SWSPHN Healthy Ageing Co-design Report

April 2022

phn SOUTH WESTERN SYDNEY

An Australian Government Initiative

Certified System Quality ISO 9001 SAI GLOBAL

Acknowledgement

This co-design project and report was developed with contribution from the following people and thanks is given for their work on this project.

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- SWSPHN Stakeholder Engagement Team

Thank you also to all the community members, health professionals and service providers who contributed their time, experiences and perspectives to this project. For privacy reasons, their specific names are not provided.

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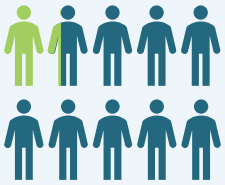
Introduction

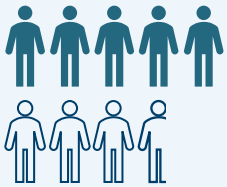
Key Facts



13% of South Western Sydney population is an older person

1 in 5 live alone

1 in 3 speak a language other than English



The number of older people in SWS is expected to increase by 74% by 2031

The number of people aged 85+ years is expected to increase by 92% by 2031

The number of older people requiring a residential aged care facility placement is expected to double during the next 15 years

The overall burden of disease for older Aboriginal and Torres Strait Islander people is **MORE THAN TWICE** that for non-indigenous Australians

In December 2021, the Department of Health issued a schedule to South Western Sydney Primary Health Network (SWSPHN) which included the following requirements:

Support older people to live at home for longer (including those not currently receiving aged care services) through the commissioning of early intervention initiatives that promote healthy ageing and the ongoing management of chronic conditions

Given the broad nature of healthy ageing and the potential areas in which services could be commissioned, the need for co-design was identified, specifically to prioritise which area of supporting healthy ageing represented the greatest need within South Western Sydney (SWS) as well as the greatest opportunity to effectively use the funding.

Purpose of the Healthy Ageing Co-design

Ageing is a phenomenon that occurs continuously throughout all stages of life - and presents health challenges at all ages. Healthy ageing is the process of developing and maintaining the functional ability that enables wellbeing in older age (World Health Organisation). Older persons are those aged 65 years and over for non-Aboriginal and 50 years and over for Aboriginal population.

The purpose of the Healthy Ageing Co-design was to identify the needs and opportunities to support older people to remain living in the community and delay their entry into residential aged care homes. The Healthy Ageing Co-design had the following objectives:

- Identify the health and social needs of older people living in the community
- Identify any service gaps in South Western Sydney in meeting those needs
- Identify where SWSPHN should focus their investment into Healthy Ageing

Once needs and service gaps were identified by the initial community consultations, a subsequent advisory session was planned to gather information on expected outcomes of the service to be commissioned to assist the tendering process.

Co-design Methodology

The project team delivered the Healthy Ageing Co-design project utilising a structured co-design approach aligned to the steps outlined in the SWSPHN co-design framework. The co-design adopted an experience-based approach, where participants are encouraged to identify the needs associated with healthy ageing considering previous experience (both professional and lived experience), and design solutions to better meet these needs, within the context of available funding.

A co-design framework using a combination of consultation methods (including survey, consultation workshops and advisory group) was selected due to:

- The range of stakeholders to be engaged (health consumers, primary care, Local Health District, aged care service provides, community service providers)
- The need to split the co-design into two components (initial identification of area to commission services, design of service outcomes to assist in the tendering process)
- The time limitations placed on the co-design to ensure the procurement and contracting phases could be achieved for the commissioned service to commence in the early stages of the 2022-23 financial year.

Project Phases

Data Gathering
Review of population health data and research

Discovery
Engage with community, health professionals and service providers

Determination
Select area of focus and type of service to be commissioned

Data Gathering Phase

Information was gathered from the following sources to help guide this co-design:

- South Western Sydney Primary Health Network Needs Assessment 2022-2025
- South Western Sydney Primary Health Network Strategic Plan 2021-2026
- World Health Organization
- Department of Health Policy Guidance for the PHN Aged Care Funding Schedule

Discovery Phase

The discovery phase includes both surveys, face-to-face and virtual consultation sessions.

Stakeholder Surveys

Two surveys were sent out via SWSPHN communication channels. They were promoted on social media, local newspaper (Southern Highlands) and via direct email messaging.

The first survey was targeted towards community members and was completed by both carers and older people, carers making approximately a third of the 35 respondents. Some key figures from the survey are given below.

The second survey was targeted towards health professionals and received only two responses. Due to the small sample size the co-design team couldn't extrapolate the findings/responses.

Consultation Workshops

A series of consultation workshops were scheduled and ran across South Western Sydney for community members, health professionals and service providers to attend and provide their experiences and perspectives.

Community Workshops

Macarthur
21 March 2022 (11 participants)

Fairfield
22 March 2022 (6 participants)

Southern Highlands
24 March 2022 (7 participants)

All community workshops were held face-to-face and ran for two hours. Some virtual presentations were included due to a member of the co-design team being in COVID-related isolation.

While the community workshops were focused on gaining the perspectives of community members, several community-based organisation representatives also attended. At the Fairfield workshop, only organisational representatives attended. During the three community workshops, there were a total of 24 attendees, being 7 community members and 17 being SWSLHD, community organisation and aged care service staff.

A virtual workshop was held on Wednesday, 23 March 2022, for health professionals. GPs were specifically targeted to attend this workshop to ensure the co-design gained primary care insights and perspectives. The workshop was held in the evening to ensure GPs and other health professionals would be able to attend.

Virtual Workshop

23 March 2022

Three GP participants

One SWSLHD Staff Specialist

Three community organisation representatives from mental health, disability and aged care sectors

Determination Phase

A final half-day workshop with targeted representation was scheduled for 7 April 2022. This targeted representation included EOIs received from the discovery phase and selected representatives from SWSLHD. This session was attended by two community/consumer representatives, two SWSLHD representatives, and one representative from a community organisation.

