South Western Sydney PHN

Consultation: Healthcare for Older People in Wingecarribee

Findings Report

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SOUTH WESTERN SYDNEY

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Acknowledgements

This needs assessment and report were developed and contributed to by the following people. Thanks is given for their contributions.

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Under the guidance of the Wingecarribee Aged Care Steering Committee, the recommendations report has been developed based on feedback received through stakeholder consultations.

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Thank you is also given to all community members, healthcare professionals and service providers that contributed to the consultations by sharing their perspectives and experiences. To maintain privacy, their specific names will not be provided in this report.

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Introduction

Approximately 52,709 people reside in Wingecarribee Local Government Area (LGA) (ABS)[1]. The median age of residents is 48 years, 23% higher than the NSW average age (39 years years). Wingecarribee has the highest proportion of older people to total LGA population; 27.8% of residents are aged ≥ 65 years (n= 14,701), a slight increase from 2016 (25.9%). The highest proportion of older people is represented by 70–74-year-olds at 7.6% (n= 4,021).

An ageing population increases the burden of disease and incidence of age-related conditions, such as frailty, memory and mobility disorders, and general decline[2]. An ageing population can result in higher health care system costs due to increased primary and hospital service utilisation, impacting the ability for older people to access aged care.

This project was developed in response to feedback South Western Sydney Primary Health Network (SWSPHN) received from stakeholders relating to service utilisation and challenges in coordinating care for older people across the region. This feedback reinforced findings gathered from the Healthy Ageing and Care Finder consultations facilitated by SWSPHN in 2022.

This report will address the unique challenges for the older people aged 65 years and over, residing in the Wingecarribee LGA, to accessing healthcare. Furthermore, it will highlight the barriers and opportunities for service providers to enhance patient care and health outcomes.

Henceforth, in this report 'older people' or 'older population' will refer to people aged 65 years and over, unless a different age group is specified.

Purpose of the Consultation

The purpose of this consultation was to explore how health care is experienced by older people residing within Wingecarribee. All levels of healthcare were explored including primary, secondary, and acute care. The project aimed to cover the experiences of older people residing both in community and in residential aged care facilities.

Objectives

1. Identify the barriers to access healthcare for the older people
2. Identify the barriers and challenges in coordinating care for older people
3. Identify the service gaps to support care coordination for older people
4. Identify the enablers to improve healthcare access and utilisation amongst older people

Findings from the consultation were synthesised to inform a series of recommendations developed in consultation with the Consultation Steering Committee.

Methodology

The consultation- was delivered using co-design methodology as per the SWSPHN co-design framework.

Data gathering phase

The data gathering phase involved research into how healthcare is being accessed and used by older people residing in Wingecarribee. Information was gathered from the following sources to inform this report:

- Australian Institute of Health and Welfare (AIHW)
- South Western Sydney Local Health District (SWSLHD) Emergency Department (ED) presentation data
- SWSPHN 2022-2025 Health Needs Assessment

Discovery phase

The discovery phase of the project involved surveys, face-to-face and virtual consultations with service providers across Wingecarribee.

Stakeholder surveys

Two surveys were developed in Survey Manager:

- General Practitioner (GP) survey: 9 respondents completed the survey * *One Practice Nurse completed the General Practitioner survey. Responses were unable to be removed.*
- Service provider survey: 17 respondents completed the survey

Provider consultations

An invitation to participate in a targeted, semi-structured interview was disseminated to key stakeholders across the region, including:

- General Practices: 12 GPs and 8 primary care nurses and managers participated
- Residential Aged Care Facilities (RACFs): 5 facilities participated
- SWSLHD personnel: 5 staff participated
- Community service providers: 10 providers participated

There was a total of 40 service providers engaged via interview.

Co-Design Findings

Findings from data gathering phase

Aged care service utilisation

There are three main types of care provided within the aged care system:[4-5]

- **Residential aged care:** Provides care and accommodation on a permanent or respite (temporary) basis. Residents with higher care needs may be supported with nursing care, basic medical and pharmaceutical supplies, and therapy services.
- **Home support (Commonwealth Home Support Package):** Provides entry-level home-based support focusing on assisted daily living to promote independence. Support is available for the person requiring support and their carer. Offered services include domestic assistance, personal care, social support, allied health, and respite.
- **Home care (Home Care Packages Program):** Provides a comprehensive care package based on the individual needs of the person requiring support. The primary focus is to maintain independence, connectedness to community, remaining at home, and healthy ageing. There are 4 tiers of home care packages available.

Residential aged care utilisation

On June 30, 2022, 58.3 people per 1000 population (70+) were in residential care across SWS (ACPR), greater than the corresponding NSW figure (57.4 per 1000 people). [3] Permanent residential aged care demand in SWS is expected to reach 10, 894 persons needing care by 2031.[4]

There were 608 persons estimated to be using permanent residential care in the Southern Highlands Statistical Area 3 (SA3); representing 10.1% of people using residential care in South Western Sydney (SWS) Aged Care Planning Region (ACPR). Southern Highlands had the second highest number of people (17.2%) in respite residential care across SWS.[6]

Home care package utilisation

On March 31, 2022, SWS had the highest number of people using Home Care Package (HCP) Level 1 'basic-level care needs' (952) and Level 2 'low-level care needs' (3,884) compared to other ACPRs in NSW. There were 2,536 in Level 3 'intermediate care needs' and 1,100 in Level 4 'high-level care needs' HCP.[7]

SWS had the highest number of new entries to an HCP in the March 2023 quarter (930 people) compared to other ACPRs in NSW. SWS also had the second highest number of people waiting on an HCP at their approved level (*Level 1*, 85; *Level 2*, 392; *Level 3*, 488; *Level 4*, 134). The supply of HCP is not keeping up with the demand in SWS. This validates consultation findings that patients are experiencing delayed access to services, particularly home care packages, which is a significant barrier in accessing healthcare.

Table 1: Number of people using aged care services in SA3 [Southern Highlands], 30 June 2022 (CHDATA).[6]

Type of aged care service	No.	Type of aged care service	No.
Residential Care (Permanent)	608	Home Support	1,944
Respite Residential Care	55	Transition Care	0
Home Care	251		

Characteristics of people using aged care

The characteristics of people residing in Southern Highlands using home support in 2021-2022 were:[6]

- 16.46% (320 people) had a carer
- 1.44% (28 people) identified as Aboriginal and/or Torres Islander
- 1.44% (28 people) spoke a language other than English
- 20.37% (396 people) were born overseas
- 23.25% (452) had a disability
- 39.66% (771) lived alone

On June 30, 2022, the proportion of people using permanent residential care with a dementia diagnosis was higher compared to people without dementia in Southern Highlands; 52% and 48% respectively. Southern Highlands had the second lowest proportion of people with diagnosed dementia compared to the other SA3 regions in SWS; Bankstown and Wollondilly were highest at 62% each.

Leaving permanent residential aged care in Southern highlands (SA3)

In 2021-2022, the primary reason for discharge from permanent residential care was death (85.3%) with 30.7 months mean length of stay (LOS).[6] Followed by discharge to other residential care (7.9%; 25.9 months mean LOS), return to community (6%; 10 months mean LOS), and to hospital (6%; 4.8 months mean LOS).

Compared to other SWS regions, Southern Highlands had the lowest maximum LOS for older people who died within residential care (114.4 months). Older people in Southern Highlands who were discharged from permanent residential care into community had the third highest maximum LOS (55.4 months) compared to other SWS regions (Campbelltown 190.2 months; Fairfield 87.8 months).

Medicare-subsidised service utilisation

In 2021-22, there were 20.8 GP attendances per residential aged care patient in South Western Sydney with a total of 170, 499 attendances.[9] Medicare-subsided GP attendance for older people was lower in Southern Highlands (1,331.57 per 100 people) compared to the SWSPHN region total (2,028.06 per 100 people). Southern highlands had the second lowest specialist attendance and allied health attendance compared to other SWS regions.

ED presentations

Between January 2021 - May 2023, there were 53, 343 ED presentations at Bowral & District Hospital (B&DH) of which 39, 826 patients (74.6%) resided within Wingecarribee LGA. The high number of presentations from non-residents of Wingecarribee could be attributed to tourism in the Southern Highlands. The proportion of non-resident ED presentations at Bowral & District Hospital is not dissimilar from other hospitals within our region (Camden Hospital 78% were Camden residents; Campbelltown Hospital 56% were Campbelltown residents).

