Western Victoria Primary Health Network

Aged Care Scoping: Final Report

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1. Executive Summary

The Western Victoria Primary Health Network (PHN) covers 21 local government areas across and surrounding the major regional townships of Ballarat and Geelong to the east and Warrnambool and Horsham to the west. In 2018, 617,931 people resided in the catchment, with 120,892 – or just under 20 per cent – aged 65 years or older (Australian Bureau of Statistics, 2018).

Western Victoria Primary Care Network (PHN) appointed Everybody's Business to undertake an area-specific scoping of the aged care service system. This included two intersecting parts:

- An environmental scan to document existing services supporting older people. This included providers of residential care, community and health care, assessment and other funded supports for older people.
- Consultations with a range of people who interface with the system supporting older people, including community, residential and health care providers and consumers and carers.

The intention behind this investigation was to gain an overview of the strengths and issues with the current local aged care system, as well as gather ideas and suggestions about what could support people to age well in place.

The outcomes of this scoping exercise will be used to:

- identify priority care needs;
- improve access through government funding; and
- co design localised solutions to improve health care systems across western Victoria.

A variety of methods were utilised to gather the information and opinions of providers and consumers, including a survey, face to face consultations and telephone discussions. Provider and consumer consultations were conducted separately. Online search engines (including My Aged Care, Aged Care Guide and the Victorian Department of Health and Human Services) were used to map where organisations are based and what services they deliver.

Overall, 225 contributions were made to this project, with 72 being from consumers, carers and family members (32%); 9 from GPs (4%); and, 144 (64%) from service providers. There were significant consistencies in participants' experiences when interfacing with the aged care sector, whether as consumers, carers or providers. There was also a noticeable uniformity across the sub regions, with some local variation regarding the availability of allied health, GPs and psychology supports.

Main findings

Access and navigation

- Access and navigation are currently causing considerable challenges.

- People from culturally and linguistically diverse (CALD) and Aboriginal and Torres Strait Islander backgrounds generally require additional support to access and take up services.
- The introduction of My Aged Care as the central point of information and access is regarded as unsuitable for the current cohort of older people.
- Up to one third of consumers who are directed to My Aged Care do not follow through with it, as they see it is as too hard.
- Access to GPs, long waiting times for a home care packages, difficulty accessing transport and social isolation were the top issues raised by consumers, carers and providers.
- The long waiting times for some services had people questioning whether the system can deliver on what it says it can and adequately support them to stay safely in their own homes.
- Generally, GPs report that the support available for older people to stay at home is inadequate.

Mental health

- Access to mental health services and supports were seen as inadequate for older people, both in the community and in residential care.
- The number of older people at risk of social isolation came up repeatedly.

Home Care Packages

- There are 62 Home Care Package (HCP) providers who nominate as supplying services in the region, with approximately 18 of these stating they cover the whole region.
- The long wait for HCPs (especially Levels 3 and 4) – resulting in people being left for extensive periods of time with inadequate supports – was identified as being of high importance to consumers, GPs and providers.
- Concerns were also raised about safety risks, and in particular how some people were being forced into residential care prematurely and/or against their preference to stay at home.
- The costs attached to HCPs meant some people had to enter residential care, against their preference to stay at home.
- Being able to choose your own provider and navigate through all the information was too overwhelming for some.

Health services

- There are 26 health services across western Victoria.
- Both access to health professionals and services from the acute and sub-acute programs were reported as good.

Commonwealth Home Support Program

- The range of services available under the Commonwealth Home Support Program (CHSP) and access to allied health were reported as mixed.
- Two other CHSP service types that are clearly unavailable for most people in western Victoria are gardening and goods and equipment.

Residential aged care

- Across the entire catchment, there are 122 residential aged care facilities providing 7453 beds, with 81 012 people aged 70 years and over.

- The average bed per 1000 to people aged over 70 across the PHN catchment is 90.5, above the Commonwealth target.
- The increased reliance on personal care assistants in residential aged care facilities and less registered nurses was seen as a significant concern.

General Practitioners

- Attracting younger GPs to take up patients in residential care is proving challenging and concerning, as the current range of GPs doing this work are typically older.
- Working with patients in residential care is not as financially attractive for GPs as working in a surgery or clinic.
- Consumers talked highly of the support they get from their GPs.
- Availability of GPs in the smaller, more rural areas is reported as challenging.

Workforce

- Every provider talked about recruitment, retention and shortages of well qualified and skilled staff.
- The majority of consumers reported that staff understood the needs of older people (71%); that they were confident in their competency (75%) and, that they treated older people with respect (86%).
- There has been little uptake of assistive technology and eHealth, yet these innovations could be a useful way to target a workforce when a shortage is anticipated.

Service coordination

- Local networks, opportunities to share knowledge and discuss individuals were seen as good practice that help reduce gaps between services and increase coordination.
- The My Aged Care system has reportedly made coordination amongst providers more challenging.
- Providers felt that a more siloed approach was evolving with the introduction of the reforms and a competitive marketplace.
- Healthy ageing could be an ideal platform to bring community and providers together to co design ways to support older, local people.