The aim of this session was to determine:

- The area of focus for the funding
- Target area and population
- Activities, outcomes, and outcome measures of the commissioned service

Co-design Findings

The Healthy Ageing Co-Design project received submissions from 35 community members via survey. There were 31 participants in the consultation workshops, with a good mix of consumers, health professionals and community organisation representatives.

Findings from Data Gathering Phase

Current and future South Western Sydney older people population needs

Findings from SWSPHN's regional health needs assessment demonstrate the need for targeted approaches that improve healthy ageing services within the community.

According to Australian Bureau of Statistics (ABS) 2016 census, about 126,720 people were older adults in South Western Sydney. This makes up about 13% of the total population. 1 in 5 people live alone and 1 in 3 speak a language other than English at home.

SWS has a higher proportion of aged care recipients over 50 years of age who need assistance with core activity (16.3%) and significantly higher proportion of recipients born overseas (58.9%) and who preferred a language other than English (44.9%) compared with NSW (21%) and Australia (17.6%).

There are large geographical variations in these measures as they are not evenly spread across all LGAs. Much of the non-English population is located across the northern LGAs (Bankstown, Fairfield, and Liverpool) and population in Wollondilly and Wingecarribee have lower rates of non-English speaking people.

The largest populations of older adults across SWS reside in Bankstown and Fairfield LGAs, followed by Liverpool. While a smaller number of older people live in Wingecarribee compared to the northern LGAs, they represent about 24.7% of the whole population in Wingecarribee.

Dementia, falls and falls related injury and chronic disease contribute to the greatest disease burden among older adults. The overall burden of disease for Aboriginal and Torres Strait Islander people is more than twice that for non-Indigenous Australians.

It is expected that the number of people aged 65 years and older will reach up to 220,620 by 2031, an increase of 74%. The growth in the next 15 years is expected to be particularly significant amongst those over 85 years of age (increase of 92%) with an additional 14,660 people. Most people in this age group will have at least one chronic condition.

Whilst Bankstown and Fairfield LGAs are still expected to have the largest populations of older people, the most significant increase in the older population in the next 15 years will be in the Macarthur region, specifically Camden LGA (expected increase of 181.5%).

Impact of CALD Status on Health Literacy

People from a CALD background typically have lower levels of health literacy. This assertion is supported by data from Australian Bureau of Statistics (ABS) that people from CALD background have considerably lower levels of health literacy compared with the general population (ABS Health Literacy Survey, 2018). Individuals whose first spoken language was English were more likely to have 'adequate or better' health literacy (44%) than those whose first language was not English (25%).

Australian born individuals were more likely to have 'adequate or better' health literacy skills (43%) compared to overseas born individuals (30%).

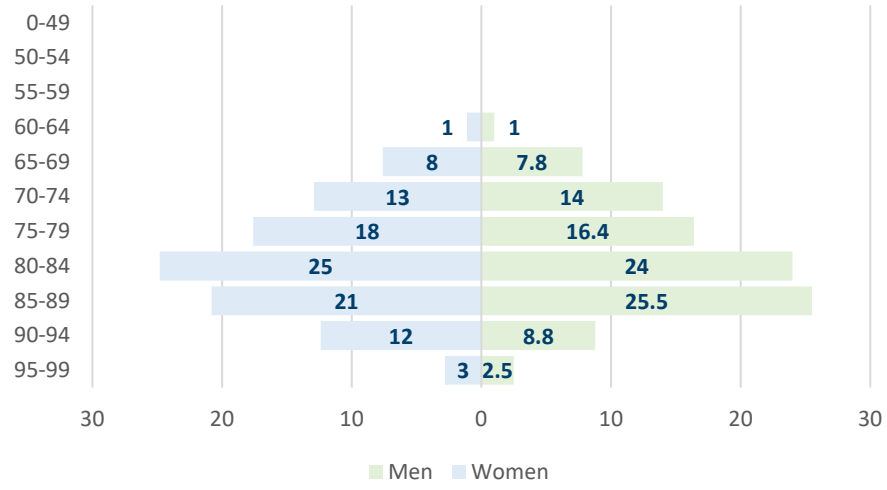
There are many reasons for low health literacy in CALD populations, such as low English language proficiency, unfamiliarity with the health system in Australia, and cultural differences. This means CALD population groups are less likely to access the services that they need or understand issues related to

their health and are more likely to experience social isolation and be at risk of mismanaging their medication.

Need for Residential Aged Care Facilities

The rate of persons requiring permanent residential aged care in SWS in 2016 was 0.7% for the region, with this expected to increase significantly in the region with the number of persons requiring this type of care expected to almost double in the next 15 years (from 5,937 to 10,894 by 2031).

Figure 1: Proportion (%) of people in South Western Sydney first admitted into aged care by age and gender, 2019–20



As of 30 June 2020, the rate of residential aged care recipients across SWSPHN was 66 per 1000 people. There are 68 RACFs (7427 places), 67 home care services and 73 home support outlets. The occupancy rate for residential care in SWS was 87.9% with 55.1% among those having a diagnosis of dementia. There are not enough residential aged care placements available to cater for the growing population of older people. Transition care and short-term restorative care places are also low. Not-for-profit providers were dominant in residential aged care (52.8%), 45.7% were charitable, and 1.5% were government operated.

Findings of Service Mapping

As part of the Healthy Ageing co-design, the project team conducted a service mapping and created a comprehensive list of services available for older people in SWS. It was found that many of the available programs cover physical activity, falls prevention, nutrition, health coaching, disability and recreational aspects. The main services in SWS (current and past) are listed in **Appendix A: Findings of service mapping.**

Aged care supports available in SWS for older people not living in RACFs

Currently, the aged care system offers a continuum of care under three main types of service:

Commonwealth Home Support Program (CHSP)

CHSP provides entry-level services focused on supporting individuals to undertake tasks of daily living to enable them to be more independent at home and in the community. Most people in the CHSP only need 1 or 2 services to help them stay independent. The program aims to help people live as independently as possible, focus on working with them, rather than doing things for them, and give a small amount of help to a large number of people. The CHSP has variable service availability by location. In SWS, the rate of CHSP recipients is 189 per 1000 people.

