local iwi and community organizations to design and deliver culturally competent care.
    - Provide training for ARC staff on cultural competence and sensitivity.

Appetite for change

The sector generally believes there is a strong need for change and have a healthy appetite for it.



Regional differences

- **Te Manawa Taki Region (Hamilton and Gisborne)**: Championed the importance of culturally appropriate care and strong partnerships with local iwi to ensure that care meets the needs of Māori and Pacific peoples.
- **Central Region (Porirua and Palmerston North)**: Emphasised addressing inequities in ARC design and high turnover of nurses, suggesting funding for allied health and career pathways as opportunities. They also highlighted gaps in communication between primary care and ARC facilities, with a need for better coordination and information sharing.
- **Te Waipounamu Region (Dunedin and Christchurch)**: Focused on challenges related to the integration of care in rural areas, where resources and services are more limited. They noted opportunities in telehealth and flexible ARC approaches.
- **Northern Region (Whangarei)**: Raised issues related to the variability in funding models and the impact on the quality and consistency of care. They called for better integration of medical records and transparency in regulatory processes, with opportunities in integrated medical record systems and Kaupapa Māori options for ARC.
- **Auckland Metro**: Stressed equity for Māori and Pacific populations and addressing fragmentation in care, suggesting increased nurse practitioners and AI use for workforce issues as opportunities. They reported better integration and communication between providers but still faced challenges with funding and ensuring care pathways are easy to navigate for patients and families.

2.2 Short-term ARC care

Ideal future state

System perspective	Person perspective
ARC is not just for long term care but can support people in the short term until they are ready to go home.	I am not left in hospital when my health needs could be met and supported in an ARC facility.

In the ideal future state, short-term aged residential care (ARC) support is seamlessly integrated into the healthcare continuum, providing flexible, responsive, and high-quality care for older individuals who require temporary assistance. This model ensures that short-term ARC services are available to support older people during transitions from hospital to home, recovery from acute health episodes, and respite for family caregivers.

Short-term ARC support is designed to meet the diverse needs of older individuals, offering a range of services from rehabilitation and restorative care to respite and palliative care. This approach promotes continuity of care, reduces hospital readmissions, and supports older individuals in maintaining their independence and quality of life.

Key aspects:

- **Flexible and responsive services:** Short-term ARC services are adaptable to meet the varying needs of older individuals, providing care for a few days to several weeks as required. Services include rehabilitation, restorative care, respite care, and palliative care, ensuring comprehensive support.
- **Seamless transitions:** Effective coordination between hospitals, primary care, and ARC facilities ensures smooth transitions for older individuals from one care setting to another. Discharge planning and follow-up care are integrated into the care pathway to facilitate timely and safe transitions back home or to long-term care.
- **Rehabilitation and restorative care:** Short-term ARC provides specialised rehabilitation services to help older individuals recover from surgery, illness, or injury. Restorative care focuses on improving functional abilities and promoting independence, with tailored interventions from physiotherapists, occupational therapists, and other allied health professionals.
- **Support for family caregivers:** Respite care services offer temporary relief for family caregivers, ensuring they can take a break and recharge while their loved ones receive quality care. Flexible respite options are available to accommodate the needs of caregivers and older individuals.
- **Enhanced access and equity:** Short-term ARC services are accessible to all older individuals, regardless of their geographic location or socioeconomic status. Services are designed to be culturally competent and inclusive, meeting the unique needs of Māori, Pacific, and other diverse communities.

Summary of themes

The feedback emphasised the need to incentivise short-term support options within ARC facilities to facilitate recovery and transition back to home. Key challenges include insufficient availability of short-term beds, limited protocols for short-term stays, overwhelming paperwork for short stays and lack of funding incentives for this type of care.

Opportunities include developing flexible short-term care models, enhancing discharge planning, and integrating ARC with community and primary care services.

Key challenges

1. **Availability of short-term beds**
    - Limited availability of beds designated for short-term stays.
    - High demand for both long-term and short-term ARC services.
    - Difficulty in balancing the needs of long-term residents with those requiring short-term care.
2. **Limited protocols for short-term care**
    - Absence of standardised protocols for managing short-term stays in ARC.
    - Inconsistent criteria for admission and discharge of short-term residents.
    - Challenges in coordinating care between hospital, ARC, and home.
3. **Funding constraints**
    - Inadequate funding models to incentivise short-term ARC services.
    - Financial pressures on ARC facilities to prioritise long-term residents.
    - Need for flexible funding that accommodates varying lengths of stay.

Opportunities and ideas

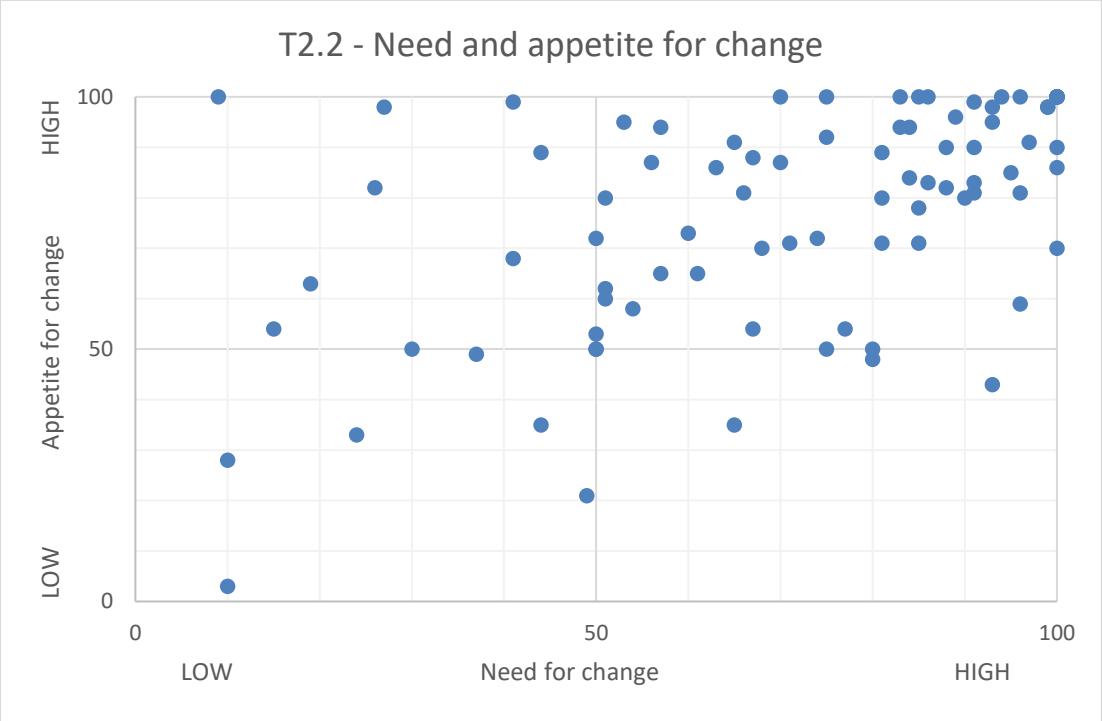
1. **Flexible short-term care models**
    - Commission care models that allow ARC facilities to offer both short-term and long-term care.
    - Ensure these models are responsive to the individual needs of residents.
    - Implement pilot programs to test and refine short-term care approaches.
2. **Enhanced discharge planning**
    - Improve discharge planning from hospitals to ensure smooth transitions to ARC and back home.
    - Involve multidisciplinary teams in creating discharge plans.
    - Provide support and resources to families to facilitate home care post-discharge.
3. **Integrated care services**
    - Strengthen the integration of ARC with community and primary care services.
    - Develop partnerships between hospitals, ARC, and home care providers.
    - Use technology to support continuity of care and information sharing.
4. **Flexible funding models**
    - Advocate for funding models that support both short-term and long-term care needs (such as ratios, or allocated beds)

- Ensure funding reflects the intensity and duration of care required for short-term residents.
- Provide financial incentives or mandates for ARC facilities to offer short-term care options.

5. **Standardised admission and discharge criteria**
    - Establish clear, standardised criteria for the admission and discharge of short-term residents.
    - Ensure these criteria are consistently applied across all ARC facilities.
    - Develop tools and resources to support ARC staff in managing short-term stays to ensure quality of care.

Appetite for change

The sector generally believes there is a strong need for change and have a large appetite for it.



Regional differences

- **Te Manawa Taki Region (Hamilton and Gisborne)**: Emphasised the need for culturally appropriate short-term care models that respect the traditions and values of Māori and Pacific peoples. They also raised their need for upgrading facilities, improving the speed and quality of assessments, and ensuring affordability. Attitude shifts towards elderly care was a strong focus as well.
- **Central Region (Porirua and Palmerston North)**: Highlighted the administrative burdens and the necessity of transparency in bed allocations. They emphasised integrated data systems, transitional care models, and the need for a cultural shift among staff.

- **Te Waipounamu Region (Dunedin and Christchurch)**: Focused on the challenges of providing short-term care in rural areas where resources are limited. They pointed out the need for skilled workforce and better communication during transitions. They stressed early conversations about care options, differentiated funding for short-term care, and reducing compliance burdens.
- **Northern Region (Whangarei)**: Raised concerns about the availability of short-term beds and the need for better funding models. They advocated for flexible funding for palliative patients, improved access to physio and OT services, and a distinct funding model for short-term care.
- **Auckland Metro**: Reported better availability of short-term care options but still faced challenges with integrating these services into the broader care continuum. They cited the high costs and inadequate funding models that discourage short-term care. They suggested developing the workforce for rehab roles, expanding interim care services, and ensuring better communication and medication management for short-term admissions.

2.3 Case-mix funding for ARC

Ideal future state

System perspective	Person perspective
Our funding system reflects assessed needs derived from InterRAI LTCF – as described in the NZ RUGIII-15 case-mix.	The care I receive is right for my level of need and my care provider is funded to recognise my needs.

In the ideal future state, funding for aged care services is allocated based on the assessed needs of older individuals, ensuring that resources are directed where they are most required. This model prioritises equity, transparency, and efficiency, enabling a more responsive and sustainable aged care system. By basing funding on comprehensive assessments, the system can deliver personalised and high-quality care that adapts to the evolving needs of older people.

The funding model supports a continuum of care that spans home support, community services, and ARC, promoting independence and enhancing the quality of life for older individuals. It also addresses regional disparities and ensures that all older people, including those from Māori, Pacific, and other diverse communities, receive equitable access to services.

Key aspects:

- **Needs-based allocation:** Funding is allocated based on thorough and regular assessments of individual needs, ensuring that resources are used efficiently and effectively. Assessment tools, such as interRAI, are employed to determine the level and type of care required, facilitating personalised care planning.
- **Equity and transparency:** The funding model is transparent, with clear criteria and processes for determining funding levels based on assessed needs. Efforts are made to eliminate regional disparities and ensure that all older individuals, regardless of location or socioeconomic status, receive fair and equitable support.
- **Comprehensive assessments:** Regular and comprehensive assessments are conducted to capture the full spectrum of an individual's needs, including physical,

mental, and social aspects. Assessments are person-centred, taking into account the preferences and goals of older individuals and their families.

- **Flexibility and responsiveness:** The funding model is flexible, allowing for adjustments based on changing needs and circumstances, such as acute health episodes or transitions between care settings. Resources are allocated in a timely manner to ensure that older individuals receive the appropriate level of care when they need it.
- **Support for diverse communities:** The funding model is designed to be inclusive and culturally competent, addressing the unique needs of Māori, Pacific, and other diverse communities. Culturally appropriate care practices are integrated into service delivery, ensuring respect and responsiveness to cultural values and traditions.
- **Sustainable and efficient use of resources:** By basing funding on assessed needs, the model promotes the efficient use of resources, reducing waste and ensuring sustainability. Investment in preventive and restorative care is prioritised to reduce long-term healthcare costs and improve health outcomes.