Viability

- Some providers were bothered about their viability, especially given the higher costs involved in delivering services in smaller, more rural communities.

Summary of recommendations

- That additional investment is considered to provide face to face support to older people in accessing and navigating the system, paying particular attention to at risk groups.
- That social isolation be tackled by trialling and implementing strategies to strengthen social inclusion across the community.
- Multi-disciplinary mental health supports should be made more readily available, particularly for people living in residential care.

- That the PHN leads advocacy around the gaps and impediments in service provision. Areas could include: transport; goods and equipment; rural subsidies for travel costs; increased availability of home care packages; staffing ratios in residential care; better Medicare rebates for GPs providing services to people in residential care; and adequate unit cost funding.
- That consideration be given to after hour service options.
- There should be further development of HealthPathways to assist GPs to navigate community options for older people.
- That a local workforce strategy be developed to strengthen recruitment and retention of all parts of the workforce across the catchment.
- That opportunities to collaborate around locally focused projects and strategies aimed at strengthening healthy ageing, clinical practice and innovation be provided and supported.
- That providers be supported to explore new models of service delivery that are more sustainable, flexible and consumer focused.
- That support be given to providers of services to high risk or vulnerable groups to better understand and consider their business needs.
- That healthy ageing be given a stronger and more prominent platform across service provision in the Western Victorian PHN.
- Explore ways that assistive technology and eHealth could complement service delivery, particularly in more rural communities.
- Provide support to develop innovative models of integrated care.

2. Introduction

The Western Victoria PHN covers 21 local government areas across and surrounding the major regional townships of Ballarat and Geelong to the east and Warrnambool and Horsham to the west. The PHN works with health service providers, users and communities to develop and improve access to the right primary health services, in the right place, at the right time.

In 2018, 617,931 people resided in the catchment, with 120,892 – or just under 20 percent – aged 65 years or older (Australian Bureau of Statistics, 2019). The Borough of Queenscliffe has the highest percentage of people aged over 65 years at 40.5% (n=1156) and the Golden Plains Shire has the lowest at 13.4% (or 2,914 people).

Local government area	**Total population**	**Percentage aged over 64**	**Total number aged over 64**
Ararat Rural	11 600	23.1	2 675
Borough of Queenscliffe	2 853	40.5	1 156
Central Goldfields Shire	12 995	28.2	3 667
City of Ballarat	101 686	17.3	17 581
City of Greater Geelong	233 429	18.6	43 363
Colac Otway	20 872	21.7	4 554
Corangamite Shire	16 051	22.7	3 644
Glenelg Shire	19 557	22.2	4 339
Golden Plains Shire	21 688	13.4	2 914
Hepburn Shire	15 330	24.5	3 761
Hindmarsh Shire	5 721	26.9	1 538
Horsham Rural City	19 642	20.1	3 957
Moorabool Shire	31 818	15.7	4 980
Moyne Shire	16 495	18.6	3 069
Northern Grampians Shire	11 439	24.9	2 843
Pyrenees Shire	7 238	24.7	1 788
Southern Grampians	15 944	23.4	3 731
Surf Coast Shire	29 397	17.5	5 149
Warrnambool City	33 655	18.9	6 355
West Wimmera Shire	3 093	24.7	964
Yarriambiack Shire	6 674	27.4	1 827

Like much of Australia, as the ageing population increases, the area that Western Victoria PHN covers is expected to face increasing pressures on services supporting older people. In fact, a higher proportion of the population in this region is currently aged 65 years or older, compared to Victorian and national statistics. It is also worth noting that this number is projected to increase in the next decade across most of the area covered by the Western Victoria PHN.

Not only is a greater proportion of the population ageing, but people are also living longer, often with chronic health and/or disabilities. This demographic shift is placing an ever-increasing demand on primary health care and aged care-specific services. These include those provided by medical practitioners, specialists, other health professionals, hospitals and clinics, respite and support services, transition services and community-based and residential aged care.

Older people are increasingly remaining in their homes and using community services to support them. Data from the Australian Institute of Health and Welfare (2015) shows that between 2002-03 and 2010-11, the proportion of older people in residential aged care decreased. At the same time, the proportion of the older population using any of the community-based services increased.

As demonstrated in Figure One, Australia currently has a multi-tiered approach to aged care. The most resource intensive and highest level of support is provided by residential aged care facilities (RACFs) which accommodate seven percent of Australia's older population (AIHW, 2019b). The pyramid base illustrates older people living independently without any formal supports, which comprise the majority of older Australians at 71 percent (AIHW, 2019b). The middle section depicts community-based programs such as the entry level Commonwealth Home Support Program (CHSP) and more intensive Home Care Packages (HCP). Both of these programs provide a range of services aimed to support people to age well in their own homes, accounting for 22 percent of older Australians (AIHW, 2019b).

