2019

Needs Assessment Summary

OLDER PEOPLE

Older People

Local health needs and service issues

• High numbers of preventable hospital admissions for older adults are recorded for Chronic Obstructive Pulmonary Disease, urinary tract infections, angina and heart failure.

• Lack of established clinical coordination tools and processes that result in fragmentation of the local health system in patient centred care – management and problematic after-hours management.

• Low use of advance care directives - plans and deficits in confidence and capacity of staff to provide adequate and/or quality palliative care.

• Residents in residential aged care presenting with increasing complexity of care, including dementia behaviour management, mental health, palliative and end of life care.

• Limited uptake of existing education, training and resources to RACF's, GPs and health care professionals in early identification and management of palliative care – end of life.

• Limited capacity to provide a coordinated and sustained coverage for palliative and end of life care – within RACF's out of hours.

Key findings

The Gold Coast has a higher proportion of older adults aged 65 years and over compared to the rest of the country, with several areas with higher numbers of older people (Gold Coast North, Ormeau - Oxenford and Broadbeach-Burleigh).

The age profile of the Gold Coast population is increasingly becoming older and this is projected to continue. The Gold Coast sub-regions of Southport and Robina report high rates of older people with profound or severe disability, which is likely attributable to consumers with complex needs residing in close proximity to major public hospitals.

Gold Coast older residents report higher levels of health and wellbeing and lower levels of disability than other regions of Australia. Fewer older people in the Gold Coast receive an age pension than the national average, which could indicate less socio-economic disadvantage. More older adults in the Gold Coast live alone than other South East Queensland regions. This, combined with high levels of older people moving to the Gold Coast in their later years who may lack informal care and support networks, raises concerns of social isolation and limited ability to access services without support.

Mortality and morbidity for older people in the region arises from cardiovascular disease and stroke, dementia, fall- related injuries, chronic obstructive pulmonary disease (COPD) and urinary tract infections (UTIs).
There are high utilisation rates of primary health care, particularly GP attendances (standard and after-hours) which were higher for older people on the Gold Coast when compared to the national population.

Utilisation rates of publicly-funded aged care services, both residential and home care, is high with a significant number of providers spread across the region. However, there appears to be relatively low accessibility and utilisation of palliative care services and advance care planning.

Consultation highlighted the impact of aged care reforms and system changes on delivering timely and appropriate care to older Australians, including NDIS reforms and challenges with home care package wait times. Significant concerns were raised around limited service awareness and community health literacy and continued low update of advance care planning.

What is commissioning?

In Primary Health Network (PHN) context, commissioning is the continual practice of purchasing services aligned to:

- local needs
- outcomes from strategic planning
- Gold Coast PHN's unique objectives and
- identified national priorities.

Scope

This health needs assessment provides evidence-based information to inform commissioning processes, including:

- Establishing local health needs through qualitative and quantitative data analysis
- Informing annual planning, reporting and evaluation processes for Gold Coast PHN
- Informing service planning and co-design mechanisms for effective aged care after-hours service commissioning.

Focus areas aligned to Gold Coast Primary Health Network's (GCPHN) organisational objectives relating to older people (with a focus on RACF and After-Hours Services) include:

- Access to after-hours services to the individual's home (including RACFs) inclusive of community organisations, general practice and medical deputising services
- Primary and community-based programs delivering services to older people within RACFs
- Services and/or programs focused on reducing preventable emergency presentations and admissions from the individual's home (including RACFs).

Methodology

A mixed methodology was used to ensure a complete needs assessment evaluation including quantitative data analysis, service mapping, patient journey mapping, consultation and co-design workshops.

Quantitative data analysis

Quantitative data indicators used for this report provide a detailed analysis of the drivers of service demand and levels of existing service utilisation to strategically guide future program investment for GCPHN. Data sources included but not limited to:

- Australian Bureau of Statistics Census data
- Social Health Atlases of Australia, Public Health Information Development Unit (PHIDU)
- Australian Institute of Health and Welfare (AIHW) Gen Aged Care Data Portal
- AIHW My Healthy Communities Data Portal
- Medicare Item Reports
- Data supplied by Gold Coast Health

Other sources of data explored, ensured a rounded and holistic view of data-informed need. Analysis was primarily limited to that data which was publicly available with breakdown at a regional level. Where possible, indicators were examined at a subregional level.

Service mapping

Service mapping was undertaken in a systematic way, commencing with the existing GCPHN knowledge base relating to aged care services and providers.

Service mapping focused on a breakdown of service type, provider, geographic location, target population (e.g. mainstream or specific priority populations) and provider type (e.g. for-profit, not-for-profit, government).

Patient journey mapping

Patient journey mapping was utilised as an engagement tool to understand service issues and enablers from the perspective of health consumers. Patient journey mapping was developed in partnership with Council on the Ageing Queensland (COTA Queensland) to capture knowledge and expertise to effectively undertake consumer engagement.

COTA Queensland presented distinct patient journeys reflecting common pathways into residential aged care services in the Gold Coast PHN region using the following approach.

Key Activity	Process
Determine Common Journey Types	Utilise the expertise of GCPHN and the Aged Care Leadership Group to determine common journey Types for the Gold Coast aged care and after-hours environment.
Identification of Gold Coast Common Journey Pathways (based on Common Journey Types)	Facilitate a two-hour workshop with local stakeholders (based on peak bodies local networks) to identify common journey pathways based on the pre-determined common journey types Explore both positive and negative experiences within each common journey type Identify why individuals (health professionals or patients/ residents/ family members) felt the experience was positive or negative
Develop Common Journey Pathways into a visual format (including a narrative) for co-design workshops	Develop a visual representation of the Patient Journey Pathways to inform the co-design and planning phases of the project.

The aim of the patient journey mapping was to identify components of the local service system that are working well and highlight potential areas for improvement. Consumer interactions and experiences with a range of stakeholders were considered including but not limited to:

- Family, carers and informal support networks
- Aged care service providers
- Primary health care services, particularly after hours
- Hospital services
- Queensland Ambulance Service
- Pharmacies
- Community and psychosocial supports

Target consultation

Recognising the importance of the project and need for a collaborative approach a multifaceted consultation methodology was taken to inform this needs assessment.

GCPHN has established high-functioning advisory mechanisms to provide expert input and advice into PHN core business and activities. These groups were key in providing direct feedback on initial drafts of this report and include:

- GCPHN Community Advisory Council
- GCPHN Clinical Advisory Council
- GCPHN Primary Care Partnership Council

In July 2018, GCPHN established the Aged Care Leadership Group to provide advice and guidance for the development of the needs assessment, the subsequent regional plan and guiding implementation of resulting strategies and activities. The Leadership Group included representation from:

- Gold Coast Health
- service providers
- GCPHN
- general practitioners
- consumer/carer representatives.

Further consultation with the sector and community occurred through an Older Persons co-design workshop (with a focus on after hours and RACF services) held in partnership with COTA Queensland on 13 September 2018. The workshop was attended by 27 sector representatives including Gold Coast Health, non-government organisations (NGOs), consumers, carers and several aged care facilities.

Evidence

Demographics

The estimated resident population of the Gold Coast Primary Health Network (GCPHN) region aged 65 years and over, referred hereafter as 'older adults' was 94,531 people.

Table 1: Number and proportion of estimated resident population by broad age group, Gold Coast PHN region, 2016

	Number of people			% of total population		
Age group	Male	Female	Total	Male	Female	Total
65-74 years	26,866	28,143	55,009	9.3	9.3	9.3
75-84 years	13,034	14,497	27,531	4.5	4.8	4.7
85 years or more	4,525	7,466	11,991	1.6	2.5	2.0
Sub-total of 65+yrs	44,425	50,106	94,531	15.4	16.5	16.0

Table 1: Number and proportion of estimated resident population by broad age group, Gold Coast PHN region, 2016
Source: Australian Bureau of Statistics (ABS), 2016 Census of Population and Housing

53% of the Gold Coast older adult population are female, compared to 51.2% of the all-age population, which is likely due to a higher life expectancy for females.

Overall, the age profile of the Gold Coast population is becoming relatively older. The proportion of the regional population aged over 65 years and over, represented 16.0% of the total population in the Gold Coast PHN region in 2016.

This is slightly higher than the proportion of people in this age group nationally of 15.2%. In 2012, the proportion of people aged 65 years and over represented only 14.6% of the total Gold Coast population. While the Gold Coast local government area (LGA) has slightly different geographical boundaries than the GCPHN region, data from Gold Coast City Council forecasts the number of older people aged 65 years and over residing in the Gold Coast LGA to double by 2030 which will account for over 20.2% of the total Gold Coast LGA population[1].

Table 2 describes the size and proportion of the older person population across the GCPHN region. Within the region, the areas with the highest proportion of residents aged over 65 years are Gold Coast North (e.g. Runaway Bay, Labrador, Paradise Point, Biggera Waters), Coolangatta, Broadbeach-Burleigh and Surfers Paradise.

1 Gold Coast City Council, Social Planning and Research Reports, http://www.goldcoast.qld.gov.au/thegoldcoast/gold-coast-seniors-statistics-888.html

Table 2: Estimated Resident Population by age group and SA3 region, 2016

Region	65-74 years		75-84 years		85 years or more	
	Number of persons	% of total pop.	Number of persons	% of total pop.	Number of persons	% of total pop.
Broadbeach - Burleigh	6,591	10.2	3,693	5.7	1,620	2.5
Coolangatta	5,713	10.4	3,180	5.8	1,607	2.9
Gold Coast - North	8,623	12.6	4,783	7.0	2,031	3.0
Gold Coast Hinterland	2,273	11.9	888	4.7	237	1.2
Mudgeeraba - Tallebudgera	2,824	8.2	1,164	3.4	371	1.1
Nerang	5,795	8.3	2,829	4.1	1,187	1.7
Ormeau - Oxenford	8,509	6.8	3,304	2.6	1,131	0.9
Robina	4,529	8.8	2,497	4.8	1,355	2.6
Southport	5,405	8.8	3,000	4.9	1,637	2.7
Surfers Paradise	4,747	11.1	2,193	5.1	815	1.9
Gold Coast	55,009	9.3	27,531	4.7	11,991	2.0
Australia	-	8.6	-	4.6	-	2.0

Table 2: Estimated Resident Population by age group and SA3 region, 2016
Source: Australian Bureau of Statistics (ABS), 2016 Census of Population and Housing

There are 1,524 people aged 50 years and over identifying as Aboriginal and Torres Strait Islander who reside on the Gold Coast, which is the age of eligibility for Aboriginal and Torres Strait Islander people to enter the public-funded aged care system. This represents a proportion of 0.8% of all people aged 50 years, compared to a national rate of 1.4%. The highest numbers of older people identifying as Aboriginal and Torres Strait Islander reside in Ormeau-Oxenford (282 persons), Gold Coast-North (231 persons) and Coolangatta (221 persons).

Data from the 2016 Census reports a total of 1,798 people aged over 65 years residing in the Gold Coast region whose rated proficiency in speaking English is 'not well' or 'not at all'. This represents 1.9% of the older adult population in the region. The rates of older people with poor self-rated proficiency in spoken English are highest in Southport (3.1%) and Robina (3.0%).

The proportion of people aged 65 years and over in a region receiving a government age pension provides an indication of the socioeconomic status and financial vulnerability of older people. As at June 2016, there were 61,523 Gold Coast residents receiving an age pension, which represents 68.7% of people aged 65 years and over which is lower than the national level of 71.1%. This finding aligns with the lower levels of socio-economic disadvantage observed within the wider Gold Coast population relative to other regions. Table 3 outlines the absolute number and relative proportion of age pensioners within the Gold Coast PHN region.

Table 3: Number and proportion of age pensioners by SA3 region (June 2016)

Region	Number of age pensioners	% of persons aged 65+ who are age pensioners
Broadbeach - Burleigh	7,626	62.6
Coolangatta	7,079	69.9
Gold Coast - North	10,454	72.3
Gold Coast Hinterland	2,163	64.6
Mudgeeraba - Tallebudgera	2,901	68.1
Nerang	6,952	76.2
Ormeau - Oxenford	8,186	68.9
Robina	5,439	68.0
Southport	6,839	76.4
Surfers Paradise	3,898	54.0
Gold Coast	61,537	68.7
Australia	-	71.1

Table 3: Number and proportion of age pensioners by SA3 region (June 2016)
Source: Social Health Atlas of Australia, compiled by Public Health Information Development Unit (PHIDU) based on data from the Department of Social Services

A total of 6,572 older people aged 65 years and over who reside on the Gold Coast migrated to the region from interstate or overseas within the last 5 years, which represents 7.0% of the older adult population. Over 30% of these people migrated within the last 12 months. This may provide an indirect indication of the extent of older people who may not have strong informal caring and support networks such as family and friends.

The number of older adult lone person households in the Gold Coast region is 19,519. This represents around 9.1% of all household types in the region, which is slightly higher when compared to the rate for South-East Queensland more broadly (8.5%).

Table 4 below outlines the number of older person households residing in self-contained retirement villages across the Gold Coast region.

Table 4: Number of dwellings in self-contained retirement villages in Gold Coast region in 2016, by household type and SA3 region

Region	Lone person dwellings	Two or more person dwellings
Broadbeach - Burleigh	110	42
Coolangatta	183	54
Gold Coast - North	712	635
Gold Coast Hinterland	25	15
Mudgeeraba - Tallebudgera	17	4
Nerang	404	175
Ormeau - Oxenford	402	573
Robina	169	56
Southport	557	264
Surfers Paradise	36	6
Gold Coast	2,611	1,833

Table 4: Number of dwellings in self-contained retirement villages in Gold Coast region in 2016, by household type and SA3 region
Source: Census of Population and Housing, 2016, TableBuilder

These figures, particularly for single person dwellings, may provide an indication of the potential future demand for public-funded services.

The proportion of people aged 15 years and over on the Gold Coast who identify as having informal caring responsibilities (9.9%) is lower than the Australian rate (11.3%). This is recorded in the 2016 Census as those reporting the provision of unpaid assistance to a person with a disability, long-term illness or problems related to old age. While only an indirect indicator of the number of carers of older people within the region, the absence of informal carers can be a contributing factor to older people being unable to remain at home and requiring entering the residential aged care system.

Health Status

Between 2012 and 2016, the median age at death for Gold Coast residents was 82 years, 79 years for males and 85 years for females[2]. These figures are comparable to the Australian population. The top five leading causes of mortality for Gold Coast residents are:

1. Coronary heart disease (13.8% of all deaths)

2. Lung cancer (6.8%)

3. Cerebrovascular disease (5.6%)

4. Prostate cancer (5.1%)

5.Dementia and Alzheimer disease (4.9%)

2 AIHW, Mortality Over Regions and Time (MORT) books 2012-2016

Chronic diseases represent the cause of many deaths in the GCPHN region, similar to the wider Australian population.

Several well-established risk factors for chronic disease including obesity, excessive alcohol intake, poor nutrition, physical inactivity and smoking are provided in Table 5 noting the prevalence of these chronic disease risk factors amongst older people residing in the GCPHN region. For each known risk factor, there has been minor upward and downward variation over the reporting periods available, but no significant improvement or deterioration observed.