Summary of themes

The current funding system for Aged Residential Care (ARC) faces significant challenges, including the complexity and time-consuming nature of the interRAI assessments, which detract from direct patient care and add administrative burden. There is a need for a more streamlined, flexible, and transparent funding model that accurately reflects the diverse and evolving needs of residents, ensuring equity and quality across different care levels. Additionally, the integration of culturally appropriate care and support, better workforce development, and improved communication between stakeholders are critical to enhancing the effectiveness of ARC services. Opportunities exist to leverage technology, increase funding for specialised services, and foster a more holistic, patient-centred approach to care that includes both medical and social needs. This would support better transitions between care settings, reduce hospitalizations, and improve the overall sustainability and responsiveness of the ARC system.

Key challenges

1. **Current funding model not fit-for-purpose**
    - Current funding models are blunt and don’t reflect the diversity of patient needs assessed.
    - The current funding system does not always cater to individual needs and can be complex to administer.
    - There is a need for more funding to ensure appropriate staff ratios and facility maintenance.
    - Significant administrative burdens associated with managing funding.
2. **Inequities in funding distribution**
    - The current system does not adequately address the inequities in access to services, especially for rural and low-income populations.
    - Specific challenges were raised around providing adequate care and funding models for rural areas and specialised conditions such as dementia.
    - Inconsistent application of funding criteria across regions.

3. **Need for more accessible and flexible assessment tools**
    - The current version of the InterRAI assessment tool is seen as too complex and time-consuming, detracting from direct care.
    - Lack of a standardised tool to assess the needs of ARC residents.
    - Inconsistent assessments leading to variability in care quality.
    - Difficulties in aligning funding with actual care needs.
    - There is a lack of integration between different health services and levels of care because the assessment tools are not accessible

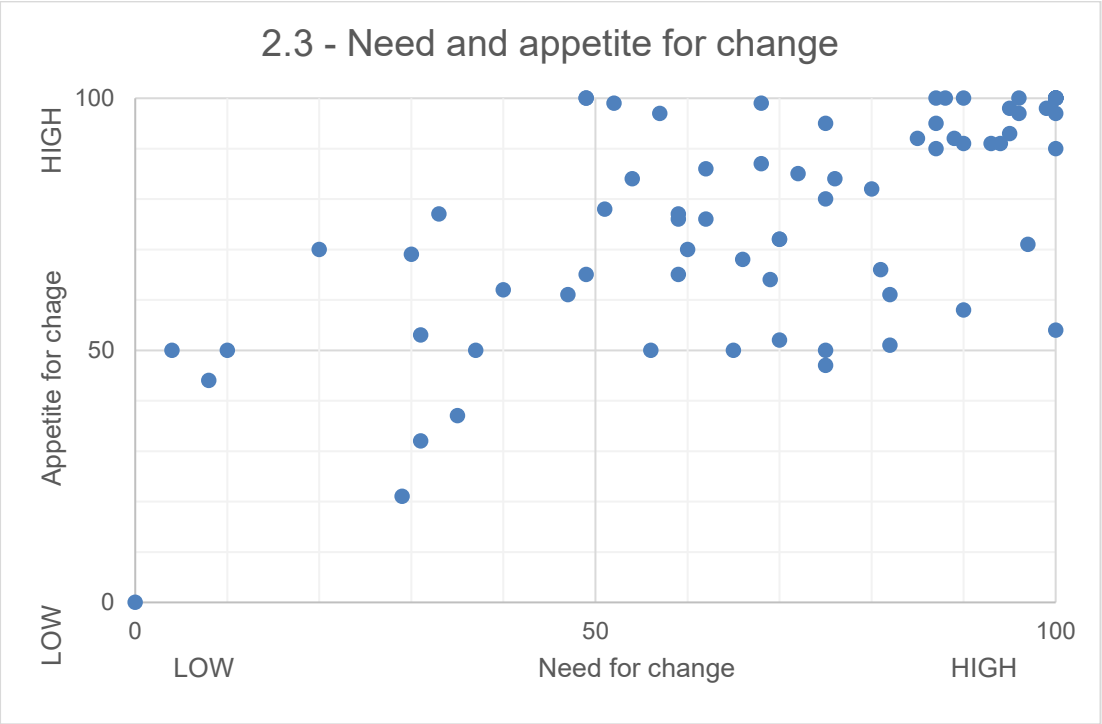
Opportunities and ideas

1. **Adapt funding to needs:**
    - Develop and test flexible funding models that cater to individual needs and complexities (including case-mix funding model based on comprehensive assessments like the interRAI LTCF)
    - Ensure funding reflects the specific care needs of each resident, and their family and whānau context, in addition to their health needs.
    - Develop guidelines for consistent application of the funding models across the motu
    - Ensure transparency in the funding allocation process and monitor and evaluate funding distribution to address inequities.
2. **Improve the needs assessment process**
    - Improve assessment process to ensure accuracy and consistency, while not wasting people's time
    - Expand who is trained to the use of assessment tools to enhance reliability.
    - Regularly review and update assessments to reflect changes in residents' needs.
    - Simplify the interRAI tool and its assessment process to ensure it accurately reflects the needs of the residents.
3. **Ensure equity in funding models**
    - Adapt funding models to address disparities based on socioeconomic status and geographic location.
    - Ensure funding models are responsive to the unique needs of rural and underserved communities.
    - Provide additional support to regions with higher care demands.
    - Incorporate cultural appropriateness and social needs into care assessments, planning and funding.
    - Develop models and funding to support care in rural areas and for specialised conditions like dementia.
4. **Increase access and understanding of assessment data**

- Educate healthcare providers and caregivers about the benefits and functionalities of the InterRAI tool to promote its effective use and integration into care planning.
- Leverage InterRAI assessment data to enhance coordination between home care, hospitals, and ARC facilities, ensuring smooth transitions and continuity of care.
- Use InterRAI data to inform care planning and develop targeted interventions that address specific needs within the lead categories.

Appetite for change

In this area, the sector generally believes there is a strong need for change and have a large appetite for it.



Regional differences

- **Te Manawa Taki Region (Hamilton and Gisborne)**: There is a strong emphasis on creating culturally competent assessments and funding models to better reflect the unique needs of Māori and Pacific peoples. Stakeholders stress the importance of culturally tailored services and equitable resource distribution to address the specific challenges faced by these communities.
- **Central Region (Porirua and Palmerston North)**: Standardising assessment tools to ensure consistent and fair funding distribution is a primary concern. This region highlights the need for robust training programs for staff to accurately assess needs and allocate resources efficiently.
- **Te Waipounamu Region (Dunedin and Christchurch)**: Addressing funding disparities in rural areas is a key focus. This region often faces limited access to resources and specialized care. There is a call for increased funding to support the high care demands and to attract and retain healthcare professionals in these remote locations.

- **North Region (Whangarei)**: Simplifying the current funding models is crucial. Stakeholders express the need for more transparent and easier-to-navigate funding processes. Additionally, there is a call for equitable distribution of resources to ensure that all residents receive the necessary support regardless of their location.
- **Auckland Metro**: While there is better access to funding and services in this region, challenges remain in ensuring equitable distribution across its diverse population. Stakeholders emphasize the importance of maintaining consistent care standards and addressing the needs of underserved communities within the metropolitan area.

3. Supporting our carers

3.1 Access to carer respite options

Ideal future state

System perspective	Person perspective
Our health system proactively provides flexible support for carers to reduce their stress and enable them to continue to support their family/whānau member.	My carers can access meaningful respite options that meet our needs and allow us to maintain a healthy relationship.

In the ideal future state, the aged care system offers comprehensive and flexible support for carers, recognising their crucial role in the well-being of older individuals. This model ensures that carers have access to the resources, respite, and assistance they need to provide effective and sustainable care. By supporting carers, the system promotes the health and quality of life of both carers and the older people they look after.

The support system is designed to be responsive to the diverse needs of carers, offering a range of services that can be tailored to individual circumstances. This includes financial assistance, respite care, education and training, and emotional support. The aim is to alleviate the burden on carers, enhance their capacity to provide care, and ensure their own health and well-being.

Key aspects:

- **Comprehensive respite services:** A variety of respite options are available to meet the differing needs of carers, including in-home respite, residential respite, and day programs. Respite services are designed to be easily accessible and flexible, allowing carers to take breaks when needed to recharge and prevent burnout. These options are integrated into care plans. Care coordinators work with carers to navigate the healthcare system, access services, and ensure continuity of care for older individuals.
- **Training and social support:** Carers have access to ongoing education and training opportunities to enhance their skills and knowledge, enabling them to provide better care. Training programs cover a range of topics, from specific health conditions to practical caregiving skills and emotional resilience. Carers have access to counselling services, support groups, and peer networks to address emotional and psychological needs.
- **Support for diverse communities:** Carer support services are culturally competent and inclusive, addressing the specific needs of Māori, Pacific, and other diverse

communities. Culturally appropriate resources and services ensure that carers from all backgrounds receive the support they need.

Summary of themes

Carers play a vital role in supporting older adults, but they often face significant challenges that impact their well-being and ability to provide care. To achieve the ideal future state of proactive support for carers, key challenges include the need for flexible and diverse respite options, difficulties in navigating and accessing support services, inadequate funding mechanisms, and significant mental health and burnout issues among carers. Additionally, there is a need for culturally sensitive respite services tailored to Māori and Pacific communities. Opportunities for improvement involve expanding respite services to include home-based and day support options, proactively assessing and identifying carers' needs, simplifying funding processes, and increasing financial support. Providing access to mental health and well-being services, developing culturally appropriate respite services, and strengthening community support networks are also crucial. By addressing these areas, the health system can better support carers, reduce their stress, and enable them to continue supporting their family members effectively.

Key challenges

1. **Administrative complexity**
    - Carers face significant barriers in navigating the administrative processes required to access support. They don’t know what is available, what they quality for, or how to request it.
    - The complexity of filling out forms and submitting invoices for subsidies is a deterrent.
    - Inconsistent application and understanding of policies across regions add to the difficulty.
    - The funding and support mechanisms are often too rigid and do not accommodate the individual needs of carers and their families.
2. **Difficult and inconsistent access to respite services**
    - Carers face significant challenges in navigating the available support options, and there is a lack of awareness about the resources and services available.
    - Availability of respite care varies significantly across different regions.
    - Many carers report difficulties in finding available respite services even when they are allocated.
    - The lack of restorative respite models that support carers' well-being is a major concern.
3. **Insufficient mental health support**
    - Carers often experience high levels of stress and burnout due to their caregiving responsibilities.
    - There is a lack of accessible mental health resources tailored to carers.
    - Support systems for carers' emotional and psychological well-being are inadequate.

4. **Cultural and regional respite options**
    - The support system does not adequately address the cultural and regional needs of different communities, particularly Māori and Pacific populations.
    - Respite options are limited in rural areas, if they are available at all.