This trend is consistent when looking at the weekend (Saturday and Sunday), 73.2% of ED presentations at Bowral and District Hospital between January 2021- May 2023 were Wingecarribee residents and 26.8% were by non-Wingecarribee residents. At Campbelltown Hospital 54.6% of ED presentations were Campbelltown residents and 77.3% of ED presentations at Camden Hospital were Camden residents. There have been verbal reports that Bowral and District Hospital have a high rate of weekend presentations by non-residents. The aforementioned data highlights that this is a common theme across Campbelltown and Camden Hospitals too.

There is a high proportion of Wollondilly residents presenting to Bowral & District Hospital ED compared to other regions (17.1% Bowral & District Hospital; 9.4% Camden Hospital; 5.6% Campbelltown Hospital) in all time periods.

The older population represent 35.4% (14,127) of ED presentations by residents of Wingecarribee. Table 2. illustrates the proportion of patients presenting to Bowral & District Hospital by reporting years and age group.

Table 2. No. ED presentations at Bowral & District Hospital (Overall vs patient residence in Wingecarribee)

Year	No. presentations to BDH (overall)				% of Patients Residing in Wingecarribee			
	65-74	75-84	>85	Total	65-74	75-84	>85	Total
2023	1064	1,305	679	**3,048**	827 (77.7%)	1,070 (81.9%)	591 (87%)	**2,488 (81.6%)**
2022	2,709	3,002	1,622	**7,333**	2,138 (78.9%)	2,512 (83.6%)	1,358 (83.7%)	**6,008 (81.9%)**
2021	2,657	2,692	1,474	**6,823**	2,106 (79.2%)	2,235 (83%)	1,290 (87.5%)	**5,631 (82.5%)**

The ED data presented in this report from this point has been filtered for:

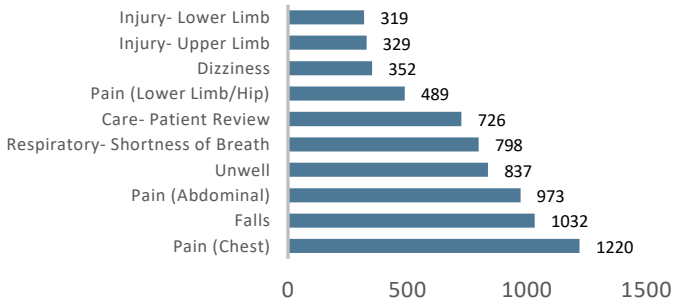
- Patients: >65 years
- Facility: Bowral & District Hospital
- Patient Local Government Area (LGA): Wingecarribee

Between January 2021-May 2023, the primary source of referral was self-referral (n= 12,197), followed by GP/Dentist (n= 872) and RACF (n= 644). The urgency of care is defined as the triage category used in ED to determine the time in which a patient's medical or nursing care needs to commence.[10] The triage category for each referral source was:

- **Self-referral/friend/family:** Triage Category 1-3, 66.4%; Triage Category 4-5, 33.6%.
- **General practitioner or Dentist:** Triage Category 1-3, 71.3%; Triage Category 4-5, 28.7%.
- **Residential Aged Care Facility:** Triage Category 1-3, 30.7%; Triage Category 4-5, 69.3%.

The top presenting issues were chest pain (8.6%), falls (7.3%), abdominal pain (6.9%). Figure 1. Shows the

Figure 1. Top 10 ED presenting issues for older people (Jan 21 - May 23) at BDH.



top 10 presenting issues for the older population residing in Wingecarribee.

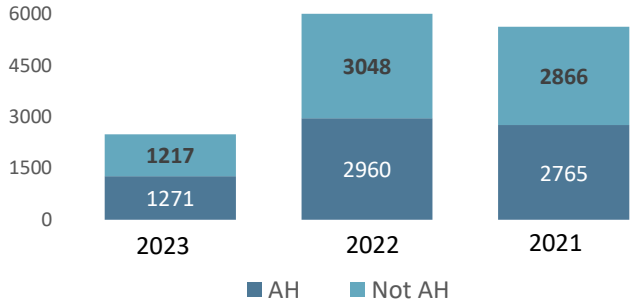
Almost half of lower urgency ED presentations in older people occurred in the after-hours period (47.3%).

After-hours presentations

The after-hours period is defined as: Monday to Friday 6:00pm to 8:00am; Saturday from 12:00pm; and Sunday and public holidays all day.[11]

Between January 2021 - May 2023, 49.5% of all ED presentations for older people at Bowral and District Hospital occurred in after-hours (refer to Figure 2.). The 75–84-year age group had the highest rate of presentation (40.3%), followed by 65-74 years (36.8%), and 85+ years (22.9%).

Figure 2. Comparison of After-Hours and Non-After-Hours ED Presentations at BDH

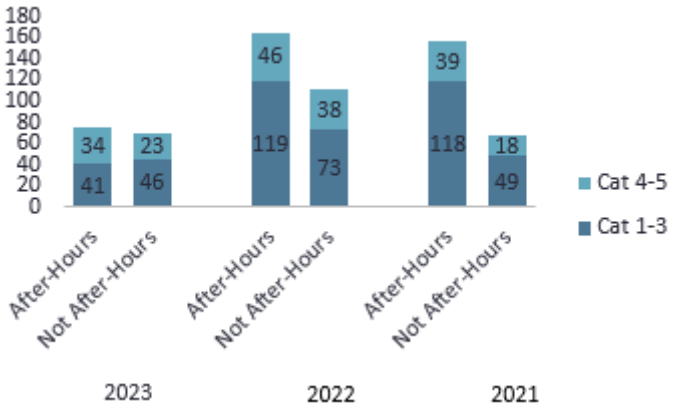


After-Hours presentations were greatest on Sundays and Saturdays; 1,962 and 1,464 presentations, respectively. The main source of referral was self-referral (89.5%), followed by transfers from RACFs (5.7%) and GP/Dentist referral (2.3%). In total, 4,718 people left ED with treatment completed and 1,218 people were admitted to the non-critical ward. The top presenting reasons in the after-hours period for older people were chest pain (8.6%), abdominal pain (7.8%) and falls (7.4%).

RACF referrals to ED

In 2021 and 2021, more than half of ED presentations from RACFs occurred within the after-hours period (2022, 58%; 2021, 70%). The top presenting issues from residents was falls (25.3%), injury to head (7%), and respiratory- shortness of breath (6.2%). Refer to figure 3.

Figure 3. ED presentations to Bowral & District Hospital from RACFs



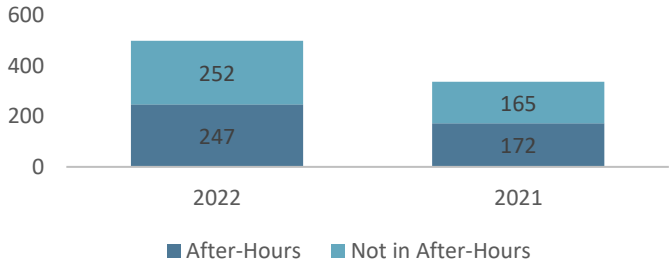
Falls presentations

In 2022, there were 499 ED falls presentations to Bowral & Hospital in the older population; representing 8.3% of total ED presentations. This was a 48.1% increase in falls ED presentations compared to 2021 (n=337). Females had a higher number of presentations compared to males, 298 and 201 respectively. Falls presentation was greatest in the 85+ cohort with 222 presentations (representing 44.5% of falls

presentations). The number of presentations in the 85+ population was 63.1% higher compared to the 65–74-year-olds.

Almost half (49.5%) of falls presentations occurred in the after-hours period. Most referrals made after-hours (79.8%) were self-referrals, followed by RACF referrals (17.8%). RACFs referred more patients for falls after-hours (165 people) compared to the non-after-hours period (111 people). Falls was the second highest presenting reason for older people in 2022. The top falls diagnoses were falls 28.1%, elderly fall 20%, accidental fall 11%, head injury 29.3%, and fractured femur neck 3.6%. Refer to figure 4.

