PCPC MEETING
3 SEPTEMBER 2026

The Gold Coast Primary Care Partnership Council met at the GCPHN offices.

Attendees:

Runaway Bay Doctors Surgery
Co.AS.IT Community Services
Gold Coast Hospital and Health Service
Gold Coast University Hospital
Homeworld Helensvale Medical Centre
Multicultural Communities Council Gold Coast
Kalwun Seniors Services
Multicultural Families Organisation
Queensland Ambulance Service
Salvation Army - Still waters
Cancer Council Queensland
Dementia Australia
Bolton Clarke
Footprints
Ozcare
Right at Home
Carers Queensland
Services Australia

Guest Presenters:

Anja Piggott,
Bolton Clarke

Anna Garcia del Barrio,
Care Finders, Footprints

Lauren Martin,
Tansition Care Team, Gold Coast Health

GCPHN Staff

Kellie Trigger,
A/Executive Director of Digital Insights & Performance

Sarah Coleman,
Communications & Stakeholder Engagement Manager

Kerry McCormick,
Regional Partnerships & Engagement Officer

Initial Discussion

The meeting opened with a welcome, apologies and brief introductions from members and guests across primary care, aged care, hospital, government, community and not-for-profit sectors. Conflicts of interest were invited (NIL received), previous meeting actions were noted, and members were encouraged to share updates or resources for inclusion in the post-meeting communication.

SUPPORT AT HOME: A 9-month pulse check

Important Context

The group and GCPHN have no direct influence over national aged care reform settings, funding arrangements or program rules. However, the discussion provided an important opportunity to better understand how these reforms are being experienced locally and to identify where collective action may help reduce pressure points.

Details

Members and guests were invited to participate in the Support at Home – A 9-month pulse check, with presentations and discussions on aged care reforms, consumer experience, Care Finder supports and transition of care to the community.

SUPPORT AT HOME: A 9-month pulse check

Reforms – An overview and impacts for providers

The aged care reforms mark a significant shift in how older Australians access support to remain living safely and independently at home. From 1 November 2025, the new Support at Home program replaced the Home Care Packages Program moving from four package levels to eight funding classifications based on assessed need. Support at Home includes allowances for assistive technology and home modifications (AT/HM). The reforms are intended to create a simpler, more flexible and person-centred system and to support dignity, independence, and quality of life.

Key changes include the full government funding of personal care services from 1 October 2026, continued funding for the Commonwealth Home Support Program (CHSP) until 30 June 2029, and updated prescription requirements for AT/HM supports. While these changes provide important transition time and may improve access for some consumers, providers continue to report challenges including long wait times, affordability pressures, lower client service utilisation, assessment limitations and uncertainty for clients moving between CHSP and Support at Home.

Discussion

Consumer Experience - Care Finders

The Care Finder Program provides free, specialist and intensive support for vulnerable older people who are eligible for aged care services but are unable to navigate the system without assistance and have no trusted person available to help them. Care Finders work directly with clients to build trust, explain My Aged Care processes, support assessment and referral pathways, and connect people with aged care, health, housing and community supports. The program has a strong role in identifying unmet need, coordinating referrals, advocating for clients and highlighting where aged care system processes are not working well for people who require more intensive assistance.
Despite system challenges, the program is improving outcomes locally, with 66% of clients improving unmet needs identified at commencement.

Key Challenges

High client vulnerability, complexity and support intensity:

Care Finder clients often experience multiple and overlapping barriers, including social isolation, cognitive impairment, low literacy, homelessness, communication barriers, past trauma, mistrust of services or limited informal support.

Issues across the aged care pathway:

These include difficulty identifying and engaging isolated clients, mistrust of government and aged care systems, housing and safety concerns, assessment delays, limited face-to-face assessments, funding allocation delays, limited interim CHSP availability and uncertainty about service contributions.

On the Gold Coast,
81% of clients are socially isolated,
26% have cognitive impairment,
14% are culturally and linguistically diverse,
14% are experiencing homelessness and
14% have low literacy

40,000 new Care Finder clients
70% require more than 5 support hours
30% require more than 15 support hours
Nationally to 31 Dec 2024

Strong demand for navigation, referral and coordination support:

Care Finders support people who may otherwise fall through gaps by helping them access My Aged Care, assessments, aged care services and broader community supports. The Gold Coast Care Finders made 1,424 referrals in the past year to aged care providers, housing providers, community groups and assessment organisations, reflecting the breadth of support required.