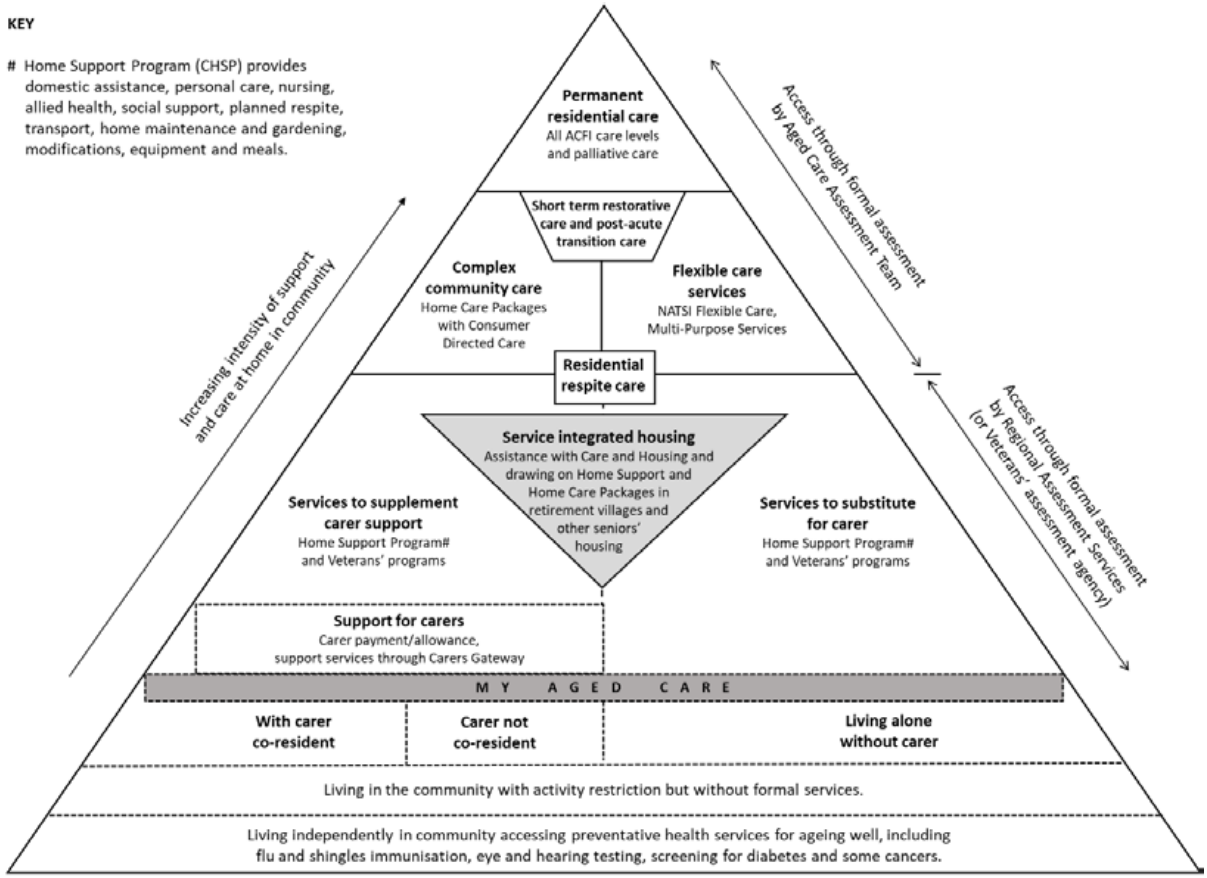
The CHSP is intended to provide ongoing or short-term care and support services, such as help with housework, personal care, meals and food preparation, transport, shopping, allied health, social support and planned respite.

HCP provide a more structured and comprehensive package of home-based care support, provided over four levels of care:

- Level 1—to support people with basic care needs;
- Level 2—to support people with low level care needs;
- Level 3—to support people with intermediate care needs; and
- Level 4—to support people with high care needs.

Under a HCP, a range of personal care, support services, clinical services and other services are tailored to meet the assessed needs of the person.

Figure One: Type and intensity of aged care supports



(Anna Howe, as adapted by The Royal Commission into Aged Care Quality and Safety 2019, p.8)

Additionally, as shown in the diagram, MAC acts as the gateway to the formal aged care service system for all older people seeking support. This is in the process of being supplemented by the Carers Gateway (to be introduced in late 2019), which will provide a designated pathway that offers a range of packages and supports to meet carers' needs.

In the Western Victoria PHN *2018 Needs Assessment*, two specific issues for older people were identified:

- a higher proportion of people rated their access to aged care services as 'poor' compared to other regional parts of Victoria; and,
- there are fewer residential care places per 1000 people than the rest of Victoria.

The federal government has introduced key reforms that are impacting both the range and delivery of community and residential services for older people. These include a greater emphasis on consumer control and choice and changing some service types from block funding to funding per service user. Alongside this, it is expected that there will be increased levels of competition in the marketplace, offering older people greater choice about services and how these will be delivered (although whether this occurs beyond the major townships is yet to be

seen). This includes the full range of support from community services, packaged care and residential care options.