Home Care Packages Program (HCPP)

HCPP supports older Australians with complex needs to remain living at home through a coordinated package of care and services to meet the individual needs of consumers. There are four levels of care ranging from low level care needs (home care package level 1) to high care needs (home care package level 4). Services provided under these packages are tailored to the individual and might include personal care, support services and/or clinical care. The HCP Program has a history of long wait times, high overhead costs charged by some providers, and high levels of unspent funds.

As of 31 December 2021, there were 8933 people on a HCPP across SWS and Southern Highlands, of which 1568 people were new entries in the December 2021 quarter. Currently there are, there are 55 HCP providers and 1810 people waiting on a HCPP at their approved level on 31 December 2021, who had yet to be offered a lower lever HCPP. In SWS, the rate of home care packages recipients is 43 per 1000 people.

Transition Care (TC) and Short-Term Restorative Care Programme (STRC)

Transition Care assists older people in regaining physical and psychosocial functioning following an episode of inpatient hospital stay to help maximise independence and avoid premature entry to residential aged care. Short-term restorative care, which expands on transition care to include anyone whose capacity to live independently is at risk.

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

This program provides culturally appropriate aged care at home and in the community.

Future State: 'Support at Home' and 'Care Finder' Programs

In line with the Royal Commission's recommendations, from 1 Jul 2023, the *Support at Home Program* will replace the CHSP, HCP and SRTC programmes. In 2023, SWSPHN will implement the *Care Finder Program* to establish and maintain a network of care finders to provide specialist and intensive assistance to help people within the target population to understand and access aged care services and connect with relevant supports in the community.

More information on these is available in **Appendix B**. As we know these programs are coming, it is important that any Healthy Ageing at Home commissioned service is not replicating this type of service.

Findings from Discovery Phase

Community survey

Demographics

- 66% of respondents identified as an older person, 33% as carers
- 80% were female, 17% were male and 3% identified as other
- 66% were over the age of 65 years
- 2 respondents identified as Aboriginal or Torres Strait Islander
- 66% of respondents live in the Macarthur region with smaller representations from Fairfield and Bankstown. This may be due to the survey only being provided in English
- 28 respondents reported still being able to drive, 10 reported relying on family, 11 identified using other modes of transport, such as public, community or private transport services
- 88% lived in the community, 9% lived in a retirement village or similar

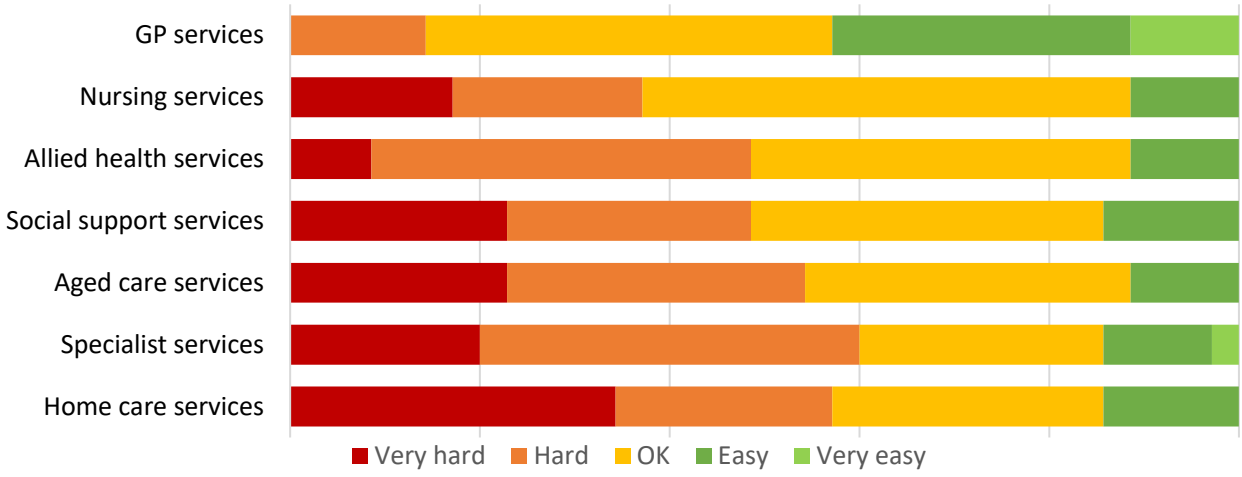
Perceptions of health

- 53% of respondents identified their health as good or excellent
- 58% of respondents reporting having been diagnosed with a chronic health condition
- 61% of respondents identified a health condition impacted their ability to keep active and healthy (25% responding it had a significant impact)

Access to healthcare and supportive services (within the last six months)

- 32 respondents had visited their GP
- 1 respondent had no interaction with any health professional
- Eight respondents had attended the Emergency department with 4 being admitted to hospital
- 86% were able to access healthcare services when needed, with most using public and bulk-billing services.
- GP services were reported as having the greatest perceived ease of access, with specialist and home care services being the most challenging
- 15 respondents required home-care support, with the main needs being cleaning, gardening and transportation services. 50% felt their home care needs were being met.
- 46% of respondents rated their social supports as good or very good. The most common type of supports identified were family and friends
- 47% identified not having issues with accessing social supports. For this that did find it difficult, the main reasons were cost and awareness of services in the area