Risk of disengagement, health decline and hospital presentation:

System delays, affordability pressures and limited interim supports can increase the risk that vulnerable clients disengage from care, experience health decline or present to hospital without appropriate supports in place.

Transition of Care to the Community

The Gold Coast Health Transition Care Program supports older people to return home safely after a hospital stay by providing short-term rehabilitation, nursing, allied health, personal care, domestic assistance, transport and case management for up to 12 weeks. The service is available to people aged over 65, or over 50 for Aboriginal and Torres Strait Islander people, who have had an Aged Care Assessment Team (ACAT) assessment while in hospital and are discharged directly home.

On the Gold Coast, the program manages 104 packages, including 88 community-based places and 16 residential transition care places for people who are not yet ready to return home. The service works alongside existing CHSP or Support at Home supports where possible, without duplicating services, and aims to stabilise people after discharge, support recovery and prevent avoidable hospital readmission.

Key Challenges

Eligibility and access limitations:

Transition Care can only be accessed directly from hospital following an ACAT assessment, meaning GPs cannot refer patients once they have returned home, even when post-discharge needs become clear.

Delays in ongoing supports and equipment:

Delays in Support at Home funding, assistive technology, home modifications, interim equipment and additional CHSP supports can create gaps in care during or after the 12-week Transition Care period.

Limited flexibility and affordability of community supports:

Urgent or additional supports, particularly domestic assistance, may be difficult to access, and some clients face barriers contributing to care costs or navigating hardship processes.

Pressure on hospital discharge and community capacity:

Staff are spending more time planning safe discharge, hospital length of stay is increasing, and programs such as Transition Care, Geriatric Evaluation and Management in the Home (GEMITH) and Multidisciplinary Avoidance and Post Acute Service (MAPS) are operating at or near full capacity.

Risk of readmission and system cycling:

Inadequate home and community supports can lead to falls, health deterioration and early return to emergency departments, placing further pressure on hospitals and community care services.

Need for clearer escalation and interim pathways:

Faster access to urgent supports, interim equipment or equipment pools, clearer escalation pathways and greater flexibility are needed to better meet complex post-discharge needs.

SUPPORT AT HOME: A 9-month pulse check

Issues and Opportunities

Following the presentations, the group was invited to consider how the issues identified could be addressed to improve outcomes for older people across the Gold Coast community.

How can we address the identified issues to deliver better outcomes for the Gold Coast Community?

The discussion recognised that many challenges are shaped by broader aged care reform, funding and system settings; however, participants also identified practical opportunities to strengthen local communication, improve referral and escalation pathways, support earlier connection with services, and better coordinate the supports people need to remain safe and well at home. The themes below capture the key issues raised and provide a basis for identifying actions within local influence, as well as matters that may require broader advocacy.

Key themes identified

Complex and fragmented pathways:
Older people, families, carers and providers are navigating unclear pathways across primary care, hospitals, aged care assessment, Care Finders, CHSP, Support at Home and community services.

Late engagement and crisis-driven access:
Many older people seek support only when existing care arrangements are under pressure, increasing risks for patients, carers, and increasing pressure on general practice, hospitals and community services.

Growing pressure on general practice and primary care:
GPs and practice teams are increasingly supporting older patients with complex medical, psychosocial and aged care needs, often while waiting for other services or escalation pathways to respond.

Need for clear information and trusted navigation:
Patients, families, carers and primary care teams require simple, consistent information about aged care reforms, My Aged Care, Support at Home, CHSP, assessment pathways, local services and free navigation options.

Delays, affordability and practical support gaps:
Delays in assessment, funding, assistive technology, home modifications, interim CHSP, domestic assistance and affordable supports create care gaps, increase risk at home and raise equity concerns for people with limited financial flexibility.

Hospital discharge and readmission pressures:
Limited community-based supports contribute to longer hospital stays, delayed discharge, repeated presentations, falls, deterioration and earlier consideration of residential aged care.

Limited community-based specialist support:
Participants identified gaps in accessible geriatrician, multidisciplinary, in-home and practical supports that help people remain safely at home.