These reforms are also developing different pathways for older people accessing supports, primarily through the implementation of MAC and the Carer Gateway as centralised entry points and sources of information. These programs will be complemented by the re-development of assessment services across the country for older people, planned for 2020.

Sitting alongside the reforms is the Royal Commission into Aged Care Quality and Safety. The Commission has been in progress since October 2018, and an interim report was released in November 2019. The final report is expected later in 2020. As the Commission is considering both current and future models of care, it is likely to impact on providers in the Western Victoria PHN catchment.

The reforms and outcomes of the Royal Commission are challenging the business models of existing service providers, the way services are to be delivered and the way people both access and receive support from services.

The range of reforms – and the growing demand on services and health supports – provide an ideal opportunity to consult with a range of key stakeholders to better understand what is working, what is proving challenging and also identify ideas for how things could work better in the aged care environment in the Western Victoria PHN catchment.

The outcomes of this scoping exercise will be used to:

- identify priority care needs;
- improve access through government funding; and
- co design localised solutions to improve health care systems across western Victoria.

2.1 Project aims and objectives

Western Victoria PHN appointed Everybody's Business to undertake an area-specific scoping of the aged care service system. This included two intersecting parts:

- An environmental scan to document existing services supporting older people. This included providers of residential care, community and health care, assessment and other funded supports for older people.
- Consultations with a range of people who interface with the system supporting older people, including community, residential and health care providers and consumers and carers.

The intention behind this investigation was to gain an overview of the strengths and issues with the current local aged care system, as well as gather ideas and suggestions about what could support people to age well in place.

The objectives include:

- providing key stakeholders with a range of opportunities to share their views and ideas;

- gaining an understanding of how providers predict they will proceed with the aged care reforms;
- understanding the key factors that prevent and promote ageing well in place, such as socioeconomic status and rurality; and
- identifying areas that should be prioritised for development and/or advocacy.

More specifically, we were seeking to find out:

- What is working for people who are accessing aged care supports?
- What are the current challenges?
- What are the perceived future challenges?
- What are the suggestions and ideas for how we can better assist older people to remain well in their communities?
- What are the priorities?

3. Methodology

A variety of methods were utilised to gather the information and opinions of providers and consumers across the western district of Victoria. Provider and consumer consultations were conducted separately.

Our team undertook a staged approach to build a profile and understanding. The stages included:

a) An environmental scan of existing services for aged care in the region.
b) Initial consultations with a select range of stakeholders to understand:
   - where existing networks and opportunities to engage exist across the region; and
   - identification of high-level challenges and issues with the current aged care system.
c) Development of a consultation plan.
d) Development of invitations and marketing materials for all stakeholders.
e) Distribution of marketing materials and the background paper via Western Victoria PHN and other identified channels.
f) Establishing appointments with identified networks and alliances.
g) Establishing an online booking system for scheduled consultation sessions.
h) Coordinating consultation participants, venues and plans.
i) Delivering consultations.
j) Completing the analysis.

At all times, we endeavoured to incorporate the following key principles that are essential to successful engagement, including:

- access to enable both individuals and organisations to engage with us on their unique issues and ideas;
- interactive, transparent structures for engaging that focused on outcomes and which always had a clear purpose and scope;
- timely, clear communication about emerging issues that enabled opportunities for feedback;
- sharing of the outcomes from engagement;
- accessible and inclusive processes that enabled both participation and awareness through a range of channels and methods;
- access to information that enabled better stakeholder awareness and contributions; and
- a thoughtful and efficient approach to time commitments.

3.1 Providers

Four methods were used to engage with providers across the region:

- formal consultation sessions;
- network or group consultations;
- individual consultations; and
- a survey.

Providers were sent a series of emails and telephone contact was made with a selection of key stakeholders. These contacts were obtained from both the consultants' and the PHN's mailing lists.

Registration for the workshops was lower than anticipated, with the following reasons cited by providers:

- Consultation fatigue: many providers have been involved in a series of workshops, the majority of which were aimed at responding to the Royal Commission into Aged Care Quality and Safety, the introduction of the new Aged Care Standards and the aged care reforms;
- "It has all been said already": some providers referred us to existing submissions to the Royal Commission they took part in as their contribution to this project;
- Confusion: some providers were unsure about the role of the PHN and how it relates to aged care; and
- The timing of the project and the short timeframes.

3.1.1 Formal consultation sessions

Originally, eight formal consultation sessions targeting assessment, RACFs, HCP, CHSP and health providers were planned, with two made available across each of the four sub-regions: Ballarat and Maryborough; Geelong and Colac; Warrnambool and Hamilton; and, Horsham and Stawell. The sessions planned for Horsham and Stawell were cancelled as no one registered to participate.

