Gold Coast Primary Health Network

NEEDS ASSESSMENTS 2020

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An Australian Government Initiative

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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, congestive cardiac failure, and cellulitis

• 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.

• Transient and lower skilled workforce in RACF

• Lack of role clarity and access to the relevant information to support 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.

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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 SA3 regions 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 near 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 uptake of advance care planning.

Keleher,H & Murphy,B, 2004, Understanding health : a determinants approach. Edited by Keleher, Helen and Murphy, Bernadette, Oxford University Press, Oxford, England.

Evidence

Demographics

The estimated resident population of the Gold Coast aged 65 years and over, referred hereafter as 'older adults' was 101,738 people in 2018.

Table 1 provides a breakdown of the older adult population in the Gold Coast region by sex and age group based on 2016 Census data.

Table 1: Number and proportion of estimated resident population by broad age group, Gold Coast PHN region, 2018

	Number of people			% of total population		
Age group	Male	Female	Total	Male	Female	Total
65-74 years	28,671	30,297	58,968	9.5	9.5	9.5
75-84 years	14,852	15,809	30,391	4.8	5.0	4.9
85 years or more	4,709	7,715	12,424	1.6	2.4	2.0
Sub-total of 65+yrs	47,962	53,821	101,738	15.4	16.5	16.4

Source: Australian Bureau of Statistics (ABS), 2018 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 65 years and over, represented 16.4% of the total population in the Gold Coast PHN region in 2018.

This is slightly higher than the proportion of people in this age group nationally of 15.7%. 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.

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	6,906	10.5	3,899	5.8	1,707	2.6
Coolangatta	6,135	10.8	3,283	5.7	1,673	2.8
Gold Coast - North	9,024	12.6	5,317	7.4	2,060	2.9
Gold Coast Hinterland	2,355	12	1,060	5.4	266	1.4
Mudgeeraba - Tallebudgera	3,051	8.5	1,316	3.7	410	1.2
Nerang	6,228	8.4	3,136	4.2	1,275	1.7
Ormeau - Oxenford	9,686	7.3	3,968	3.2	1,242	1
Robina	7,774	8.8	2,633	4.9	1,268	2.5
Southport	5,688	9	3,216	5.1	1,605	2.5
Surfers Paradise	5,121	11.3	2,563	5.7	918	2.1
Gold Coast	61,968	9.9	30,391	5.1	12,424	2.1
Australia	-	8.9	-	4.7	-	2

Source: Australian Bureau of Statistics (ABS), 2016 Census of Population and Housing

Keleher,H & Murphy,B, 2004, Understanding health : a determinants approach. Edit Gold Coast City Council, Social Planning and Research Reports, http://www.goldcoast.qld.gov.au/thegoldcoast/gold-coast-seniors-statistics-888.html ed by Keleher, Helen and Murphy, Bernadette, Oxford University Press, Oxford, England.

There are 1,683 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%.

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 of June 2017, there were 61,243 Gold Coast residents receiving an age pension, which represents 62.5% of people aged 65 years and over, which is slightly lower than the national level of 63.6%. 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 2017)

Region	Number of age pensioners	% of persons aged 65+ who are age pensioners
Broadbeach - Burleigh	7,309	59.4
Coolangatta	6,906	63.7
Gold Coast - North	10,523	67.5
Gold Coast Hinterland	2,113	54.9
Mudgeeraba - Tallebudgera	2,914	63.8
Nerang	6,955	69
Ormeau - Oxenford	8,506	62.9
Robina	5,376	64.3
Southport	6,858	66.5
Surfers Paradise	3,783	47.6
Gold Coast	61,243	62.5
Australia	-	63.6

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

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 2014 and 2018, the median age at death for Gold Coast residents was 82 years. 79 years for males and 84 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 (n=2,280 or 12.4% of all deaths)
2. Dementia and Alzheimer disease (n=1,551 or 8.5% of all deaths)
3. Cerebrovascular disease (n=1,221 or 6.6 % of all deaths)
4. Lung cancer (n=1,062 or 5.8% of all deaths)
5. Chronic obstructive pulmonary disease (n=784 or 4.3% of all deaths)

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

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 5.

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 5: Prevalence of chronic conditions for active and recent patients (last 12 months) of general practices aged 65 years and over in Gold Coast PHN region, as of July 2020

Patient condition	Number of patients 65+	Proportion of 65+ patients (%)	Proportion of patients aged 18-64 (%)
Chronic obstructive pulmonary disorder (COPD)	9,119	8.3%	1.1%
Coronary heart disease	14,604	13.3%	1.2%
Diabetes (Type 1 or 2)	13,005	11.8%	2.7%
Chronic renal failure	5,867	5.3%	0.3%
Total number of patients recorded in PATCAT	110,137	-	348,522

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.
As of the 30th June 2018, 51.8% of people using permanent residential aged care in South Coast aged care planning region (Gold Coast) had a diagnosis of dementia.