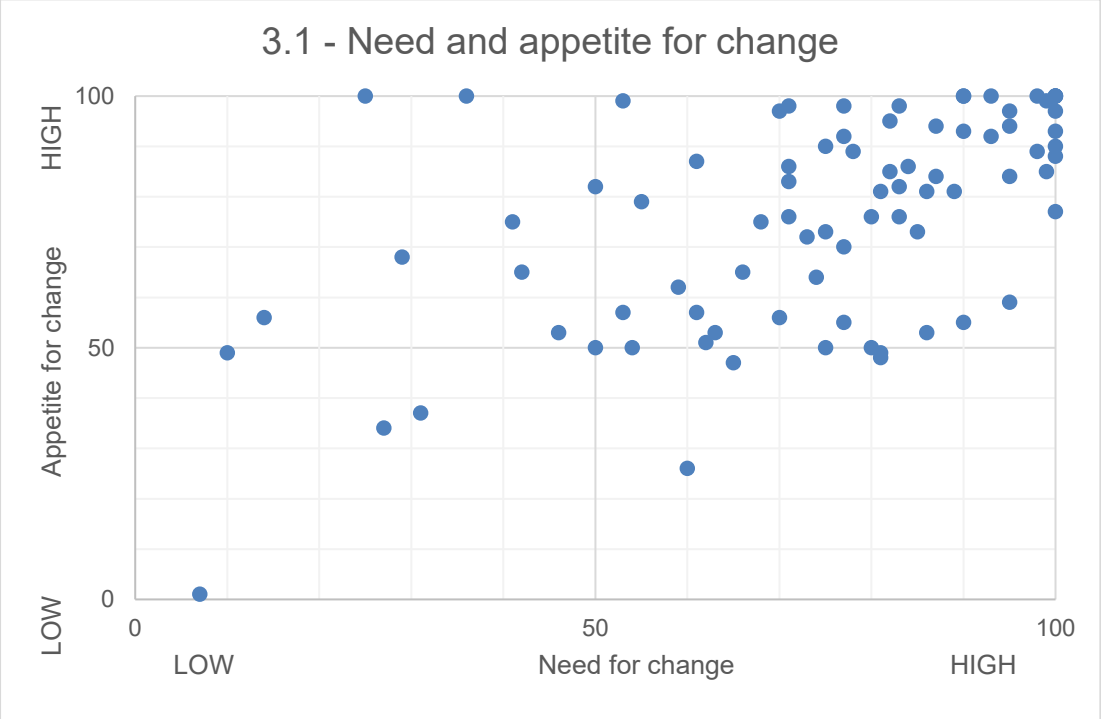
Opportunities and ideas

1. **Increase availability and flexibility of respite services**
    - Develop and support a variety of flexible respite options that can be tailored to the needs of individual carers, such as in-home respite, night care, and day support, across all regions
    - Increase provision for emergency respite care provisions.
    - Promote restorative respite models that focus on both the carer and the cared-for person.
    - Ensure there are culturally appropriate or sensitive options for respite in all regions.
    - Explore possible individualised funding packages.
2. **Improve navigation and support systems**
    - Implement systems to help carers navigate available resources more easily and provide continuous support through dedicated navigators.
    - Establish of navigation services to guide carers.
    - Enhance system navigation support for carers.
    - Provide digital booking systems for respite care.
3. **Simplify access to funding and services**
    - Simplify the process of accessing funding and services for carers to reduce barriers and enhance support.
    - Simplification of carer support paperwork and processes, such as user-friendly online platforms for submitting forms and invoices.
    - Provide clear guidelines and support for carers to navigate administrative requirements.
    - Streamline funding models to reduce administrative tasks to expedite decision-making and communication.
4. **Promote carer mental health and well-being**
    - Increase support for carers' mental health and well-being through accessible counselling, support groups, and respite options tailored to their needs.
    - Provide training and resources to help carers manage stress and prevent burnout.
    - Establish support groups and networks to connect carers with peers and professionals.
5. **Support culturally responsive care**

- Ensure that all carers, regardless of location, have access to the support they need. Particularly, address disparities in service availability between urban and rural areas.
- Implement policies that promote equity in carer support services. Such as, culturally sensitive training for care providers.
- Develop culturally specific respite care services and ensure that care provision is culturally sensitive and appropriate. Engage with ethnic communities to tailor respite care.

Appetite for change

In this area, the sector generally believes there is a strong need for change and have a large appetite for it.



Regional differences

- **Te Manawa Taki Region (Hamilton and Gisborne)**: Emphasised the need for culturally appropriate carer support services and better integration with iwi-based care models.
- **Central Region (Porirua and Palmerston North)**: Highlighted the importance of simplifying administrative processes and providing more consistent access to respite services. They also highlight the need for innovative solutions and localised support, particularly for rural communities, and emphasise mental health support for carers.
- **Te Waipounamu Region (Dunedin and Christchurch)**: Focused on addressing the lack of available respite services in rural areas and the need for better mental health support for carers. They recommended prioritising emergency respite care, NGO-led programs, and simplifying funding access, with significant concern for carer burnout.

- **Northern Region (Whangarei)**: Raised concerns about the complexity of accessing subsidies and the variability in service quality, particularly in rural areas who may not have access to any options at
- **Auckland Metro**: Reported better access to services but still faced challenges with administrative complexity and ensuring comprehensive support for carers. They also reiterated the need to ensure culturally sensitive care for Māori, Pacific and Asian communities.

3.2 Access to NGO support

Ideal future state

System perspective	Person perspective
Our health system takes a planned, integrative approach to support improved access to the wider NGO system.	After receiving a specific diagnosis, I am feeling overwhelmed and anxious. After a visit from a relevant NGO specialist service, I have clarity about what this means for me and my future.

In the ideal future state, non-governmental organisations (NGOs) are integral to the aged care system, providing essential support and services that complement those offered by public and private sectors. This model ensures that older individuals and their carers have seamless access to a wide range of NGO services, which play a critical role in enhancing the quality of life, promoting independence, and supporting holistic well-being.

NGOs bring unique strengths, including community connections, specialised expertise, and innovative approaches to care. By fostering strong partnerships between the healthcare system and NGOs, the aged care system can deliver more comprehensive and person-centred care that meets the diverse needs of older people, including those from Māori, Pacific, and other culturally diverse communities.

Key aspects:

- **Seamless integration of NGO services:** NGO services are fully integrated into the aged care continuum, ensuring that older individuals can easily access a broad spectrum of support, from social and recreational activities to specialised health services. Collaboration between NGOs and public health providers is facilitated through effective communication and coordination mechanisms. Partnerships and collaborations between NGOs, government agencies, and other stakeholders are encouraged to enhance service delivery and resource sharing.
- **Equitable access:** Efforts are made to ensure that NGO services are accessible to all older individuals, regardless of their geographic location, socioeconomic status, or cultural background. Funding and resources are allocated to NGOs in a way that promotes equity and addresses regional disparities in service availability.
- **Comprehensive information and referral systems:** Older individuals and their carers have access to comprehensive information and referral systems that help them navigate available NGO services. Care coordinators and navigators assist with connecting individuals to appropriate NGO services based on their needs and preferences.

Summary of themes

NGOs provide critical support services for carers and older adults, yet there are significant challenges in integrating these services into the broader health system. To achieve the ideal future state where our health system takes a planned, integrative approach to support improved access to the wider NGO system, several key challenges need to be addressed. The current system requires enhanced integration and collaboration between healthcare providers and NGOs to ensure coordinated and holistic care. Carers often face difficulties accessing relevant information and services, highlighting the need for clear, accessible pathways and improved health literacy programs. Proactive support and early intervention are essential, with systems for early proactive assessments to identify families needing assistance. Culturally and linguistically appropriate models are crucial to meet the diverse needs of carers and those they support. Additionally, securing adequate funding and resources for NGOs and healthcare providers is vital to deliver comprehensive and effective support. By addressing these challenges, we can create a more cohesive and supportive environment for carers and their families.

Key challenges

1. **Limited awareness of NGO services**
    - Carers and older adults are often unaware of the full range of NGO services available to them.
    - Information about NGO support is not readily accessible or well-publicised.
    - Healthcare providers may lack knowledge about NGO resources to refer patients appropriately.
2. **Inconsistent integration with healthcare providers**
    - Collaboration between NGOs and healthcare providers varies significantly across regions. Carers often struggle to access relevant information and services due to complex systems and insufficient support.
    - Lack of formal referral pathways hinders seamless integration of NGO services.
    - Carers and older adults face difficulties in navigating between healthcare and NGO services.
3. **Funding and infrastructure constraints**
    - NGOs often struggle with limited and unstable funding sources.
    - Financial pressures impact the ability of NGOs to provide consistent and comprehensive support.
    - Funding disparities exist between different regions and types of services.

Opportunities and ideas

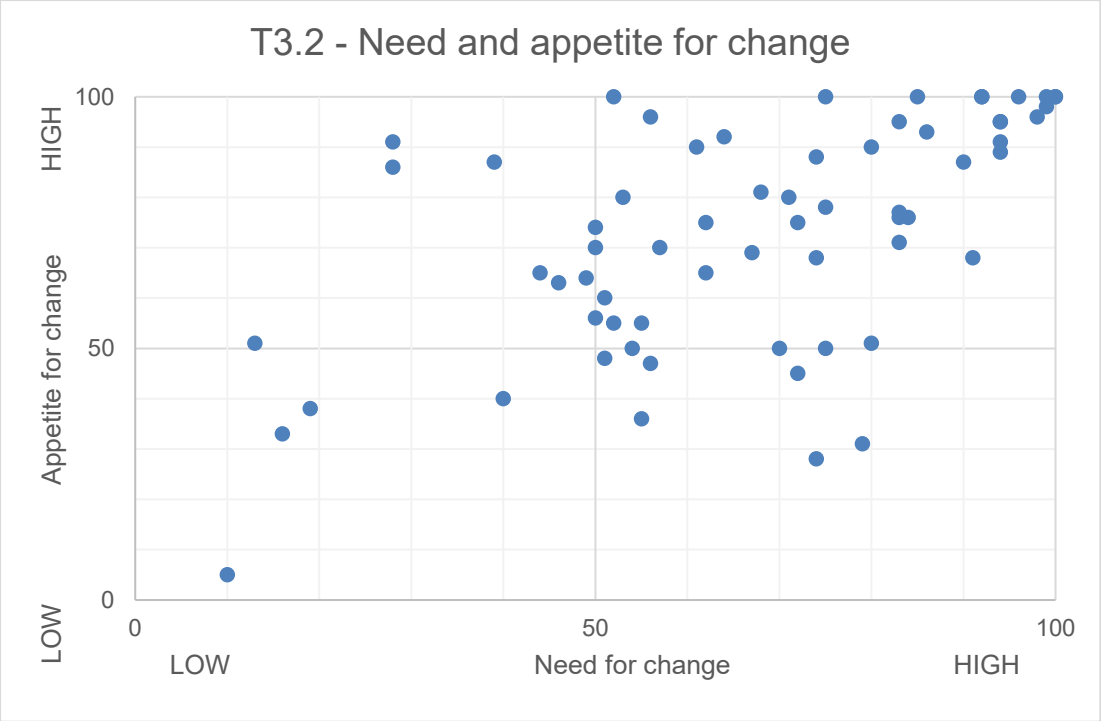
1. **Increased awareness and accessibility of NGO services**
    - Ensure that no matter ‘what door someone knocks on’, they are able to start a pathway for care that includes NGO options.

- Provide comprehensive directories and online resources listing NGO services, and train healthcare providers to effectively refer patients to appropriate NGO services.
- Strive for consistent treatment options and accessible options across regions.

2. **Streamlined referral processes**
    - Importance of early referral to NGO services where required.
    - Proactive identification of families that need support.
    - Utilise navigators to coordinate and arrange appropriate solutions.
    - Simplify the referral process to NGOs through centralised platforms.
    - Develop standardised referral protocols to ensure consistency.
    - Monitor and evaluate referral outcomes to continuously improve the process.
3. **Enhanced collaboration with healthcare providers**
    - Develop more integrated care pathways and partnerships that include NGOs and other community services.
    - Facilitate regular communication and coordination meetings between NGOs and healthcare teams through shared care plans.
    - Create clear, accessible pathways for all types of carers to find and use relevant information and services.
4. **Improve cultural and linguistic appropriateness**
    - The support system needs to be culturally and linguistically appropriate to meet the diverse needs of carers and those they care for.
    - This includes support for cultural traditions and appropriate care models, the need for information and services in multiple languages and recognition of Māori and Pacific definitions of care.

Appetite for change

In this area, the sector generally believes there is a strong need for change and have a large appetite for it.