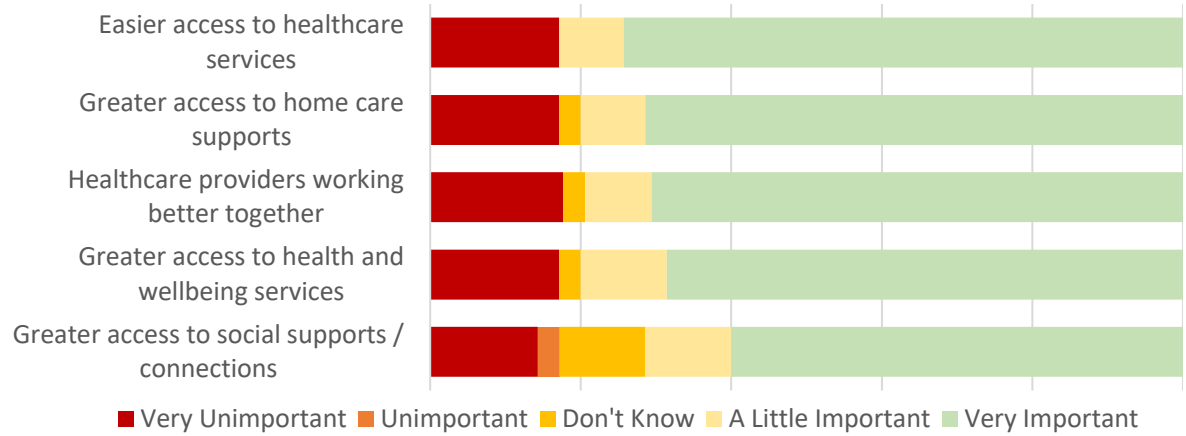
Figure 2: Survey respondents' perceived ease of access to services



Perceptions of Ongoing Community Living

- 89% reported not wanting to move into an aged care facility
- 56% expected that within the next 1-5 years, they would require more assistance than can be provided at home
- Respondents rated *"easier access to healthcare services"* as being the greatest need to supporting people to live at home for longer
- Access to home care supports was second
- Access to social supports and connections scored as the lowest need

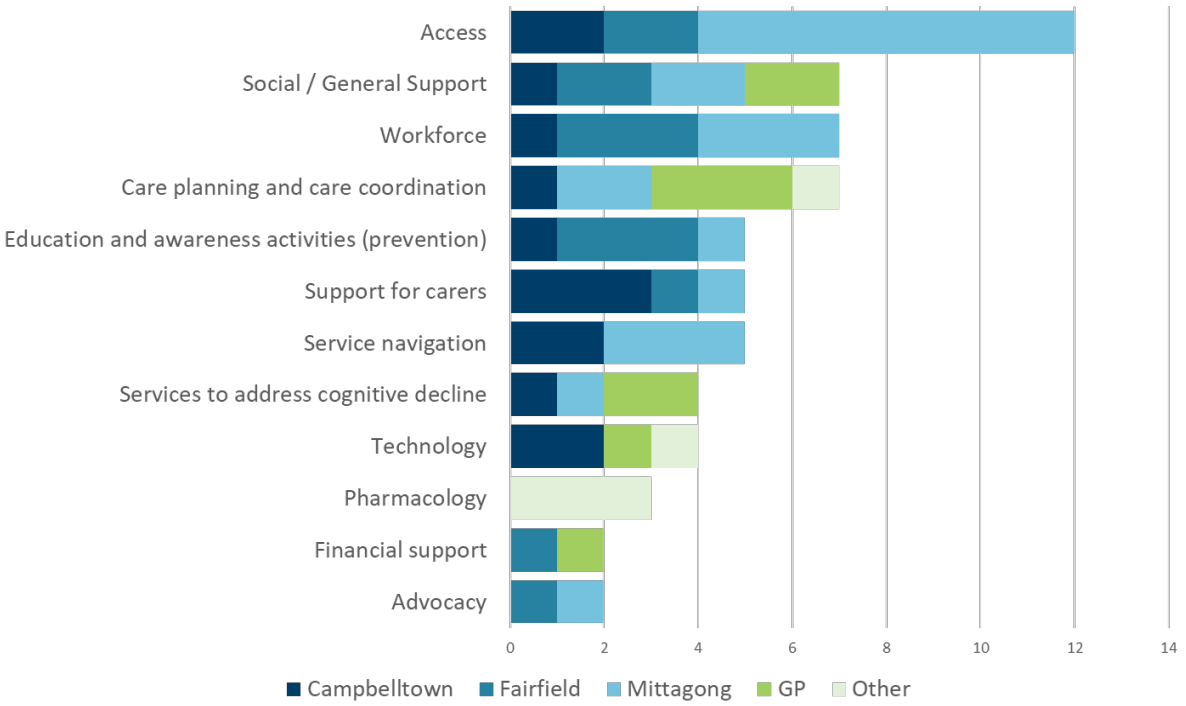
Figure 3: What is needed to support people to live at home for longer as per survey respondents



Consultation Workshops

The outputs captured were classified into several themes and are summarised in figure 10. A detailed presentation of the findings captured is depicted in **Appendix B: Outputs from co-design.**

Figure 4: Themes identified in each workshop



Findings from Determination Phase

The advisory group was presented with five themes from the identified twelve arising from the discovery phase. For a full list of rationales for deselecting seven of the discovery themes, see **Appendix C**. The themes progress to the advisory meeting are outlined in Table 4. The advisory group was then able to prioritise a single area of focus, target area for investment and type of service to be provided.

Table 1: Core group of themes for prioritisation by advisory group

Social / General Support	Workforce	Care planning / coordination	Education and awareness	Service Navigation
Tailor existing programs (e.g., HEAL) to older adults	Training for health prof. on how to communicate / interact with older people	Services to help people plan healthy ageing (functional ability-based)	Health promotion campaigns by councils and PHN re: support services	Directory and help to use / central information hub for culturally appr services
Engage older people in peer / community led social services / clubs	Training and support to provide culturally appropriate care for CALD	Shared care model b/w specialist and GP for chronic disease (incl MH)	Healthy ageing community advocacy groups - "health champions in each area"	Care coordinator / navigator to help transition between services
Enabler programs that enhance independence	Engage young people on career pathways into aged care support services	Central info hub for GPs, health workers and public	Health literacy / aged care information hubs to support access to services	Aged Care Coordination of services - connector program
Shared living arrangements or day programs	Bilingual staff and culturally aware workforce	Improved discharge planning / handover	Education re: diet, exercise, falls prevention etc	GP to understand older people's needs and relevant services
Isolation support when spouses pass away	Volunteer workforce not enough (mainly older people)	Care planning in disaster prone areas	How to engage with multicultural org, Service NSW, Centrelink	Assistance for tasks such as bills, letters, yard maintenance etc

Area of Focus

Advisory group participants were asked to prioritise and rank the core group themes. Education and awareness activities was voted as the first choice, followed by service navigation and care planning/coordination.