Table 6 shows that the number of dementia related hospitalisations in the region has increased by over 24% in the last three available reporting years.

Table 6: 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.

The rate of falls to Gold Coast Public Hospitals Emergency Department (ED) among residents from residential Aged Care Facilities (RACF) between July 2018 to June 2019 was 9% of all presentations. Falls were the leading ED presentation for residents from RACFs to Gold Coast Emergency Departments.

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 Australian 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.

Table 7 outlines the number and rate of hospitalisations for heart failure in the GCPHN region in 2014-15.

Table 7: Number and rate of hospitalisations for heart failure in Gold Coast, by SA3 region, 2014-15

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

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 8 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).

Table 8: People with a profound or severe disability aged 65 years and over within Gold Coast PHN region, 2016

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

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 9 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.

Table 9: 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

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

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

COVID-19

Isolation

Before COVID-19 began, national studies indicated a large percentage of older people were socially isolated. Having few social connections and feeling isolated have been associated with multiple health related conditions, including chronic disease and psychiatric disorders. Social distancing during the pandemic was never meant to prevent social connections, but many family members, friends and neighbours of older adults are staying away to avoid exposing their loved ones to the virus

Accessing regular care

Throughout COVID-19 pandemic, it was critical all individuals continued to receive regular access to their normal GP for continued care through face to face consultations or through telehealth. Medicare Benefits Schedule Queensland data for health assessments for people aged 75 years and older (MBS item 701,703,705 and 707) during 2019 Q2 (April, May, June) saw 44,172 requested Medicare items to be processed, during the same reporting period in 2020 this figure decreased to 34,587 [1].

Health assessments for older people is an in-depth assessment and provides a way of identifying health issues and conditions that are potentially preventable or amenable to interventions in order to improve health and/or quality of life. They encompass:

- Preventative care
- Prescription review
- Managing conditions

As the above data indicates, patients aged over 75 were not accessing regular care during quarter two of 2020 and this may have negative impact on the older population in future years.

Influenza

Influenza is a serious issue in residential care facilities both because of the vulnerability of residents and the environment of communal living which facilitates the spread of respiratory virus. Prior to COVID-19, Australian Government-subsidised providers of residential aged care were required to offer staff and volunteers access to annual influenza vaccinations at the providers' cost.

After 1st May 2020, everyone entering a residential aged care facility were required to be vaccinated including all residents, staff, and volunteers. An outcome of this was an increase in demand for access to the influenza vaccine and also vaccine service providers to ensure all those who required to be vaccinated prior to 1st May were (Residents had the right to refuse vaccination).

1. Medicare Statistics, Services Australia, Australian Government, http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp

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.

Table 10 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 10: Number of users and allocated places for South Coast ACPR by care type and provider type, as at 30 June 2020

Care type	Number of allocated places
Residential	5,577
Home care	NA
Transition care	99
Short Term Restorative Care	68

Source: AIHW, GEN Aged Care data portal, extracted from www.gen-agedcaredata.gov.au

There was a total of 56 different residential care services, 49 home care services, and 47 home support services available to care recipients.

Residential care services: A facility that provides residential care. The service must meet specified standards in the quality of the built environment, care, and staffing levels in accordance with the Aged Care Act 1997. Some people refer to these services as 'nursing homes.

Home Care Services: Support and care services given to older people in their own homes. Services are offered in packages of care, which can consist of personal care and domestic support, as well as clinical and allied health services. There are four levels of care to support those with basic (Level 1), low (Level 2), intermediate (Level 3), and high (Level 4) care needs. Home Care Packages were started in 2013, combining previous programs, namely: Community Aged Care Package (CACP), Extended Aged Care at Home (EACH), and Extended Aged Care at Home Dementia (EACHD).

Home Support: Entry-level support for older people in their homes, consisting of the Commonwealth Home Support Program (CHSP)

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 11.

Table 11: Estimated waiting time for home care package on National Prioritisation Queue, as at March 2018

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

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 12.

Table 12: Number of allocated places for permanent residential care across Gold Coast by SA3 region, as of June 2019

Broadbeach - Burleigh	363
Coolangatta	503
Gold Coast - North	1,141
Gold Coast Hinterland	38
Mudgeeraba - Tallebudgera	383
Nerang	251
Ormeau - Oxenford	803
Robina	876
Southport	1,046
Surfers Paradise	107
Gold Coast	5,511

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 (except for 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, and people using aged care services during the year 2018 is outlined in Table 13. It includes a breakdown for various demographic characteristics such as age, sex, Indigenous status, and preferred language.