Table 5: Prevalence of chronic disease risk factors for Gold Coast PHN residents aged 65 years and over, by survey year

Risk factor	2009-10 (%)	2011-12 (%)	2013-14 (%)	2015-16 (%)
Obesity (BMI > 30)	19.5	21.3	21.7	16.5
Lifetime risky drinking	-	13.9	14.3	15.5
Insufficient daily fruit intake	-	-	34.0	38.5
Insufficient daily vegetable intake	-	-	92.8	91.6
Insufficient physical inactivity	48.4	45.8	46.7	49.4
Daily smoker	8.2	6.2	7.3	6.6
Source: Queensland Survey Analytics System (QSAS) regional detailed data, Nov 2016				

More detailed analysis on the prevalence of chronic conditions amongst the older adult population was analysed via patient data collected and reported by general practices across the Gold Coast seen in Table 6. This includes data for patients aged 65 years and over who are active attending a GP (3 GP attendances in last 2 years) and recent (last recorded result within last year).

Table 6: Prevalence of chronic conditions for active and recent patients of general practices aged 65 years and over in Gold Coast PHN region, as at Aug 2018

Patient condition	Number of patients 65+	Proportion of 65+ patients (%)	Proportion of patients aged 18-64 (%)
Chronic obstructive pulmonary disorder (COPD)	7,466	7.9	1.1
Coronary heart disease	12,406	13.2	1.2
Diabetes	12,743	13.6	3.0
Chronic renal failure	4,627	4.9	0.3
Patient has a GP Mental Health Treatment Plan	1,965	2.1	6.3
Total number of patients recorded in PATCAT	93,983	-	-

Source: PATCAT data extracted by Gold Coast PHN
Note: PATCAT is a web-based platform designed for PHNs to collect and aggregate de-identified general practice data from practices within their region. This data is typically used for program and population health planning purposes.

Dementia

One of the health conditions that causes significant levels of disability amongst older people is dementia. While estimates on the prevalence of people living with dementia at a given time are difficult to obtain, modelling done by Alzheimer's Australia in 2011 projected that the number of people living with dementia in the Gold Coast region in 2018 would be 9,477 people—5,319 females and 4,159 males[3].

This is projected to almost double to 16,271 people by 2030. This modelling ranked the Gold Coast region as having the third highest prevalence of dementia in Queensland consistently across the period 2011 to 2050. For older people living in permanent residential aged care in the Gold Coast region, 51.9% had a diagnosis of dementia[4].

In 2015-16, there were a total of 436 overnight hospitalisations relating to dementia in the GCPHN region, which represented a total 5,232 hospital bed days, or an average length of hospital stay of 12 days. The age-standardised rate for the region (6 per 10,000 people) ranks 13th highest out of all 31 regions.

Table 7 shows that the number of dementia related hospitalisations in the region has increased by over 24% in the last three available reporting years.

Table 7: Overnight hospitalisations for dementia, by SA3 region, 2013-14 to 2015-16

Region	Number of hospitalisations			Rate of hospitalisations per 10,000 people, 2015-16	Rate of bed days per 10,000 people, 2015-16
	2013-14	2014-15	2015–16		
Broadbeach - Burleigh	45	37	49	5	65
Coolangatta	24	47	51	6	64
Gold Coast - North	68	56	84	7	96
Gold Coast Hinterland	9	13	8	NP	NP
Mudgeeraba - Tallebudgera	17	19	12	NP	NP
Nerang	27	26	48	7	64
Ormeau - Oxenford	38	45	50	6	63
Robina	41	58	47	7	74
Southport	55	46	72	10	134
Surfers Paradise	27	26	15	NP	NP
Gold Coast	351	373	436	6	74
Australia	-	-	-	6	93

Source: AIHW MyHealthyCommunities portal, www.myhealthycommunities.gov.au

3 Projections of dementia prevalence and incidence in Queensland 2011-2050, Alzheimer's Australia Qld

4 Data item extracted from GEN Aged Care data portal, www.gen-agedcaredata.gov.au

Falls

Another significant cause of morbidity and impaired quality of life among older people is falls, often related to impaired balance, immobility and frailty, as well as feeling dizzy and poor vision which can be an undetected side effect of dementia. While the availability of data relating to falls among older people is limited, data on hospital admissions for hip fractures in people aged 65 years and over can provide an indication of incidence, as the vast majority of hip fractures are associated with falls.

In the Gold Coast region in 2012-13, there were a total of 530 hospitalisations for people aged 65 years and over for hip fractures at an age-standardised rate of 635 per 100,000 people[5]. This is noticeably higher than the Queensland (628) and Australia (610) rates.

Heart Failure

Heart failure is a chronic health condition associated with impaired physical functioning, poorer quality of life, increased hospitalisation and co-morbidity. While only an estimated 1-2% of the A ustralian population lives with heart failure at a given time, the prevalence rises steeply with age. Two-thirds of people living with heart failure in Australia are aged over 65 years. This provides a forecast of the number of people with heart failure aged under 65 years who are likely to experience disability and have higher support needs in their older years.

Region	Number of hospitalisations	Sex and age-standardised rate per 100,000 people
Broadbeach - Burleigh	129	129
Coolangatta	148	164
Gold Coast - North	236	210
Gold Coast Hinterland	30	148
Mudgeeraba - Tallebudgera	67	252
Nerang	117	170
Ormeau - Oxenford	165	218
Robina	100	155
Southport	136	183
Surfers Paradise	58	107
Queensland	-	210
Australia	-	196

Table 8: Number and rate of hospitalisations for heart failure in Gold Coast, by SA3 region, 2014-15

Source: PATCAT data extracted by Gold Coast PHN

Source: Australian Commission on Safety and Quality in Health Care (ACSQHC), The Second Australian Atlas of Healthcare Variation, 2017

Disability

The care needs of the older adult population are generally higher than the rest of the population, due to disability, illness and injury.

A person with profound or severe limitation is defined as someone that needs help or supervision always or sometimes to perform core activities of self-care, mobility and/or communication. Table 9 outlines the absolute number and relative proportion of older people aged 65 years and over within the GCPHN region with a profound or severe disability.

The data within Table 9 includes figures for all older people, and older people living in the community and excludes those in residential aged care facilities, non-self-contained residences and psychiatric hospitals. The figures indicate that there are higher proportions of older people living with high care needs in Southport (both in the community and not) and Robina (not in the community), with high absolute numbers of older people living with high care needs in Gold Coast-North (both in the community and not).

Region	Total		Living in the community (i.e. self-contained accommodation)	
	Number of persons with a disability	% persons aged 65 years and over with a disability	Number of persons with a disability	% persons aged 65 years and over with a disability
Broadbeach - Burleigh	1,815	13.8	1,552	11.8
Coolangatta	1,833	16.1	1,467	12.9
Gold Coast - North	2,519	17.3	1,930	13.3
Gold Coast Hinterland	393	11.8	363	10.9
Mudgeeraba - Tallebudgera	647	15.8	550	13.4
Nerang	1,570	17.0	1,384	15.0
Ormeau - Oxenford	2,123	17.5	1,625	13.4
Robina	1,670	20.7	1,001	12.4
Southport	2,191	22.6	1,516	15.6
Surfers Paradise	992	10.9	894	9.9
Gold Coast	15,753	16.6	12,282	13.0
Australia	-	18.4	-	14.3

Table 9: People with a profound or severe disability aged 65 years and over within Gold Coast PHN region, 2016

Source: Public Health Information Development Unit (PHIDU) www.phidu.torrens.edu.au, based on the ABS Census of Population and Housing data, August 2016

Aged Care Assessment Teams (ACATs) conduct comprehensive assessments of the care needs of older adults when entering the government-subsidised aged care system. ACATs assess the needs of older people across three different areas of care:

- Activities of daily living
- Cognition and behaviour and
- Complex health care.

Table 10 shows the care need ratings of people in permanent residential care in the Gold Coast region compared to national levels. Across all domains, the proportion of people needing high levels of care are lower in the Gold Coast region. Notable trends in this dataset indicate:

• The proportion of people requiring high levels of care increases with age for the 'activities of daily living' and 'complex health care' domains, whereas the rate decreases with increasing age for the 'cognition and behaviour' domain

• Females have a higher proportion of people requiring high levels of care for 'activities of daily living' and complex health care' than males. However, this may be driven by the age-related trend above due to a higher life expectancy for females.

• People who have a preferred language other than English are more likely to have high care needs across all domains.

Region	Care domain	Care need rating (%)			
		Nil	Low	Medium	High
Gold Coast	Activities of daily living	1.1	16.5	30.3	51.6
	Cognition and behaviour	5.1	12.5	21.5	60.4
	Complex health care	3.1	16.5	30.4	49.4
National	Activities of daily living	0.6	12.8	30.1	56.6
	Cognition and behaviour	4.3	10.9	22.1	62.7
	Complex health care	1.9	15.0	28.1	55.0

Table 10: Care need ratings of people in permanent residential aged care in Gold Coast region based on Aged Care Funding Instrument assessment, at 30 June 2017

Source: Data supplied by Australian Institute of Health and Welfare from National Aged Care Data Clearinghouse

Service Utilisation

Aged care services

The public aged care service system provides support to people aged 65 years and over (under 65 considered with medical evidence), and for Aboriginal and Torres Strait Islander People aged 50 years and over, who can no longer live without support in their own home.

The services available within the publicly-funded aged care system known as 'My Aged Care' include:

• Home support (Commonwealth Home Support Program), which provides entry-level support at home across services such as personal care, transport, home modification, nursing and allied health, meals, household duties, mobility equipment and social activities

• Home care (Home Care Packages Program), which provides coordinated packages of aged care services for people with more complex needs to remain living at home, ranging from basic care needs (Level 1) through to high-level care needs (Level 4)

• Residential care, which offers both permanent and short-term respite in an aged care facility

• Transition care, which provides short-term care to restore independent living after a hospital stay

• Short-term restorative care to help improve wellbeing and independence, and delay or avoid the need to enter long-term care; can be provided in a home setting or residential care setting, or a combination of both

• Multi-purpose services, which offer aged care alongside health services in regional and remote areas

• Innovative Pool, which pilots new approaches to providing aged care

• The National Aboriginal and Torres Strait Islander Aged Care Program (NATSIACP), which provides culturally- appropriate aged care at home and in the community

• The Australian Department of Health provides a range of services to support older people, their families and carers. These include access to information through My Aged Care and support services relating to dementia, diverse backgrounds, carers, community visitors' scheme, advocacy and complaints

Table 11 shows the number of users and allocated places for aged care services in the Aged Care Planning Region (ACPR) of 'South Coast', which mostly aligns to the GCPHN boundaries.

Table 11: Number of users and allocated places for South Coast ACPR by care type and provider type, as at 30 June 2017

Care type	Number of users	Number of allocated places
Residential	4,606	5,117
Home care	1,575	NA
Transition care	85	96
Short-term restorative care	0*	0*
Multi-purpose service	0^	0^
NATSIACP	0	0
Innovative pool	0	0

Source: AIHW, GEN Aged Care data portal, extracted from www.gen-agedcaredata.gov.au
Note: does not include home care places, or home support users or places
** Short-term restorative care places only allocated since 2016-17 Aged Care Approvals Round (ACAR)*
^ Multi-purpose places are only allocated in regional and remote locations

There were a total of 52 different residential care services, 45 home care services, and 47 home support services available to care recipients.

The number of people using the home support program is not available at a regional level, but nationally it represents the vast majority of all aged care services utilised (73.6%), which reflects its role as a high-volume, low- intensity entry point to the aged care system.

Current waiting lists to access home care packages are extensive both within the Gold Coast region and nationally, which is likely to impact the utilisation of other aged, community and health services. The number of people on the National Prioritisation Queue for a home care package residing in the South Coast Aged Care Planning Region (ACPR) who are not accessing or not been assigned a package was 1,347 people as at 31 March 2018.

The majority of these people are approved for Level 3 packages (571 people), followed by Level 2 packages (384) and Level 4 packages (372). Estimated wait times for people entering the National Prioritisation Queue are outlined in Table 12:

Package level	First package assignment	Time to first package	Time to approved package
Level 1	Level 1	3-6 months	3-6 months
Level 2	Level 1	3-6 months	6-9 months
Level 3	Level 1	3-6 months	12+ months
Level 4	Level 2	6-9 months	12+ months

Table 12: Estimated waiting time for home care package on National Prioritisation Queue, as at March 2018

Source: Department of Health, Home Care Packages Data Report 1 January to 31 March 2018.

The Commonwealth Government's GEN Aged Care data portal shows the Gold Coast region had a higher rate of places allocated for residential aged care facilities (RACFs) for people aged over 70 years (85.4 per 1,000 people) when compared to Queensland (73.4) and Australia (76.5).

The majority (63%) of residential aged care places are allocated to private providers. A sub-regional breakdown of the allocation of permanent residential aged care places across the Gold Coast PHN region is outlined in Table 13.

Broadbeach - Burleigh	363
Coolangatta	503
Gold Coast - North	1,140
Gold Coast Hinterland	38
Mudgeeraba - Tallebudgera	299
Nerang	251
Ormeau - Oxenford	707
Robina	803
Southport	944
Surfers Paradise	107
Gold Coast	5,155

Table 13: Number of allocated places for permanent residential care across Gold Coast by SA3 region, as at June 2017

Source: Australian Institute of Health and Welfare, GEN Aged Care data portal, extracted from, www.gen-agedcaredata.gov.au

It shows areas within the Gold Coast region with high numbers of RACF places, particularly Gold Coast North and Southport. The areas with higher rates of placements are reflective of the SA3 areas with a higher proportion of 65+ population (with the exception of Broadbeach – Burleigh) demonstrating an adequate representation of facilities across the GCPHN. Other areas of higher density include Southport and Robina, which is unsurprising given they are clustered around the location of public hospitals.

Utilisation trends for permanent residential aged care services in the GCPHN region, including number of admissions, people using aged care services, average length of stay and exits during the year 2016-17 is outlined in Table 14. It includes a breakdown for various demographic characteristics such as age, sex, Indigenous status and preferred language. Several points observed from the data include:

Breakdown		Number of admissions	No. of people using aged care Due to death	Average length of stay (mths)		No. of exits from aged care	
				Due to other reasons	Due to death	Due to other reasons	Due to other reasons
Total		1891	4631	31	17	1431	394
Age group	0-49	9	21	NA	44	0	7
	50–54	9	13	49	14	2	5
	55–59	27	42	5	23	6	10
	60–64	31	97	20	23	10	7
	65–69	81	169	18	17	37	23
	70–74	136	291	23	16	64	27
	75–79	271	514	28	11	142	70
	80–84	372	785	27	14	228	71
	85–89	477	1198	30	18	310	90
	90–94	360	1036	34	18	410	68
	95–99	111	424	39	35	182	12
	100+	7	41	46	41	40	4
Sex	Male	778	1561	25	20	584	223
	Female	1113	3070	36	14	847	171
Indigenous status	Yes	9	16	14	14	5	2
	No	1882	4606	31	17	1421	392
Preferred language	English	1830	4489	31	17	1393	377
	Other	59	136	44	10	37	16

Table 14: Admissions, utilisation, length of stay and exits from permanent residential aged care, Gold Coast PHN region, 2016-17

Source: Australian Institute of Health and Welfare, GEN Aged Care data portal, extracted from www.gen-agedcaredata.gov.au

This data is limited to people residing in aged care facilities through the public system as the availability of data on older people who utilise aged care services privately is limited. However, it is acknowledged that understanding the role of the privately funded system is important in understanding and predicting potential future demand for public- funded services that might be driven by socioeconomic changes, such as financial crises affecting retiree incomes.