Table 2: Voted options and sub-themes from core group

Themes voted and ranked from highest to lowest priority	Subthemes emerging from the voting process
Education and awareness	*"What you don't know, you don't know"* *"Huge need for more education in CALD communities about healthy ageing"* *"How will people know if there is no education and awareness"* *"Falls prevention, how to make home safer, pain management etc."*
Service Navigation	*''Linking of the services is vital''* *''Next step after care planning to navigate what services are needed''* *''There is lack of knowledge around the whole system and services available''*
Care Planning	*''Most frequently asked questions service providers get asked is about care planning. Big gap on what is required before needing it (advance planning)''* *''Care planning should consider factors such as social determinants of health''* *''This is the biggest factor that clients appreciate''*
Workforce	*''Digital literacy and reablement''* *''Workforce is focused on serving and not and not on enabling''* *''Need for bi-lingual staff providing services and education to CALD community'* *''The workforce needs to recognise and assist older people to live in the home for longer independently''*

Target Area and Population

Participants also voted on whether the funding should focus on:

- The whole of South Western Sydney
- Part of South Western Sydney (specific LGA/group of LGAs)
- Specific population group (e.g. CALD community)

Participants unanimously voted to focus the funding on a low socio-economic area, specifically Fairfield LGA and parts of Liverpool LGA with high areas of Department of Housing residents. It was agreed having defined boundaries avoided dilution of funding.

Outcomes and Outputs to Commission

Once an area of focus and target population had been selected, the advisory group worked on developing the outcomes and activities to be achieved by the service SWSPHN will commission. The results of this component of the workshop are provided below.

What outcome are we trying to achieve?

Enable older people to make changes in their life to improve their overall health and wellbeing and access the services they need. It may be done via

- Improving health literacy regarding service navigation, general health, and specific conditions, and promote healthy lifestyles
- Improve awareness of older people and carers to access services

How will this be achieved?

- Workforce education:
    - Engaging and educating group/community leaders in identification of health needs.
    - Building the capacity of aged care professionals
- Community education: Engaging relevant community groups through their community organisations/structures to provide group education
- Care educators to provide small-group enablement sessions regarding health and service access

Insights and recommendations

Identified Areas of Need for Older People in South Western Sydney

The Healthy Ageing Co-Design Project identified a number of common themes across the focus area of 'supporting older people to age well at home'. These included:

- Social / general support – the need for activities and groups to support older people to maintain an active lifestyle
- Workforce – the need for a workforce sensitive to the needs of both older people and people from a CALD background
- Care planning / coordination – the need for ongoing improvements in coordinating healthcare across the different levels of care and ensuring that people are connected to the right services
- Education and awareness – the important of health literacy and consumer empowerment to take control of their health and minimise the health risks of ageing
- Service navigation – the awareness of local services, both by health professionals and health consumers

There were a number of region-specific themes that were identified during the consultation process. These includes:

- Fairfield – the need for culturally appropriate services.
- Southern Highlands – access issues due to rural setting and lack of healthcare providers, particularly bulk-billing healthcare providers, in the region.

Recommendations

The outcome of the Healthy Ageing Co-Design was to commission a service providing education to both community organisations and health service workforce, as well as the running of small-group education sessions for older people.

A program logic model has been developed which will guide the procurement and commissioning of this service. You can view the program logic model at **Appendix E: Program Logic Model**.

It is recommended services should be targeted with defined boundaries to avoid dilution of funding. The defined boundaries recommended are the Fairfield LGA and part of Liverpool LGA.

- Fairfield LGA has a SEIFA Decile Ranking of 1 (meaning the Fairfield area is among 10% of the most Socio-Economically disadvantaged LGAs in the country) with a high proportion of older residents being from CALD and refugee backgrounds and low levels of health literacy.
- Liverpool LGA has a Socio-economic Index for Areas (SEIFA) Decile Ranking of 4 (40% most disadvantaged areas). This population is Culturally and Linguistically Diverse (CALD), with 52% of residents speaking a language other than English at home. In the Liverpool LGA, the service is recommended to be focused within the Miller / Hoxton Park region where there is a large concentration of public housing.

Next steps

The co-design process identified several needs and opportunities to promote healthy ageing across SWS regions. These were considered by advisory group participants and refined to the final theme of 'education and awareness' activities. As mentioned earlier, several other suggested activities may not fall within the broader scope of healthy ageing funding. Additionally, some of the themes may reflect existing bodies of work by SWSPHN or other stakeholders or may not be clearly linked to 'healthy ageing' within this co-design's context.

The healthy ageing co-design process provided several process and practical learnings in terms of SWSPHN's engagement with communities and aged care, disability and mental health stakeholders. This could involve engagement with community organisations and service providers at a strategic level to identify diverse needs and solutions.

The next steps for SWSPHN following this co-design are to move to the procurement stage to commission the identified service. Information gather during this co-design process will also be included in the annual update to the SWSPHN Needs Assessment.

Evaluation

In both the discovery and decision phases, participants were given the opportunity to provide feedback about the workshops via the HealthChat platform and via paper evaluation forms. A total of 21 evaluations were received via both methods. Overall, the workshops were rated anywhere from 6-10 on a Likert scale. Specific input regarding the strengths and areas of improvement are summarised in the table below.

Given the low representation of CALD community members completing the survey or attending the consultation workshops, more planning is needed to ensure future co-designs are provided in a more accessible format (surveys provided in community languages, bi-lingual facilitators where applicable, etc.)