Figure 4. Falls ED presentations at Bowral and District Hospital between 2021 and 2022.



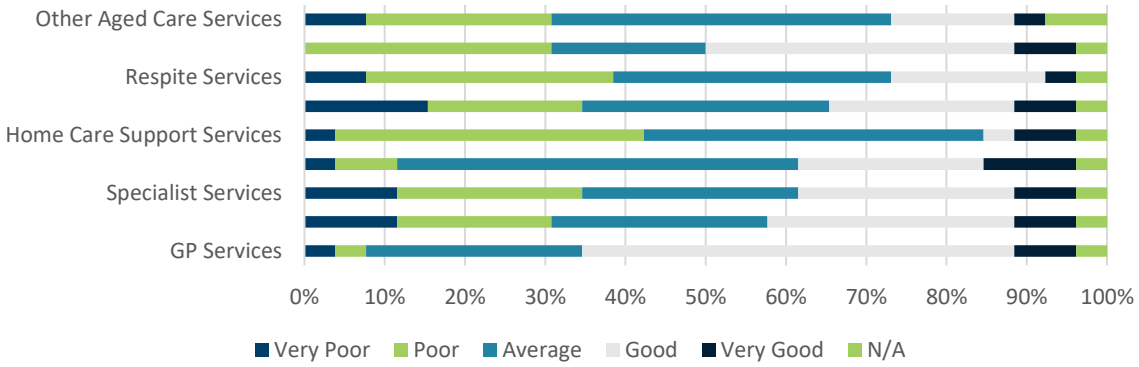
Findings from discovery phase

GP and service provider survey findings

Access to healthcare and support services

- GP's* had the highest perceived accessibility with 61.5% of respondents reporting access as 'good' or 'very good'.
- Home care support services had the lowest accessibility with 42.3% of respondents reporting access as 'very poor' or 'poor'. This was seconded by respite services, with 38.5% of respondents reporting access as 'very poor' or 'poor'. Refer to figure 5.

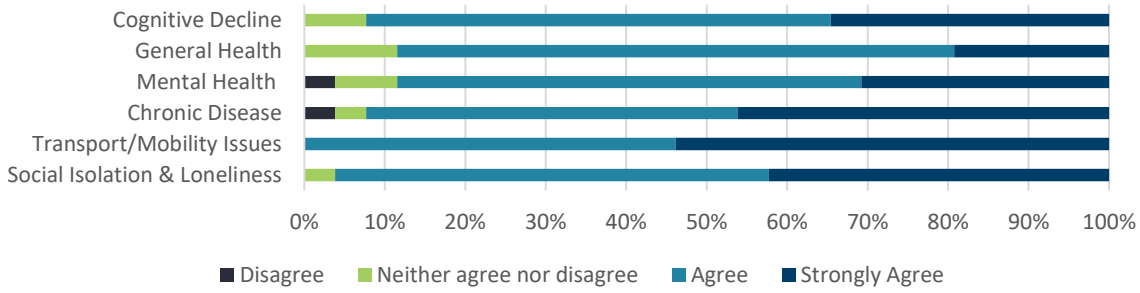
Figure 5. Survey respondents' perceived access to healthcare and support services for older residents of Wingecarribee Shire



Emerging health concerns

- Transport/mobility issues were identified as the prominent emerging health concern for older people, with 100% of respondents in agreement (46.2%) or strong agreement (53.8%). Social isolation and loneliness were seconded at 96.2% agreement or strong agreement. Refer to figure 6.

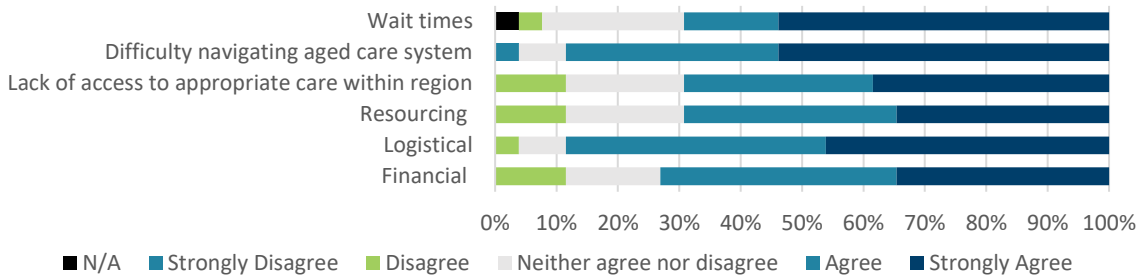
Figure 6. Survey respondents' perceptions of emerging health concerns for older residents of Wingecarribee Shire.



Barriers in local health systems impacting healthcare access

- Logistical barriers, including limited community transport and distance to services, and difficulty navigating the aged care system were identified as the biggest barriers for older people accessing healthcare within the region. This finding is consistent with feedback received through consultation.
- Findings highlighted the system is complex which can be confusing to determine which package and option a patient should receive.
- This was seconded by financial barriers (e.g., limited bulk-billing) with 73.1% of respondents in agreement or strong agreement. Refer to figure 7.

Figure 7. Survey respondents' perceptions of barriers for older residents to access healthcare in Wingecarribee Shire.



Care provision to older people

- 100% of respondents that completed the GP survey identified lack of public services to refer to as the primary barrier in providing care. Poor communication and coordination of care between primary and secondary care services was the second biggest barrier at 66.7%.
- Lack of private services to refer to (22.2%), lack of clinical support/education (22.2%), and lack of available after-hours services (22.2%) were the lowest ranked barriers experienced by GPs.
- 55.6% of GPs believe there are sufficient aged care services to refer older people within the region. Service gaps included:
    - long wait times
    - no service agency opening
    - home care services, access to psychiatry, palliative care, and public allied health
    - difficulties finding a local geriatrician.

Provider levels of confidence (GPs)

- 66.7% were 'fairly confident' in diagnosing dementia; 22.2% in provision of ongoing management
- 66.7% were 'fairly confident' in advance care planning; 66.7% in accessing resources to support delivery of care
- 88.9% were 'fairly confident' in knowledge and management of chronic disease; only 11.1% were 'confident' in provision of ongoing management
- 55.6% were only 'somewhat confident' in knowledge of mental health services and support
- Refer to Appendix B, figures 7- 11 for further detail

Figure 8. Survey respondents' levels of confidence in care provision for patients with Dementia

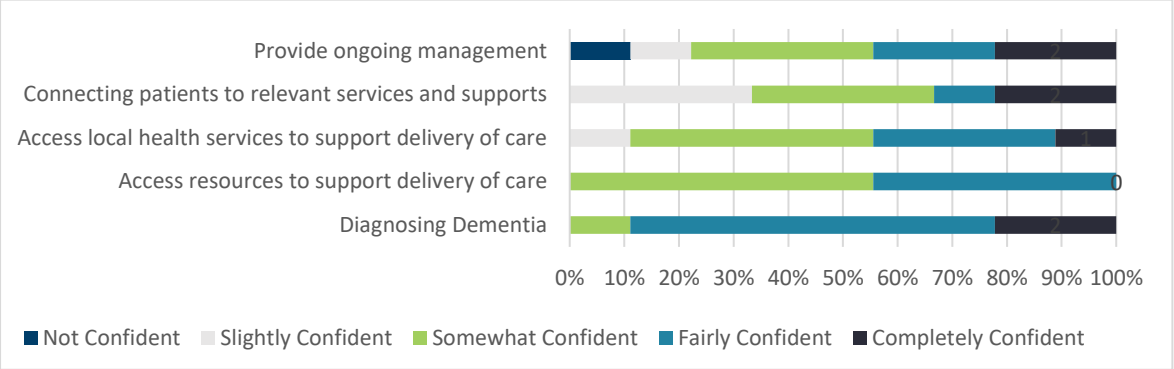


Figure 9. Survey respondents' levels of confidence in care provision for patients requiring Palliative Care