Hospitalisations

Reducing the number of avoidable hospital admissions is a performance priority for PHNs across the country. Data supplied by Gold Coast Health for potentially preventable hospitalisations (PPHs) for people aged 75 years and over shows that there were 4,302 PPHs recorded in Gold Coast public hospitals between July 2016 and June 2017. See Table 15.
The five leading causes of PPH bed days in this age group are:
1. diabetes complications

2. congestive cardiac failure

3. chronic obstructive pulmonary disorder (COPD)

4. urinary tract infections (UTI) and

5. pneumonia and influenza.

Age group	PPH condition	Number of bed days	All PPH separations	PPH as primary diagnosis - separations	% primary diagnosis of all PPH separations	Avg. length of stay, primary diagnosis (days)
75+ years	Diabetes complications	5,323	968	199	5.9%	5.78
	Congestive cardiac failure	2,469	515	515	15.2%	4.79
	COPD	2,379	626	626	18.5%	3.80
	UTIs including pyelonephritis	2,265	659	659	19.4%	3.44
	Pneumonia and influenza	1,119	182	106	3.1%	4.83
	All PPH conditions	17,721	4,302		100%	3.60
All ages	All PPH conditions	42,632	13,851	-	-	3.10

Table 15: Potentially preventable hospitalisations (PPHs) for Gold Coast public hospitals by age and condition, Jun 2016 to Jul 2017

Source: Supplied by Gold Coast Health, Queensland Hospital Admitted Patient Data Collection (QHAPDC).
Note: One admitted patient may have more than one condition that is classified as a potentially preventable hospitalisation and therefore the total numbers of PPH may not equal the number of patients admitted

When compared to include all causes of overnight hospitalisations for older people (i.e. not just those categorised as preventable), the leading five causes are:
1. Encountering health services in other circumstances (e.g. review of medications or assessment results, assisted living or transition to assisted living facility)

2. COPD

3. Person awaiting admission to residential aged care service

4. UTI

5. Pneumonia

Additional data supplied by Gold Coast Health relating to emergency department presentations and inpatient admissions for residents of Gold Coast RACFs shows that:

• 5,551 or 3.14% of patients presenting to a public emergency department (ED) in 2017-18 were transferred from an RACF. Of these, 26 patients (0.46%) died in hospital.

• The number of patients presenting to Emergency Departments (EDs) from RACFs has been increasing steadily over the last 5 years, up 62% from 3,441 presentations in 2013-14. However, the proportion of these patients who died in ED has generally decreased (except for 2017-18).

• 7,430 or 4.5% patients admitted to a public hospital as an inpatient in 2017 were transferred from an RACF. Of these, 205 patients (2.8%) died in hospital. Over 15% of all inpatient deaths in public hospitals were residents of RACFs.

Primary care providers

The capacity of the primary health care system to manage the ongoing health needs of older people, particularly those living in RACFs, is critical in preventing unnecessary transfers to hospital facilities. The number of GP and specialist attendances per person for the GCPHN region based on Medical Benefits Schedule (MBS) claims data is outlined in Table 16. Unsurprisingly, older people on the Gold Coast had higher claim rates than the all-age population in the region.

GP attendances (standard and after hours) were higher for older people on the Gold Coast when compared to the older adult population nationally, but specialist attendances were lower.

	GP attendances		After-hours GP attendances		Specialist attendances	
Population	65+ years	All ages	65+ years	All ages	65+ years	All ages
Gold Coast	13.3	6.8	0.77	0.66	2.2	0.86
Australia	11.8	6.1	0.6	0.49	2.5	0.95

Table 16: Number of GP and specialist attendances per person, Gold Coast PHN region, 2016-17

Source: Australian Institute of Health and Welfare, MyHealthyCommunities portal, www.myhealthycommunities.gov.au
Note: Results are based on the patient's Medicare enrolment postcode

There are several items on the Medicare Benefits Schedule (MBS) specifically for professional attendances at an RACF. Claim rates for these items can provide an indication of the level of coordination and integration between RACFs and general practitioners. Table 12 outlines the number of services claimed for these MBS items across the GCPHN region and shows they have typically increased significantly over the last five years, except for medication management.

Items	2012-13	2013-14	2014-15	2015-16	2016-17
GP attendances at RACFs (20, 35, 43, 51)	81,967	87,615	88,981	96,737	105,091
Other medical practitioner (non-GP) attendances at RACFs (92, 93, 95, 96)	0	756	526	0	1,663
After hours GP attendances at RACFs (5010,5028, 5049, 5067)	12,255	13,740	17,834	18,566	19,599
After hours non-GP attendances at RACFs (5260, 5263, 5265, 5267)	0	0	29	219	0
GP contribution to multi-disciplinary care plan for resident of RACF (731)	3,416	3,916	3,447	4,473	4,211
Medication management review for resident of RACF (903)	2,579	2,419	1,772	2,224	1,653

Table 17: Number of MBS items relating to residential aged care facilities (RACFs) claimed in Gold Coast PHN region, 2012-13 to 2016-17

Source: Department of Human Services, Medicare Australia Statistics
Note: Claims data is based on the street address of the provider rather than the patient's place of residence

Prescribed medications

Dispensing rates under the Pharmaceutical Benefits Scheme (PBS) provide an indication of the utilisation of medications compared to other regions as well as an insight into the health needs of older people within the region. Table 18 provides dispensing rates for medications listed on the PBS under several relevant categories for older people including antidepressants, anxiolytics (for treating anxiety), anti-psychotic and anticholinesterase (for treating conditions including Alzheimer's) medications.

The rates of dispensing for anxiolytic and anticholinesterase medicines is higher than the state and national rates in almost all regions of the Gold Coast. Southport has particularly high rates of dispensing across all four selected medicine types.

Region	Age-standardised rate of prescriptions dispensed per 100,000 people aged 65 years and over			
	Anti-depressants	Anti-psychotics	Anxiolytics	Anti-cholinesterases
Broadbeach - Burleigh	182,793	18,533	45,666	14,121
Coolangatta	196,998	19,341	54,714	14,782
Gold Coast - North	201,933	22,025	53,587	14,830
Gold Coast Hinterland	183,492	18,967	39,013	17,052
Mudgeeraba - Tallebudgera	220,915	21,381	52,490	16,263
Nerang	192,221	17,161	43,510	11,993
Ormeau - Oxenford	216,858	18,259	43,619	14,672
Robina	176,026	13,888	40,708	10,202
Southport	230,803	34,386	62,901	14,126
Surfers Paradise	176,153	17,442	49,921	14,426
Queensland	221,409	31,763	42,664	11,655
Australia	196,574	27,043	37,695	12,650

Table 18: Rate of prescriptions dispensed for selected medications for people aged 65 years and over in Gold Coast PHN region, by SA3 region, 2013-14

Source: Australian Commission on Safety and Quality in Health Care (ACSQHC), The First Australian Atlas of Healthcare Variation, 2015

Advance Care Planning

Advance Care Planning (ACP) involves planning for future health and personal care should a person lose their decision-making capacity. ACP can lead to completion of Advance Health Directive (AHD), a legal document intended to apply to future periods of impaired decision-making.

There are no dedicated MBS item numbers for Advance Care Planning, instead it is undertaken as part of standard GP consultations, health assessments, chronic disease management plans or case conferencing items.

As such, there is no regional data to indicate the number of ACP services being undertaken by GPs. A survey to measure the prevalence of AHDs undertaken in 2014 found that around 14% of the Australian population has an AHD, with that level as high as 19% in Queensland[6]. Those people who had made a Will or had an Enduring Power of Attorney were more likely to have an AHD. However, these findings are limited by the small sample size.

A Statement of Choices document enables a patient to record their wishes and choices for health care into the future. In 2017-18, there were a total of 451 Gold Coast PHN residents who had a completed Statement of Choices uploaded to Queensland Health's 'The Viewer' system, which is an increase of 270 on the previous year. Almost 90% of completed Statement of Choices recorded were for residents of an RACF[7].

Service Mapping

There are a range of stakeholders to consider when mapping services for older people. For the purpose of this report, the focus will include;

- After-hours service providers inclusive of not-for-profit organisations
- GPs and medical deputising services and
- RACFs.

Aged care services

An overview of the number of publicly-subsidised aged care services available in the GCPHN region by the type of aged care program and the type of provider is in Table 19.

Table 19: Number of aged care services in Gold Coast PHN region by program and provider type, as at June 2018

Provider type	Residential care			Home care	Home support
	Permanent	Respite Low Care	Respite High Care		
Private	32	24	24	17	3
Not-for-profit	20	19	24	24	43
Government	0	0	0	0	2
Total	52	43	48	41	48

Source: GEN Aged Care data portal, AIHW

There are 52 RACFs in the Gold Coast region stretching from Ormeau to Coolangatta. The RACFs range from capacity of 12 beds to much larger 167 bed facilities providing differing levels of care and services across general aged care, palliative, respite and dementia care.

Variation of the different levels of care and support have been widely reported throughout the consultation phase of this project. Information is limited around the type of supports available in some of the smaller, private and non- government funded facilities.

The register of providers of aged care services in the publicly-subsidised 'My Aged Care' system includes information about whether services focus on the needs of diverse groups. Table 20 shows the number of RACFs that identify as focusing on particular need groups by sub-region.

A full list of aged care service providers within each sub-region of the Gold Coast by program type can be referred to in Appendix 1, Service Mapping.

Table 20: Number of residential aged care services in Gold Coast PHN region identifying services specifically for diverse groups, as at June 2018

Region	Financial disadvantage	Aboriginal and Torres Strait Islander	LGBTI	CALD	Dementia	All services
Broadbeach - Burleigh	1	1	1	1	1	3
Coolangatta	4	2	2	2	4	5
Gold Coast - North	8	3	3	3	9	11
Gold Coast Hinterland	1	1	1	1	1	1
Mudgeeraba - Tallebudgera	2	2	1	1	2	4
Nerang	2	0	0	0	2	4
Ormeau - Oxenford	5	0	0	1	3	7
Robina	4	3	1	2	6	8
Southport	8	2	1	1	8	10
Surfers Paradise	1	0	0	0	1	1
Total	36	14	10	12	37	54

Note: Includes residential, home care and home support services
Source: GEN Aged Care data portal, AIHW

An identified issue on the Gold Coast is the level of skilled nursing staff available in RACFs, particularly availability of Registered Nurses (RNs) during the after-hours period. Table 21 shows that while the number and rate of RNs working in aged care (residential and home care) in the Gold Coast PHN region has been increasing over recent years, the rate is still lower than the national level.

Table 21: Number and rate of aged care nursing staff per 1,000 users of aged care services in Gold Coast PHN region, 2014 to 2017

Region	Nurse type	Number of aged care nursing staff			Rate of aged care nursing staff per 1,000 aged care users		
		2014	2015	2016	2014	2015	2016
Gold Coast	Registered Nurse	543	577	615	87.5	93.0	99.1
	Enrolled Nurse	389	387	408	62.7	62.4	65.7
National	Registered Nurse	-	-	-	113.7	116.8	120.9
	Enrolled Nurse	-	-	-	74.8	73.9	74.2

Source: AIHW, Health Workforce Data Planning Tool and GEN Aged Care Data Portal

Primary Care

General Pracitioners

In the context of older people's health needs in the primary care sector, General Practitioners (GPs) play a pivotal role in managing and coordinating an individual's health care needs. GPs deliver continuity of care for older people as they age and use their clinical judgements to make decisions about the most appropriate care for the individual. Roles carried out by GPs generally include:

- recognition and management of health conditions
- assessment of functional capacity of the individual
- recognition of their accommodation and care needs
- identification of the impacts on family and carers and associated needs for respite care.

A GP's role in the requirement for and facilitation of ACP is critical due to their ongoing and trusted relationships with patients. In the Gold Coast region, GPs provide services for older people in practices, at an individual's private residence and into RACFs.

As at March 2017, there were a total of 759 GPs on the Gold Coast across 180 practices. They are supported by a total of 1,225 non-GP staff working in general practice (e.g. nurses, allied health professionals, practice managers and administration). GP clinics are generally well distributed across the GCPHN region, with majority in populated coastal and central areas. Three practices are available for after-hours care (after 6pm and before 8am) at Surfers Paradise, Southport and Palm Beach.

Medical deputising services

The National Association for Medical Deputising includes a number of services that offer after-hours care in in the Gold Coast region. Services such as The House Call Doctor, National Home Doctor Service and Dial A Home Doctor provide after-hours doctors to attend appointments at a person's residence, whether that be an RACF or own home. These services account for approximately 65% of the after-hours home and RACF visits in Australia[8].

These services bulk bill eligible patients with a Medicare or DVA card and the consultation notes are electronically transferred, faxed or posted to the individuals' preferred local doctor.

Research has found that the most utilisation of after-hours GP services are children under the age of 4 years and elderly people, both in their homes or in aged care facilities. However, it should be taken into consideration that deputising services operate on a triage system that prioritise children, followed by the elderly. After hours services operate between 6pm – 6am Monday – Friday, 12pm Saturday - 6am Monday and all hours on public holidays.

As at March 2017, there were four medical deputising services operating on the Gold Coast providing in-home and after hours visits from a doctor.

Allied health services

Many different allied health groups contribute to the care of older people on the Gold Coast both individually or as part of multidisciplinary care teams. Allied health can be provided in a community or hospital setting and range from dieticians, physiotherapists, occupational therapists, pharmacists, podiatrists, psychologists and social workers.

Allied health plays a key role in care for older people by providing:
• Interventions to promote healthy ageing and reduce the impact of chronic conditions and disabilities

• Rehabilitative care to support people to regain function and strength after serious injury or an illness such as a stroke

• Strategies to support people to live independently in their own home

• Care co-ordination to assist people navigate the aged care system and make choices that are best for them[9]

In addition to allied health counsellors and pastoral care workers can provide a range of support to RACF residents.