Regional differences

- **Te Manawa Taki Region (Hamilton and Gisborne)**: Emphasised the importance of integrating NGO services with iwi-based care models and improving awareness among Māori communities.
- **Central Region (Porirua and Palmerston North)**: Highlighted the need for better collaboration between NGOs and healthcare providers and consistent referral processes. They also emphasised the economic burden on relatives (particularly female) who act as carers.
- **Te Waipounamu Region (Dunedin and Christchurch)**: Focused on addressing funding constraints and ensuring equitable access to NGO services in rural areas.
- **Northern Region (Whangarei)**: Raised concerns about the limited awareness of NGO services and the need for more accessible information.
- **Auckland Metro**: Reported better integration with healthcare providers but still faced challenges with sustainable funding and comprehensive support.

3.3 Restorative respite care

Ideal future state

System perspective	Person perspective
Respite care is responsive and meaningful and supports functional improvement and increased independence.	When I am away from my main carer, I am supported to maintain and/or regain function in a meaningful way.

In the ideal future state, respite care is responsive, accessible, and tailored to meet the diverse needs of older individuals and their carers. This model ensures that respite services are available when and where they are needed, providing essential relief and support for carers while promoting the health and well-being of older people.

Respite care services are comprehensive, offering a range of options including in-home respite, residential respite, and day programs. The goal is to support carers by giving them the necessary breaks to maintain their health and resilience, while ensuring that older individuals receive consistent and beneficial care during these periods.

Key aspects:

- **Flexible and accessible respite options:** A variety of respite care options are available to cater to different needs, including in-home respite, residential respite, and community-based day programs. Respite services are easy to access and book, with minimal administrative barriers and wait times, ensuring timely support for carers. Efforts are made to ensure that respite care services are equitably distributed across different regions, addressing disparities in access and availability. Special attention is given to underserved areas and populations to ensure that everyone has the opportunity to benefit from respite care.
- **Integration with community care:** Respite care is seamlessly integrated with other community care services, facilitating smooth transitions and continuity of care. Care coordinators work with carers and healthcare providers to ensure that respite services align with the overall care plan for the older person. Clear and comprehensive information about available respite care options is provided to carers and older individuals, helping them make informed decisions. Care coordinators assist with referrals and navigating the respite care system, ensuring that families can easily access the support they need.
- **Restorative and rehabilitative focus:** Respite care includes elements of restorative and rehabilitative support, helping older individuals maintain or improve their functional abilities during respite periods. Activities and therapies aimed at enhancing physical and mental well-being are incorporated into care programs. Restorative care is delivered by trained and qualified professionals who are skilled in meeting the specific needs of older individuals. Services are person-centred, ensuring that care plans are tailored to the individual's health, preferences, and routines.
- **Culturally competent and inclusive services:** Restorative care services are designed to be culturally sensitive and inclusive, catering to the diverse needs of Māori, Pacific, and other culturally diverse communities. Cultural values and preferences are respected and integrated into care practices, ensuring that all individuals feel understood and valued.

Summary of themes

Achieving the ideal future state for restorative care involves addressing several key challenges and leveraging various opportunities for improvement. Challenges include the lack of collaborative care planning and integration between healthcare providers and NGOs, inflexible and limited respite or restorative options, insufficient and inconsistent funding, and poor understanding and awareness of respite and restorative care options. Additionally, there is a need for better education and support for carers. Opportunities for improvement include implementing collaborative and holistic care plans, expanding flexible and accessible respite options, ensuring funding follows the person, increasing funding for specialised respite facilities and allied health support, and enhancing education and support for carers. By addressing these challenges and utilising these opportunities, respite care can become

more responsive, meaningful, and supportive of functional improvement and increased independence for both carers and those they care for.

Key challenges

1. **Insufficient availability and awareness of respite services**
    - Limited availability and high demand of respite care options across different regions, leads to long waiting times. Carers often struggle to find suitable respite care when needed.
    - Poor understanding and awareness of respite care options among carers and healthcare providers.
2. **Lack of restorative and respite care options**
    - Many respite services do not include restorative components to increase the independence of the older person.
    - Non-restorative respite care may lead to further stress and burnout for carers or lower uptake of services due to lack of trust.
    - The potential benefits of restorative respite care are not being fully realised.
3. **Need for more flexible respite options**
    - Respite services often lack flexibility to accommodate the varying needs of carers. Fixed schedules and rigid criteria make it difficult for carers to access respite care.
    - Lack of appropriate, culturally safe, and timely respite care settings.

Opportunities and ideas

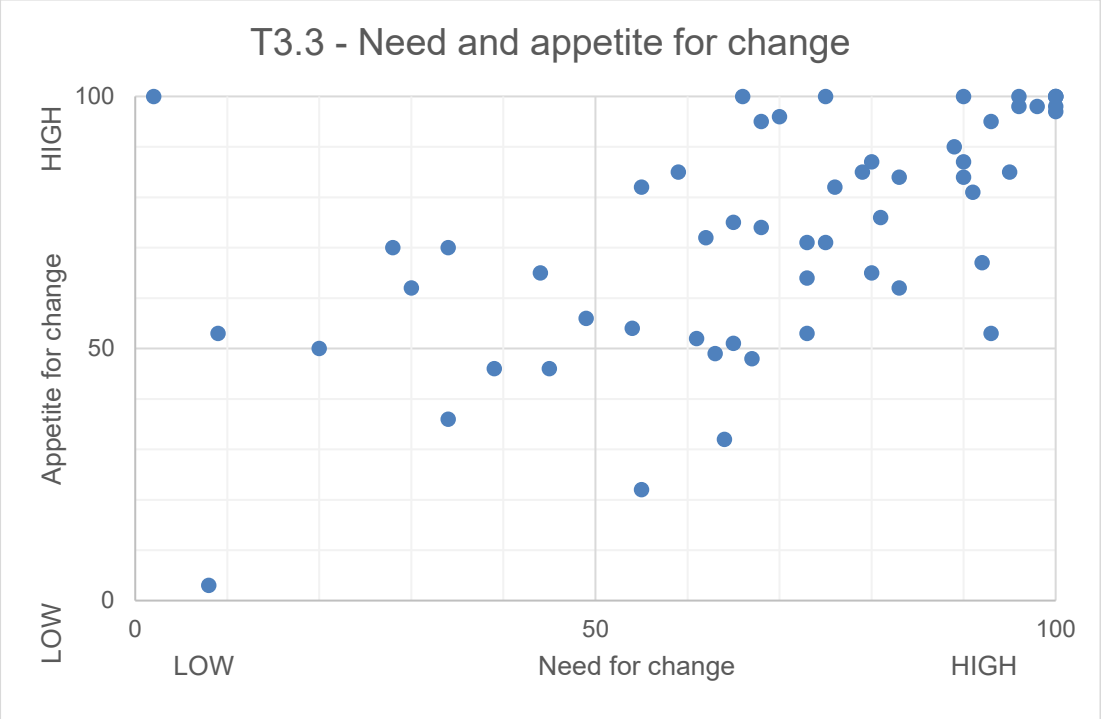
1. **Expand availability of respite services**
    - Increase the number of respite care facilities and programs across regions.
    - Ensure respite services are easily accessible to all carers, regardless of location.
    - Develop mobile respite care units to serve remote and underserved areas.
2. **Expand restorative respite care models**
    - Implement restorative care programs that focus on the well-being of both carers and care recipients.
    - Provide therapeutic activities and support during respite stays.
    - Evaluate and refine restorative respite models based on feedback and outcomes.
3. **Offer flexible and customizable respite options**
    - Offer a variety of respite care options, including day programs, overnight stays, and in-home respite.
    - Develop flexible scheduling and booking systems to accommodate carers' needs.

- Create personalised respite plans that cater to individual preferences and circumstances.
- Ensure funding allows for flexibility and choice in respite care

4. **Integrate with the wider Home and Community Support Services network**
    - Ensure respite care is integrated with other community and healthcare services.
    - Implement collaborative care planning and integrated support involving HCSS, NGOs, and social services.
    - Use technology to support seamless coordination and communication between services.
    - Develop holistic care plans that include social, health, and wellness aspects.
5. **Offer support for carers beyond respite**
    - Provide comprehensive support for carers during respite periods, including mental health and well-being programs.
    - Offer educational resources and training to help carers make the most of respite care.
    - Establish peer support groups and networks for carers to share experiences and advice.

Appetite for change

Around this topic, the sector generally believes there is a strong need for change and have a large appetite for it.



Regional differences

- **Te Manawa Taki Region (Hamilton and Gisborne) and Auckland Metro**: Both regions emphasised the need for culturally appropriate respite care options that incorporate Māori and Pacific values and practices. This included cultural competency training for providers.
- **Central Region (Porirua and Palmerston North)**: Highlighted the importance of flexible and customizable respite care to meet the diverse needs of carers.
- **Te Waipounamu Region (Dunedin and Christchurch)**: Focused on addressing the lack of respite care availability in rural areas and developing restorative respite models.
- **North Region (Whangarei)**: Highlighted the importance of integrating restorative respite care with existing community support networks. They emphasized leveraging the strengths of local NGOs and community groups to create a more cohesive support system for older adults and their carers.

4. Enhanced General Practice and Pharmacy

4.1 Integrated primary care and pharmacy services

Ideal future state

System perspective	Person perspective
Primary care teams, including Pharmacy services are integrated into the wider aged care system to collectively enable an older person to stay healthy at home as long as possible.	Every one of my health professionals support me to live my best life in my home.

In the ideal future state, primary care teams are fully integrated and work collaboratively to provide holistic, continuous, and high-quality care for older individuals. This model ensures that older people receive comprehensive care that addresses their physical, mental, and social needs, promoting overall health and well-being. Integrated primary care teams include General Practitioners (GPs), Nurse Practitioners (NPs), Registered Nurses (RNs), allied health professionals, and other care providers who work together to deliver coordinated and patient-centred care.

The integration of primary care teams enhances communication, reduces fragmentation of services, and ensures that older individuals receive timely and appropriate interventions. This approach supports preventive care, early detection of health issues, and effective management of chronic conditions, reducing the need for hospital admissions and improving health outcomes.

Key aspects:

- **Collaborative care approach:** Primary care teams operate collaboratively, with all members contributing their expertise to develop and implement comprehensive care plans. Care plans are personalised and consider the physical, mental, and social aspects of health, ensuring a holistic approach to care. Older individuals and their families are actively involved in care planning and decision-making processes.

- **Seamless coordination and communication:** Integrated electronic health records facilitate real-time information sharing among care team members, ensuring continuity of care. Clear communication protocols are established to keep all team members informed about the patient's health status and care needs.
- **Proactive and preventive care:** Primary care teams focus on preventive care and early intervention, providing regular health check-ups, screenings, and immunizations. Health education and promotion activities are conducted to encourage healthy lifestyles and self-management of chronic conditions.
- **Improved management of chronic conditions:** Integrated care teams provide comprehensive management of chronic conditions, including medication management, monitoring, and lifestyle support. Multidisciplinary approaches are used to address complex health needs, reducing the burden of chronic diseases and improving quality of life.
- **Enhanced access to care:** Primary care services are accessible and available in a variety of settings, including community clinics, home visits, and telehealth. Efforts are made to reduce barriers to access, such as transportation and mobility issues, ensuring that all older individuals can receive the care they need.

Summary of themes

The integration of primary care teams, including pharmacy services, into the wider aged care system is essential for enabling older adults to stay healthy at home and receive the clinical care when needed within ARC facilities. Key challenges include fragmented care delivery, inadequate coordination among healthcare providers, and limited access to comprehensive primary care. Opportunities focus on enhancing collaboration among primary care teams, leveraging technology for seamless communication, and implementing integrated care models that ensure continuous support for older adults.