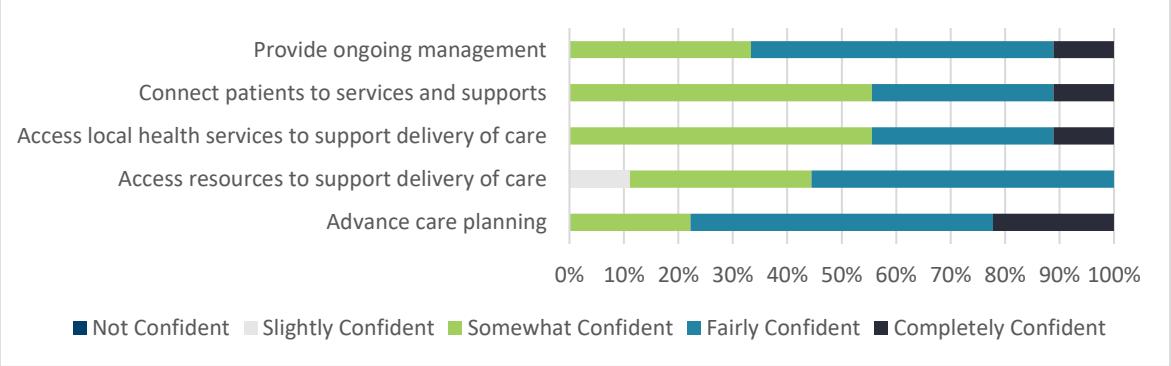


Figure 10. Survey respondents' levels of confidence in care provision for patients with Chronic Disease

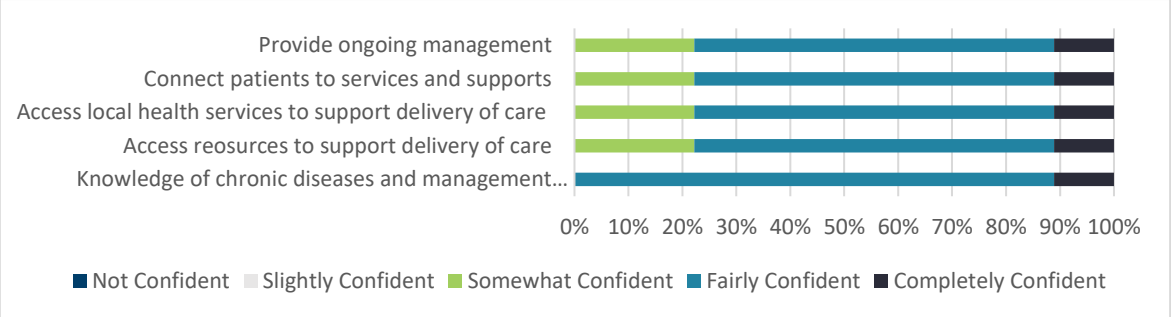
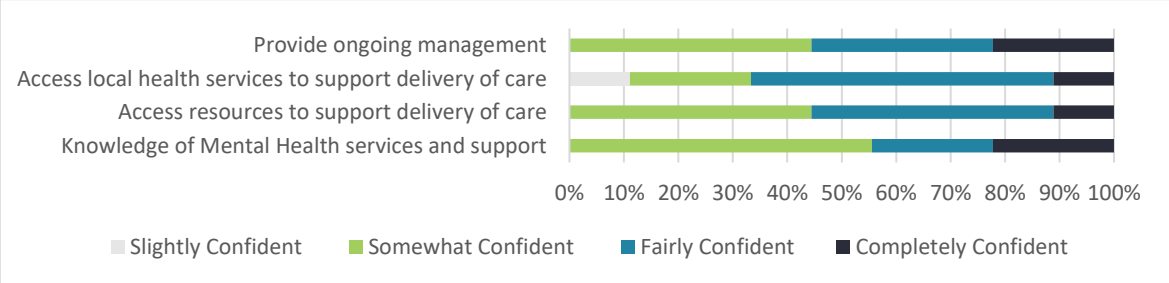


Figure 11. Survey respondents' levels of confidence in care provision for patients with Mental Ill-Health



Opportunities to support delivery of care (Service providers)

- 88.2% of respondents that completed the service provider survey reported the existing aged care workforce is adequately supported to deliver care to older people.
- 76.5% agreed the availability of aged care services for older people in Wingecarribee to be referred to is not adequate. The following needs were highlighted:
    - More facilities to decrease wait times
    - Increased staff training and availability (including community nurses, social workers, and occupational therapists)
    - Hospice
    - Respite
    - More home care support
    - Improved transportation
    - Mobile mental health service provision
    - Decreased wait times and costs to access services
    - Improved care coordination was the highest scored opportunity (88.2%) to reduce acute hospitalisations in older people residing in Wingecarribee. Greater access to falls prevention services was second at 70.6%.
    - Improved medication management was the lowest reported opportunity at 47.1%.
    - Other mentioned opportunities include greater access to services to support cognitive decline, ongoing education and exercise groups for maintenance following acute issues, and mental health clinicians to overcome the impact of isolation.

Consultation findings

The dominant health concern raised was age-related conditions, especially frailty and weakness, and the subsequent increased risk of falls. Many clinicians emphasised the need to focus on falls prevention and improving balance to support the ageing population in Wingecarribee (refer to recommendation 3).

The prolonged Aged Care Assessment Team (ACAT) wait times was raised by many consultation participants. The wait time for patients within the community is between 8-12 weeks. Activities of Daily living (ADLs) is imperative to support patients maintain their independence and stay longer at home; delayed access to services prevent this and can lead to escalation of functional decline.

Feedback specific to the Aboriginal and Torres Strait Islander community were raised through consultation. The primary health concerns are transportation (isolation impacts ability), shame

(incontinence and health literacy), poor access to health services, and inadequate confidentiality when accessing services in the region.

Table 3. Primary Health Concerns identified through consultation

Physical & Health Conditions	Age-related Conditions	Inadequate Service Access & Awareness	Other
Dementia	Frailty and weakness	ACAT wait times	Health literacy
Chronic disease (including diabetes, lung, and heart disease) and comorbid conditions	Decreased mobility	Delayed access to maintain independence and remain at home	Social isolation
Pain (including pain relief from osteoarthritis)	General and cognitive decline (degeneration from social isolation)	Transportation barriers to access required services	Process of diagnosis
Continence issues	Sarcopenia	Lack of awareness of services	Discharge process
Parkinson's disease	Increased falls risk	Poor geriatric and psychiatry access	Advocacy for consumer rights and choice

Findings from determination phase

Findings collected through consultation were provided to the Steering Committee monthly. A series of recommendations were developed in response to the data gathered from the discovery phase of the project. The Steering Committee were presented with 7 overarching recommendations and provided their endorsement.

Recommendation 1: Improve care coordination for older people both within community and residential care

This recommendation aims to enhance patient-centred care through effective coordination of patient care between different services across the region.

Care coordination is essential for good clinical care. Inefficient care coordination and communication between health professionals were emerging themes throughout consultations. Identified barriers for providers delivering care to older people are outlined in Appendix B, Table 4.

Streamlined transfer of patient information across services is critical, especially when primary care providers are not able or willing to provide care coordination. Improved technological interoperability would assist the smooth flow of patient information across primary care and aged care services.

General opportunities identified to improve care coordination

Recommendations	Evidence and Consultation Outputs
1.1.1: Implement integrated models of care with an emphasis on strengthening communication and collaboration between health professionals and community service provider	• Consultation participants reported that the disintegration of care and information is a prominent barrier in delivering care to older people.
1.1.2: Increased awareness of limitations of care within the community	• Consultation participants highlighted the benefit of interagency communication of limitations of care within community (primary and aged care).

1.1.3: Strengthen care coordination for patients at high risk of hospital admission or re-admission	• SWLHD have initiated the CO-PILOT (Community, Older Persons, Intervention, Liaison, Out-Reach team) program which focuses on keeping people healthy through appropriate planning. • Patients at urgent risk of readmitting or admitting to hospital can be referred. Successful implementation of CO-PILOT will strengthen relationships with primary care providers and reduce patient hospitalisation for low acuity issues. Therefore, promoting more effective coordination across aged care services.