Allied health services

Gold Coast Health provides a range of specific services for older people in the region, including:
• Aged Care Assessment Teams at Gold Coast University Hospital (GCUH) at Southport, Robina Hospital, Helensvale Community Health Centre and Palm Beach Community Health Centre

• Specialist palliative care in an inpatient and community setting

• Older Persons Mental Health Unit at Robina Hospital: 16 inpatient beds and community outreach

• Complex Needs Assessment Panel (CNAP) 65+ providing coordination of care and services to support older people with complex mental health needs

• Geriatric Evaluation and Management in the Home located at GCUH

• Bereavement services at Robina Hospital and GCUH

8 http://www.namds.com/wp-content/uploads/2017/01/Deloitte-Report-Analysis-of-after-hours-primary-care-pathways-1.pdf

9 https://ahpa.com.au/key-areas/aged-care/

Non-Government Organisations

There are a range of not-for-profit providers who deliver after hours and in-home care. Services can include:

- Home modification and maintenance
- Cleaning
- Personal care
- Shopping
- Social outings
- Transportation to respite care
- Palliative care and dementia care.

The cost of the individual's community care can often be supported through Commonwealth Home Support Program (CHSP) and Home Care Package (HCP) depending on the eligibility. Co-contributions are an expectation for individuals accessing CHSP and HCP except in cases of hardship.

Consultation

Patient Journey Mapping

One of the key items taken to consultation was Patient Journey Mapping. These visual representations of common patient journeys developed in partnership with COTA Queensland support the consumer engagement component of the consultation.

Four common pathways were documented for further consultation including:

- Dementia/CALD/family pathway, Keng
- Complex co-morbid ED presentation/social isolation pathway, Betty
- Self-funded retiree/Advance Care Plan/loss and grief pathway, Peter
- RACF palliative care pathway (prepared by Palliative Care Queensland), Mary

These were validated by Gold Coast PHN and the Aged Care Leadership Group.
Overarching issues identified across all common pathways worth noting included:

- Aged care reforms and system changes
- Lack of consumer and carer system literacy
- NDIS Reforms (links with dementia)
- Untimely re-assessment and scarcity of HCP 3 and 4 packages
- Unique challenges regarding CALD groups
- Cognitive impairment and decision making
- Advance Care Planning

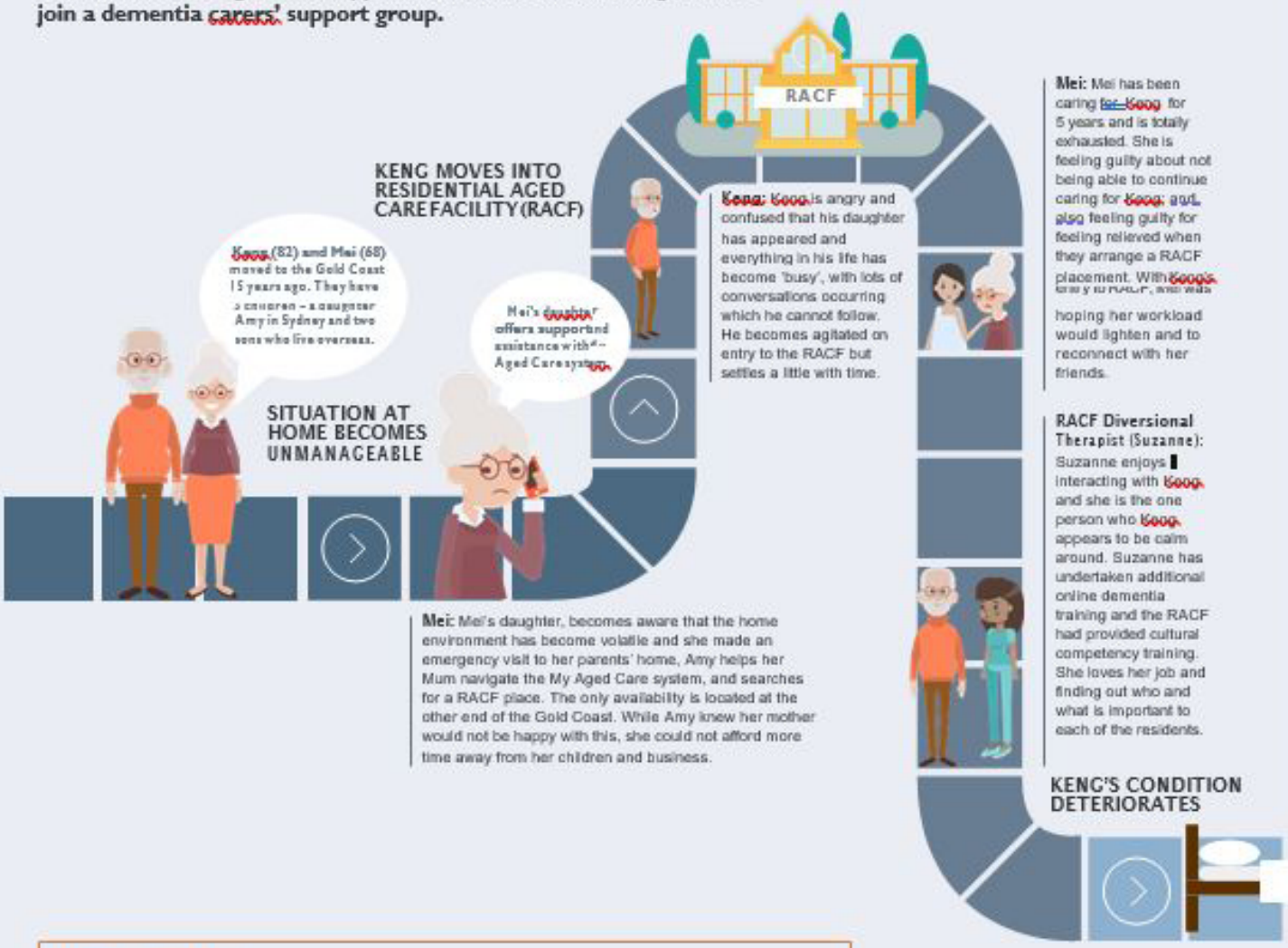
Workforce issues:

- Decrease in nursing in the community setting
- Under-resourcing of nursing in RACF
- Capacity and capability issues regarding assessors and assessment teams
- GPs not compensated for going in to RACFs / time required
- Lack of allied health in RACFs.

The common pathways with extracted key themes and issues specific to each journey can be found below:

Keng's journey

Keng's hobbies include reading, gardening and meeting weekly with a group of other Chinese men. A few years ago, Keng was diagnosed with dementia. His diagnosis came as a shock and Keng and his wife Mei were in denial for some time. Keng would not allow Mei to tell others. Mei tried to calm Keng's growing frustration and distress; and over time, withdrew from her own regular social activities. Mei's daughter began to realise the severity of Keng's condition and the impact on her mother's health. Through her volunteer work with a community organisation, Mei's daughter Amy knew how to assist Mei to get some support in the home and encouraged Mei to join a dementia carers' support group.



Keng: Keng is angry and confused that his daughter has appeared and everything in his life has become 'busy', with lots of conversations occurring which he cannot follow. He becomes agitated on entry to the RACF but settles a little with time.

Mei: Mei has been caring for Keng for 5 years and is totally exhausted. She is feeling guilty about not being able to continue caring for Keng; and also feeling guilty for feeling relieved when they arrange a RACF placement. With Keng's entry to RACF, Mei was hoping her workload would lighten and to reconnect with her friends.

Mei: Mei's daughter, becomes aware that the home environment has become volatile and she made an emergency visit to her parents' home, Amy helps her Mum navigate the My Aged Care system, and searches for a RACF place. The only availability is located at the other end of the Gold Coast. While Amy knew her mother would not be happy with this, she could not afford more time away from her children and business.

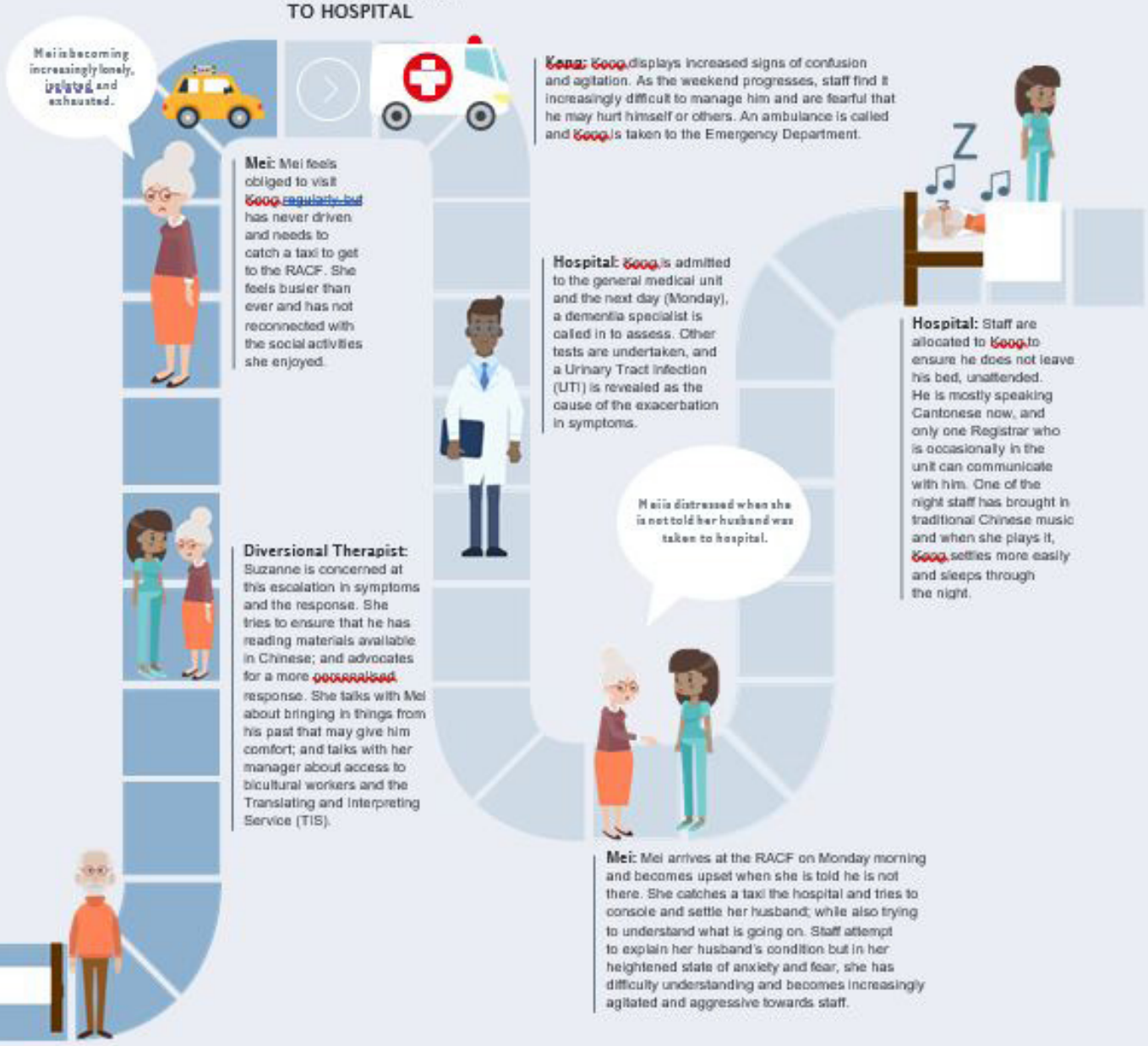
RACF Diversional Therapist (Suzanne): Suzanne enjoys interacting with Keng and she is the one person who Keng appears to be calm around. Suzanne has undertaken additional online dementia training and the RACF had provided cultural competency training. She loves her job and finding out who and what is important to each of the residents.

KENG'S CONDITION DETERIORATES

Key themes:

- Community knowledge about aged care and support available in the home improves service identification and navigation
- Important life decisions often made in made in times of emergency and distress
- Limited family supports can impact timely identification of issues and responses
- High emotional and physical stress for carer
- Appropriate recruitment of RACF staff e.g. Staff that are able to provide support across a range of health and social conditions including dementia and people from diverse backgrounds
- Timely comprehensive medical assessment in the RACF in response to escalating conditions
- Recognition of a person's social, cultural, spiritual and emotional needs

KENG IS ADMITTED TO HOSPITAL



Mei: Mei feels obliged to visit Keng regularly but has never driven and needs to catch a taxi to get to the RACF. She feels busier than ever and has not reconnected with the social activities she enjoyed.

Keng: Keng displays increased signs of confusion and agitation. As the weekend progresses, staff find it increasingly difficult to manage him and are fearful that he may hurt himself or others. An ambulance is called and Keng is taken to the Emergency Department.

Hospital: Keng is admitted to the general medical unit and the next day (Monday), a dementia specialist is called in to assess. Other tests are undertaken, and a Urinary Tract Infection (UTI) is revealed as the cause of the exacerbation in symptoms.

Hospital: Staff are allocated to Keng to ensure he does not leave his bed, unattended. He is mostly speaking Cantonese now, and only one Registrar who is occasionally in the unit can communicate with him. One of the night staff has brought in traditional Chinese music and when she plays it, Keng settles more easily and sleeps through the night.

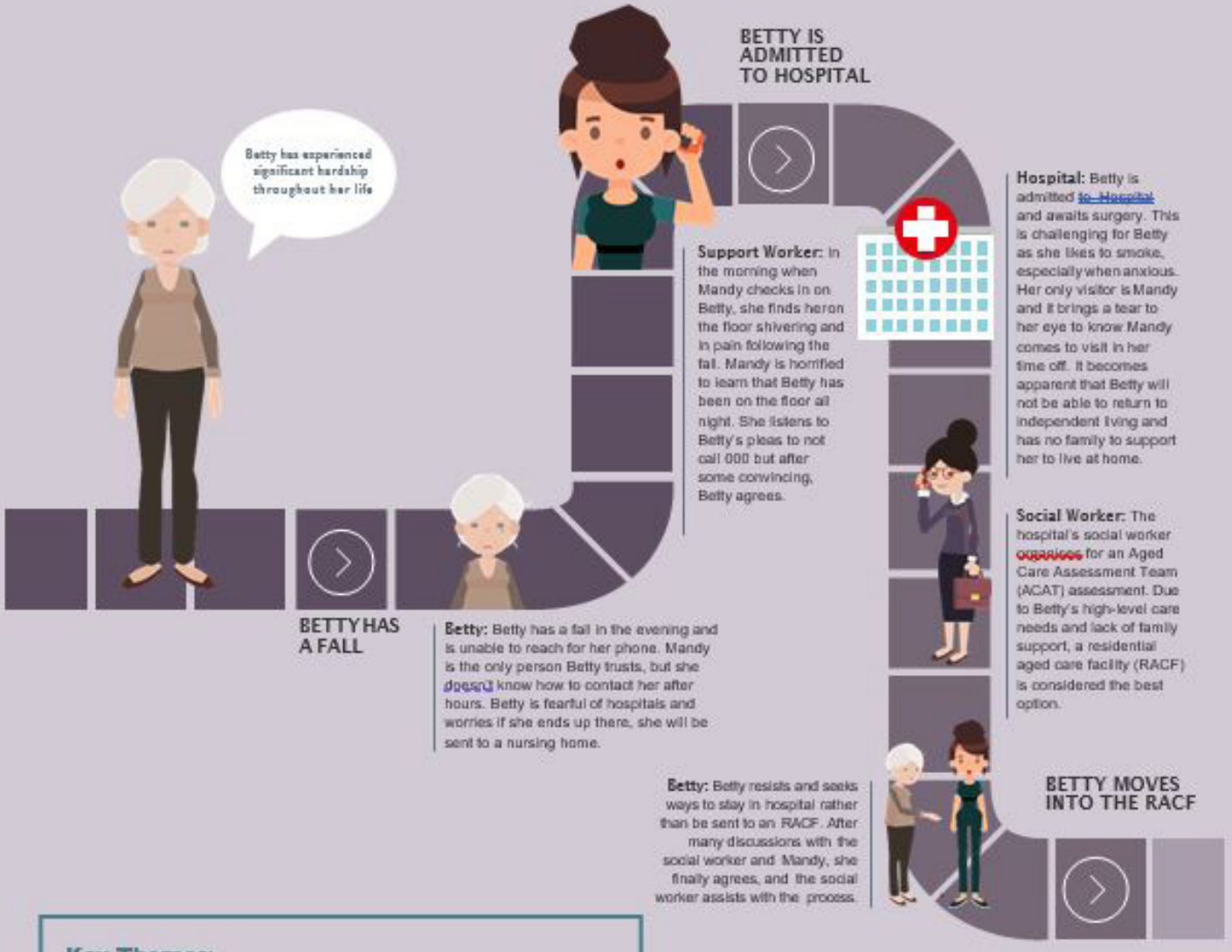
Diversional Therapist: Suzanne is concerned at this escalation in symptoms and the response. She tries to ensure that he has reading materials available in Chinese; and advocates for a more personalised response. She talks with Mei about bringing in things from his past that may give him comfort; and talks with her manager about access to bicultural workers and the Translating and Interpreting Service (TIS).