Table 3: Evaluation feedback

Strengths of the codesign process	• Face-to-face method of delivery • Interactive, open discussion in small groups about needs & service gaps • Opportunity to collaborate with a great mix of providers and older people (industry & lived experience) • Communication with clear purpose • Concise summaries, use of visual data • Facilitator was clear and ran the group well including time constraints
Recommendations of improvement	• Hand out of common acronyms used in aged care • Brochures on what SWSPHN is and what services they offer so participants can take them home • More time needed to share the event with networks • More clarity on scope • Visuals/slides to be sized up to enable them to be read more easily by older people

Appendices

Appendix A: Findings of Service Mapping

No.	Area covered	Services available
1.	Physical Activity	-Gentle Exercise (Heart & Move It/Lift for Life/Men's Exercise Class/Pilates / Tai Chi = Canterbury Bankstown Council subsidized) (Easy Moves for Active Ageing / The Pit Martial Arts = Campbelltown) (Active Bodies / Folk Dancing Wingecarribee) (Gymtastic- fitter life for seniors / Yoga Wollondilly) -Swimming or Hydrotherapy (Fairfield – Prairiewood Leisure Centre) -Online Exercise (Dance for Parkinson's /Chair Yoga /Pilates) -Online Information (Healthy Active Living – directory of service providers, Get Healthy (55% enrolled are 50+ years) -Private providers (Tai Chi & Qigong /Gymnasiums e.g., Curves / Share- Fitter and Stronger -Parkrun -RSL – Heart Health program (practical exercise, nutritional education, lifestyle management) -Get Healthy at work, Aboriginal Knockout Challenge (25% enrolled are 50+ years)
2.	Falls Prevention	-Online Information (Stepping Up – directory of service providers) -Able Stable Falls Prevention program (Fairfield) -SWSLHD – Community Rehabilitation Service
3.	Nutrition Programs	-RSL – Cooking for One or Two -Meals on Wheels (Canterbury Bankstown Council; Fairfield Food Services; Liverpool; Villawood Senior Citizens; Cabramatta/Fairfield Polish Senior Citizens; Nutrition Links (home visiting community nutrition services); Diverse Community Care (dementia meal monitoring); Catholic Care (dementia support). -SWSLHD (Oral Health Intake & Information Service)
4.	Health Coaching	-RSL – Wellbeing and Support Program (Case Management: coordination and communication between participant and practitioners and support groups); Coordinated Veteran's Care Social Assistance (CVC) – assist with management of chronic conditions. -Five Good Friends (digital connection) -Let's Talk -LIVE WELL program – not strictly health coaching, more integration services and MOC for lifestyle behaviour risk management service provision with mental health inclusion
5.	Disability Services	-Macarthur Disability Services: day programs, living skills, allied health services and NDIS services; Education and training – SWS Recovery College and CHSP sector support. -RSL – home services, community nursing, aids, equipment and modifications, respite care, Veterans Home Care -Multicultural Respite Network – support for carers of frail aged and people with disability of CALD background. -Day Care (Bankstown Ethnic; Muslim Care; Chester Hill; Arabic Seniors; Riverwood Canterbury and Disability Support Service; Greek Welfare Centre; Liverpool/Fairfield Elders Group (Aboriginal and Torres Strait Islander); Fairfield; Cabramatta; Greenfield Park; CALD Centre; Multicultural; Liverpool; Myrtle Cottage Group; Uniting Care NSW) -Warambucca Aboriginal Home Care Service -Baptist Care -Kincare -Southern Cross Community Healthcare (Liverpool only) -Stroke Recovery Groups -Pathways to community living for people with mental health conditions
6.	Arts and Recreational Activities	-Wollondilly Council: Seniors Festival held annually -Camden Council: CHARM Festival with health and wellbeing focus -Campbelltown Shire Council: Seniors Festival, Arts Program, Parks for Older Persons and aqua fitness -Canterbury- Bankstown Council: Older Women's Network has variety of arts and recreational programs for older women

		-Fairfield City Council: Senior Week, Seniors Concerts, Grandparents Day; walking paths and cycle ways and a recreational director for seniors; Carers week; digital literacy workshops -Liverpool City Council: Keeping pets and aged owners healthy; Seniors Concerts, Seniors Active Living programs; Mobility map for people with disabilities -Wingecarribee Shire Council: Seniors Festival, Seniors Directory of services, Hear Me See Me Know our Stories project -Probus Moorebank: Social network for retirees -EACH social group Campbelltown: centre based respite/social activities -Men's Shed: (Bonnyrigg, Moorebank, Liverpool, Busby, Bankstown, Oakdale, Menangle; Campbelltown, Narellan, Airds Bardbury, Break the Cycle Glenquarie, Mittagong, Bowral, Moss Vale, Bunadnoon, Colo Vale Village, Bargo, Tahmoor) -CWA: (Bowral, Moss Vale, Bundanoon, Fairfield, Campbelltown, Camden, The Oaks, Picton) -Senior Citizens (a number of meeting places, incl. neighbourhood centres across the region) -Service Groups (Lions Club, Rotary Club) -RSL sub-branch: (Camden, Campbelltown, Ingleburn, Liverpool, Maltese Ex-Servicemen's Assoc.-Bossley Park, Canley Heights, City of Fairfield, Smithfield, Chester Hill – Carramar) and RSL Day Clubs -friendship, social support, health and wellbeing activities (Bankstown, Chester Hill, Smithfield) -HammondCare Social Club
	Support with My Aged Care	-CASS Care: Triple H and aged care accommodation, settlement services for migrants/refugees -My Care Path Sydney -St Vincent's Care Home NSW -Uniting Home Care Sydney Metro -Catholic Healthcare Home Care Services – Western Sydney Harris Park -Catholic Care – neighbour aid links program -Wesley Home Care Packages – South West Sydney -Health Care Australia -Five Good Friends -Australian Unity Home Care – NSW -CareAbout -Benevolent Society (Campbelltown, Liverpool) -Presbyterian Aged Care -Carers NSW -MND NSW (motor neurone disease) -Graceland Care Services -Multicultural Community Care Services (companion connections)

**This list is not exhaustive, and some services may be outdated*

Appendix B: Support at Home and Care Finder programs

Support at Home Program overview

The new *Support at Home Program* will start in July 2023. The new program will support senior Australians to remain independent and in their own homes for longer. Support at Home will reform the delivery of in-home aged care. This includes assessment, provider funding, and regulation of the market. Support at Home will put a greater focus on reablement and restorative care. It will provide more clarity to senior Australians and providers with individualised support plans and clear service inclusions. This is in line with the Royal Commission into Aged Care Quality and Safety's recommendation 35 to implement a new aged care program and recommendation 118 to introduce a new funding model for care at home.