Identified opportunities to improve care coordination within RACFs

Recommendations	Evidence and Consultation Outputs

1.2.1: Appropriate documentation to be provided for resident transfers, enabling holistic and appropriate delivery of care.	• Residents transferred from facility need the appropriate documentation to ensure timely holistic care. Document can be provided with patient followed by handover via phone. In emergencies paperwork can be faxed or electronically sent. Documentation includes:
	  ○ Medication chart
	  ○ Patient care plan
	  ○ Guardianship orders
	  ○ Patient daily requirements
	  ○ Health summary
	  ○ Vaccination record

1.2.2: Strengthen interdisciplinary approaches to improve older person health outcomes	• Inadequate discharge planning was an identified barrier raised by consultation participants.
	• Effective discharge planning is needed in the region with greater interdisciplinary collaboration.
	• Patients discharged from hospital without established community care. Patients presenting to General Practice for community health referrals. Potential issues:
	  ○ Inadequate transition between tertiary and primary care.
	  ○ Residents returned to RACFs have inadequate follow-up and plans are not patient- centred, lacked collaboration with the resident and carer.
	• Facilities are not always notified of resident transfer back to facility. There are rare instances of patients being returned without notice.

1.2.3: Address the fragmentated continuity of care (interpersonal and informational) for RACF residents	• Continuity of care is imperative for older people transitioning from community into residential care. • In October 2023, there were 70 GPs, excluding registrars), practicing in Wingecarribee; only 51.4% serviced RACFs. • Consultation participants emphasised interpersonal continuity of care is critical for residents in RACFs. However, GP willingness to provide this service is decreasing across the district. • Implementing a model of care that engages GPs on a rotating roster can mitigate the lapse in continuity of care. • Implementing Nurse Practitioner Models of Care in RACFs. • GP barriers to providing care within RACFs are outlined in Appendix B, table 4 • There is a lack of initial screening and checks for delirium before transition into aged care. • Access to previous medical history is difficult with new admissions not from GP's practice. Instances of new patients with complex conditions in which only a basic health summary is available.

Identified opportunities to improve care coordination within community

Recommendations	Evidence and Consultation Outputs
1.3.1: Utilise the care finder program connect patients to services	• The Care Finder program can address gaps in care coordination for patients residing within community. • Better promotion of the service to GPs in required.
1.3.2: Better promotion of existing services and resources	• There are existing services and resources available within the region, however there is not enough awareness by clinicians or the community.
1.3.3: Scope social prescribing models of care	• Steering Committee members identified the potential for social prescribing as a model of care.

Recommendation 2: Establish effective provider communication

This recommendation aims to address clinical communication inefficiencies experienced by service providers across the region. Effective communication will focus of the timely and seamless exchange of clinical information to promote continuity of patient care.

Effective communication between primary and tertiary care is pivotal for continuity of care. Consultation participants emphasised the need for increased information exchange to support delivery of care.

General opportunity to improve provider communication

Recommendations	Evidence and Consultation Outputs
2.1.1: Improve consistency of electronic discharge summaries receival from ED and wards	• Ward discharge letters are not received quickly. When patients are admitted, communication between primary care and tertiary care does not always occur. Delayed representation to their GP (without a discharge letter) fragments care patient as there is no communication of medication and management changes.
2.1.2: Improve exchange of information between services	• Hospital specialist changes are not always communicated; however, it would be beneficial for efficient and timely communication. • Notifications of patient admission and death in hospital are not received unless primary care provider was aware of patient being admitted. • My Aged Care providers not notifying primary care provider when patients access services. • Confirmation of receipt for sent fax and emails is required to reduce communication inefficiencies and delayed access to care.
2.1.3: Optimise communication between Bowral and District Hospital and RACF upon patient discharge back to facility	• There are rare instances in which residents are transferred back to facility from hospital without communication. • Upon resident discharge the relevant personal from RACFs should be available to communicate with hospital staff to ensure effective discharge and handover.

Identified Opportunities to improve provider communication within RACFs

Recommendations	Evidence and Consultation Outputs
2.2.1: Clinical staff to utilise effective communication in clinical handover of patients transitioning between hospital and RACFs.	• Clear delineation of communication responsibility and accountability is pivotal at transitions of care.[12] • Consultation participants raised the need for improved clinician knowledge of the ISBAR (Identify, Situation, Background, Assessment and Recommendation) to ensure adequate clinical handovers, thus ensuring continuity of care. • This was emphasised for resident transfers following hospitilisation. Evidence suggests the

	ISBAR framework can mitigate the risk of adverse patient outcomes and reduce the duplication of services.[13]
2.2.2: Improve the functionality of RACF systems to enhance information exchange with GP	• Poor digital interface was a primary barrier impacting GP delivery of care to older people in RACFs. • Non-GP centric systems are used in which clinical notes are among non-clinical notes; requiring time for GPs to locate relevant documentation. • Electronic medication charts are not available at all facilities; requiring time from GPs to communicate back and forth via email/fax to chart medications. • Medication requests are sometimes sent without medication chart; delaying resident access to medications and requiring GPs to spend additional time chasing up documentation.
2.2.3: Adoption of MHR use within RACF systems to streamline information sharing between Hospitals and RACFs	• Some facilities operating without discharge letters (requires access to MHR which is difficult) • My Health Record (MHR) is poorly utilised • Information within facility does not integrate with MHR
2.2.4: Improve communication between aged care services to ensure preferences for symptom management (e.g., for delirium) are respected	• Residents are sometimes heavily medicated upon transfer from hospital, fragmenting patient care. o Advocacy for medications to be utilised as a last resort. o RACFS work hard on non-drug interventions. Needing support from other aged care services. There is a significant gap in shared understanding.
2.2.5: Review and update of SWSPHN Aged Care GP-RACF Communication Manual (2019-2020) in Wingecarribee	• Consultation participants reported inconsistencies across the region pertaining to communication between services. • SWSPHN previously developed a communication manual to facilitate effective provider communication. Reviewing and implementing this document could address communication barriers.

Recommendation 3: Increase service accessibility for older people both within community and residential care

This recommendation aims to address the disproportionate availability of services, public and private, across the region**.**

The increase in services delivered by Bowral and District Hospital the quality of service provided to older people, albeit many health professionals indicated the availability of services don't meet need demand of the region. A prominent barrier for service providers in the delivery of care for older people was limitations in services to refer patients.

Recommendation	Evidence and Consultation Outputs
3.1: Plan health services and programs that meet the demand and health needs of older people within the region	• Consultation participants emphasised the need for increased service availability across the region.
3.2: Improve access to acute GP care to improve continuity of care and reduce potentially avoidable hospitalisations	• Poor acute GP care access can lead to low-acuity ED presentations: ○ Limited home visit and same-day appointments availability. Patients access
3.3: Increase primary care provider awareness of local health and support services to refer patients	• Feedback indicated GP uncertainty of the public Geriatrician at Bowral & District Hospital.
3.4: Implement aged care liaison to bridge the gap between clients and my aged care services.	• Patients require navigation supports.
3.5: Maintain service information through My Aged Care portal	• The My Aged Care portal is difficult to navigate. Providers need to regularly update their service information to ensure that services are displayed under the correct tags.
3.6: Increase the utilisation of Allied Health Professionals in RACFs to support patient health outcome (e.g., early intervention of functional decline)	• Increased utilisation and availability of AH in RACF visits to improve care coordination

3.7: Increase accessibility of public services to available locally	• **Increase public geriatric access**
	  ○ Need for increased geriatrician access to support the delivery of care for older people with a particular need within the public system.
	  ○ Improving awareness of the geriatric service will boost GP lead referrals, thus

	improving health outcomes of older people in Wingecarribee. Noting the lack of geriatricians in the region, services that support older people with neurological conditions (e.g., alcohol affected) would assist geriatricians.
	• **Increase Community Health access**
	  ○ Hospital in the Home (HITH) access for RACFs
	  ○ Incontinence program with private appointments (sensitive issues)
	  ○ Palliative care
	  ○ Wound care, especially in RACFs
	• **Increase outpatient clinic accessibility**
	  ○ Increased public access to AH, particularly podiatry, diabetic educators, and dieticians
	  ○ Comorbid conditions need better integration within public system
	  ○ Having patients travel to other regions can be overwhelming, particularly for those residing in more rural locations

3.8: Increase accessibility of private services to support needs of older people	• **Increase access to Allied Health**
	  ○ Need better private access, especially Occupational Therapists (OT)
	  ○ Access to OTs for driving assessments when GPs have reservations about someone's driving capacity
	  ○ Remote access to AH, especially Podiatry
	• **Increase access to Mental Health**
	  ○ Inadequate choice of therapists is a barrier to people accessing quality care
	  ○ Extensive private psychiatry waitlists so patients travel to Campbelltown which is an issue in urgent mental health situations
	• **Increase palliative care provided by GPs**
	  ○ Provision of care is dependent on the GP (not provided by many bulk billing GPs)
	  ○ GPs receiving referrals for new patients requiring
	• **Increase access to specialists**
	  ○ Need more psychiatrists and vascular specialists
	  ○ Waitlists for pain clinics are long
	• **Need for respite care**
	  ○ Emphasis on the need for respite cottages within the region
	  ○ There is limited local respite options. Patients and carers accessing respite in Camden or Goulburn.
	  ○ Carer stress is rising, increasing carer respite would improve quality of care provided

Reduced service accessibility across the region was identified as a primary barrier for older people requiring appropriate care. Other perceived barriers to accessing healthcare are outlined in Appendix B, table 5.