Mei: Mei arrives at the RACF on Monday morning and becomes upset when she is told he is not there. She catches a taxi the hospital and tries to console and settle her husband; while also trying to understand what is going on. Staff attempt to explain her husband's condition but in her heightened state of anxiety and fear, she has difficulty understanding and becomes increasingly agitated and aggressive towards staff.

Keng: Keng moves to a more 'secure' wing of the RACF but feels trapped and becomes increasingly agitated as he cannot find his way 'home'. He frequently reverts to his first language of Cantonese.

Betty's journey

Betty is 78 years old and is prematurely aged due to her life circumstances. She has been homeless at times in her last 30 years and is grateful to now be living in a self-contained unit. Betty has the support of a Housing Support Worker, Mandy, who supports Betty to maintain regular check-ups at the local bulk-billing General Practitioner (GP) clinic and to stay on her medications for her mental health condition.



Betty: Betty has a fall in the evening and is unable to reach for her phone. Mandy is the only person Betty trusts, but she doesn't know how to contact her after hours. Betty is fearful of hospitals and worries if she ends up there, she will be sent to a nursing home.

Support Worker: In the morning when Mandy checks in on Betty, she finds her on the floor shivering and in pain following the fall. Mandy is horrified to learn that Betty has been on the floor all night. She listens to Betty's pleas to not call 000 but after some convincing, Betty agrees.

Hospital: Betty is admitted to Hospital and awaits surgery. This is challenging for Betty as she likes to smoke, especially when anxious. Her only visitor is Mandy and it brings a tear to her eye to know Mandy comes to visit in her time off. It becomes apparent that Betty will not be able to return to independent living and has no family to support her to live at home.

Social Worker: The hospital's social worker organises for an Aged Care Assessment Team (ACAT) assessment. Due to Betty's high-level care needs and lack of family support, a residential aged care facility (RACF) is considered the best option.

Betty: Betty resists and seeks ways to stay in hospital rather than be sent to an RACF. After many discussions with the social worker and Mandy, she finally agrees, and the social worker assists with the process.

Key Themes:

- Limited capacity of RACF to support complex, high needs residents
- RACF staff require adequate training and support to recognise, understand and work with the needs of people with mental health conditions
- Limited access to mental health specialist services for RACF residents and staff
- Lack of shared medical records between systems can result in lack of good continuity of care

BETTY'S CONDITION DETERIORATES

Betty: Six months on, a few incidents impact Betty's wellbeing. Ron has disappeared, and with no information on his condition shared, Betty assumes he has died. There has been a change in nursing staff and Betty doesn't feel as comfortable with the new Nurses. She refuses to answer questions and gets angry with staff when they encourage her to join in activities. This relationship escalates to a point where staff start to avoid Betty and leave her alone in her room. Betty withdraws further, loses her appetite, and is reported as showing aggressive behaviour when staff enter her room.

Betty: The move was not as bad as Betty was expecting. Most of the staff are friendly and encouraging. Betty enjoys chatting to Ron each day, who she often shares a table with in the common area. She likes one of the volunteers who comes in weekly – he always makes her laugh.

Betty's limited medical history impacts care planning

RACF Staff: Betty's medical discharge plan is provided, however there is very little history on Betty's medical history. Betty is very private and not willing to share her personal history or interests. The staff pay particular attention trying to ensure a comfortable transition. Betty has no visitors and receives no regular General Practitioner (GP) visits.

ED Staff: ED staff attempt to determine what medications Betty is on for her condition and a mental health assessment is undertaken. This is a complicated process as there has been limited communication between the RACF, ambulance and ED staff, especially after hours.

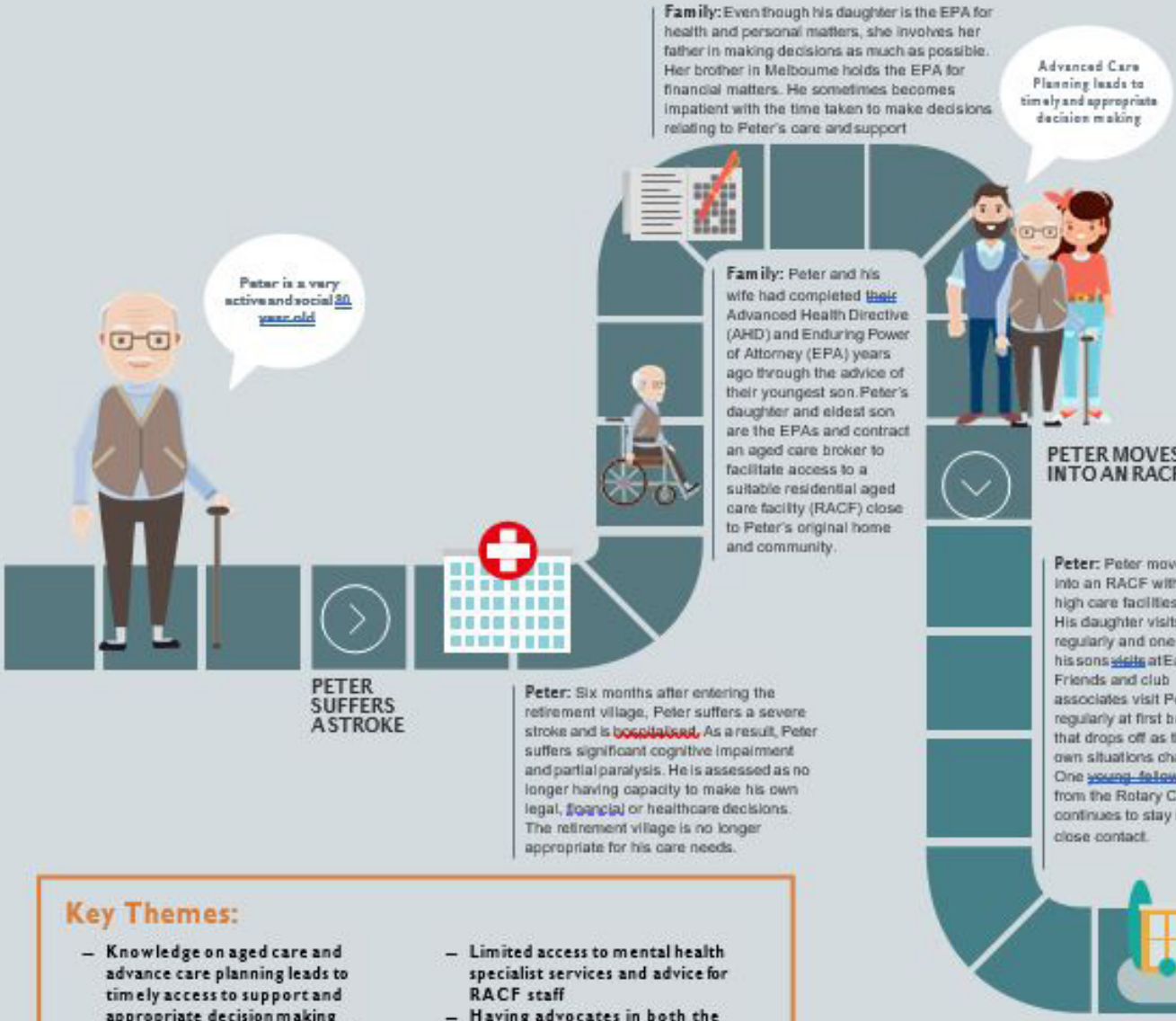
BETTY IS TRANSPORTED TO THE EMERGENCY DEPARTMENT (ED)

Betty: The situation between Betty and a staff member escalates one evening and Betty becomes physically violent.

RACF Staff: RACF staff call an ambulance and Betty is taken to the ED.

Peter's journey

Peter is 80 years old and has moved to a retirement village unit after the death of his wife. It was a difficult transition to move from their home of 50 years. Peter is supported by his family, especially his daughter who lives on the Gold Coast. He is a long-standing member of the local Lions Club and the golf club and continues to enjoy an active life. Peter's daughter supports him to arrange for some paid weekly cleaning. He visits and dines with friends and family and loves looking after his youngest grandchild every Thursday. He regularly attends the general practitioner (GP) he and his wife have used for the last twenty years.



Peter: Six months after entering the retirement village, Peter suffers a severe stroke and is hospitalised. As a result, Peter suffers significant cognitive impairment and partial paralysis. He is assessed as no longer having capacity to make his own legal, financial or healthcare decisions. The retirement village is no longer appropriate for his care needs.

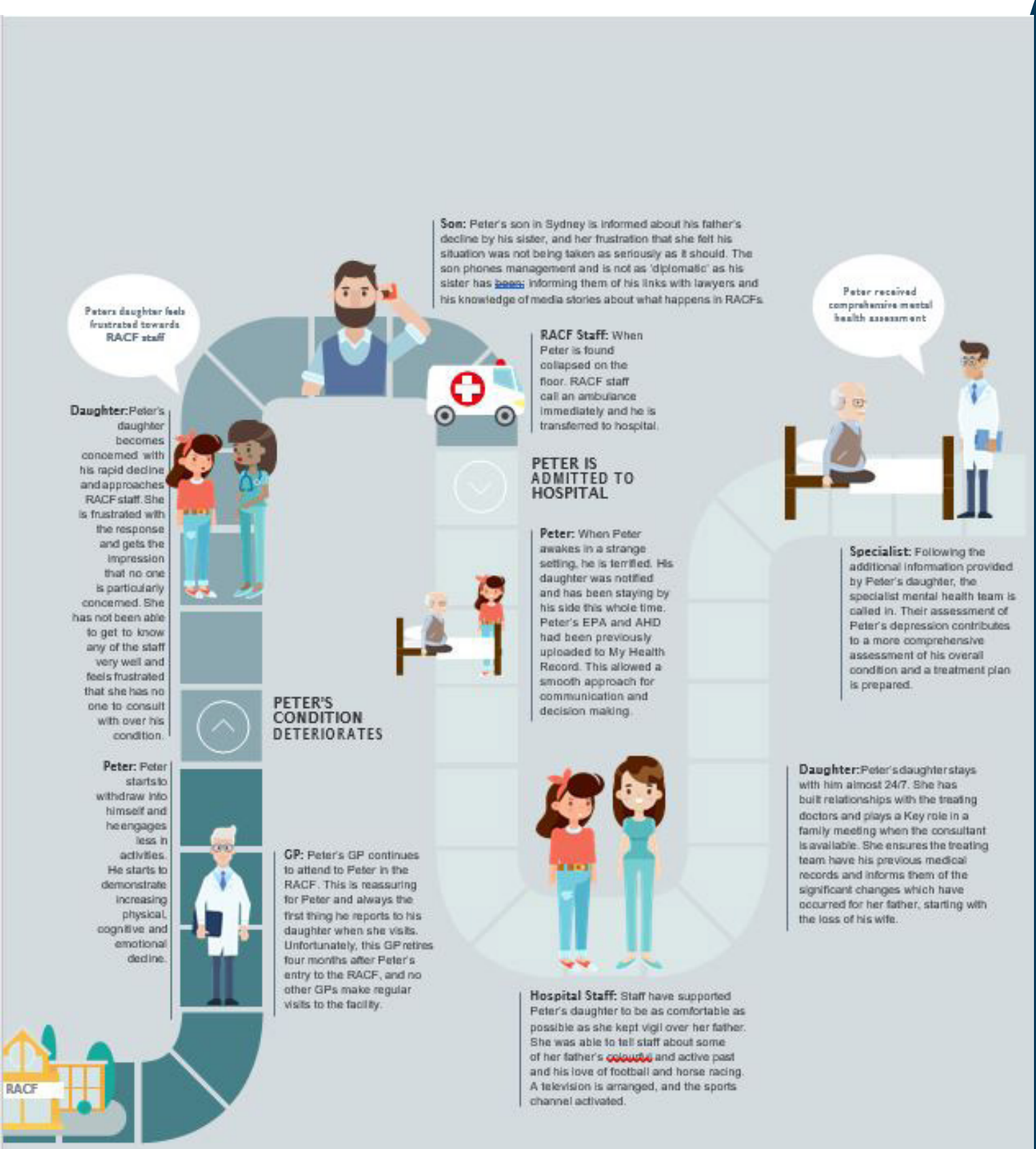
Family: Peter and his wife had completed their Advanced Health Directive (AHD) and Enduring Power of Attorney (EPA) years ago through the advice of their youngest son. Peter's daughter and eldest son are the EPAs and contract an aged care broker to facilitate access to a suitable residential aged care facility (RACF) close to Peter's original home and community.

Family: Even though his daughter is the EPA for health and personal matters, she involves her father in making decisions as much as possible. Her brother in Melbourne holds the EPA for financial matters. He sometimes becomes impatient with the time taken to make decisions relating to Peter's care and support

Peter: Peter moves into an RACF with high care facilities. His daughter visits regularly and one of his sons visits at Easter. Friends and club associates visit Peter regularly at first but that drops off as their own situations change. One young fellow from the Rotary Club continues to stay in close contact.