Table 13: Admissions, utilisation, length of stay and exits from permanent residential aged care, Gold Coast PHN region, 2018

Breakdown		Number of admissions	No. of people using aged care
Total		3477	4736
Age group	0-49	10	14
	50–54	4	15
	55–59	27	38
	60–64	51	74
	65–69	179	191
	70–74	288	351
	75–79	397	511
	80–84	675	863
	85–89	870	1142
	90–94	702	1021
	95–99	248	456
	100+	26	60
Sex	Male	1488	1627
	Female	1989	3109
Indigenous status	Yes	15	20
	No	3459	4711
Preferred language	English	3359	4579
	Other	109	143

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. Potentially preventable hospitalisations (PPHs) for people aged 65 years and over shows that there were 10,466 (10,663 per 100,000 people) PPHs recorded in Gold Coast public hospitals between July 2017 and June 2018 compared to 345,835 (9,121 per 100,000 people) nationwide. See Table 14.

The five leading causes of PPH in this age group are:

1. chronic obstructive pulmonary disease (COPD)
2. urinary tract infections, including pyelonephritis
3. congestive cardiac failure
4. cellulitis
5. diabetes complications

Table 14: Potentially preventable hospitalisations (PPHs) for Gold Coast public hospitals by age and condition, Jun 2017 to Jul 2018

Age group	PPH condition	PPH per 100,000 people	Number of PPH	Number of PPH bed days	Average length of stay (days)
65+ years	Cellulitis	782	748	3,745	5.00
	Urinary tract infections, including pyelonephritis	1,498	1,471	6,371	4.30
	COPD	1,880	1,846	8,914	4.80
	Congestive cardiac failure	1,279	1,256	7,502	6.00
	Diabetes complications	708	695	3,946	5.70
	All PPH conditions	10,663	10,466	47,967	4.60
All ages	All PPH conditions	3,579	21,695	73,247	3.40

Source: Australian Institute of Health and Welfare 2019. Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2017–18. Cat. no. HPF 36. Canberra: AIHW

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 15. 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.

Table 15: Number of GP and specialist services per 100 people, Gold Coast PHN region, 2018-19

	GP attendances		After-hours GP attendances		Specialist attendances	
Population	65-79	All ages	65-79	All ages	65-79	All ages
Gold Coast	1,214	714	59	61	200	82
Australia	1,055	631	41	49	238	95
	GP attendances		After-hours GP attendances		Specialist attendances	
Population	80+ years	All ages	80+ years	All ages	80+ years	All ages
Gold Coast	1,879	714	140	61	242	82
Australia	1,611	631	104	49	273	95

Source: Australian Institute of Health and Welfare (AIHW) analysis of Department of Health, Medicare Benefits claims data, , 2014–15, 2015–16, 2016–17, 2017-18 and 2018-19

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 16 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.

Table 16: Number of MBS items relating to residential aged care facilities (RACFs) claimed in Gold Coast PHN region, 2012-13 to 2016-17

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

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 17 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

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].

6 *White B et al (2014). Prevalence and predictors of advance directives in Australia, Intern Med J, 44(10):975-80*
7 *Data supplied by Office of Advance Care Planning, Metro South Hospital and Health Service (HHS)*

Service System

Services	Number in the GCPHN region	Distribution	Capacity discussion
General practices	207	Clinics are generally well spread across Gold Coast; majority in coastal and central areas	• GP services include preparation of chronic disease management plans, team care arrangements, medication prescribing and management, health checks and plan review

General Practitioners	846, They are supported by a total of 592 non-GP staff working in general practice (e.g. nurses and allied health staff).	Clinics are generally well spread across Gold Coast; majority in coastal and central areas	• 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

Residential Aged Care Facilities	56	Residential Aged Care Facilities are spread from Ormeau to Coolangatta	• The RACFs range from capacity of 36 beds to much larger 167 bed facilities providing differing levels of care and services across general aged care, palliative, respite and dementia care.

Aged Care Services	Permanent: 52
	Respite low care: 43
	Respite high care: 48
	Home care: 41
	Home support: 48
			• Eligibility is based on factors like individual's health, how they are managing at home, and any support they currently receive. Individuals may be eligible for aged care services if they have:
			  ◦ Noticed a change in what they can do or remember
			  ◦ Been diagnosed with a medical condition or reduced mobility
			  ◦ Experienced a change in family care arrangements
			  ◦ Experienced a recent fall or hospital admission
			  ◦ 65 years or older (50 years for Aboriginal or Torres Strait Islander people)

Medical deputising Services	5	Service Gold Coast region	• The National Association for Medical Deputising includes several services that offer after-hours care in in the Gold Coast region • As of August 2020, there were five medical deputising services operating on the Gold Coast providing in-home and after hour's visits from a doctor.

Allied health services	471	Services are generally well spread across Gold Coast; majority in coastal and central areas	• Many different allied health groups contribute to the care of older people on the Gold Coast both individually and 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 anddisabilities
			  • 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 forthem
			• In addition to allied health counsellors and pastoral care workers can provide a range of support to RACF residents.

Hospital and Health Service (Gold Coast Health)	2 Hospitals at Southport and Robina and Helensvale Community Health Centre and Palm Beach Community Health Centre		• 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

Non-Government Organisation			• 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 (2018). These visual representations of common patient journeys developed in partnership with COTA Queensland support the consumer engagement component of the consultation.