Recommendation 4: Increase the focus on falls prevention

This recommendation aims to support patients with sarcopenia, frailty, and mobility issues, to reduce the risks of falls and prevent avoidable ED presentations for older people.

Mobility is a cornerstone of quality of life. The promotion of mobility by allied health professionals, particularly physiotherapists, is imperative for the maintenance and improvement of mobility in older people.[2] Consultation feedback indicated age-related decreased mobility, frailty, weakness, and sarcopenia are primary health concerns for older people within Wingecarribee.

Identified opportunities to increase focus on falls prevention

Recommendation	Evidence and Consultation Outputs
4.1: Increase visibility of existing falls prevention services, both public and private, within the region.	• The SWSLHD falls prevention program 'Stepping On' was identified as a good service accessible prior to COVID-19. However, clinicians were uncertain if the service was still operational. • Consultation participants were not well informed on the availability of local private falls prevention and group exercise- services.
4.2. Increase the availability of current falls prevention services to meet the demand of the region.	• Consultation findings emphasised that the availability of falls prevention services does not meet the demand of the region.
4.3. Increase community awareness of available falls prevention and group exercise programs locally, and support to access these services.	• Consultation participants recognised group exercise within community settings would have positive social and physical impacts on older people.
4.4. Greater availability of Allied Health professionals servicing RACFs to focus on falls prevention, mobility, and balance	• Evidence suggests the prevalence of sarcopenia is higher in older people residing within residential care.[18] This supports the identified need for increased access to allied health professionals in RACFs to support patients with deteriorating mobility, frailty, and sarcopenia.
4.5. Incorporate patient and carer education into GP delivery of care to drive good health outcomes	• Patient engagement with falls prevention and group exercise classes can be improved though strengthened GP approaches in management.

Recommendation 5: Build capacity across the aged care workforce in Wingecarribee

The aim of this recommendation is to develop a competent aged care workforce in which all clinical staff are working to the top of scope, thus improving health outcomes of the older population. This recommendation also focuses on enhancing the local aged care workforce to meet the need of the older

population in Wingecarribee. Addressing workforce competency gaps is critical for good health outcomes for older people residing within community and RACFs.

Identified training and education opportunities for RACFs

Recommendation	Evidence and Consultation Outputs
5.1.1: Build nursing capacity in RACFs to support improved patient outcomes.	• Aged care nurses are not bound by policy and are not mandated to perform skills that are not routinely practiced (or if not confident in), such as ear syringes. • Identified need, through consultation, for training in: ○ Ear syringing ○ Infection control ○ Wound care ○ Palliative Care ○ Specialised aged care ○ Dementia
5.1.2: Engage with relevant agency to develop specialised training modules	• Universities are graduating nurses without sufficient aged care and dementia knowledge.
5.1.4: Provide education to personal care staff to prevent escalation of conditions	• Common scenario in which patients with dementia become paranoid and GP needs to be aware of these changes. • Growing need for increased knowledge around patient skin and cognitive changes

Identified training and education opportunities for Primary Care workforce

Recommendation	Evidence and Consultation Outputs
5.2.1: Continue to deliver General Practice nurse targeted face-to-face CPD events in Wingecarribee	• CPD and webinar events facilitated by SWSPHN are valuable but there needs to be increased availability of face-to-face events to accommodate clinicians practicing in Southern Highlands.
5.2.2: Increase training opportunities and competency in nursing skills	• Identified need, through consultation, for training in: ○ Urinary Tract Infections (UTIs) ○ Wound management ○ Older persons' nutrition ○ Blood pressure management
5.2.3: Orientation session to encompass an introduction to nursing homes	• Quality of care provided by registrars is not always the same at usual GP • New GPs need enhanced education on providing care for older people within Aged Care • Providing additional support may increase willingness for new GPs to take on RACF patients, therefore reducing the burden on the workforce

5.2.4: Increase GP education and training to support patients within community and RACFs	• Need to increase GP awareness of patient's mental state to achieve good physical health
	• Some GPs don't have strong dementia understanding (e.g., incorrect terminology utilised)
	• Identified need, through consultation, for training in:
	• Provide of training and education:
	  ○ Patient emotional wellbeing
	  ○ Advanced Care Directives
	  ○ Diagnosing dementia and cognitive issues
	  ○ De-prescribing

Identified training and education opportunities to improve health outcomes of First Nations people

Recommendation	Evidence and Consultation Outputs
5.3.1: Continue to develop a culturally safe and competent workforce to improve the health outcomes of First Nations people living in Wingecarribee Shire.	• Health assessments should be performed by clinicians trained in trauma-informed approaches.[2] • Only 65.9% of the GP workforce (excluding GP registrars) in Wingecarribee have completed training.[14] Higher rates of completion will promote cultural responsiveness in General Practice and aged care.

Identified opportunities to enhance workforce

Recommendation	Evidence and Consultation Outputs
5.4.1: Establish access to aged care specialists	• Consultations participants emphasised the need for increased access to local private and public geriatricians • Access to a neuro-geriatrician would be beneficial in this region given the prevalence of dementia and complex needs.

Recommendation 6: Reduce avoidable ED presentations

This recommendation aims to reduce avoidable ED presentations by increasing awareness of alternative acute care pathways, increasing access to after-hours services, and the development of clear escalation pathways within RACFs.

Consultation results indicated that the primary reasons for high ED presentations at Bowral and District Hospital are attributed to poor acute GP accessibility, social and environmental factors, limited service accessibility, and low-acuity resident transfers. Outputs are outlined in Appendix C, table 6.

Identified opportunities to increase awareness of alternative acute care pathways

Recommendation	Evidence and Consultation Outputs
6.1: Increase patient awareness on alternative options to going to the ED	• Poor acute GP access was a primary reason identified for patient's self-presenting to ED.
6.2: Increase awareness of the GP After-Hours service among the Emergency Department staff, potentially reducing the burden on the ED in that after-hours period.	• There is a region need for increased patient awareness of alternative options, particularly in the after-hours period.
6.3: Increase GP awareness of appropriate ED referrals	• There is poor awareness of the after-hours service that low acuity patients can be directed to. • Need for increased collaboration between RACFs and SWSLHD to determine suitable ED presentations.

Identified opportunities to increase access to after-hour services

Recommendation	Evidence and Consultation Outputs
6.4: Increase utilisation of the GP After-Hours service.	• There is capacity for the service to be used more and act as a triage service to help sieve the ED.
6.5: Increase accessibility to imaging services	• There is a region need for increased access to after-hours x-ray and ultrasound services.

Identified opportunities to support patients ageing within community

Recommendation	Evidence and Consultation Outputs
6.6: Improve the built infrastructure to assist healthy ageing and maintain independence	• Prevalence of mechanical falls within community due to poor infrastructure and poor mobility • Trip hazards being a source of ED presentations (fractured wrists, fractured hips, and head trauma) • Older people with mobility issues, particularly 85–90-year-olds, have difficulty ambulating in

	the central regions of Wingecarribee (Bowral and Moss Vale) due to poor infrastructure connecting services.
6.7: Implement a medication dispensing service for GPs to refer patients to mitigate medication errors	• Poor medication management contributing to ED presentations. This is a particular concern for patients with dementia living within the community.