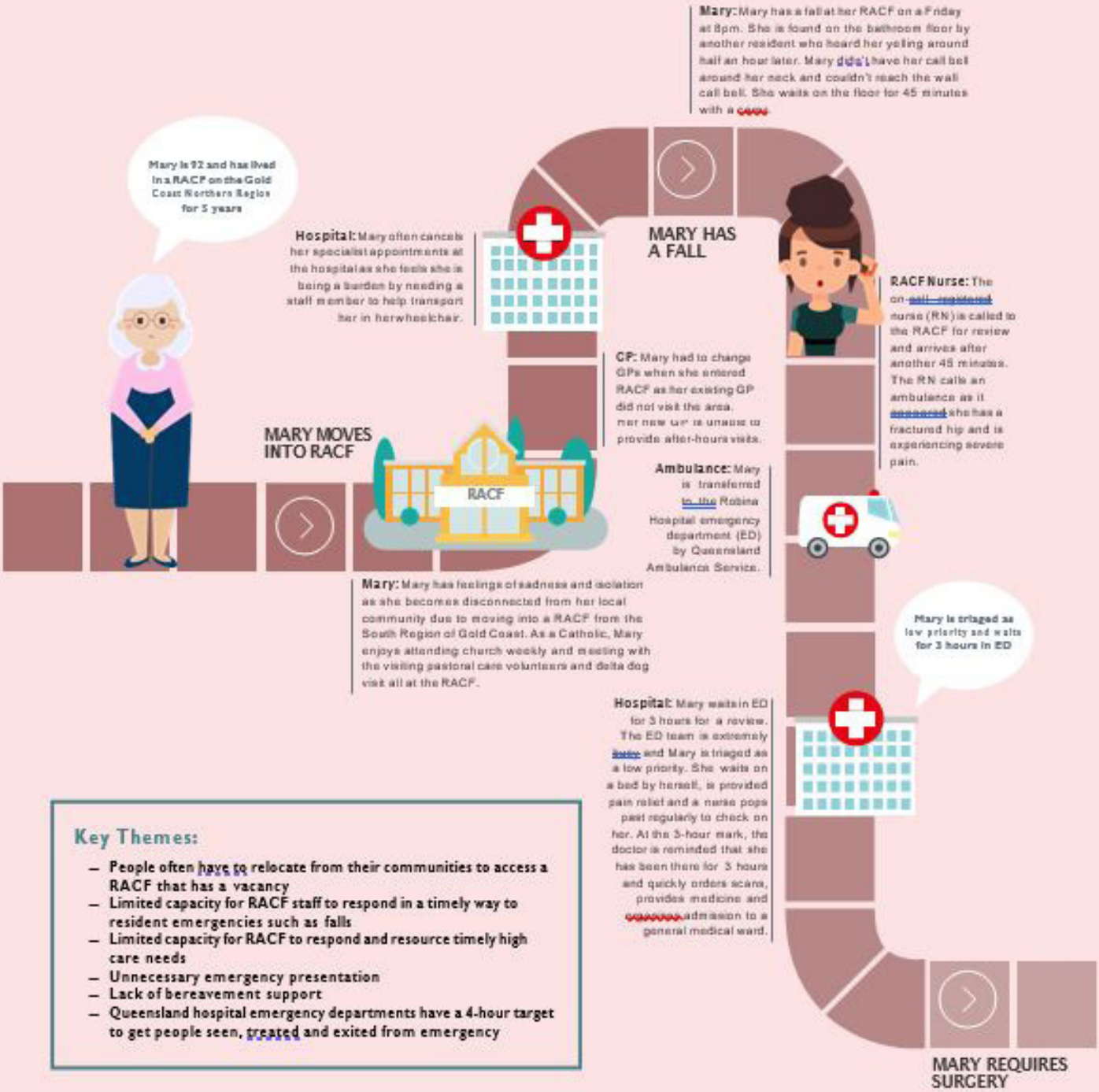
Key Themes:

- Knowledge on aged care and advance care planning leads to timely access to support and appropriate decision making
- Staffing numbers and skill levels (clinical and social) in RACF can make a significant impact to care on a daily basis as well as during an emergency
- RACF staff require adequate training and support to understand the ageing process and the impact of loss, disability and grief
- Limited access to mental health specialist services and advice for RACF staff
- Having advocates in both the RACF and hospital setting makes a significant difference in effectively assessing a person's condition and developing a comprehensive care plan


Peters daughter feels frustrated towards RACF staff
Daughter: Peter's daughter becomes concerned with his rapid decline and approaches RACF staff. She is frustrated with the response and gets the impression that no one is particularly concerned. She has not been able to get to know any of the staff very well and feels frustrated that she has no one to consult with over his condition.
Peter: Peter starts to withdraw into himself and he engages less in activities. He starts to demonstrate increasing physical, cognitive and emotional decline.
RACF
PETER'S CONDITION DETERIORATES
GP: Peter's GP continues to attend to Peter in the RACF. This is reassuring for Peter and always the first thing he reports to his daughter when she visits. Unfortunately, this GP retires four months after Peter's entry to the RACF, and no other GPs make regular visits to the facility.
Son: Peter's son in Sydney is informed about his father's decline by his sister, and her frustration that she felt his situation was not being taken as seriously as it should. The son phones management and is not as 'diplomatic' as his sister has been informing them of his links with lawyers and his knowledge of media stories about what happens in RACFs.
RACF Staff: When Peter is found collapsed on the floor. RACF staff call an ambulance immediately and he is transferred to hospital.
PETER IS ADMITTED TO HOSPITAL
Peter: When Peter awakes in a strange setting, he is terrified. His daughter was notified and has been staying by his side this whole time. Peter's EPA and AHD had been previously uploaded to My Health Record. This allowed a smooth approach for communication and decision making.
Hospital Staff: Staff have supported Peter's daughter to be as comfortable as possible as she kept vigil over her father. She was able to tell staff about some of her father's colourful and active past and his love of football and horse racing. A television is arranged, and the sports channel activated.
Daughter: Peter's daughter stays with him almost 24/7. She has built relationships with the treating doctors and plays a Key role in a family meeting when the consultant is available. She ensures the treating team have his previous medical records and informs them of the significant changes which have occurred for her father, starting with the loss of his wife.
Specialist: Following the additional information provided by Peter's daughter, the specialist mental health team is called in. Their assessment of Peter's depression contributes to a more comprehensive assessment of his overall condition and a treatment plan is prepared.
Peter received comprehensive mental health assessment

Mary's journey

Mary is a Gold Coast local with three children; one (John) who lives in Brisbane, while the others live interstate. Mary's husband died 5 years ago, after which she decided with the help of her family to move into a Residential Aged Care Facility (RACF). Mary suffers from heart failure and several other co-morbid conditions. She requires some support to shower and needs a wheelchair to move long distances. She was previously active with a local craft group but hasn't seen them since moving into the RACF.



Key Themes:

- People often have to relocate from their communities to access a RACF that has a vacancy
- Limited capacity for RACF staff to respond in a timely way to resident emergencies such as falls
- Limited capacity for RACF to respond and resource timely high care needs
- Unnecessary emergency presentation
- Lack of bereavement support
- Queensland hospital emergency departments have a 4-hour target to get people seen, treated and exited from emergency

RACF: The RACF Manager completes an assessment of Mary's needs to be done to seek additional funding for her increased care needs. An Activities Coordinator brings some music and cuddles for Delta dogs to visit.

Hospital: The ambulance arrived quickly to transfer Mary back to the RACF so hospital staff didn't have a chance to chat to Mary about Goals of Care or Advance Care Planning.

Doctor: Mary's doctor tries to decide on the best way forward — to operate or treat conservatively? As Mary has no cognitive issues she is able to make the decision herself, but it's a difficult conversation to have.

Mary returns to the RACF, where she is largely confined to her room at the end of a hallway, rarely seeing other residents and unable to go to activities. She experiences increasing feelings of isolation. Mary deteriorates quickly and requires assistance for feeding in her bed, but staff struggle to get there and she often tries to feed herself "to save them time".

MARY RETURNS TO RACF

RACF: The discharge nurse hands Mary's case over to the RACF Manager. Mary's needs have changed, now requiring a high level of care placing further burden on the RACF's limited staffing and available equipment.

Family: Her family is concerned that she won't receive the care she requires if she returns and becomes 'bed bound'.

Mary: Mary decides she doesn't want the operation, as she has lived a good life and would rather just go back to her residence to have conservative treatment.

Mary is in a single room in the general ward waiting on surgery for her fractured hip. Doctors are concerned that due to her age and her heart condition she "might not make it". She does not have an advance care plan as her family have struggled to talk about dying with her husband's quick death 5 years ago.

Mary's care transitions from curative care to palliative care.

GP: Mary's GP is unavailable to visit until two days after she returns from hospital. Mary is reviewed by her GP and is diagnosed with aspiration pneumonia. She is treated with antibiotics which has limited effect, after which her GP informs staff that she is palliative.

Priest: The RACF priest visits Mary to attend to her spiritual needs.

Family: Mary's son John visits as much as possible, while her other family make arrangements to visit from interstate.

MARY'S CONDITION DECLINES

Mary: Mary is increasingly drowsy, has increased pain and restlessness and is provided a syringe driver by her GP. At midnight Mary begins screaming in pain, and becomes increasingly restless, as the syringe driver battery has run out.

RACF: The only RN is at another facility assisting with a fall and is unable to get there within the hour, so RACF staff call an ambulance. Mary is without pain relief for at least 3 hours.

Ambulance: Ambulance arrives and takes Mary back to the ED.

RACF: The RACF staff assist John and family to clean out her room but become aware how angry the family are, overhearing them talk about the "bad care she received". The RACF priest provides support to the other residents who know Mary.

Mary's family is very angry about her death and they receive no formal debrief.

Family: Mary's family are devastated they are not given any formal debrief. Mary's children attend the funeral. They all remain very angry with what happened.

Hospital: The funeral directors provide support to John and his family.

A BEREAVED FAMILY

Hospital: ED staff give Mary and her son John a private room and a social worker sits with them. Mary dies in ED 3 hours later.

RES

GCPHN Clinical Council

In June and August 2018, GCPHN undertook engagement with their Clinical Council to explore ineffi- ciencies and oppor- tunities within the aged care sector. The qualitative data is summarised under two main domains:

- Medications
    - o Access to some medications can be problematic if stocks are low
    - o Medication dispensed days ahead, problematic if GP recently changed medication. This causes issues with wastage of medications.
    - o Some corporate pharmacies request backdated scripts, which is illegal for a GP.
    - o Medication can often be prescribed on admission, however reviews can be overlooked
- Staffing
    - o High staff turnover and limited expertise in palliative care
    - o Number and experience of staff – high likelihood of transfer of resident to hospital
    - o Some RACFs can be 'unwelcoming' to visiting GPs
    - o Residents are often described in quote 'rosy terms' when in fact, their behaviour is worse
    - o Limited time to engage or upskill staff. Unsupported by facility when staff are required to deliver front line services.

While these issues are not representative of all RACFs, this information identifies inconsistencies across the sector. The importance of understanding the size and scope of the private fee-for-service aged care environment was noted, acknowledging the challenges in sourcing data.

Anecdotally, it was reported that the Gold Coast has pockets of high socio-economic status with people willing to self-fund care to avoid wait lists and maintain choice. It was noted that the local context can change quickly, for example with financial crises leading to a greater number of older people accessing publicly-funded services who may have previously been self-funded.

Alongside issues presented, there was a range of opportunities identified by the Clinical Council, including:

• Case conferencing between GPs and Hospital and Health Service (HHS) staff to work together on more complex cases such as dementia to avoid unnecessary hospital transfers

• Networking across RACFs and GPs to ensure backup outside of the individual facility

• Trialling new models of care in which a GP services RACFs in an area.

GCPHN Community Advisory Council

Recent (June 2018) feedback obtained through the GCPHN Community Advisory Council (CAC) found 93% of CAC members either agreed or strongly agreed on the needs identified in the Older Persons Needs Assessment Summary document released in December 2017.

The CAC highlighted the provision of transport assistance is a fundamental factor contributing to older people's ability to continue to stay at home. It therefore, needs to be considered when planning future service models.

In previous consultation carried out with the CAC in 2016, Advance Care Plan (ACP) was a key topic. It was emphasised that people preferred their GP to raise ACP with them, particularly if there is diagnosis of chronic disease. At the same time, the formal ACP documentation was labelled as not consumer friendly.

Loneliness was identified is a key consideration for older people. Particularly in the Gold Coast region where women often relocate after their husband passes away leaving them with limited social support or social connection. Loneliness, a predominant risk factor for prolonged grief can have catastrophic physical, mental, social, spiritual and financial health implications for the individual.

Considerations need to be given to the opportunities NDIS funding provides for this population group, if a person under 65 is approved for a NDIS package, they will continue to receive their package as they age. It would be advantageous to promote NDIS to those individuals nearing 65 with an impairment or condition that is likely to be permanent and reduces independence.Further engagement with this group recognised the level of need for PHN Commissioned Services is higher in RACFs and After-Hours Services compared to palliative care.

The CAC reconvened in August 2018 to provide review and feedback on the aged care with a focus on RACF and After Hours Draft One Needs Assessment Summary, their feedback has been incorporated into the report. Additional key themes which emerged and need to be considered include:

- Medical Tourism on the Gold Coast
- COPD need to be targeted as action area
- High variability of the types and quality of services available to people within RACFs

Co-Design Workshop

Co design workshops with 27 sector representatives and in partnership with COTA Queensland were held to inform the design and delivery of a regionalised approach to GCPHN's investment in an after-hours response relating to aged care.

The outcomes from the co-design workshop along with the findings of the needs assessment will directly inform the development of GCPHN's three-year strategic service planning report – "The Regional Plan for Older People (with a focus on After-Hours and RACF services)".

The co-design workshops were designed to maximise participation, incorporating a variety of feedback mechanisms including small group sessions, whole-of-room sessions or individual opinion in an anonymous format. Informal breaks were included for networking and further discussion and integration amongst the group.

Key themes emerged from the co design workshop included:
Workforce capacity building – The need for meaningful, appropriate, accessible workforce capacity building across the aged, community and primary care sectors was a prominent theme. It was reported that confident, skilled, and connected staff would lead to a reduction in potentially preventable hospitalisations.

Community awareness and education - While some difficulties were reported in measuring community awareness and education outcomes, it was still a leading theme throughout the workshop. Some recurring areas for education and awareness identified were advance care planning, aged, community and health service awareness, and health and death literacy.

Advance Care Planning – Advance Care Planning continues to carry significant importance across both the aged care and palliative care sectors on the Gold Coast. It has been reported that uptake remains low, which can be attributed to the difficulty and complexity of the paperwork involved. However, it is reported that having an Advance Care Plan in place results in a more informed, seamless, coordinated and appropriate journey for the individual in line with their values, beliefs and wishes at the end of life.

Service navigation and coordination – While activities around service navigation and coordination were strongly supported by participating representatives, measures to improve this can often be challenging in a constantly evolving and time-poor sector. Activities proposed to improve service navigation and coordination on the Gold Coast were dependent on having a key a navigator role to support individuals through their personal journeys.

Service integration –The need for more effective service integration on the Gold Coast was a significant theme. This can be attributed to the reported fragmentation between hospital services, RACFs and primary and community- based services. Challenges in accessing and receiving clinical support within RACFs have consistently been reported during this project, meaning RACFs have limited capacity and capability to respond to complex situations. Activities focusing on service integration with RACFs are an important consideration.