Risk of private navigation market pressure:
Growing demand for aged care navigation may increase reliance on expensive or unregulated private services, creating a risk that vulnerable older people and families may be disadvantaged.

Importance of local coordination, advocacy and collective action:
Strong local relationships and shared evidence are critical to solving complex cases, improving local responses and advocating through appropriate channels for broader system improvements.

SUPPORT AT HOME: A 9-month pulse check

Opportunities

Promotion of information on strategies for healthy ageing:

Continued promotion of information on strategies for healthy ageing to delay the need for support at home and premature RACH admissions

Clarify local referral and escalation pathways:

Map key referral points and contacts across primary care, hospitals, assessment services, Care Finders, CHSP, Support at Home and community providers.

Share simple local information:

Promote plain language resources on aged care pathways, free navigation supports, eligibility, assessments, contributions, wait times and interim options.

Strengthen early identification and referral:

Support earlier referral for older people who are isolated, experiencing a decline in health, awaiting discharge or finding aged care difficult to navigate.

Strengthen local coordination:

Use existing forums to connect services, share issues and identify practical local solutions.

Promote trusted navigation supports:

Increase awareness of Care Finders, Services Australia appointments and other free supports to reduce confusion and unnecessary use of private navigation services.

Identify practical support gaps:

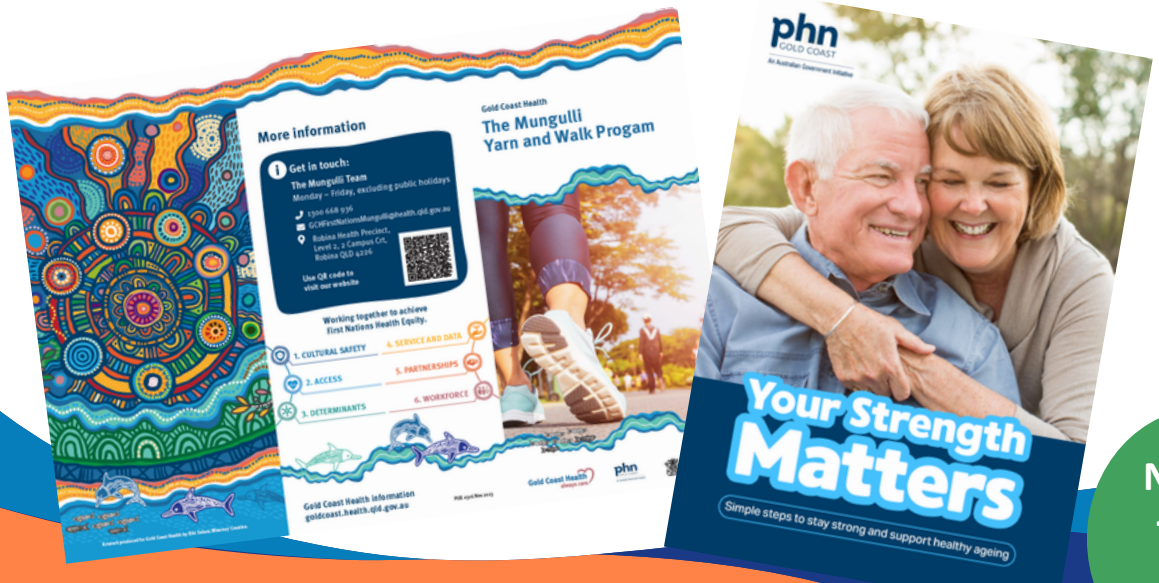
Track unmet needs such as domestic assistance, transport, gardening, equipment, home modifications and respite, and explore community-based solutions.

Support safer hospital-to-home transitions:

Improve communication between primary care, Transition Care, community services and aged care providers to reduce delays and readmission risk.

Use local evidence to support system shaping and preserve consumer outcomes:

Document recurring barriers, service gaps, wait times and patient impacts, and use mechanisms such as the Support at Home pulse check, post-meeting feedback and council discussions to monitor local impacts, identify practical actions within local influence, and inform broader advocacy. This should support ongoing sector engagement, clearer guidance and timely access to care, while preserving consumer dignity, independence and choice.



Next Meeting Thursday 12 November