Identified opportunities for RACFs

Recommendation	Evidence and Consultation Outputs
6.8: Lower acuity patient and resident transfer education to be provided to GPs and RACFs.	• Typical drivers for hospital transfers are falls, chronic cardiovascular disease, and chronic respiratory disease. However, there are instances in which residents are transferred for low acuity conditions that could have been managed within the community. • RACFs have no governing bodies (up to in-house policies).
6.9: Increase geriatric outreach to RACFs	• There is currently not enough geriatric outreach provided to RACFs (e.g., IV antibiotics) to prevent low acuity resident transfers.
6.10: Improve quality of clinical handover and communication with patients, their carers, and RACFs	• Implementation of an aged care RN in ED has been beneficial.
6.11: Implement Nurse Practitioner and/ or Medical Student Clinics in RACFs to reduce burden on GPs and ED	• The primary reason for resident ED transfer is that RNs have reached their scope. Access to medical clinics at RACFs would increase community management of low-acuity issues.
6.12: ED GP phone number to be provided to all RACFs within Wingecarribee Shire to improve communication	• RACFs don't have communication with the right person to eliminate the need to present to ED.
6.13: Increase awareness of when to escalate issues to the RN to ensure conditions do not become chronic and prevent delayed care	• Personal care staff need further training to identify changes in patient (e.g., skin conditions) and know when to escalate.
6.14: Implement escalation processes within facilities	• Dementia recogonised as the condition requiring the most support in the after-hours period. • Contingency plans for behavioural and dementia management are imperative. Consultation participants highlighted the importance of exhausting all options before presenting to hospital as dementia patients don't do well in hospital. This can lead to drug intervention which RACFs work hard to avoid. • Establishment of condition specific flip chats (e.g., for UTIs, dementia, cellulitis) would be beneficial

Recommendation 7: Promotion on patient choice and education within the healthcare system

This recommendation aims to promote older people to own and become healthy participants of their health, focusing on patient choice and education.

Consultation participants indicated patient-centred care can be improved by enabling patient choice in their healthcare. Unfortunately, patient choice is neither accessible nor respected across the region. Adequate explanations must be provided to the patient and family when desired treatments can't be done, thus ensuring informed decision making.

Recommendation	Evidence and Consultation Outputs
7.1: Increase community education and training on Aged Care services	• Increased promotion of existing directories, such as Senior Directory (Wingecarribee Shire Council) and Dementia and Palliative Care Directory (SWSPHN).
7.2: Improve consumer openness to engage with the aged care system	• Increased education on dementia, Parkinson's, and carer stress is required. • There is an associated stigma and fear for older people transitioning into aged care. Positive promotion is important.
7.3: Upskill local pharmacies to provide consumers education about aged care services	• There is a great need for improve patient awareness of local services, both social and clinical, to for their emotional and physical health • Dissemination of information to older people can be improved • Information needs to be accessible in trusted local places (e.g., pharmacies)
7.4: Advocate for consumer choice within the aged care system	• There are enough services within the region to support the delivery of care to older people, however services are not trained adequately in ensuring patients make informed decisions. • Strengthened partnership between local RACFs and hospital. This pivotal- to ensure RACFs don't become a dumping ground for patients. • Importance in empowering services to promote resident QoL, even during palliation. • Early conversations around deterioration and dying are important for dignified death.
7.5: Support for consumers to effectively communicate Advanced Care Directives, do-not-resuscitate (DNR) orders, and wishes to not go to hospital.	• Commencing difficult conversations with community members is important to ensure choice is valued at end-of-life. • Consultation feedback highlighted deterioration planning can be difficult but is imperative for patient choice and relieves carer/guardian burden.
7.6: Increase focus on First Nation Men's Health	• First Nation Men's health was an identified need through consultation.

7.7: Improve health promotion campaign targeted at First Nations people	• Increased prevention and education around diabetes and anti-smoking was an identified need through consultation.

References

1. Australian Bureau of Statistics. 2021 Census All persons QuickStats- Wingecarribee. [Online] [Cited: 01 September 2023.] https://www.abs.gov.au/census/find-census-data/quickstats/2021/LGA18350.
2. Commonwealth of Australia. Royal Commission into Aged Care Quality and Safety: Final Report Executive Summary. March 2021. Available at: https://agedcare.royalcommission.gov.au/publications/final-report [published 1 March 2021].
3. Australian Institute of Health and Welfare (AIHW). *GEN data: providers, services, and places in aged care 2022.*
4. SWSPHN. Needs Assessment (2022). Needs assessment reporting template (swsphn.com.au).
5. Australian Institute of Health and Welfare. Older Australians [Internet]. Canberra: Australian Institute of Health and Welfare, 2023 [cited 2023 Oct. 5]. Available from: https://www.aihw.gov.au/reports/older-people/older-australians.
6. AIHW National Aged Care Data Clearinghouse
7. Australian Institute of Health and Welfare (AIHW). Home care packages program data report 1 Jan-31 March 2023. September 2023 [Available from: Home Care Packages Program Data Report (gen-agedcaredata.gov.au)].
8. Austin A, Le TH, Moss T, Wark S. Actual and projected gaps in the provision of residential aged care in New South Wales, Australia. Australian health review: a publication of the Australian Hospital Association. 2022;46(4):398-404.
9. Australian Institute of Health and Welfare. Medicare-subsidised GP, allied health and specialist health care across local areas: 2021–22 [Internet]. Canberra: Australian Institute of Health and Welfare, 2022 [cited 2023 Oct. 20]. Available from: https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-gp-allied-health-and-specialis
10. Australian Institute of Health and Welfare. Use of emergency departments for lower urgency care: 2015–16 to 2018–19 [Internet]. Canberra: Australian Institute of Health and Welfare, 2020 [cited 2023 Oct. 10]. Available from: https://www.aihw.gov.au/reports/primary-health-care/use-of-ed-for-lower-urgency-care-2018-19
11. Department of Health. Health Insurance Act 1973 – Approved Medical Deputising Service Program Guidelines. Canberra; 2018.
12. Australian Commission on Safety and Quality in Health Care. Safety issues at Transitions of Care: Consultation report on pain points relating to clinical information systems. December 2017. Available at: Safety-issues-at-transitions-of-care-consultation-report.pdf (safetyandquality.gov.au) [published December 2017].
13. Burgess A, van Diggele C, Roberts C, Mellis C. Teaching clinical handover with ISBAR. BMC medical education. 2020 Dec;20(2):1-8.
14. SWSPHN (2023). *GP workforce data (Qlik).*

Appendix A

Table 4. Consultation outputs for barriers impacting delivery of care to older people in Wingecarribee

Barriers	GPs	Other Providers
Access to Services	• Difficult to OT assessments for driving assessments when GPs have reservations on a patient's driving. • Understaffing in nursing and palliative care • Inadequate access to physical maintenance programs and falls prevention clinic • Home visits are difficult on short notice, impacting access to acute care • GPs receiving new referrals for palliation this is a massive gap in care • Need better access to medication reviews in collaboration with local chemists	• Increased access to AH in RACFs needed to reduce functional decline and hospital re-presentations • Access to community resources in RACFS: o Palliative care resourcing in residential care- requiring own palliative care nurses as community nursing are at capacity. o HITH services- IV antibiotics and cannulation o Wound care in RACFs can be difficult to access. Private providers want to do telehealth which is not the preference of some facilities. • Public dental facilities • Increased number of patients moving directly into facilities creating bed blocking. • Community Transport uses different funding models for RACF residents, therefore needing to use Patient Transport Systems (increased costs). Patients being denied transportation due to inflexible criteria is a significant barrier. • Often care plans provided request services, particularly AH, which are unable to be provided • Inability to access mental health services if diagnosis of dementia • There is low incidence of post-acute care rehabilitation programs in the region's leading to hospital re-presentation and poor outcome. • Increased utilisation and availability of Allied Health in RACFs would reduce avoidable hospital presentations.
Advocacy and Support		• Residents are sometimes heavily medicated upon transfer from hospital, fragmenting patient care. o Advocacy for medications to be utilised as a last resort. o RACFS work hard on non-drug interventions. Needing support from other aged care services. There is a significant gap in shared understanding. • There are cultural issues in RACFs and there is a need for advocacy for older people • Inadequate checks and initial screening for delirium performed before residents transition into RACFs, leading to adverse events