Additional information

The Australian Medical Association (AMA) Aged Care Survey Report[10], sought feedback on members' impressions and experiences of providing medical care to older people. The survey presented some insights which need to be taken into consideration for the future planning of primary care services for older people, particularly in RACFs and after-hours periods including:

• Over a third of survey respondents reported an intention to decrease or stop attending RACFs in the coming two years, attributed to the considerable amount of paperwork involved, responding to faxes and phone calls, and discussing issues with RACF staff or relatives of residents. This was despite a reported increase in demand for RACF-visiting medical practitioners.

• Respondents reported that in almost half of instances of GPs reducing the frequency of visits to RACFs in the last 5 years it was due to unpaid non-contact time, while a further 40% was due to practitioners being too busy in their practices.

10 https://ama.com.au/system/tdf/documents/2017%20AMA%20Aged%20Care%20Survey%20Report.pdf?file=1&type=node&id=48948
11 http://www.health.gov.au/internet/main/publishing.nsf/content/79278C78897D1793CA257E0A0016A804/$File/Review-of-after-hours-primary- health-care.pdf

The 2014 Review of After-Hours Primary Health Care[11] undertaken to consider the most appropriate and effective delivery mechanisms to support ongoing after-hours primary health care services nationally. Some of the key findings are highly relevant for the purposes of this report, and support some of the concerns raised throughout the consultation process:

• Medical deputising services require better triaging to eliminate visits which can wait until usual business hours

• Consumers often had limited knowledge of the variety of services available

• Consumers expressed the need for better integration and coordination of existing services

• Better health literacy around types of after-hours services and how to access them would increase consumer knowledge, accessibility, appropriateness and efficiency

• Practice infrastructure and hours of operation was seen to impact on extended hours care, if consumers were unable to access same-day appointments with their regular GP

• Supporting continuity of care and effective communication between after-hours service providers and a patient's regular GP

• Established and emerging eHealth solutions have great potential to improve after hours health care.

What we understand works

The National Consensus Statement: Essential elements for safe and high-quality end-of-life care identified 10 essential elements for delivering safe and high-quality end-of-life care in Australia. Elements when tailored to the appropriate setting and needs of the population will strengthen opportunities for delivering best practice end-of- life care.

Models of care below have been identified through a process of consultation with GCPHN, the Aged Care Leadership Group and GCPHN advisory mechanisms and desktop evidence review.

Stakeholders were asked to submit models of care which have worked well in o ther areas, and which would have successful elements which could be adapted to meet the local health needs and service issues of the Gold Coast region.
In general, the identified models are focused towards:

- Providing education and clinical supports to RACFs

- Reducing preventable emergency department presentations and hospital admissions

- Supporting GPs to remain at the centre of a person's care

The examples below are indicative of the type of service responses that could respond to the identified local health needs and service issues.

Example models of care are described below:

Model: After-Hours Service Model	
Program Example	Hunter Primary Health's GP Access After Hours (GPAAH)
Description	The After-Hours Service Model utilised telephone patient screening service to effectively triage after hours cases, GP's co-located in public EDs and transport support for people who would otherwise be unable to attend after hours clinic or GP home visits
Evidence	Independent evaluation showed an estimated annual cost saving of $10 million to the health system, mostly attributed to diverting low-acuity patients from the ED to primary care. Hunter Research Foundation, A cost study of GP Access After Hours (GPAAH), 2015 Available at: https://hunterprimarycare.com.au/wp-content/uploads/2015/11/GP-Access-Cost-Study.pdf
Alignment to Health Needs and Service Issues	• Triaging service enabling right care, right time, right place • Reducing preventable emergency department presentations • Consistent and high-quality support provided to RACFs

Model: RACF Service Model	
Program Example	Geriatric Outreach Assessment Service (GOAS), Brisbane North PHN and Metro North HHS
Description	GOAS aims to improve quality of care and reduce emergency department presentations and hospital admissions for RACF residents who are acutely unwell. The GOAS team includes a part-time geriatrician, a full-time registrar, two clinical nurses and an administration officer. It is supported by an external service facilitator, clinical nurse consultant. GOAS services include: • Reviewing residents following hospital discharges • Management of acute conditions (e.g. pneumonia) • Exacerbation of chronic cardiac failure • Acute management of behaviour disorders in residents with Dementia • Falls • End of life care • Clinical support and education for RACF staff
Evidence	Internal evaluation found GOAS had improved access to specialist geriatric outreach care for 744 patients and delivered 960 episodes of care (an average of 4 episodes per day), of which 638 episodes (66 per cent) were considered to have been potentially prevented Emergency Department presentations. Also, inpatient hospital admissions and average length of stay was lower for in-scope RACFs. https://www.brisbanenorthphn.org.au/page/health-professionals/community-care/geriatric-outreach-assessment-service/
Alignment to Health Needs and Service Issues	• GP centre of person's care needs • Increased continuity of care • Supporting uptake of Advance Care Plans • Reduction in emergency department presentations and hospital admissions for RACF residents. • Clinical support and education for RACF staff

Model: RACF Service Model	
Program Example	Implementation of a team model for RACF care by a general practice[12]
Description	A team model is characterised by a general practice or specialist team providing rostered outreach into RACFs. Models typically enable GPs to perform clinical tasks through twice-weekly rounds, with the clinical nurses as the first point of call to triage and assess the case for follow-up by the GP or specialist where necessary. Clinical nurses in these models play and integral role in liaising with RACF staff and families, collecting patient information, drafting advance care plans and supporting patients to maintain a preferred GP.
Evidence	While testing the effectiveness of the model compared to other models is required, benefits might include promoting the use of standard MBS consultation item numbers, reduction in after-hours consultations and increased continuity of care Reed RL (2015). Models of general practitioner services in residential aged care facilities, Aust Fam Physician, 44(4), 176-179
Alignment to Health Needs and Service Issues	• GP centre of person's care needs • Increased continuity of care • Supporting uptake of Advance Care Plans • Reduction in emergency department presentations and hospital admissions for RACF residents. • Clinical support and education for RACF staff

Model: RACF Service Model	
Program Example	*Clustered domestic residential aged care in Australia*[13]
Description	Clustered domestic residential aged care facilities offer small-scale living units designed to look like a home, with staffing models and physical design that afford greater choice and flexibility in living arrangements for residents. These facilities service a smaller number of residents per unit and individualised living spaces compared to standard Australian models of residential care.
Evidence	Clustered domestic models of residential care are associated with better quality of life and fewer hospitalisations for residents, without increasing whole of system costs. Dyer SM et al (2018). Clustered domestic residential aged care in Australia: fewer hospitalisations and better quality of life, Med J Aust, 208(10, 433-438
Alignment to Health Needs and Service Issues	• Improved health and wellbeing, lower levels of social isolation • Consumer choice • Reduction in emergency department presentations and hospital admissions for RACF residents.

Gold Coast Initiatives

GCPHN is already undertaking significant projects to contribute to the organisation's strategic success in the aged care sector and is continuing to improve integration of and coordination with Gold Coast Hospital and Health Service.

InterACT Program

The InterACT Project, was established in 2017 by Gold Coast Health to provide in-hour services to best meet the needs of people living in RACFs. GCPHN provided additional funding to pilot an after-hours component of the service from March 2018. InterACT utilises a clinical nursing workforce through a mixed-modality service model to support RACF residents from 6am to 10.30 pm Monday – Friday and 2pm to 8.30pm Saturday and 8am – 12pm Sunday, 7 days a week. InterACT has supported just under 400 residents in the Gold Coast region from its inception to March 2018, demonstrating a clear need for a service of its kind.

Navigation Services in RACFs Program

GCPHN's Navigation Services in RACFs program is supporting RACFs to engage an existing nursing staff member to assume the part time role of Service Coordinator. Service Coordinators have responsibility for working with general practitioners and medical deputising services to implement consistent cycle of care aligned with the Royal Australian College of General Practitioners (RACGP) Silver Book guidelines ensuring co-ordinated multidisciplinary care and comprehensive care planning. A key role of the service coordinator will be to develop, champion and embed the process and program into the RACF to ensure sustainability beyond GCPHN funding.

The RACF service coordinator role will support:

- Education of RACF clinical staff in proactive care planning
- More effective communications between all multidisciplinary team members in a resident's care
- Increasing number of residents with Advance Care Plans
- Increase use of My Health Record
- Increased access to specialist services where required to meet patient needs.

Consideration should be given to the outcomes of these programs to support ongoing funding for the program as they are filling identified service gaps in the Gold Coast region.

Opportunities

Commonwealth and State Priorities

Aged Care reform

The Australian Government's Department of Health is progressively implementing aged care reforms and moving towards consumer-directed care, meaning people have greater choice and care will be based on their individual needs. By 2022, the Department of Health envisions Australia's aged care system to:

- Be sustainable and affordable, long into the future
- Offer greater choice and flexibility for consumers
- Support people to stay at home, and part of their communities, for as long as possible
- Encourage aged care businesses to invest and grow
- Provide diverse and rewarding career options[14]

The aged care system in Australia is currently undergoing substantial reform to support change within the system towards the delivery of more person-centred, high quality care to older Australians. The development of Single Aged Care Quality Framework[15] by the Department of Health will see a framework focused on a single set of quality standards for all aged care services, improved quality assurance measures, a charter of rights for aged care participants and publication of information about quality to assist consumers to make informed decisions on aged care services.

The National Aged Care Diversity Framework 16offers opportunities for existing aged care services to build an inclusive, respectful, and person-centred aged care system. It promotes organisations to recognise and respond to older people with diverse needs including:

- Aboriginal and Torres Strait Islander people
- People from culturally and linguistically diverse (CALD) backgrounds
- Lesbian, Gay, Bisexual, Transgender, Intersex (LBGTI) communities
- People who live in rural, remote or very remote areas
- People with mental health problems and mental illness
- People living with cognitive impairment including dementia
- People with a disability
- Parents separated from their children by forced adoption or removal
- Care-leavers
- People who are homeless or at risk of becoming homeless
- Veterans
- Socio or economic disadvantage

Mental Health

The Australian Government has announced specific funding for RACF in-reach mental health services to be delivered through PHNs. $82.5m will be distributed nationally over 4 years with services due to commence in early 2019. Services will focus on alignment of local mental health and RACF services with national consultation currently underway to determine eligibility and required resources. Individual PHN budgets are not known at this stage. However, this represents a significant opportunity for Gold Coast PHN, given local health needs and services issues reflecting unmet mental health needs in RACFs and high dispensing rates on the Gold Coast for anxiety, antidepressants and antipsychotic medications.

With residents of RACFs no longer having access to MBS funded Psychological Services a unique opportunity presents in targeting Low Intensity Psychological Services to support RACF residents in need of mental and behavioural health services and to upskill RACF staff to be able to recognise and respond to mental health related episodes of residents

ACAT Assessments

There are upcoming changes that need to be taken into consideration for planning future models of care in the Gold Coast region. ACAT assessment changes from July 1, 2018 will impact the operating environment. It has also been reported that significant changes are on the horizon with CHSP and HCP models, presenting opportunities for improvement to the current delayed care for older people on the Gold Coast due to substantial waitlists with HCP levels 3 and 4.

Palliative Care in Aged Care

As part of the 2018-19 Budget, the Commonwealth Government has committed over $32 million over four years from 2018-19 for the Comprehensive Palliative Care in Aged Care measure which will improve palliative care for older Australians living in residential aged care. It supports new and innovative approaches to how care is delivered by state and territory governments to improve palliative and end-of-life care coordination. While this opportunity overlaps with the work undertaken in the Palliative Care Needs Assessment Final Report, it aligns with several local health needs and service issues identified in this report, including the need for timely and appropriate services, capacity-building for RACF staff and presenting opportunities to enable enhanced service integration and resourcing GP support in RACFs.

Aged Care Quality and Safety

Most recently, in September 2018, a Royal Commission into Aged Care Quality and Safety was announced. The Royal Commission will primarily look at the quality of care provided in residential and home aged care to senior and young Australians. It will also explore challenges associated with caring for people with disabilities and dementia, and future challenges and opportunities in delivering aged care in the changing demographics of older Australian population.

This presents an opportunistic time for Gold Coast PHN to engage and support local RACFs in quality improvement, person-centred approaches.

As well as being a national priority, Gold Coast PHN has committed to developing a world class health system for the Gold Coast region by enabling strategic measures to improve the experience, value and outcomes of the services they commission and support. Gold Coast PHN's Strategic Plan 2017 – 2022[17] outlines indicators relevant to this project which include:

- Reduction in potentially preventable hospitalisations

- Enhanced skills and knowledge through evidence-based education and training

It is therefore a key priority of this project to influence the strategic measures of success for the Gold Coast PHN.

Locally Driven Opportunities

Throughout the needs assessment and consultation phases of this project, several key themes have evolved. These key themes represent opportunities for improvement or enhancement of existing services to lead to improved experience, value and outcomes of the services Gold Coast PHN commission, coordinate and support.

The purpose of this section is to explore these opportunities and reflect their alignment to the health needs and service issues which form the basis of this report.