At these sessions, participants had two primary opportunities to contribute their knowledge and opinions. The first part of the session required participants to add their written comments to five topics as follows:

1. Coordination of care between services
2. Gaps in the system
3. Workforce
4. MAC
5. Sustainability

The second part of the session involved a semi-structured discussion where participants shared their opinions on issues and priorities going forward. The discussion was built on topics identified in part one and used by the facilitator to prompt areas for discussion, as needed.

Overall, 43 people participated in the formal consultation sessions and represented providers of the Regional Assessment Services (n=1), Aged Care Assessment Services (n=1), RACFs (n=9), CHSP (including Aboriginal and Torres Strait Islander controlled organisations and those providing multicultural support) [n=14], HCP (n=4), health services (both large and small) [n=10] and four people from a mixture of workplaces, including Primary Care Partnerships and medical

practices. The workshop participants represented the sub regions as follows: 15 from the Geelong area; eight from the Warrnambool area; and 20 from the Ballarat area.

3.1.2 Network or group consultations

The consultants attended four network or existing group consultations:

- A general practitioners' meeting in Geelong (n=1);
- A Regional Integrated Council in Ballarat (n=12);
- A providers' network meeting covering the Grampians and Ballarat area, facilitated by the local Aged Care Assessment team (n=21); and
- A consultation with Barwon Health (n=2).

The consultants contacted many other networks across the region, but it was difficult to line up with their existing meetings and find time on their agendas.

All network consultations were conducted as semi-structured interviews focusing on the project objectives and issues as identified by each group. In total, 36 people contributed to the project in this way.

3.1.3 Individual consultations

An invitation was extended to any participants who were unable to attend one of the formal consultation sessions. Again, a semi-structured interview approach was taken with each participant. Overall, four Primary Care Partnerships, three local councils, four general practitioners, one health service, four RACF providers, one Aboriginal and Torres Strait Islander specific organisation, one multicultural provider and one Sector Development Team contributed, totalling 19 participants. The number of participants worked in the following sub regions: seven in the Geelong area; three in the Warrnambool area; five in the Horsham area; and four in the Ballarat area.

3.1.4 Survey

The final strategy used was an online survey distributed via both the consultants' and the PHN's contact lists. The survey contained a series of positive statements and asked people to state whether they agreed or disagreed, using a five point scale. Secondly, the survey asked people to select three priority areas from a list. Thirdly, participants were given an opportunity to add any further thoughts.

Fifty-six surveys were completed by providers: three general practitioners; 14 health services; 20 CHSP providers; four HCP providers; eight RACF providers; two assessment services; and five who identified as 'other'. Of all the providers: 10 work in the Horsham sub region; 17 in the Ballarat sub region; 12 in the Warrnambool sub region; and 17 in the Geelong sub regions.

3.2 Consumer, carer and community

Initially, a similar approach was taken with recruiting consumers, carers and community members, although this achieved a limited reach. To enhance the breadth of consultation, two other methods were used:

1. Engaging community groups such as senior citizens' groups and bowling clubs.
2. Requesting support from providers that host groups of consumers or carers.

Recent consultations by the Council of the Ageing to compile a submission to the Royal Commission was cited as one of the reasons why many consumers did not take up the opportunity to contribute directly to this project.

The main focus on engagement with older people and their carers or family included:

- understanding their experience of the current aged care service system;
- identifying enablers and barriers to accessing support;
- identifying gaps in the system and the impact of these; and
- identifying alternative models of support.

3.2.1 Formal consultation sessions

There was very little uptake of this approach, with only two of the four planned consumer sessions going ahead (one in Warrnambool and one in Ballarat), with a total of only two attendees. A semi-structured interview approach was used – reflective of the project objectives – to understand the consumer/carer experience.

3.2.2 Attendance at community groups

Three separate groups were consulted, including:

- 22 people from a Senior Citizens group in Lara;
- 20 members of a Geelong-based multicultural social support group, attended by an interpreter for the Italian speaking group and a language-specific consultant for the Spanish group; and
- the Senior Citizen of the Year celebrations in Goroke, attended by approximately 60 older people from around the West Wimmera district.

3.2.3 Survey

Twenty-eight surveys were completed by consumers, carers and community members: 20 by older people; four by carers of an older person; and four by family members of an older person. The consultants assisted 16 of the 20 older people to complete the survey by providing a paper-based version and transferring their responses to the online portal. The majority of respondents

were from the Horsham area (n=18). The same survey was used with both providers and consumers, carers and community members.

3.3 Service mapping

Online search engines (including MAC, Aged Care Guide and the Victorian Department of Health and Human Services) were used to map where organisations are based and what services they deliver. Where necessary, this information was checked against the organisation's website. The mapping exercise covered RACFs, HCP, CHSP, health services and assessment services.

Once the mapping was complete it was verified at the planned consultations sessions, through submissions to an online platform and by asking providers to check the mapping against their local knowledge.