Key challenges

1. **Fragmented care delivery**
    - Disjointed services and lack of continuity in care, with multiple healthcare providers working in silos.
    - Inconsistent communication among healthcare professionals.
    - Older people and their whānau spend valuable time repeating themselves and don't always have the full picture of their care
2. **Inadequate coordination**
    - Poor coordination between primary care and aged care services.
    - Limited integration of pharmacy services into the care team.
    - Gaps in care transitions, especially from hospital to home.
3. **Limited access to comprehensive primary care**
    - Insufficient primary care support for older adults living independently.
    - Lack of resources for home visits and in-home primary care services.
    - Barriers to accessing primary care in rural and underserved areas.
    - Short consultation times are inadequate, particularly for complex cases.

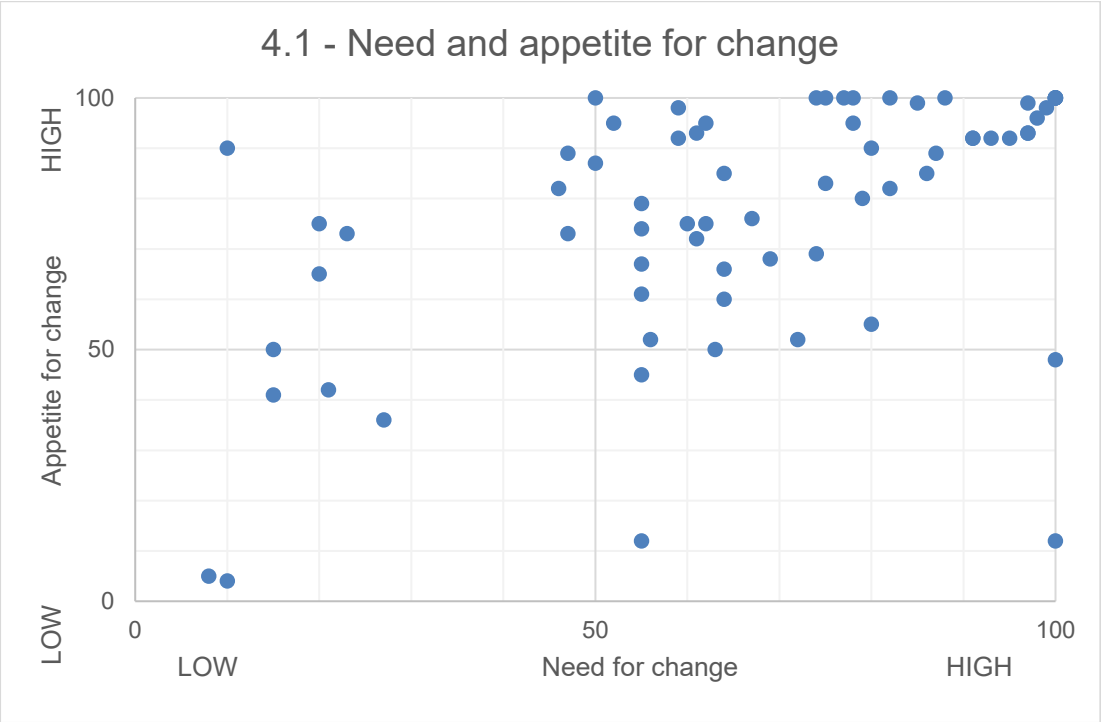
Opportunities and ideas

1. **Enhance collaboration among primary care teams**
    - Develop multidisciplinary teams that include GPs, nurses, pharmacists, and allied health professionals.
    - Implement shared care plans accessible to all team members and foster regular communication and case conferences to ensure coordinated care.
    - Enable GPs to work at the top of their scope through improved triage. Increase capability and capacity of non-physicians through training and shared information
2. **Leverage technology for seamless communication**
    - Pilot a national data platform to allow seamless sharing of health information among providers in real-time.
    - Introduce telehealth services to connect primary care teams with patients and each other.
    - Implement health passports that follow individuals through different parts of the healthcare system.
    - Implement secure messaging systems for quick communication among providers.
3. **Integrate care models**
    - Develop integrated care pathways that include comprehensive primary care, pharmacy, and aged care services.
    - Implement case management roles to coordinate care transitions and follow-ups.
    - Ensure that care models are patient-centred and tailored to individual needs.
    - Better equip primary care providers with knowledge about available ageing services, pathways and symptom identification.
4. **Support new/innovative primary care models**
    - Increase support for home-based primary care and telehealth options, particularly for remote communities
    - Utilise mobile health units to deliver in-person primary care services in remote areas.
    - Pilot primary care ‘’hubs” that are integrated with allied health and pharmacy in areas with reduced primary care access
    - Increase scope of pharmacies, such as pharmacist-led long-term chronic care management and medication reviews.
5. **Equitable access to primary care**
    - Address disparities in access to primary care across different regions and advocate for policies that support equitable distribution of primary care resources.

- Ensure that primary care services are culturally competent and accessible to all populations, including non-western medicines and approaches

Appetite for change

Around this topic, the sector generally believes there is a strong need for change and have a large appetite for it.



Regional differences

- **Te Manawa Taki Region (Hamilton and Gisborne)**: Emphasised the need for culturally competent primary care services that respect Māori and Pacific values and practices.
- **Central Region (Porirua and Palmerston North)**: Highlighted the importance of integrated care models and better coordination among primary care teams.
- **Te Waipounamu Region (Dunedin and Christchurch)**: Focused on the challenges of providing primary care in rural areas and the need for mobile health units.
- **North Region (Whangarei)**: Raised concerns about limited access to comprehensive primary care and the need for enhanced home visit programs.
- **Auckland Metro**: Reported better integration of primary care services but still faced challenges with ensuring continuity of care and seamless communication among providers.

4.2 Technology for seamless care

Ideal future state

System perspective	Person perspective

Technology enables seamless coordination of Primary Care with ARC and community services to provide consistent and aligned care.	When receiving care from multiple people, I never have to tell them something twice and I'm confident nothing gets missed.

In the ideal future state, established and emerging technology is leveraged to create a seamless and integrated care experience for older individuals. This model ensures that technology is used to enhance communication, coordination, and delivery of healthcare services, resulting in improved health outcomes and greater independence for older people. The adoption of user-friendly and accessible technological solutions supports real-time information sharing, remote monitoring, and personalised care.

Key aspects:

- **Real-time information sharing:** Integrated electronic health records (EHRs) enable real-time access to patient information for all healthcare providers, ensuring continuity and consistency in care. This allows for timely updates, accurate decision-making, and coordinated interventions across different care settings.
- **Remote monitoring and telehealth:** Telehealth services and remote monitoring technologies provide continuous oversight of an individual's health status. Wearable devices and home monitoring systems alert healthcare providers to any changes in condition, facilitating early intervention and reducing the need for hospital visits.
- **Predictive care:** Technology supports the development of personalised care plans that are tailored to the unique needs and preferences of each individual. Data analytics and predictive tools help identify potential health issues before they become serious, enabling proactive and preventive care.
- **Enhanced communication:** Digital communication platforms, such as secure messaging and video calls, allow for seamless interactions between older individuals, their families, and healthcare providers. This improves engagement, satisfaction, and coordination of care.
- **Inclusivity and accessibility:** Technological solutions are designed to be inclusive and accessible, catering to diverse needs and abilities. Features such as multi-language support, intuitive interfaces, and assistive technologies ensure that everyone, including Māori and Pacific elders, can effectively utilise these tools.

Summary of themes

Achieving the ideal future state where technology enables seamless coordination of primary care with ARC and community services requires addressing several challenges and leveraging key opportunities. Current barriers include the lack of a unified patient management system accessible to all healthcare providers, inconsistent use of software, and privacy concerns, which result in fragmented care and repeated information sharing by patients. Additionally, many older adults struggle with digital literacy and access to technology, particularly in rural areas. Effective communication and coordination are hindered by the need for better training in using prescribing and medication management technologies, poor inter-system communication, and the absence of standardised data sharing protocols. Policy and funding constraints, such as short-term funding cycles and inadequate support for technology integration, further complicate efforts. To bridge these gaps, opportunities lie in developing a national patient management system, adopting shared care plans, expanding telehealth services, and leveraging AI for medication management. Enhancing professional training, improving digital literacy among older adults, and facilitating regular sector meetings can improve care coordination. Policy reforms to

incentivise innovation and establish long-term funding frameworks are also crucial for sustaining technological advancements and integrated care approaches.

Key challenges

1. **Barriers to technology adoption**
    - **Centralised systems**: Lack of a unified patient management system accessible by all healthcare providers, leading to fragmented care and repeated information sharing by patients.
    - **System compatibility**: Inconsistent use of software across different healthcare settings, including primary care, hospitals, and community services, making it difficult to share and update patient information seamlessly.
    - **Privacy concerns**: Issues surrounding data privacy and security, with some providers reluctant to share information due to confidentiality terms and the health information privacy code. The lack of standardised protocols for data protection and security also caused confusion and hesitation around innovation.
    - **Access to technology**: Many older adults face difficulties using technology, either due to lack of digital literacy or inadequate access to internet infrastructure and devices, particularly in rural areas. Some cited financial barriers to implementing advanced technologies while older cited legacy systems as the major hurdles.
2. **Siloed communication and coordination**:
    - **Training and use cases**: Need for training healthcare professionals in the use of prescribing and medication management technologies like Medimap and eChart.
    - **Fragmented communication**: Poor communication between primary care, hospitals, ARC, and community services, leading to delays in care coordination and information sharing.
    - **Data sharing protocols**: Absence of standardised data sharing protocols and interoperability standards that facilitate smooth information flow across different healthcare systems.
3. **Lack of incentives for innovation**
    - **Funding models**: Current funding models do not adequately support the integration of advanced technologies and comprehensive care coordination, limiting innovation in primary care and community services.
    - **Long-term policy planning**: Short-term funding cycles tied to election cycles hinder long-term investments in technology and system integration

Opportunities and Ideas

1. **Unified patient data systems**
    - Develop and implement a national patient management system (or data protocols) that integrates primary care, hospital, ARC, and community

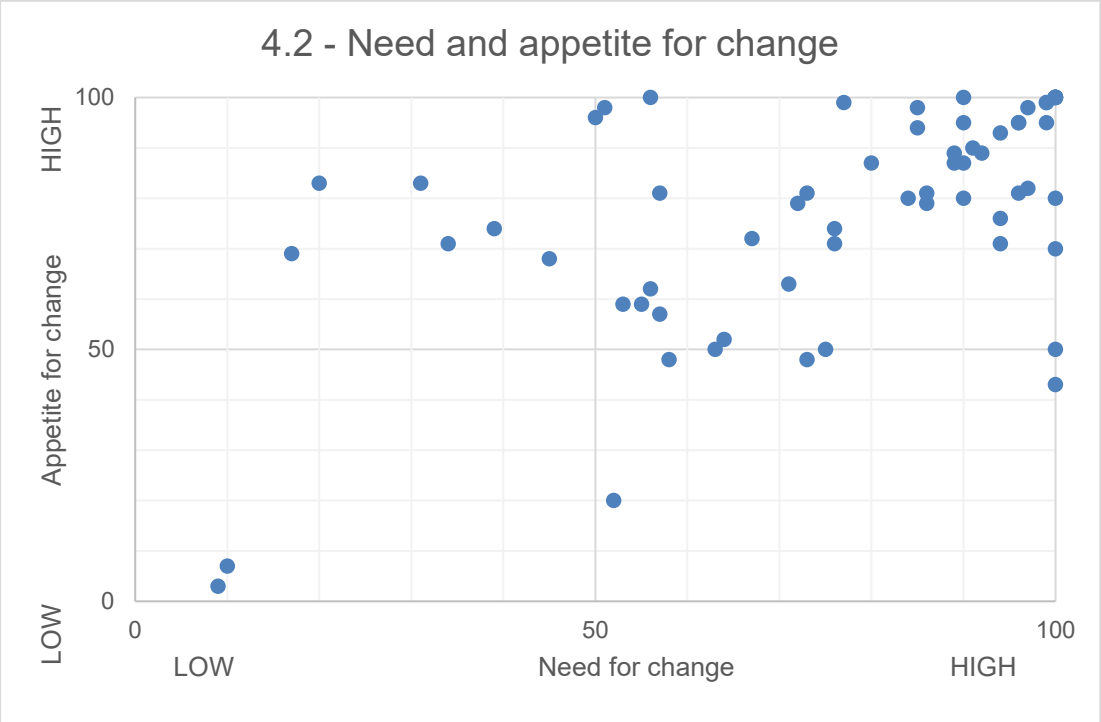
services, ensuring all providers have access to the same up-to-date patient information.