Four common Patient Journey's 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 are illustrated in Figures 1 – 4 and were validated by Gold Coast PHN and the Aged Care Leadership Group

Overarching issues identified across all Patient Journeys worth noting includ

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

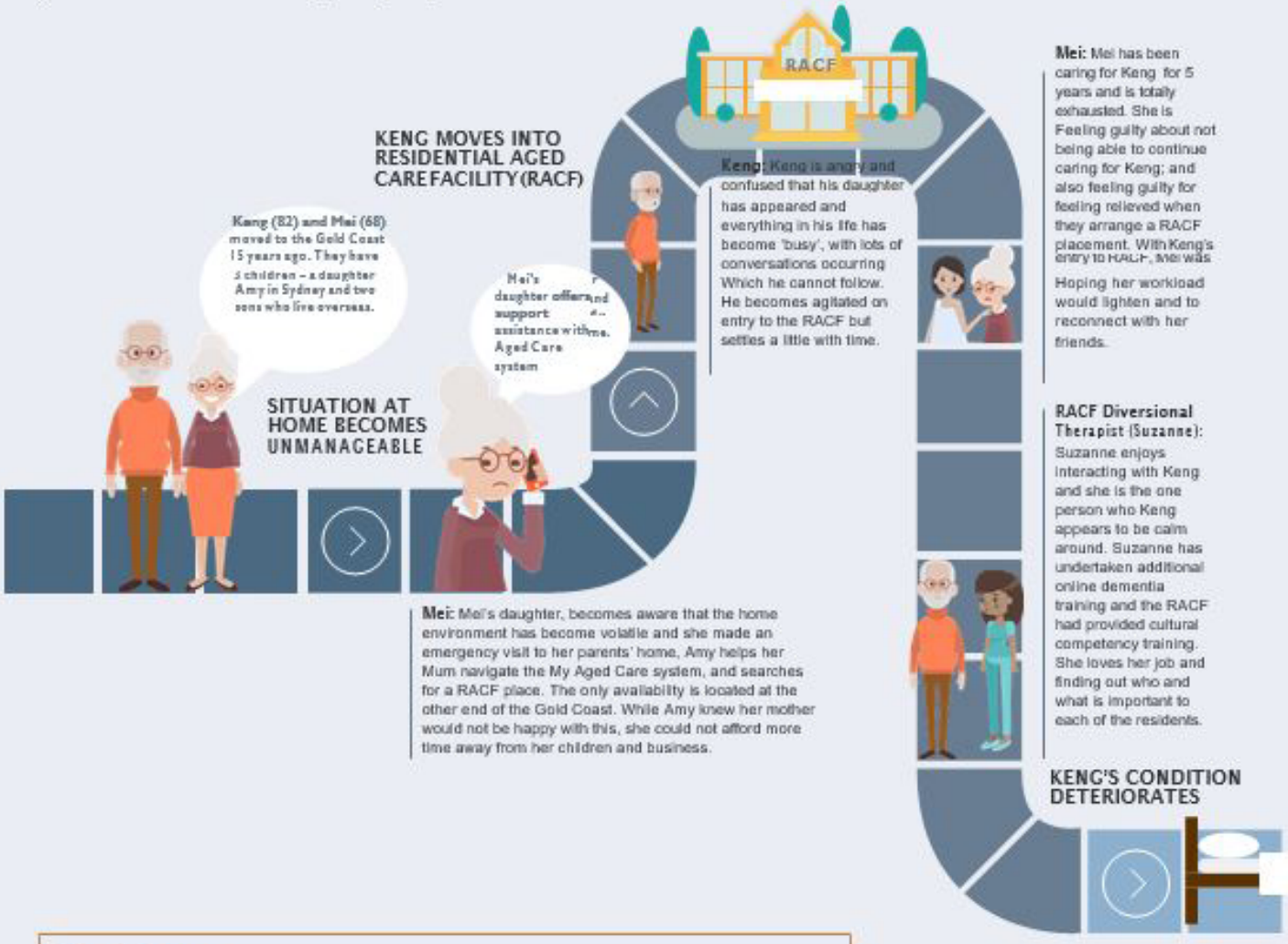
Workforce issues:

- Decrease in nursing in the community setting
- Funding levels within RACF resulting in limited nursing levels in RACF
- Capacity and capability issues regarding assessors and assessment teams
- Lack of allied health in RACFs.

The common pathways with extracted key themes and issues specific to each journey can be found beFigure1 : Dementia and CALD Journey

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.



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 is becoming increasingly lonely, isolated and exhausted.

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.