4. Findings

The following data represents results taken from both verbal consultations and the online survey. It has been broken down in four distinct sections:

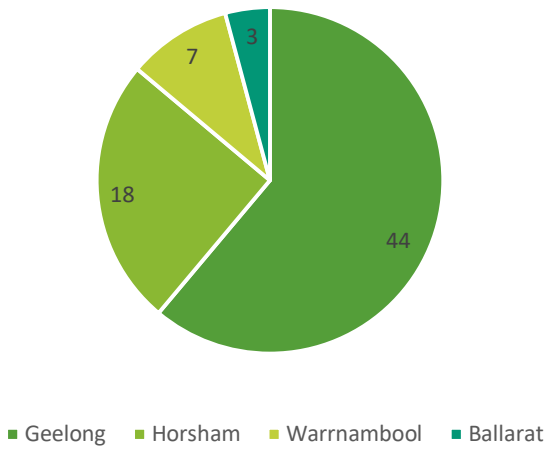
1. Consumers, carers and family
2. General practitioners
3. Service providers
4. What the service mapping showed.

All data for the first two groups was collected separately and thus was easier to report accordingly. The third group was a combination of health providers, home care package providers, residential aged care facility providers and CHSP providers. Where possible, some data in this latter group has been reported for each distinct group, although information gathered at the formal consultations involved a mixture of these providers and thus has also been reported collectively.

4.1 Consumers, carers and family

In total, 72 consumers, carers and family members contributed to the project either by participating in a consultation (n=44) or through submission to the online survey (n=28). The majority (n= 44) live in the Geelong sub region; with 18 residing in the Horsham sub region, seven in the Warrnambool sub region and only three in the Ballarat sub region. Twenty of the contributors were from a CALD background.

Figure Two: Number of consumer, carer and family members per sub region



4.1.1 Access

All consumers, carers and family members stated how hard it was to access good information about services when needed. Only those consumers who had already entered the system were aware of MAC and how it acted as the entry point. Most of those who had not yet taken up services stated they would go to their GP for advice and support to connect. *"Without the help of our family we would not be able to access any service, we do not know how to use the computer."*

Many reacted negatively to the idea of a *"faceless telephone service"* as the means of accessing information, preferring face to face contact. One person said, *"I don't know what's available, what to ask for or what we are allowed to ask for."*

Interestingly, the majority of people who completed the survey thought that information about services was easy to find and understand. Most of the people who responded positively to this resided in a more rural region and felt confident about their interaction with providers in their area. They also felt like services were easy to access and were timely.

Family members indicated that the way MAC currently operates demands a lot from them, especially when they are referring on behalf of a family member. Carers and families also noted that once a person is referred, MAC contact the person, who then declines the services as they don't understand who is calling, forget why they have been referred or are cautious of random telephone calls that come up with no caller identification. MAC also ask for a lot of personal information that people are hesitant to hand over in light of the numerous scams operating.

Eligibility and entitlement came up as a theme in one group consultation, with people stating the more you had worked and saved the less you seemed to get. People were unclear about how decisions were made and wanted more transparent information. One person claimed that *"eligibility was dependent on the assessor."*

Those that have had services for some time claimed that the collaboration between providers had declined. One stated that the reforms had *"thrown the baby out with the bath water"*, with many of the strengths in the system disappearing.

Those consumers who are internet users said that it was still hard to find out information about services. They claimed

Three people from a CALD background reported having no family or people to support them. This added extra stress, as both communicating in English and having to discuss their needs via telephone contact with MAC was challenging. One reported that their health had deteriorated significantly, and they did not understand how – or who – to follow up with whilst waiting for their home care package. They felt lost in the system.

that, when searching for MAC, a range of providers that *"look like they are the MAC website"* come up first on a search. People were unclear if they had got to the MAC website and whether these providers were offering independent advice, or if they were instead trying to capture them before they went to another provider.

4.1.2 Availability

The long waiting times for some services, including HCPs, had people questioning whether the system can deliver on what it says it can and adequately support them to stay safely in their own homes. People talked about their loved ones having to enter a RACF, as they could no longer manage at home without the supports that they were assessed for.

"Our health deteriorates rapidly at this age and the government or system seems to make things harder and many people end up living in a facility or dying before we can get access to services to live well at home."

"Slowly assessment services get to you and then you get told you are eligible but have to wait for a package. It makes no sense; it should just be available."

Those who participated in the consultations and the survey were generally pleased with the range and availability of CHSP services and the staff who provide them. They were also confident that acute and urgent care services were available if they needed them.

Most reported good access to allied health and specialists, although some stated that the limited number of sessions they can get through Medicare leaves them wanting at times, or largely out of pocket. People from a CALD background were more likely to be unaware of how to access allied health or how this could help.

Some people reported that they had paid for and installed their own renovations to better support their health needs, because the time it takes to receive support through the aged care system is too long.

Overwhelmingly, those consulted stated that access to services after hours and on weekends was challenging. This included 20 of the 28 survey respondents.

Access to mental health services was rarely raised in the face to face consultations, but the majority of survey respondents who had an opinion on this believed access was hard (71%).