		• Different quality standards between primary and aged care. RACFs have a legal obligation to advocate for residents but are not supported by other healthcare services
Aged Care Assessment Test (ACAT)	• Delays in ACAT assessments further delay patient access to services • GPs predict early deterioration and need for care within a few months (or at patient request) but can't pre-approve patients for respite. Results in significant delays when required.	
Aged Care Facility Visits	• Difficulties navigating facilities and locating residents • Mandatory RATs are time imposing • Making appointments to see residents, especially in the after-hours period • Different software platforms • Lack of staff training is difficult and requires a lot of GP clarification • Poor viability (economic and physical) of RACF visits, particularly multi-facility attendance • Some GPs not maintaining care for patients transitioning into aged care	
Awareness of Services	• There is a lack of clarity in the aged care system. Would be beneficial for GPs to receive education on how nursing homes work. • Need for increased awareness of available services for patients to be referred, including SWSPHN services • Increased visibility of existing clinical and support services within region	

Discharge Planning	• Inconsistencies in receiving electronic discharge summaries
	• Poor communication at transfer of care
	• Discharge process is multidisciplinary and there is a need for more AH in a timely manner
		• Some facilities operating without discharge letters (requires access to MHR which is difficult)
		• Residents transferred back to facilities with paper medication charts and scripts
		• Patients discharged from hospital without established community care. Patients presenting to General Practice for community health referrals. Potential issues:
		  ○ Patients don't present immediately to primary care which can lead to wound breakdown
		  ○ Financial and logistical barriers for patients to access primary care
		• Need better communication between discharge planner and RACF upon resident transfer
		• Patients not engaged with services when discharged from hospital. There would be benefit for older people, particularly those without adequate supports, to have services organised during admission.

		• Inadequate transition between tertiary and primary care. • Residents returned to RACFs have inadequate follow-up and plans are not patient- centred, lacked collaboration with the resident and carer. • Facilities not always notified of resident transfer back to facility. There are rare instances of patients being returned without notice.
Inadequate Communication	• Triple I not always responsive enough • Not enough updates to GPs when patients are admitted to hospital • Delays and inefficiencies in communication with Hospital Pathology: ○ GPs needs to request through records or pathology department, even with GP referrals • Delays in receiving ward discharge letters • Inadequate communication between GP and Palliative Care following referral	• Disintegration of information • Miscommunication of differing quality standards between primary and aged care

Limited Interoperability in RACFs	• Telehealth in RACFs can be a barrier due to inadequate internet and telehealth services.
	• Broadband/connectivity issues (particularly in a patient's room
	• Physical access to Aged Care visits could be improved
	• General Practice and RACH use standalone systems
	• Different systems impact communication efficiency
	• Systems available are not clinically good
	• Doubling handling between General Practice and RACH systems
	• Paper notes can be cumbersome for visiting GPs
		• Paper medication charts are a risk
		• RACF has poor integration:
		  ○ My Health Record (MHR) is poorly utilised
		  ○ Information within facility does not integrate with MHR
		• No common platform available in Aged Care
		• Disintegration of information leading to communication breakdown
		• Inadequate technical support offered to RACFs

Limited Interoperability in Community	• Telehealth is not feasible in the long-term
	• Telehealth is a barrier as GPs are not physically seeing the patient
	• ED discharge summaries:
	  ○ Inconsistent receival
	  ○ Some issues with GP name (instances of previous GP addressed)	

Appendix B

Tabe 5. Consultation outputs for barriers to accessing health care for older people in Wingecarribee

Barriers	Consultation Outputs
Access to Services	• Lack of home assessments to support healthy ageing at home
Environmental	• Poor footpath infrastructure impacting those with mobility and balance issues • Poor wheelchair accessibility to some facilities
Logistical	• Difficulty accessing public transport (e.g., trains and buses) in some areas across the region • Distance to some services can be significant given the wide geographical spread of the region • Community Transport is the primary mode in region but requires multiple contacts • Some patients are not physically able to travel long distances to access services • Transport is a considerable concern to patients in the Southern Villages • Lack of transport hinders community involvement
Financial	• Need more publicly available specialists and services • Expensive transportation options, particularly to access specialists only available out of the region • Limitations in Enhanced Primary Care Plans (EPC)- difficult when patients require multiple Allied Health services • Expensive specialists ○ Patients may stop treatments (e.g., medications) to cover costs of seeing specialists
Gap in Acute GP Care	• Lack of GPs within the region • Difficulty making same day appointments with usual GP ○ Patients making appointments with a bulk-billing GP (fragments patient care)

Navigation of the Aged Care System	• My Aged Care navigation is difficult.
	  ○ Patients provided with a list of codes and left to navigate themselves which can cause frustration and ultimately lead to patients not accessing services.
	  ○ Issue escalates when patients do not have engaged families to support
	• Patients opting for self-managed home care services require more education

Technological	• Lack of access to smart phones or computers • Poor computer literacy • Older patients prefer consults and reviews face-to-face, particularly those hard of hearing • eScripts can be confusing and can cause delays in access
Lack of Social Supports	• Lack of social services available
Stigma	• Associated stigma when accessing services targeted for older people. • Aboriginal and Torress Strait Islander Elders experiencing stigma around access to continence services and health literacy
Discharge Process	• Poor continuity of care post discharge from hospital. Some patients experience delays in access to services as services are not organised in hospital
Delayed Access to Home Care Services	• Long waitlists for personal care in the home- this service is imperative for maintaining independence. • Agencies being short staffed- patients experiencing delayed or no access to some services • Delayed access increases the patient's risk

Appendix C

Table 6. Consultation outputs for the reasons older people are presenting to ED at Bowral and District Hospital

Acute GP Accessibility	Social and Environmental Factors	Service Accessibility	RACF Presentations
Patients unable to see regular GP in a timely manner for pressing issue	Loneliness	One hospital in Wingecarribee	Limited resources and skills
Decreased availability of home visits	Isolation- stoic mentally leading to delayed access to primary care	Lack of ultrasound and x-ray services in AH	No communication with right person to eliminate the need to present to ED
Limited or no GP access on weekends	Deficiencies in home supports, community-based systems, and family	Lack of GP and chemist AH access	Lack of Geriatric outreach
Anxiety and fear during AH	Patient medication errors	Carers seeking respite	Low incidence of post-acute rehabilitation programs
Lack of bulk billing GPs	Previous positive experiences	Lack of Hospital in the home (HITH)	Poor utilisation of Allied Health
Homelessness	Mechanical falls within community	Lack of AH support for behavioural and dementia management	No governing bodies (up to in-house policies)
Lack of awareness of GP AH service	Trip hazards in community	Long ambulance wait times (increased self-presentations)	Need for HITH models

Appendix D

Recommendations excluded for being outside the scope of this report

Recommendation	Evidence
Systematic reform of aged care software	• There is no standard aged care platform which enables integration with other systems. Government endorsement would be required for an interactive aged care system with integration with NDIS, Medicare, and relevant clinical systems
Increase Allied Health funding to improve accessibility within RACFs	• Multidisciplinary care is imperative for care coordination. Feedback highlighted there is inadequate provision of Allied Health services within RACFs to achieve this. Addressing systemic funding barriers to make it viable for Allied Health providers to deliver within RACFs.
Ease patient transition into homecare	• Establishment of an aged care liaison within the community to support patients who are new to home care. Participating GPs identified patient resistance within the home a barrier service delivery. Patients require addition supports, especially with medication monitoring and compliance. This would be imperative to ensure patients can maintain their independence in their own home and avoid premature institutionalisation

Address aged gap workforce deficiencies	• Consultation participants identified many opportunities to support the current aged care workforce:
	  ○ Better pay and incentives
	  ○ Housing supports
	  ○ Better government support on recruitment pathways (internal and overseas recruitment)

Address financial barriers to access Allied Health and Specialists	• Insufficient EPC visits for older people, especially for patients seeing multiple professionals