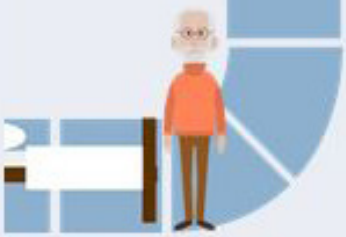
Hospital: Keng is admitted to the general medical unit and the next day (Monday), a dementia specialist is called in to assess. Other tests are undertaken, and a Urinary Tract Infection (UTI) is revealed as the cause of the exacerbation in symptoms.

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 is distressed when she is not told her husband was taken to hospital.

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.

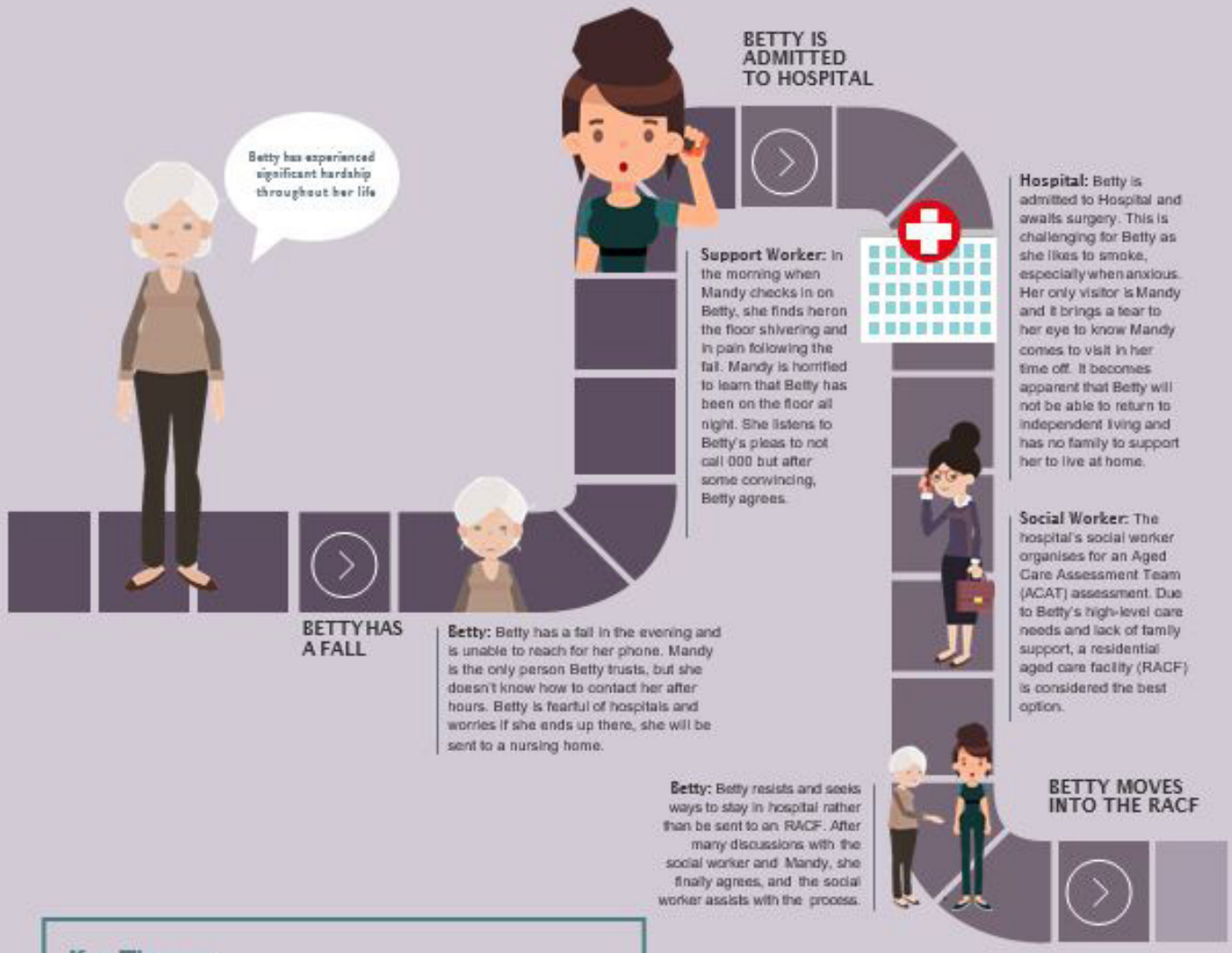
Hospital: Staff are allocated to Keng to ensure he does not leave his bed, unattended. He is mostly speaking Cantonese now, and only one Registrar who is occasionally in the unit can communicate with him. One of the night staff has brought in Traditional Chinese music and when she plays it, Keng settles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



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 heron 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

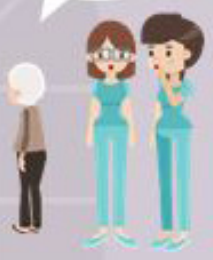
BETTY'S CONDITION DETERIORATES

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.