The department will consult on aspects of the Support at Home Program in 2022, including:

- aged care for Aboriginal and Torres Strait Islander peoples
- the assessment model
- care management, including self-management
- the service list, price list and funding model
- goods, equipment, assistive technologies and home modifications
- the evaluation framework
- the provider payment platform

A detailed overview of the program is available here: Support at Home Program Overview (health.gov.au)

Care Finder Program

PHNs will establish and maintain a network of care finders to provide specialist and intensive assistance to help people within the care finder target population to understand and access aged care and connect with other relevant supports in the community. The functions of care finders will include:

- Assertive outreach to proactively identify and engage with people in the care finder target population
- Engagement and rapport building with potential clients and intermediaries
- Supporting people to interact with my aged care so they can be screened for eligibility and referred for an aged care assessment
- Support to explain and guide people through the aged care assessment process including, where appropriate, attending the assessment
- Support to help people to find the aged care supports and services that they need and connect with other relevant supports, such as health and social supports, in the community
- High level check-in with clients on a periodic basis and follow up support once services have commenced to make sure that people are still receiving services and their needs are being met

The care finder target population is people who have one or more reasons for requiring intensive support to interact with My Aged Care (either through the website, contact centre or face-to-face in Services Australia service centres) and access aged care services.

Appendix C: Outputs from Consultations

	Macarthur	Fairfield	Southern Highlands	GP and other health professionals
Access	• A 'one stop shop' to access allied health in a private public partnership model • Less waiting time between need/MAC assessment so that needs don't change during the waiting period. • Include assessment for therapies and equipment • Better access to allied health at home. 5 visits under TCA is insufficient • Access to a range of therapies including exercise, nutritional, walking, balance, strength, and movement based)	• Access to nutritious food (e.g., food pantries) • Access to transport that suit needs/financial position/disability appropriate (e.g. certified drivers)	• Transport options for increased access to health/social services • Waiting lists/costs for independent living villages • Bulk billing GPs and allied health providers in Wingecarribee • GP home visits/follow up after hospitalisation. Bring team care to community (Geriatric flying squad) • Step down service (or respite care) for hospital avoidance e.g. rehab care after falls • Increase the number of care episodes a provider/health professional can provide per patient • In-home rehabilitation	
Advocacy		• Develop culturally appropriate resources on healthy ageing. • Translated materials (in consultation with CALD organisations)	• Money for more funding and care packages	
Education / awareness	• Health promotion and awareness campaigns by local councils and PHN about available support services	• Healthy ageing community advocacy groups - identify "health champions in each area" • Education around importance of diet, exercise, falls prevention etc. • Engage with multicultural org, service NSW, Centrelink	• Health literacy / aged care information hubs to support access to services. Education of everyone in the community - empowerment to age at home healthily	
Cognitive decline	• Health service delivery for people with dementia needs to improve		• More dementia focused services	• Isolation support when spouses pass away • Remote monitoring

	Macarthur	Fairfield	Southern Highlands	GP and other health professionals
Care planning / co-ordination	• Services to help people to plan healthy ageing (planning before needing, functional ability-based plan not age based) and prepare for future needs		• Care planning in disaster prone areas (eg: access to med records, active prescriptions, transport out of the zone etc) • GP to understand the needs of older people and connect people to relevant services	• Discharge planning and detailed discharge summaries, detailed handover and transfer of care, involve GP in multidisciplinary team meetings (especially for people with co-morbidities and complex care needs). • Future planning of care should include holiday care, A/H needs etc. • Shared care model b/w specialist and GP for chronic disease (incl. MH) • Central info hub for GPs, health workers and public
Financial support		• Funds/grants for equipment/home modifications	• Money for more funding and care packages	• Specialist access and investigation costs, reduce gap payments
Pharmacology				• Psychogeriatric care (eg: meds affecting MH) • Reducing polypharmacy • Ways to provide meds outside PBS at concessional rates
Social / connection	• Tailor existing programs (such as HEAL -Healthy Eating Activity and Lifestyle) to older adults	• Engage older people in peer / community led services to improve social engagement (e.g. preventive health / low bar exercise program) • Shared living arrangements / day programs	• Social clubs for older people • Involve animals and pets in activities	• Enabler programs that enhance independence (social, emotional, physical supports) • Isolation support when spouse passes away

Service navigation	• Directory and help to use Central information hub for culturally appr services • Someone/care co-ordinator/care navigator to help transition between services		• Aged Care Coordination of services - connector program (awareness of services in local area, direction to appropriate services, advice from community to improve services) • Health literacy / aged care information hubs to support access to services. • GP to understand the needs of older people and connect people to relevant services	
Support for carers	• Programs for carer support. Provide support before carer burn out (carer's pension, terminal care support etc.) • More recognition for carers (inclusion of carers in multidisciplinary team and decision making) • Information sessions for carer/family (what is available and how to access)	• Support network for carers (eg: some carers from CALD background don't reach out to services due to cultural barriers)	• Carer support / training in reablement, increase staffing and funding	
Technology	• Training in use of technology for older adults (telehealth, mobile phone, computer) • Use of technology to support social engagement	• Health workforce training, information and support to provide culturally appropriate care for CALD communities		• Integration of public and private services and including communication and information exchange using digital tools like secure email and messaging • Remote monitoring
Workforce	• Providers need to know how to talk to older adults. Training for health professionals on how to communicate/interact with older people.	• Engage young people on career pathways into aged care support services • Bilingual staff and culturally aware workforce • Upskilling aged care workforce: availability of competent workforce that understands the unique needs and focus on re-enablement to prevent functional decline	• Availability of assistance (or "check in") for tasks such as bills, letters, yard maintenance etc. • Prevent unnecessary entry into care homes due to socio-economic status, lack of care support etc. • Volunteer workforce not enough (mainly comprised of older people) • GP - Quality in Aged Care services/knowledge	