- Adopt shared care plans that are accessible to all healthcare providers involved in a patient's care, reducing the need for patients to repeat their stories and ensuring consistent care delivery.
- Endorse standardised guidelines for data collection, privacy and security compliance. Sunset old technology and leapfrog to modern platforms where able.

2. **Technology utilisation**:
    - Expand telehealth services and leverage AI for medication management and health monitoring, provide remote access to care and improve efficiency in prescribing and medication reconciliation.
    - Use remote monitoring devices to track patients' health status.
    - Integrate with mobile health apps for medication reminders and health management.
    - Allow patients and their families to access and manage their health records, enhancing personal agency and enabling better health management.
3. **Training and support**:
    - Support comprehensive training for healthcare professionals in using integrated health IT systems and medication management tools, ensuring effective utilisation of technology in patient care.
    - Implement programs to improve digital literacy among older adults and providing necessary technological support, such as devices and internet access, particularly in underserved areas.
4. **Enhanced communication and coordination**:
    - Develop IT systems that ensure seamless communication and data sharing between primary care, hospitals, pharmacies, and community services, reducing silos and improving care coordination.
    - Facilitate regular meetings between different healthcare providers to discuss and address coordination challenges, share updates, and streamline processes.
5. **Policy and funding reforms**:
    - Create funding models that incentivise innovation in primary care and community services, supporting the adoption of advanced technologies and integrated care approaches.
    - Establish long-term policy frameworks that support sustained investment in healthcare technology and integrated systems, beyond the constraints of time limited funding cycles.

Appetite for change

Around this topic, the sector generally believes there is a strong need for change and have a large appetite for it.



Regional differences

- **Te Manawa Taki Region (Hamilton and Gisborne)**: Emphasised the need for culturally appropriate digital health tools that meet the needs of Māori and Pacific populations.
- **Central Region (Porirua and Palmerston North)**: Highlighted the importance of improving technology infrastructure and connectivity in underserved areas.
- **Te Waipounamu Region (Dunedin and Christchurch)**: Focused on the challenges of technology adoption in rural areas and the need for better training and support.
- **North Region (Whangarei)**: Raised concerns about data privacy and security and the need for robust protection measures.
- **Auckland Metro**: Reported better technology infrastructure but still faced challenges with ensuring widespread adoption and addressing privacy concerns.

4.3 Medications management

Ideal future state

System perspective	Person perspective

Optimum medication management in the home is supported by technology innovation, high quality HCSS, and integrated general practice and pharmacy support.	My medications enable me to live my best life. I am supported and confident that I can take them when I should.

In the ideal future state, medication management is optimised through the use of advanced technology and integrated care practices to ensure the safety, effectiveness, and appropriateness of medications for older individuals. This model prioritises the accurate and timely administration of medications, reduces the risks associated with polypharmacy, and enhances the overall health outcomes of older people. By leveraging technology and a collaborative approach, healthcare providers can deliver personalised medication management that meets the unique needs of each individual.

Effective medication management involves comprehensive assessments, regular reviews, and seamless coordination between all members of the healthcare team, including pharmacists, GPs, nurse practitioners, and other allied health professionals. This approach helps to minimise medication errors, adverse drug interactions, and ensures that older individuals receive the most appropriate and beneficial medications for their conditions.

Key aspects:

- **Comprehensive medication reviews:** Regular and thorough reviews of all medications are conducted to assess their appropriateness, effectiveness, and potential interactions. These reviews involve collaboration between GPs, pharmacists, and other healthcare providers to ensure optimal medication regimens.
- **Unified health records:** Facilitate real-time access to comprehensive medication histories and current prescriptions for all healthcare providers involved in an individual's care. This integration ensures that all providers have up-to-date information, reducing the risk of errors and duplications.
- **Personalised medication plans:** Medication management plans are tailored to the specific needs and health conditions of each older individual. These plans are developed collaboratively and are regularly updated based on changes in health status or new medical information.
- **Use of technology for monitoring and adherence:** Advanced technologies, such as electronic pill dispensers, mobile apps, and wearable devices, support medication adherence by providing reminders, tracking usage, and alerting healthcare providers to potential issues. These tools help ensure that medications are taken as prescribed.
- **Education and support for patients and carers:** Older individuals and their carers receive ongoing education and support to understand medication regimens, potential side effects, and the importance of adherence. Clear communication and accessible resources empower them to manage medications effectively.

Summary of themes

Achieving the ideal future state for optimum medication management involves addressing several key challenges and leveraging various opportunities for improvement. Challenges include ensuring medication adherence and managing complex regimens, integrating technology effectively among older adults, enhancing collaboration between pharmacies and healthcare providers, and improving health literacy among patients and caregivers. Opportunities lie in developing medication management apps and robotic dispensers, expanding the roles of pharmacists for comprehensive medication reviews, encouraging

integrated care and collaboration among multidisciplinary teams, providing education and training on medication management, and adjusting funding models to support proactive and equitable medication management solutions. By focusing on these areas, we can enhance medication adherence, improve patient outcomes, and enable older adults to live their best lives with confidence in their medication management.

Key challenges

1. **Medication adherence and management**
    - Managing complex medication regimens and ensuring adherence is difficult, with older adults often facing barriers to taking medications as prescribed. This includes a lack of support and education for patients on medication use.
    - Polypharmacy is highly prevalent among older adults, leading to an increased risk of adverse drug interactions and side effects. Regular medication reviews are essential to mitigate these risks.
    - There are significant barriers to accessing medications, particularly in rural areas, which exacerbate challenges in managing medication adherence and effectiveness.
2. **Lack of coordinated medication management systems and processes**
    - Medication management is fragmented across different healthcare providers. There is inconsistent communication and information sharing about medications between providers.
    - There is a strong need for better integration and communication between pharmacies, healthcare providers, and caregivers. Technology available to support this is limited and adoption varies widely across the sector. More consistent systems across regions are needed.
    - Inadequate funding models exist to support pharmacists and other healthcare professionals in community settings.
3. **Health literacy and education**
    - Low health literacy among patients and caregivers impacts their ability to manage medications effectively.
    - There is a need for clear and accessible information about medications.

Opportunities and ideas

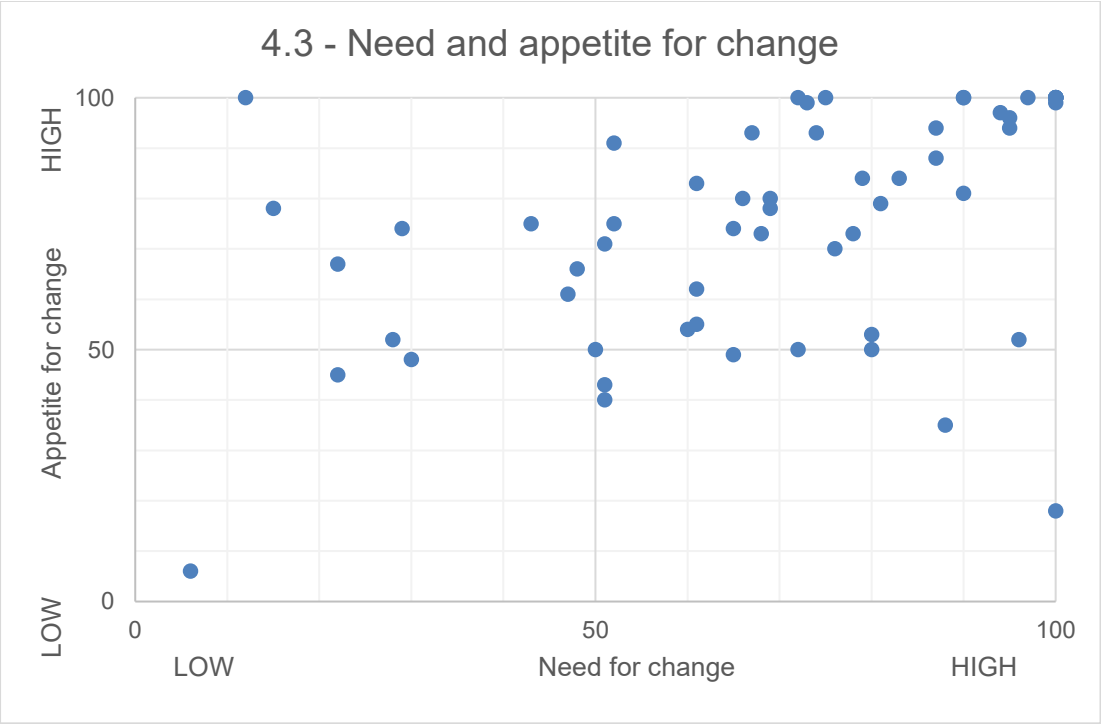
1. **Adopt innovative medication management systems**
    - Develop and implement medication management apps and robotic dispensers to support adherence. Integrate systems that allow healthcare providers to access and update medication records.
    - Use technology for reminders and tracking medication intake – support both digital and physical technologies in this space.
    - Develop telepharmacy services to provide remote medication consultations.
2. **Enhance pharmacy services**

- Expand the role of pharmacists to include medication reviews and prescribing within community settings. Develop collaborative care models that include pharmacists in the care team.
- Support blister packs and other medication packaging solutions to support patients independence and adherence.
- Explore in-home pharmacy services for medication review and management.
- Implement deprescribing protocols to reduce polypharmacy. Conduct regular medication reviews to assess and optimise prescriptions.

3. **Integrated care and collaboration**
    - Encourage collaboration between general practice, pharmacies, and home care support services. Implement real-time communication tools for sharing medication information.
    - Involve multidisciplinary teams in medication management and care planning. Ensure that medication management is a key component of care plans for older adults.
4. **Health education and Support**
    - Expand education and training for patients, caregivers, and healthcare providers on medication management.
    - Support self-help tools and community networks to build health literacy.

Appetite for change

Around this topic, the sector generally believes there is a strong need for change and have a large appetite for it.