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

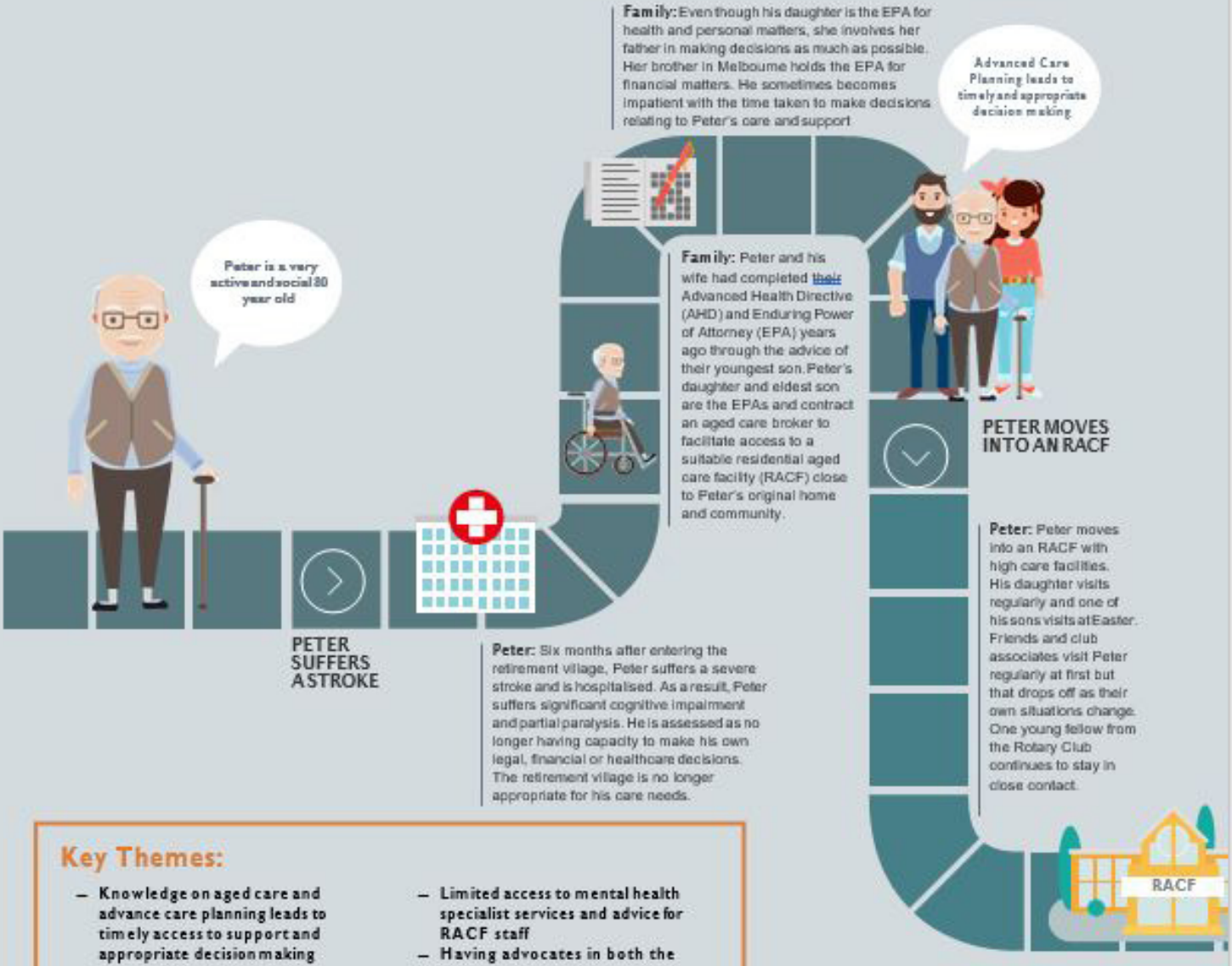
RACF Staff: RACF staff call an ambulance and Betty is taken to the ED.

BETTY IS TRANSPORTED TO THE EMERGENCY DEPARTMENT (ED)

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.

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.



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.

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.

RACF

PETER'S CONDITION DETERIORATES

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.