Appendix D: Rationale for Discarding Selected Themes

Access issues

The pre-dominant issues / areas of focus that arose as a result of access issues included:

- Lack of available public transport
- Long distances to travel in rural areas
- Distance to health services
- Long waiting lists to enter retirement villages and cost barriers

These issues are outside the scope of the funding provided and are the responsibility of local councils, state governments and private services.

Support for carers

While there is a significant need to support carers, it is outside the scope set within the funding schedule for commissioning services in healthy ageing.

Need for better technology

The pre-dominant issues identified here were regarding secure and consistent communication between primary and secondary care providers, shared clinical data, improving SWSLHD transfer of care summaries, etc. There are alternative programs already looking to resolve these issues (e.g., iRAD, Health One, NSW E-referral) and these issues require funding amounts significantly greater than what is currently available within the funding schedule.

Pharmacology issues

The issues raised during the co-design (need to reduce polypharmacy, cheaper medications) are outside the scope of this funding schedule. HealthPathways provide guidance on reducing polypharmacy and there the medication management review program is available to consumers.

Services to address cognitive decline

SWSPHN currently funds a program called the Peace of Mind Program that focuses on improving dementia care and palliative care across the district. Further investment in this area would not result in the most effective use of funds. In addition, research indicates that increased physical and cognitive activity can support people with dementia and slow deterioration. Increased activity and social programs are still in consideration as an area of focus.

Advocacy

SWSPHN, via its annual Needs Assessment and various other local, state and federal committees, can advocate for the needs of older people within South Western Sydney and will continue to do so. In addition, funding advocacy services is outside the scope of the funding schedule.

Financial support

The suggested areas of focus were funds/grants for equipment and home modifications, more care packages, and improving the affordability of specialist and medical investigation costs. Both are outside the scope of the funding schedule and the level of funding would very quickly be subsumed resulting in an inefficient use of funds to support the region.

The information from the discarded themes has been recorded and will help to inform the SWSPHN Needs Assessment to be released in November 2022.

Appendix E: Program Logic Model

Needs	Inputs (What we invest e.g. staff, money, other resources)	Activities (Activities – e.g. deliver workshop)	Outputs (Deliverables/KPIs - e.g. 'x' number of services delivered)	Short Term Outcomes (e.g. Learning, Awareness)	Medium Term Outcomes (e.g. Action, Behaviour, Policies)	Long Term Outcomes (What is the ultimate impact?)
Individual level • Knowledge and engagement with services to assist them to age well and maintain function. **Community level** • Active older person's community focused on ageing well **Sector level** • Reduced reliance on RACF placements • Increased proportion of older people living well in the community	**Funding to commission:** • Year One – $442,272.73 • Year Two – $448,272.73 • Year Three – $484,447.64 **Human resource:** PHN in kind staff: • Program advisor • Project team • Commissioning (contract, monitoring and evaluation) • Manager IPP	**Activity 1- Service mapping:** • Identify healthy ageing supports in Fairfield / Liverpool region • Work with SWSPHN to host service information on HealthPathways and Health Resource Directory	**Activity 1- Service mapping:** • Provision of service directory including healthy ageing support services • Provision of quarterly updates to service directory to SWSPHN	**Activity 1- Service mapping:** • Development of service directory of healthy ageing support services in Fairfield / Liverpool region	**Activity 1- Service mapping:** • Maintenance of service directory • Implementation of service details on HealthPathways and Health Resource Directory	**Activity 1- Service mapping:** • Maintenance of service directory • Maintenance of service details on HealthPathways and Health Resource Directory
		Activity 2- Capacity building: • Work with community services / organisations that work with to assist them to provide education and advocacy for healthy ageing • Provide education to primary healthcare providers on importance of preventative measures and how to connect senior Australians with healthy ageing supports	**Activity 2- Capacity building:** • Facilitation of XX capacity building workshops with community services / organisations per quarter • Provision of two GP CPD events per year • Provision of evaluation data from community services / organisations • Provision of evaluation data from GP CPD events	**Activity 2- Capacity building:** • Capacity building primary health care providers on how to connect senior Australians with necessary psychosocial, health, social and welfare supports	**Activity 2- Capacity building:** • Capacity building primary health care providers on how to connect senior Australians with necessary psychosocial, health, social and welfare supports • Building the capacity of aged care professionals	**Activity 2- Capacity building:** • A health and social sector with the capability and knowledge to support older people engage in and access Healthy Ageing supports
		Activity 3- Education: • Care educators to provide small-group enablement sessions regarding health and service access for older people and their carer/family • Engage identified priority groups for small group enablement sessions through their community organisations/structures	**Activity 3- Education:** • Facilitation of XX Healthy Ageing Enablement Workshops per quarter • Provision of XX Healthy Ageing Enablement Workshops per quarter for identified priority groups • Provision of evaluation data from community members attending enablement sessions	**Activity 3- Education:** • Older persons, family members and carers know the importance of healthy ageing and what to do to maintain function	**Activity 3- Education:** • Improved self-determination of health care needs by older people (improved capacity of the older person)	**Activity 3- Education:** • Improved self-determination of health care needs by older people (improved capacity of the older person) • SWS' older population will receive early intervention support to adopt healthy lifestyles and/or reduce chronic disease to • Older people continue to live at home as long as possible • Reduction in avoidable hospitalisations • Reduction in overall age-related adverse outcomes