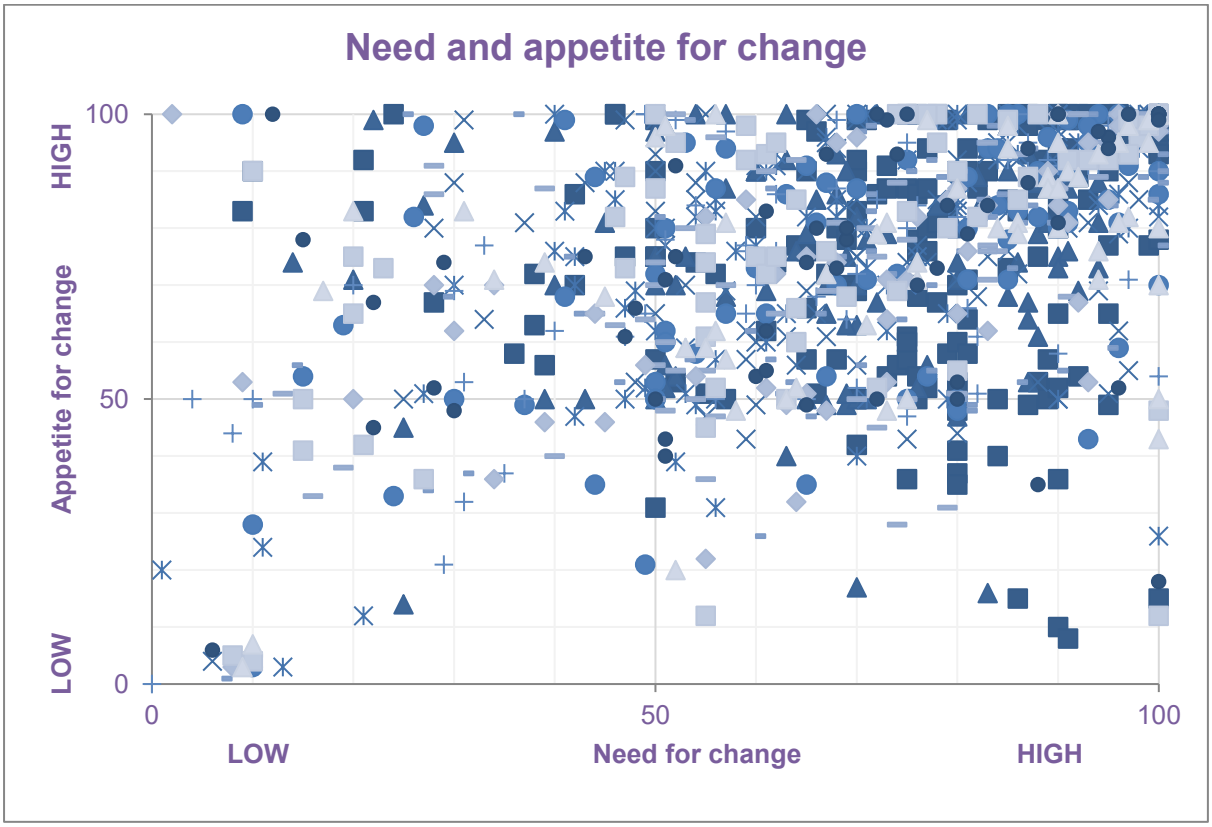


Regional differences

- **Te Manawa Taki Region (Hamilton and Gisborne)**: Emphasised the need for culturally appropriate medication management education and support.
- **Central Region (Porirua and Palmerston North)**: Highlighted the importance of improving access to pharmacy services in underserved areas.
- **Te Waipounamu Region (Dunedin and Christchurch)**: Focused on the challenges of managing polypharmacy in rural areas and the need for better medication management systems.
- **North Region (Whangarei)**: Raised concerns about medication adherence and the need for enhanced support and education for patients.
- **Auckland Metro**: Reported better access to pharmacy services but still faced challenges with optimising medication use and ensuring coordinated management.

Summary and recommendations

The need for change in New Zealand's aged care system is evident, with strong consensus across both the sector and the public on what constitutes effective care and what must evolve to better serve our aging population now and in the future. The vision is to move from a fragmented system to a fully integrated one, where services work seamlessly together to support older people in living independently, in the home of their choice, for as long as possible. The system and services within need to be flexible to accommodate individual preferences and capable of continuous learning and adaptation.



Across all the key topics and public survey responses, the following themes and recommendations emerged consistently:

Person-centred and integrated care

- *Focus on person-centred care*: Prioritise person-centred care by supporting individualised care planning for every older person that respects their needs and preferences, enabling them to live with dignity and independence.
- *Integrated and seamless service delivery:* Strengthen coordination between health services, including primary care, pharmacy, home and community support services (HCSS), aged residential care (ARC), and hospitals, to reduce fragmentation and ensure smooth transitions across different levels of care.
- *Technology integration:* Leverage technology to enhance care coordination, support self-management, and improve communication between healthcare providers and patients. This includes expanding telehealth services, implementing digital health records, and ensuring secure, culturally respectful data management.

Consistency and equity in care

- *National consistency:* Implement a consistent approach to the delivery of HCSS and ARC services nationwide, ensuring that best practices and evidence-based models are uniformly adopted.
- *Equitable access:* Address disparities in access to aged care services, particularly for Māori, Pacific populations, and rural communities. This requires the design and implementation of culturally appropriate services and the equitable distribution of resources and infrastructure.
- *Workforce development:* Invest in building a skilled, culturally competent aged care workforce. Focus on recruitment, training, and retention, particularly in under-served rural areas, to meet the growing demand for services.

Sustainable funding models

- *Policy and funding reform:* Pursue policy changes and funding reforms that support a sustainable, transparent, and equitable aged care system. This includes exploring commissioning models that incentivise integrated care.
- *Flexible and needs-based funding:* Develop funding models that are responsive to the varying levels of care required by older people. This could include case-mix funding aligned with assessed needs will support both financial sustainability and the delivery of high-quality care.
- *Support for carers:* Simplify the administration of carer support subsidies and expand access to respite services, ensuring that carers have the necessary support to continue their critical roles.

Quality and innovation in care

- *Evidence-based practices:* Adopt and scale proven models of care, such as restorative care and early supported discharge, to enhance outcomes for older people.
- *Innovative service delivery:* Encourage the development of innovative care models that improve efficiency and effectiveness, including bulk-funded home support, enhanced primary care networks, and technology-enabled self-directed care.

Cultural responsiveness and community engagement

- *Culturally appropriate services:* Commission services that meet the specific cultural needs of Māori and Pacific older people, and ensure these services are delivered by providers with cultural competence.
- *Community and cultural pilots:* Engage with local communities and cultural groups to design and deliver pilot services that meet diverse needs.
- *Community collaboration:* Strengthen collaboration with community organizations, NGOs, and iwi to deliver holistic, culturally sensitive care, ensuring that learnings and innovations are shared across the motu.

Special considerations for vulnerable groups

Through our engagement, we identified specific sub-groups of people under our remit who require unique care pathways. These include:

- The unhoused and underhoused
- Individuals with young-onset dementia and other cognitive diseases

- High-needs individuals under 65 not covered by Whaikaha
- Patients with complex co-morbidities (e.g., bariatric, behavioural concerns)
- Individuals transitioning from Corrections
- Culturally and Linguistically Diverse minorities and refugee populations

These groups will require targeted strategies as part of the revised model of care to ensure that their specific needs are met.

Key actions and guiding principles

Given the complexity of the task ahead, we have distilled our recommendations into six high-level key actions, each reflecting the effort required to achieve an equitable and effective aged care system.

Key actions

1. *Promote independence:* Prioritise policies and services that support older people in maintaining their independence.
2. *Ensure equitable access*: Guarantee that all older people, regardless of location or background, have equal access to care.
3. *Enable real-time decisions:* Implement systems that support real-time decision-making and information sharing at national, regional, and local levels.
4. *Improve investment logic:* Enhance the logic behind clinical and non-clinical investments and interventions.
5. *Support tailored services:* Ensure that support services are adaptable to individual needs and preferences.
6. *Standardise care frameworks*: Develop and enforce a national framework to ensure consistent care delivery across funded services.

Guiding principles

Our guiding principles are designed to drive effective, aligned decision-making as we reshape our aged care system. These principles will guide our actions and ensure that we consistently focus on the right priorities.

- *Prioritise the person*: Always keep the needs and preferences of older people at the forefront, ensuring access, quality, and flexibility in care.
- *Anticipate needs:* Develop flexible and sustainable funding models that reflect the diverse care needs across the motu, now and into the future. Ensure that funding models are consistent, transparent, and adaptable to changing needs.
- *Integrate and simplify*: Strive for a seamless and transparent model of care. Break down silos and ensure all services—from primary care to aged residential care—work together in a coordinated way to achieve shared goals.
- *Champion equity:* Focus first on those with the greatest needs to ensure fairness and Pae Ora obligations. Develop solutions that can be scaled to benefit everyone, ensuring equitable access and outcomes across the system. This includes both priority populations and remote and rural areas.

- *Respect and reflect our diverse cultures:* Commit to culturally competent care. Commission services that are responsive to the diverse cultural needs of our aging population, especially for Māori and Pacific communities.
- *Collaborate by default:* Lead with collaboration. Partner across the sector, including with other government agencies, NGOs, iwi, and regional teams, to drive the comprehensive changes needed in aged care.

Next steps

Our next steps will be to work with our Aged Care Expert Advisory Group, nominated working group representatives and other experts and impacted partners (including aged care providers, clinical teams, population and public health experts, and data and digital partners) along with our Health NZ regional teams to design how we can meet our future health needs and form our new model of care.

In parallel, we are developing a business case for our Commissioner, government agency partners and our Minister(s) that will provide options for consideration and change across aged care services.

Appendix

A. Engagement participants by organisation

Organisation	Type	Count
ACC	Government	5
Access Community Health	Home and Community Support Service	15
Addington Gardens	Aged Residential Care Facility	1
Age Concern	Non-Government Organisation (NGO)	20
Aged Care Association NZ	Non-Government Organisation (NGO)	1
Aged Care Facility (Unspecified)	Aged Residential Care Facility	6
Airedale Property Trust	Aged Residential Care Facility	1
Alexander House Rest Home	Aged Residential Care Facility	1
Alzheimers NZ	Non-Government Organisation (NGO)	23
Ambridge Rose	Aged Residential Care Facility	2
Anglican Church	Non-Government Organisation (NGO)	1
ANZSGM Australian and New Zealand Society of Geriatric Medicine	Non-Government Organisation (NGO)	2
Aotea Family Support Group Charitable Trust	Non-Government Organisation (NGO)	1
Ara Poutama Corrections NZ	Government	1
Aranui home and hospital	Hospital	1
Arivda Olive Tree	Aged Residential Care Facility	1
Arohanui Hospice	Hospice provider	3
Arowhenua Whānau Services	Non-Government Organisation (NGO)	3
Arvida	Aged Residential Care Facility	3
Ashburton Rural Health Services	Home and Community Support Service	1
Aspire Community Support	Home and Community Support Service	1
Bainfield Park Residential Care Facility	Aged Residential Care Facility	1
Bay of Islands Hospital	Hospital	1
Beattie Home	Aged Residential Care Facility	2
Beckford Health	Primary Care	1
Beetham Healthcare	Aged Residential Care Facility	2
Benhaven Care LTD	Aged Residential Care Facility	1
Birchleigh Residential Care Centre	Aged Residential Care Facility	2
Brackenridge Services Limited	Home and Community Support Service	1
Bupa Aged Care	Aged Residential Care Facility	7
Bupa Care Services	Home and Community Support Service	2

CAIRNFIELD HOUSE RESTHOME/HOSPITAL	Aged Residential Care Facility	3
Cambridge Resthaven	Aged Residential Care Facility	3
CAN-B Trust	Non-Government Organisation (NGO)	1
Canterbury Clinical Network	Non-Government Organisation (NGO)	1
CANZ	Non-Government Organisation (NGO)	2
Care Coordination	Primary Care	1
Care on Call (NZ) Ltd	Home and Community Support Service	1
Carers Alliance	Non-Government Organisation (NGO)	1
Carers NZ	Non-Government Organisation (NGO)	3
Caring for the Carer	Non-Government Organisation (NGO)	1
CCS Disability Action	Home and Community Support Service	1
Chelsea and Marsden Day Care Trust	Day Care Provider	1
CHT Care Homes	Aged Residential Care Facility	4
Clinical Advisory Pharmacists Association (CAPA)	Pharmacy	1
Cloud Blue Ltd	Other	1
CNSST Foundation	Non-Government Organisation (NGO)	1
College of Gerontology Nursing NZNO	Non-Government Organisation (NGO)	1
Community Care Trust	Aged Residential Care Facility	1
Counties Manuaku Homecare Trust	Aged Residential Care Facility	2
Cranford Hospice	Hospice provider	1
Custom Care Nursing	Primary Care	8
Dalcam Healthcare Group	Aged Residential Care Facility	1
Dargaville Aged Care Ltd	Aged Residential Care Facility	2
Dargaville Medical Centre	Primary Care	1
Dementia NZ	Non-Government Organisation (NGO)	7
Dunstan Hospital	Hospital	1
E tū	Union	25
Eastcliffe	Aged Residential Care Facility	3
Eden Rest Home	Aged Residential Care Facility	1
Edenvale Home & Hospital	Aged Residential Care Facility	1
Elder Care Volunteers	Non-Government Organisation (NGO)	1
Eldernet	Non-Government Organisation (NGO)	2
Elders At My Table	Allied Health	1
Elizabeth Knox Home and Hospital	Aged Residential Care Facility	3
Enliven	Home and Community Support Service	1
Equinox Health Ltd	Primary Care	1