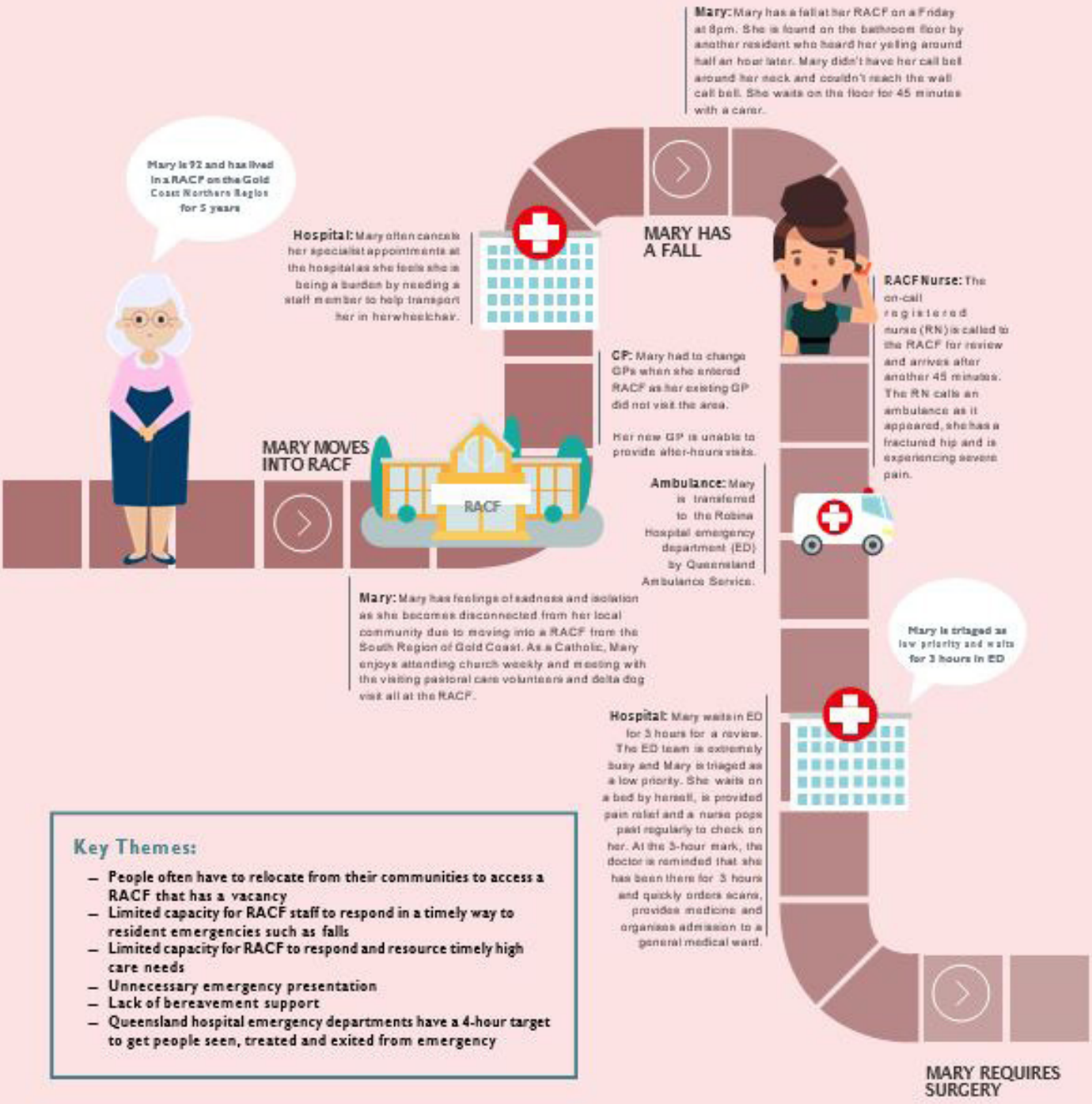
Peter received comprehensive mental health assessment

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.

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.

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 organises 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 organised for Delta dogs to visit.

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'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.

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 grieving; 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.

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.

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 farther 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'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.

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.

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: 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.

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

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.

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.

IRES

Joint Regional Plan Mental Health, Suicide Prevention, Alcohol and Other Drugs Services

• Gold Coast Primary Health Network (GCPHN) and Gold Coast Health jointly led the development of the Joint Regional Plan

• This Joint Regional Plan is a foundational plan for the Gold Coast region. As such, it aims to set out the agreed way forward for improved collaboration and integration between mental health, suicide prevention, alcohol and other drugs services in the Gold Coast region

• The process brought together cross-sectoral and community stakeholders to develop, agree and document a shared understanding of the issues our region faces, a shared vision for the future, and a roadmap for change

• The Joint Regional Plan took a person-centred approach to consultation because we understand that whilst there are unique elements to mental health, suicide prevention, alcohol and other drugs, and Aboriginal and Torres Strait Islander social and emotional wellbeing, many of the issues people face are interrelated and multifactorial.