4.1.3 Facilitators

Those supporting a family member in a RACF said that one of the most important people was the activities officer. This person often brightened the day of many residents and provided stimulating activities in an otherwise long day.

Those using CHSP services generally thought the fees were appropriate for weekday services, but out of their reach on the weekends.

People in receipt of CHSP or HCP services said that staff and case managers were often very helpful and assisted them to connect to other services. This was noted as being particularly valuable by those from a CALD background, who agreed that it was harder to find out information when you don't easily communicate in English.

The majority of survey participants reported that staff understood the needs of older people (71%); that they were confident in their competency (75%) and that they treated older people with respect (86%). There was a mixed response to the question about there being adequate staff available.

Confidence and trust in services was highest in the more rural areas at 80%, with most agreeing that providers communicate clearly (61%).

4.1.4 Challenges

One carer talked about how her mother has recently moved into residential care. Although she said her mum receives the basics (such as food and hygiene support), she is concerned about a number of things, including:

- The size of the room, stating there is no personal space.
- Staffing levels and skill mix, including insufficient nursing staff available. She said that sometimes there is no Registered Nurse in the RACF.
- Many of the staff lack the clinical and assessment skills needed to monitor the wellbeing of the residents. She cited the example of finding her mother dehydrated.
- How busy the staff are, skipping breaks and having to continually prioritise one person's needs over another's.
- Having to move facilities when her mum's needs increased from low to high care.

She is concerned about residents that don't have the cognitive skills to advocate for themselves and states her mum is okay because she is cognitively intact and has daily support from family. She says many families and residents are reluctant to speak up, as they are fearful of the ramifications. Although RACFs state they welcome feedback, she suggested that this could be done in a more constructive manner.

It was raised on more than one occasion that the expectation of being able to choose your own HCP provider and navigate through all the information was too overwhelming for some.

The costs attached to HCP were also raised by a couple of people. One carer stated that her mother could not afford to be on a HCP so entered a RACF. Another stated, *"I do not know where and how to ask for help, I feel overwhelmed. My GP and other practitioners think that I can pay for my support, but my savings are running out."*

Many people spoke about the amount of written information, agreements and fee agreements particularly related to HCP. They often found this overwhelming and unclear.

> *"Got a bunch of papers, read them and haven't had enough time to read all the information that the assessors and providers give me. People don't understand how busy life is when you are older and are a full time carer to someone with dementia."*

There was also concern about the proliferation of for profit providers. As one carer stated, *"Aged care can never be a business – it just won't work".* People worried that profit before people would become the norm in aged care.

Having staff that speak the same primary language was seen as useful, although most stated that this was very limited, and they would welcome more diversity in the staff that support them.

Availability of GPs, especially in more rural areas, was raised. Eighteen off the 28 survey respondents were concerned about access to GPs and health services.

Transport came up as a major barrier, regardless of where people were located. People living in more rural areas were more likely to drive or have family to drive them, but noted that without this support they would have to move into town or residential care. Some stated that they know of many people driving longer than they should, because they feel there are no transport options available to them if they stop driving. Not being able to get around was viewed by one group as a barrier to keeping yourself well and connected, both for your medical needs and participation in community activities.

Social isolation was raised as a major concern for over half the participants. Some stated they know people who don't leave their home, whilst others had taken a proactive approach and moved into a retirement village or township where there was more on offer.

4.1.5 Suggestions

The highest ranked desired changes people nominated in the survey were:

- improved availability of services after hours and weekends (11);
- greater access to mental health support for older people (8);

- increased range and flexibility of services (8);
- provision of viable transport options (8);
- for older people to have greater choice and control over the services they receive and how they receive them (7); and
- adequate funding to provide the supports people want (7).

When consumers, carers and family were asked about their ideas for what they would change or what could make a difference to supporting them, the following suggestions were recorded:

- Face to face assistance to navigate and access the system. Some suggested a community-based drop in centre for information and access support, whilst others thought specific positions should be allocated to enable home visits. The support could also include preparing for ageing, such as applying for Power of Attorney, end of life decision making, preparing a Will, etcetera.
- Adequate funding and resources should be made available to deliver quality services.
- Support for staff (including better ratios in RACF, access to ongoing training, improved wages and conditions).
- Better funded HCP to support people to stay at home and which also includes adequate funding to cover rural travel costs.
- Small residential pods or cluster housing with 1-2 staff to help when you need it.
- Strategies to encourage doctors and specialists to stay in the public system and work with older people.

4.2 General practitioners

There were nine general practitioners (GPs) engaged in either verbal consultations (n=6) or via the survey. They all work in the Geelong and Ballarat sub regions of the Western Victoria PHN.

4.2.1 Access

The GPs all reported how challenging it is now to assist somebody to access aged care services with the introduction of MAC. The majority of the people they see require assistance to access and interact with the MAC portal. If people don't have family support or good literacy, they can be disadvantaged. Time critical services, such as wound care, can also be slow to access because of the MAC process, although GPs report that this is improving.