Opportunity	Alignment to Health Needs and Service Issues
Opportunity One: Workforce Capacity Building	• Improved understanding of business processes for GPs and other providers could support more frequent and effective delivery of integrated services into RACFs • The increased complexity of care and support needs of RACF residents requires an appropriately skilled workforce. • The unmet needs and complexity of issues for people who are homeless or at risk of homelessness has been identified as a significant service gap inconsultations. • Low numbers of people identifying as Aboriginal and Torres Strait Islander or who have a preferred language other than English utilise RACF services, despite many RACFs self-reporting they deliver appropriate services for these priority groups. Data availability for other diverse population groups such as older adults identifying as LGBTI+ is limited. • Over 80% of residents in residential aged care facilities (RACFs) have medium-to-high care needs in the domains of daily living activities, cognition/behaviour and complex health care. • The Gold Coast has high rates of medicine dispensing for anxiety disorders and Alzheimer's compared to national rates, and pockets of high dispensing for antidepressants and antipsychotics such as Southport. • The prevalence of dementia in the Gold Coast region is projected to almost double by 2030, and the rate of hospitalisations for dementia has increased rapidly in recent years. In permanent residential aged care, over half of residents have a diagnosis of dementia. • High numbers of preventable hospital admissions for older adults are recorded for chronic obstructive pulmonary disorder, urinary tract infections, angina and heart failure
Opportunity Two: Service Integration	• Improved understanding of business processes for GPs and other providers could support more frequent and effective delivery of integrated services into RACFs • Low numbers of people identifying as Aboriginal and Torres Strait Islander or who have a preferred language other than English utilise RACF services, despite many RACFs self-reporting they deliver appropriate services for these priority groups. Data availability for other diverse population groups such as older adults identifying as LGBTI+ is limited. • The Gold Coast has high rates of medicine dispensing for anxiety disorders and Alzheimer's compared to national rates, and pockets of high dispensing for antidepressants and antipsychotics such as Southport. • The prevalence of dementia in the Gold Coast region is projected to almost double by 2030, and the rate of hospitalisations for dementia has increased rapidly in recent years. In permanent residential aged care, over half of residents have a diagnosis of dementia. • The Gold Coast population is increasingly becoming older, with future demand for aged care services likely to increase significantly

Opportunity Three: Community Awareness and Education	• National and local consultation highlights the ongoing need for timely, appropriate and accessible community information to support people in accessing, navigating and negotiating the aged care system; and the subsequent impact on all levels of the community and service sector support systems • Interstate migration to the Gold Coast for people in their older adult years potentially impacts the availability and strength of formal and informal support systems • The issue of 'reluctant consumers' of conventional services and support, particularly in relation to entering RACFs, is a hidden need which potentially impacts all levels of the community and service sectors. • Low uptake, awareness and confidence in relation to advance care planning, including documentation, legal requirements and how to approach conversations, for both service providers and community members. • Home Care Package waitlists are substantial (HCP 3 and 4 in particular), delaying the delivery of care to older people to support them to remain at home, which can lead to acute hospitalisations and premature placement in an RACF • Low numbers of people identifying as Aboriginal and Torres Strait Islander or who have a preferred language other than English utilise RACF services, despite many RACFs self-reporting they deliver appropriate services for these priority groups. Data availability for other diverse population groups such as older adults identifying as LGBTI+ is limited.
Opportunity Four: Service Navigation and Coordination	• Home Care Package waitlists are substantial (HCP 3 and 4 in particular), delaying the delivery of care to older people to support them to remain at home, which can lead to acute hospitalisations and premature placement in an RACF • Interstate migration to the Gold Coast for people in their older adult years potentially impacts the availability and strength of formal and informal support systems • The issue of 'reluctant consumers' of conventional services and support, particularly in relation to entering RACFs, is a hidden need which potentially impacts all levels of the community and service sectors. • National and local consultation highlights the ongoing need for timely, appropriate and accessible community information to support people in accessing, navigating and negotiating the aged care system; and the subsequent impact on all levels of the community and service sector support systems • The Gold Coast has high rates of medicine dispensing for anxiety disorders and Alzheimer's compared to national rates, and pockets of high dispensing for antidepressants and antipsychotics such as Southport.
Opportunity Five: Advanced Care Planning	• Low uptake, awareness and confidence in relation to advance care planning, including documentation, legal requirements and how to approach conversations, for both service providers and community members. • The prevalence of dementia in the Gold Coast region is projected to almost double by 2030, and the rate of hospitalisations for dementia has increased rapidly in recent years. In permanent residential aged care, over half of residents have a diagnosis of dementia. • Over 80% of residents in residential aged care facilities (RACFs) have medium-to-high care needs in the domains of daily living activities, cognition/behaviour and complex health care.

Appendices

Service Mapping: Aged Care service providers by SA3 region

SA3	Organisation name	Service name	Residential care	Home Care Packages	Home Support Program
Broadbeach - Burleigh	McKenzie Aged Care	SandBrook Aged Care	Yes	No	No
Broadbeach - Burleigh	Meals on Wheels Queensland	Broadbeach Meals on Wheels	No	No	Yes
Broadbeach - Burleigh	Ozcare	Ozcare Day Respite Centre - Burleigh Heads	No	No	Yes
Broadbeach - Burleigh	Ozcare	Ozcare Ozanam Villa Burleigh Heads Aged Care Facility	Yes	No	No
Broadbeach - Burleigh	Tricare	Mermaid Beach Aged Care Residence	Yes	No	No
Broadbeach - Burleigh	Volunteering Services Australia	Volunteering Gold Coast Transport Service	No	No	Yes
Broadbeach - Burleigh	**Sub-total**		**3**	**0**	**3**
Coolangatta	Australian Unity	Australian Unity Home Care Service Tweed Heads	No	Yes	Yes
Coolangatta	Bannister In Home Care	Bannister In Home Care Queensland	No	Yes	No
Coolangatta	Blue Care	Blue Care Kirra Community Care	No	No	Yes
Coolangatta	Blue Care	Blue Care Kirra Aged Care Facility	Yes	No	No
Coolangatta	Blue Care	Blue Care Elanora Community Care and Allied Health	No	Yes	Yes
Coolangatta	Blue Care	Blue Care Elanora Pineshaven Aged Care Facility	Yes	No	No
Coolangatta	Bolton Clarke	RSL Care Gold Coast - Galleon Gardens	Yes	No	No
Coolangatta	Bupa	Bupa Tugun	Yes	No	No
Coolangatta	Carers QLD Australia	Carers Queensland South/Gold Coast Region	No	No	Yes
Coolangatta	Coolangatta Senior Citizens Centre	Coolangatta Senior Citizens Centre	No	No	Yes
Coolangatta	Feros Care	Feros Care (CHSP) and (STRC) - South Coast QLD	No	Yes	Yes
Coolangatta	Gold Coast Home Care	Home Care and Allied Health Gold Coast Services	No	No	Yes
Coolangatta	Meals on Wheels Queensland	Palm Beach Meals on Wheels	No	No	Yes
Coolangatta	Opal Aged Care	Opal Kirra Beach	Yes	No	No
Coolangatta	**Sub-total**		**5**	**4**	**8**
Gold Coast - North	501 Care Centre	501 Respite & Care Services	Yes	No	No
Gold Coast - North	Blue Care	Blue Care Southport Community Care	No	Yes	Yes
Gold Coast - North	Blue Care	Blue Care Labrador Aged Care Facility	Yes	No	No

Gold Coast - North	Blue Care	Blue Care Arundel Woodlands Lodge Aged Care Facility and Blue Care Arundel Community Care	Yes	Yes	Yes
Gold Coast - North	Bupa	Bupa Runaway Bay	Yes	No	No
Gold Coast - North	Dementia Australia	Alzheimer's Australia Gold Coast	No	No	Yes
Gold Coast - North	HomeCare Australia	HomeCare Australia - Gold Coast	No	Yes	No
Gold Coast - North	Islamic Women's Association of Australia	IWAA - Gold Coast	No	Yes	Yes
Gold Coast - North	Labrador Memorial Senior Citizens Association Incorporated	Labrador Memorial Senior Citizens Assn Inc	No	No	Yes
Gold Coast - North	Meals on Wheels Queensland	Paradise Point Meals On Wheels	No	No	Yes
Gold Coast - North	Ozcare	Ozcare Day Respite Centre - Runaway Bay	No	No	Yes
Gold Coast - North	Ozcare	Ozcare Keith Turnbull Place Aged Care Facility	Yes	No	No
Gold Coast - North	Ozcare	Ozcare Parkwood Gardens Aged Care Facility and Respite Centre	Yes	No	Yes
Gold Coast - North	Paradise Lakes Care Centre	Paradise Lakes Care Centre	Yes	No	No
Gold Coast - North	Provectus Care	Harbour Quays Aged Care	Yes	No	No
Gold Coast - North	St Vincent de Paul Society	St Vincent de Paul Gold Coast	No	No	Yes
Gold Coast - North	St Vincent's Care Services	St Vincent's Care Services Arundel	Yes	No	No
Gold Coast - North	Tricare	Labrador Aged Care Residence	Yes	No	No
Gold Coast - North	Tricare	Bayview Place Aged Care Residence	Yes	No	No
Gold Coast – North	**Sub-total**		**11**	**4**	**9**
Gold Coast Hinterland	Beaumont Care	Beaumont Care - Roslyn Lodge	Yes	No	No
Gold Coast Hinterland	Tamborine Mountain Community Care Association	Tamborine Mountain Community Care	No	No	Yes
Gold Coast Hinterland	**Sub-total**		**1**	**0**	**1**
Mudgeeraba - Tallebudgera	Blue Care	Blue Care Tallebudgera Talleyhaven Aged Care Facility	Yes	No	No
Mudgeeraba - Tallebudgera	Carinity	Carinity Cedarbrook	Yes	No	No
Mudgeeraba - Tallebudgera	Estia Health	Estia Health Mudgeeraba	Yes	No	No
Mudgeeraba - Tallebudgera	Kalwun Development Corporation	Kalwun Aged Care Project	No	Yes	Yes
Mudgeeraba - Tallebudgera	Lutheran Services	St Andrews	Yes	Yes	No
Mudgeeraba - Tallebudgera	**Sub-total**		**4**	**2**	**1**
Nerang	Adventist Retirement Plus	Melody Park Adventist Residential Care residence (also called Wisteria Lodge)	Yes	No	No
Nerang	Churches of Christ Care	Churches of Christ Care Homesteads Aged Care Service	Yes	No	No
Nerang	Clanwilliam Aged Care	Nerang Nursing Centre	Yes	No	No

Nerang	Liberty Community Connect	Liberty Community Connect	No	Yes	Yes
Nerang	Meals on Wheels Queensland	Nerang And Districts Meals On Wheels	No	No	Yes
Nerang	**Sub-total**		**4**	**2**	**2**
Ormeau - Oxenford	Arcade	Arcare Home Packages QLD Gold Coast	No	Yes	No
Ormeau - Oxenford	Arcade	Arcare Hope Island	Yes	No	No
Ormeau - Oxenford	Arcade	Arcare Helensvale	Yes	No	No
Ormeau - Oxenford	Arcade	Arcare Sanctuary Manors	Yes	No	No
Ormeau - Oxenford	Arcade	Arcare Helensvale St James	Yes	No	No
Ormeau - Oxenford	Baldwin Living	Baldwin Living HomeServe (Sequana)	No	Yes	No
Ormeau - Oxenford	Blue Care	Blue Care Coomera Community Care	No	Yes	Yes
Ormeau - Oxenford	Blue Care	Blue Care Beenleigh Allied Health and Community Care	No	Yes	Yes
Ormeau - Oxenford	CPSM Care	Magnolia Aged Care Coomera	Yes	No	No
Ormeau - Oxenford	Enrich Living Services (formerly St Ives Home Care)	Enrich Living Services QLD (formerly St Ives Home Care) - 1300 20 20 03	No	Yes	No
Ormeau - Oxenford	Lions Haven for the Aged	Lions Haven For The Aged	Yes	No	No
Ormeau - Oxenford	Queensland Government Gold Coast Health	Helensvale Community Health Centre	No	No	No
Ormeau - Oxenford	Tricare	TriCare Pimpama Aged Care Residence	Yes	No	No
Ormeau – Oxenford	**Sub-total**		**7**	**5**	**2**
Robina	Allity	Villa Serena Aged Care	Yes	No	No
Robina	Anglicare	Anglicare Southern Queensland Gold Coast	No	Yes	Yes
Robina	Bupa	Bupa Merrimac	Yes	No	No
Robina	Care Connect	Care Connect Queensland Home Care Package Level 1-4	No	Yes	No
Robina	Hibernian (QLD) Friendly Society	BalliCara HomeCare	No	Yes	Yes
Robina	HillView	HillView - Merrimac	Yes	No	No
Robina	Just Better Care	Just Better Care Gold Coast	No	Yes	Yes
Robina	McKenzie Aged Care	The Terraces Aged Care	Yes	No	No
Robina	Opal Aged Care	Opal Varsity Rise	Yes	No	No
Robina	Opal Aged Care	Opal Varsity Rise	Yes	No	No
Robina	Ozcare	Ozcare - Gold Coast	No	Yes	Yes
Robina	Superior Care Group	Merrimac Park Private Care	Yes	No	No
Robina	Tricare	TriCare Cypress Gardens Aged Care Residence	Yes	No	No
Robina	Vision Australia	Vision Australia Gold Coast	No	No	Yes
Robina	Wesley Mission Australia	Wesley Mission Queensland - Community Care (South Coast)	No	Yes	Yes
Robina	**Sub-total**		**8**	**6**	**6**
Southport	Anglicare	Anglicare SQ Abri Home for the Aged	Yes	No	No
Southport	Australian Red Cross	Australian Red Cross Social Support - Bridges	No	No	Yes
Southport	Bolton Clarke	RSL Care Gold Coast - Bolton Clarke	No	Yes	Yes

Southport	Churches of Christ Care	Churches of Christ Care Marana Gardens Aged Care Service	Yes	No	No
Southport	Churches of Christ Care	Churches of Christ Care Golden Age Aged Care Service	Yes	No	No
Southport	CURA	CURA Community Services	No	Yes	Yes
Southport	De Paul Villa Aged Care	De Paul Villa Aged Care	Yes	No	No
Southport	Diversicare	Diversicare - South Coast	No	Yes	Yes
Southport	Estia Health	Estia Health Gold Coast	Yes	No	No
Southport	FSG	FSG Home Care Gold Coast	No	Yes	No
Southport	Gold Coast Health	Gold Coast Transition Care Program	No	No	Yes
Southport	Hibernian (QLD) Friendly Society	BallyCara HomeCare Gold Coast	No	Yes	No
Southport	HillView	HillView - Ashmore	Yes	No	No
Southport	Home Care Assistance Gold Coast	Alzheimer's Care on the Gold Coast	No	Yes	No
Southport	Home Care Assistance Gold Coast	Home Care Assistance Gold Coast	No	Yes	No
Southport	Home Instead Senior Care QLD	Home Instead Senior Care	No	Yes	No
Southport	Home Support Services	Home Support Services - South Coast	No	Yes	No
Southport	KinCare	KinCare	No	Yes	Yes
Southport	Luminise Care Solutions - The Henley	Luminise Care Solutions - The Henley	No	Yes	No
Southport	Meals on Wheels Queensland	Gold Coast And Districts Home Care Meals On Wheels And Senior Citizens Welfare Organisation	No	No	Yes
Southport	Opal Aged Care	Opal Leamington	Yes	No	No
Southport	Opal Aged Care	Opal Ashmore	Yes	No	No
Southport	Retreat Care	Ashmore Retreat	Yes	No	No
Southport	Southern Cross Care	Southern Cross Care Community Services - Gold Coast Office	No	No	Yes
Southport	Southport Lodge	Southport Lodge	Yes	No	No
Southport	St Vincent's Care Services	St Vincent's Care Services - Gold Coast Home Care	No	Yes	No
Southport	Transcord Community Transport Organisation - Gold Coast Inc.	Transcord Community Transport Organisation - Gold Coast	No	No	Yes
Southport	**Sub-total**		**10**	**13**	**10**
Surfers Paradise	Angels in Aprons	Angels in Aprons Gold Coast	No	Yes	No
Surfers Paradise	Avida Care	Avida Care	No	Yes	Yes
Surfers Paradise	Churches of Christ Care	Churches of Christ Care Lady Small Haven Aged Care Service	Yes	No	No
Surfers Paradise	CO.AS.IT Community Services	CO.AS.IT Community Services Inc. - South Coast	No	Yes	Yes
Surfers Paradise	Greek Orthodox Community of St George	GOC Care Gold Coast	No	Yes	Yes
Surfers Paradise	PresCare	PresCare Community Care Gold Coast	No	Yes	No
Surfers Paradise	STAR Community Services	Star Community	No	No	Yes
Surfers Paradise	**Sub-total**				

Gold Coast Primary Health Network

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