Current state and identified gaps	Desired state	Headline measures	Long term outcomes
Mental health and aged care related issues (eg. Dementia) are often treated in isolation of each other or as separate disciplines. Limited access to assessment and treatment by public sector geriatricians to patients in the community	1. Improved co-working across mental health and aged care disciplines to address comorbidities	• Rate of RACF residents accessing psychological services (PHN funded) • Rate of older people receiving access to mental health specialist support (Gold Coast Health) while in RACF • Rate of older people presenting to Gold Coast Health Emergency Departments with mental health concerns • Rate of older people admitted to Gold Coast Health mental health wards and case management team • Rate of older people accessing MBS mental health services	• Improved trust, confidence, and transparency across the sector to facilitate more comprehensive care • People who deliver services are adequately trained and supported to fulfil their roles with compassion and confidence • Peoples mental health and physical health are both supported to optimise quality of life • People's complexity is recognized to ensure a holistic response (physical, mental health, suicide prevention, AOD, family, culture)
Gaps in clinical resources, knowledge and supports in the community result in people referring to Older Person's Mental Health unit (tertiary service) as a default option or last resort	**2.** Increased older persons mental health specialist support to primary care and RACFs, including training updates and telephone advice		
Isolation and loneliness can have a significant impact on people's mental and physical health. The growing and changing population of the Gold Coast has resulted in loss of connection and sense of community that can be natural or informal support systems. The Gold Coast has more older adults living alone than in 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 among older people and potentially limited ability to access services without support. Proactive engagement can prevent further social isolation and loneliness, however activities in the community that support inclusion/connection may not be targeted or inclusive of older people and their needs.	**3.** Enhanced community connections to reduce the impact of social isolation and loneliness		

GCPHN Clinical Council

In June and August 2018, GCPHN undertook engagement with their Clinical Council to explore inefficiencies and opportunities 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 2018

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 partici
pation, 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 Report10, 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.

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.

11 http://www.health.gov.au/internet/main/publishing.nsf/content/79278C78897D1793CA257E0A0016A804/$File/Review-of-after-hours-primary- health-care.pdf

What we understand works

The National Consensus Statement: Essential elements for safe and high-quality end-of-life care identified 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 other 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.

12 https://www.racgp.org.au/afp/2016/april/implementation-of-a-team-model-for-racf-care-by-a-general-practice/
13 https://www.mja.com.au/journal/2018/208/10/clustered-domestic-residential-aged-care-australia-fewer-hospitalisations-and

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

InterACT, was trialed between 2017 – 2019 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.f the service from March 2018. InterACT utilised 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. This program was replaced with GCH Residential Aged Care Facility Support Service (RaSS) in 2019 and GCPHN discontinued support of this service from 30 June 2020.

Nurse Educator in Residential Aged Care (Palliative Care)

A collaborative partnership project between the Gold Coast Hospital and Health Service (GCHHS) and Gold Coast Primary Health Network (GCPHN) in establishment of a pilot program, delivered by a Palliative Care Clinical Nurse Educator (PC-CNE), of education and upskilling to five (5) Residential Aged Care Facilities (RACFs) in the Gold Coast Region was commenced in November 2019. The project was initiated and worked effectively until Covid 19 restricted access to RACF's and it could not be continued in its intended model. GCPHN agreed to utilize the funding to support RaSS Specialist Palliative Care Collaboration 2020 detailed below.

Mental Health Psychological Services for Residential Aged Care Residents

The Australian Government has announced in 2018 specific funding for RACF in-reach mental health services to be delivered through PHNs. $82.5m was be distributed nationally over 4 years. Services commence on the Gold Coast in early 2019 while a co-design process was conducted with key stakeholders to refine the model, with the full service commencing from November 2019.

GCH Residential Aged Care Facility Support Service (RaSS)

In 2019 The Frail Older Persons Collaborative was established state-wide as it became a ministerial priority to improve the quality and safety of the frail older person. Residential Aged Care Facility Support Services (RaSS) were set up in each health service to:

- Optimise quality of care for residents of RACFs with acute health care needs
- Improve resident choice for site of care delivery in line with their goals of care
- Improve access to supportive and specialist palliative care

GCH RaSS Specialist Palliative Care Collaboration 2020

On March 30th 2020, due to additional funding as part of the Covid-19 response, RaSS and Specialist Palliative Care started working collaboratively to meet the needs of RACF residents on the Gold Coast; with creation of the Gold Coast RACF Response Specialist Palliative Care Team (ReSPeCT).
This additional funding will cease 31st October 2020.

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 [16] offers 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

14 https://agedcare.health.gov.au/aged-care-reform
15 https://agedcare.health.gov.au/quality/single-quality-framework-focus-on-consumers
16 https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/04_2018/aged_care_diversity_framework.pdf

ACAT Assessments

Proposed ACAT assessment changes from July 1, 2018 have been put on hold by the Commonwealth Department of Health until further notice .

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. This initiative SPACE (Specialist Palliative Care in Aged Care) is currently been rolled out across Queensland by Queensland Health with Gold Coast Health receiving a four-year funding package commencing 1 July 2020.

The goals (non- limited to) for the funding is to:

- Increase the capacity and capability of General Practice and RACF STAFF
- Support the promotion of pre-emptive planning to crisis management
- Provide specialist consultation to support management to residents with complex end of life needs.
- When clinically appropriate and where aligns to the residents wishes, avoiding unnecessary transfer to hospital.

GCPHN is negotiating with Gold Coast Health the opportunity to co-contribute to this funding to build sustainable capacity in primary care providers (RACF's and General Practitioners).

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 – 202217 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 2018 needs assessment and consultation, 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.

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"Building one world class health system for the Gold Coast."

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