Equip	Non-Government Organisation (NGO)	1
Everil Orr Living Care	Aged Residential Care Facility	2
Evolution Healthcare	Primary Care	1
Experion Care Limited	Aged Residential Care Facility	2
Ferry Enterprises	Aged Residential Care Facility	2
FOCUS	Home and Community Support Service	2
Forrest Hill Home and Hospital	Aged Residential Care Facility	1
Forward Care	Home and Community Support Service	4
Geneva Healthcare	Home and Community Support Service	2
Gisborne Hospital	Hospital	1
Golden Bay Community Health	Primary Care	3
Golden Healthcare Group	Aged Residential Care Facility	2
Gore Health	Primary Care	1
Grey Power New Zealand	Non-Government Organisation (NGO)	2
Harbour Hospice	Hospice provider	1
Hauora Hokianga | Hokianga Health	Primary Care	2
HCHA	Non-Government Organisation (NGO)	1
Health and Disability Commissioner	Government	2
Health HB	Primary Care	1
Health NZ	Health New Zealand Services	139
Healthcare Compliance Solutions	Non-Government Organisation (NGO)	2
Healthcare New Zealand	Primary Care	17
Healthvision	Home and Community Support Service	11
Heritage Lifecare	Aged Residential Care Facility	17
Hokianga Health	Primary Care	3
Home and Community Support Service (Unspecified)	Home and Community Support Service	2
Home Support North Charitable Trust	Home and Community Support Service	2
Hopper Living	Aged Residential Care Facility	1
Hospice (Unspecified)	Hospice provider	1
Hospice Mid-Northland and Far North Community Hospice	Hospice provider	2
Hospice New Zealand	Hospice provider	1
Hospice Tairawhiti	Hospice provider	1
Hospice Taranaki	Hospice provider	1
Hospital (Unpsecified)	Hospital	1
Howick Baptist Healthcare Limited	Aged Residential Care Facility	1

Huakina Development Trust	Primary Care	3
IDEA Services	Home and Community Support Service	6
Iwi (Unspecified)	Iwi	1
Jass Holdings	Aged Residential Care Facility	2
Kahungunu Executive	Primary Care	1
Kaikohe Care	Aged Residential Care Facility	2
Kaikoura Physiotherapy	Allied Health	1
Kaipara medical	Primary Care	1
Kamo Home & Village	Aged Residential Care Facility	2
Kapiti Retirement Trust	Aged Residential Care Facility	1
Kemp Home & Hospital, Wellington City Mission	Aged Residential Care Facility	1
Kenderdine Park	Aged Residential Care Facility	1
Kerikeri Retirement Village	Aged Residential Care Facility	2
Keringle Park Residential Care	Aged Residential Care Facility	1
Kimihia Home & Hospital	Aged Residential Care Facility	1
Kōkiri Marae Māori Women's Welfare League	Non-Government Organisation (NGO)	1
Lavender Blue Nursing and Home Care Agency Ltd	Home and Community Support Service	1
Life Plus	Primary Care	1
Lonsdale Total Care Centre	Aged Residential Care Facility	2
Mana Atea	Home and Community Support Service	2
Mana Ātea	Home and Community Support Service	1
Manor Park Private Hospital	Hospital	1
Māori Women’s Welfare League	Non-Government Organisation (NGO)	5
Maraeroa Marae Association Incorporated	Iwi	2
Masonic Villages Trust	Non-Government Organisation (NGO)	5
Massey University School of Nursing	Academic Institution	2
Maungatapere Medical Centre	Primary Care	3
McKenzie Healthcare Ltd	Aged Residential Care Facility	1
Medwise	Pharmacy	1
Mercury Bay Medical Centre	Primary Care	2
Mercy Hospital Dunedin	Hospital	1
Metlifecare	Aged Residential Care Facility	6
Middlemore Hospital	Hospital	1
Millvale lodge lindale DCNZ	Aged Residential Care Facility	1
Ministry of Social Development	Government	7
Moana House and Village	Aged Residential Care Facility	1

Mobile Foot Care Ltd	Home and Community Support Service	1
Montecillo Veterans Home & Hospital	Aged Residential Care Facility	1
Muskaan Care Trust NZ	Non-Government Organisation (NGO)	1
myCare	Home and Community Support Service	4
New Vista Rest Home and Hospital	Aged Residential Care Facility	2
New Zealand Council of Christian Social Services (NZCCSS)	Non-Government Organisation (NGO)	3
New Zealand Down Syndrome Association	Non-Government Organisation (NGO)	1
New Zealand Health Group	Home and Community Support Service	3
New Zealand Nurses Organisation	Non-Government Organisation (NGO)	4
New Zealand Society of Diversional and Recreational Therapy	Non-Government Organisation (NGO)	1
Nga Iwi O Mokai Patea Services Trust	Non-Government Organisation (NGO)	1
Ngati Ranginui Iwi	Iwi	1
Niuvaka Trust	Non-Government Organisation (NGO)	1
Non-Government Organisation (NGO) Unspecified	Non-Government Organisation (NGO)	1
North Haven Hospice	Hospice provider	3
North Health Ltd	Aged Residential Care Facility	1
North Shore Hospital Waitemata	Hospital	1
NORTHLAND DISABLED CHARITABLE TRUST	Day Care Provider	1
Not specified	Not specified	3
Nurse Maude	Home and Community Support Service	6
Nurse Maude Care Home Physiotherapy	Allied Health	1
NZ aged care services ltd	Non-Government Organisation (NGO)	1
NZ Dementia Foundation	Non-Government Organisation (NGO)	1
NZ Society of Diversional and Recreational Therapists	Aged Residential Care Facility	1
NZACA	Non-Government Organisation (NGO)	1
NZSDRT Inc.	Non-Government Organisation (NGO)	1
Ocean View Residential Care	Aged Residential Care Facility	2
Oceania Healthcare	Aged Residential Care Facility	22
O'Conor Home Memorial Trust	Aged Residential Care Facility	1
Office of the Health and Disability Commissioner	Government	3

On the Go Physio Ltd (New Zealand)	Allied Health	1
Ora Toa	Primary Care	1
Otago Community Hospice	Hospice provider	1
OTNZ-WNA	Non-Government Organisation (NGO)	1
Pacific Homecare	Home and Community Support Service	2
Park Estate Home and Hospital	Aged Residential Care Facility	2
Parkside Pharmacy	Pharmacy	1
Parkwood Trust Inc	Aged Residential Care Facility	1
PASS Consultants	Other	1
Pathways (Wise Group) NZ	Non-Government Organisation (NGO)	1
Pegasus Health	Primary Care	4
Pharmaceutical Society of New Zealand	Non-Government Organisation (NGO)	1
Phoenix Healthcare Group	Non-Government Organisation (NGO)	2
Physiotherapy - Te Whatu Ora	Allied Health	1
Physiotherapy NZ	Allied Health	3
PillDrop	Pharmacy	1
Portwell Care Ltd	Aged Residential Care Facility	1
Presbyterian Support	Home and Community Support Service	31
PSA	Union	2
Qestral cooperation	Aged Residential Care Facility	1
Radius Residential Care Ltd	Aged Residential Care Facility	2
Rahiri lifecare	Aged Residential Care Facility	1
Rangiura Care Home and Hospital	Aged Residential Care Facility	1
Rauawaawa Kaumatua Charitable Trust	Non-Government Organisation (NGO)	1
Rongomaiwahine Iwi Charitable Trust	Non-Government Organisation (NGO)	2
rosebanklifecare	Aged Residential Care Facility	1
Roselea Specialised Dementia Care	Aged Residential Care Facility	1
Roseridge Rest Home Henderson	Aged Residential Care Facility	1
RURAL Primary Health Care	Primary Care	1
Ryman Healthcare	Aged Residential Care Facility	3
Ryman Healthcare	Aged Residential Care Facility	1
Selwyn Village	Aged Residential Care Facility	1
Service user	Service user	5
Sound Care Group	Aged Residential Care Facility	3
South canterbury	Home and Community Support Service	1

St Barnabas Fendalton	Non-Government Organisation (NGO)	1
Stroke Foundation NZ	Non-Government Organisation (NGO)	1
Summerset	Aged Residential Care Facility	12
TAH	Primary Care	1
Tairawhiti Maori Womens Welfare League	Non-Government Organisation (NGO)	1
Tamahere Eventide Home Trust	Aged Residential Care Facility	1
Tasman Care Ltd	Aged Residential Care Facility	1
Tauranga Hospital	Hospital	1
Te Ata Rest Home Ltd	Aged Residential Care Facility	1
Te Hiku Hauora	Primary Care	1
Te Hopai - Wellington	Aged Residential Care Facility	1
Te Kohao Health Limited	Non-Government Organisation (NGO)	3
Te Korowai Hauora O Hauraki Ohu Kainga	Non-Government Organisation (NGO)	1
Te Kōtuku Hauora	Primary Care	1
Te Omanga Hospice	Hospice provider	5
Te Oranganui Trust	Home and Community Support Service	2
Te Puna Ora o Mataatua	Non-Government Organisation (NGO)	3
Te Ropu Wahine Maori Toko i Te Ora Maori womens Welfare League	Iwi	1
Te Rūnanga o Ōtākou	Iwi	1
Te Runanga o Toa Rangatira	Iwi	1
Te Whare Hauora o Te Aitanga a Hauiti	Iwi	1
Tend	Primary Care	1
Tender Loving Care	Home and Community Support Service	2
The Asian Network Inc. (TANI)	Non-Government Organisation (NGO)	2
The CARE Village	Aged Residential Care Facility	1
The Lifewise Trust	Non-Government Organisation (NGO)	1
The Mobile Physio	Allied Health	1
The O'Conor Institute Trust Board	Non-Government Organisation (NGO)	1
The Practice on Francis Street	Primary Care	1
The Redwood Club	Day Care Provider	2
The Royal District Nursing Service	Home and Community Support Service	7
The Sunrise Foundation	Non-Government Organisation (NGO)	1
Think Hauora	Primary Care	1
Third Age Health	Primary Care	4
Timaru Hospital	Hospital	2

Toi Ohomai	Academic Institution	1
Tranquillity Bay Care Ltd	Aged Residential Care Facility	2
Ultimate Care Group	Aged Residential Care Facility	4
Unichem Bramwells Pharmacy	Pharmacy	1
University of Auckland	Academic Institution	4
University of Waikato	Academic Institution	1
Visionwest	Home and Community Support Service	6
voguehaven	Aged Residential Care Facility	1
Waicare Day Activity	Day Care Provider	1
Waiheke Health Trust	Primary Care	1
Waihi Lifecare	Aged Residential Care Facility	3
Wai-iti House Medical Centre	Primary Care	1
Waireka Lifecare NZACS	Aged Residential Care Facility	1
Wairoa District Council	Government	1
Wairoa Taiwhenua Ngāti Kahungunu Inc	Iwi	1
Wellington City Mission	Non-Government Organisation (NGO)	1
Wellington City Mission	Non-Government Organisation (NGO)	2
WellSouth Primary Health Network	Primary Care	1
Wesley Community Action	Non-Government Organisation (NGO)	3
Wesley Community Action	Non-Government Organisation (NGO)	1
Whaikaha	Government	1
Whaioranga Trust	Iwi	2
Whānau	Service user	2
Whangaroa Health Services Trust	Non-Government Organisation (NGO)	2
Windsorcare	Aged Residential Care Facility	1
Woodlands	Aged Residential Care Facility	1
Grand Total		**783**