For the people who can access MAC, GPs report a positive experience, although the variability of what can be provided by services is dependent on location. Once a person is linked into one service, it tends to be easier to access others.

GPs also reported how they miss the direct interaction with the assessment service, reporting that it *"now feels like double handling",* as the person needs to go to the MAC and the GP needs to talk to the assessment service. The personalised and localised connection between the GP and ACAS (Aged Care Assessment Services) is being eroded.

There seems to be an influx of people accessing MAC, independent of whether they need services. GPs say that this is delaying assessment and access to services for those that do need them. According to one GP, MAC is also generating an *"unrealistic expectation"* that people can get services when they need them, when it is well known that they are not available.

4.2.2 Availability

Generally, GPs report that the support available for older people to stay at home is inadequate. The long waiting times for HCP – especially for those needing level 3 and 4 – is causing great concern and strain on both the primary health system and the RACFs. People are left to manage on inadequate supports and GPs are often left carrying the burden of trying to organise alternatives when things go awry. *"People are either dying or going into care because the HCP is just not responsive enough."*

Both access to health professionals and services from the acute and sub-acute programs were reported as good. One GP talked about how he has good support from geriatricians, nurse practitioners and district nursing, especially when he had a patient in a tricky situation. Residential respite was also reported as generally easy to access in the Geelong area if a person had the correct paperwork and was prepared to go outside their immediate area. It was more challenging in the other districts.

The range of services available under the CHSP was reported as mixed. Access to currently available services was seen as adequate, but there is no support for gardening, very limited transport and people report their dislike of delivered meals. Where volunteer driving services exists, it makes a difference to *"reduce isolation and to get people to their appointments etcetera."*

A gap identified by one GP was assistance with washing clothes. The GP talked about one of her patients, who could not manage his own laundry and was forever turning up in dirty clothing. She said this man was socially isolated and found it hard to connect to people because of his appearance. *"It seems like such a simple, low skilled support required to maintain independence and to increase his ability to remain socially connected."*

One GP talked a lot about community-based activities aimed at targeting older people at risk of social isolation. She stated that there are limited interest-based activities and transport to access them. Social isolation is increasingly presenting as a contributor to poor health and poorer wellbeing. She cited Creswick as a township where there is a good variety of activities, noting, *"Patients do better that have these available and access them, compared to my patients that don't."*

Access to allied health is also reported as variable. Both the range of allied health and the cost were cited as barriers: *"There is only one podiatrist in Geelong that does home visits".*

Cost is seen as one of the biggest barriers for older people. They can get some services through Enhanced Primary Care, but this is often not enough and leaves the person having to pay full cost. The cost of getting a taxi to a GP appointment (which was suggested at being about $30 for a round trip), any out of pocket expense for the consultation fee and then the purchase of medication (if prescribed) all adds up to be expensive for older people and out of the reach of some.

Access to mental health support is also reported as limited for older people, as is dementia and crisis care. GPs state there is an increase in the number of people living with dementia, but not the specialist services to support them. Psychological support for people in RACFs was mentioned as a significant challenge – many older people in RACFs have primary mental health concerns such as depression, anxiety, grief and loss, and social isolation.

GPs commented that there seems to be adequate medical supports available in the community, but this is not always so for RACFs. All GPs consulted remarked on the way many older people are discharged from the acute sector too early, even when the GP tries to intervene.

4.2.3 Facilitators

The Residential in Reach Program operating in the Geelong area was cited as a great acute care prevention program. The program is auspiced by Barwon Health and rosters GPs to cover patients in RACFs if their usual GP is unable to attend. The GPs involved in this program state that it is good having this back up option and knowing that people will be taken care of when they cannot attend.

The second example nominated as good practice was the location of GP clinics onsite with larger RACFs. This secures work for the GP, whilst offering residents access to GPs when the clinic is in operation. Others were not so supportive of this, as they said the residents were forced to accept services from these clinics and thus lost the continuity of care with the GP they had been seeing for a number of years.

GPs also mentioned the value of HealthPathways as a supportive tool for patients with certain health conditions, although these do not exist for the generally frail older person.

4.2.4 Challenges

Attracting younger GPs to take up patients in RACF is proving challenging and concerning, as the current range of GPs doing this work are typically older. It was also reported as not being as attractive financially as working in a surgery or medical clinic. Most GPs who work in RACFs report having too many people to see and wish more GPs would take up geriatric medicine.

"Working across RACF is not always a 9-5 job and not everyone wants to be there all hours."

"The role is good for those who like it. We're autonomous, flexible, and have low business expenses. If you have an interest in geriatrics, it's a great role and the variety is fantastic. Ten years ago I was the only person doing it and now there's 4-5 full timers and some part time, but it's still not enough."

Another challenge was the ability to keep abreast of all the options available and where to go for these options, especially when these are needed urgently. This is also compounded by the constant changes in availability.

"I had a patient who cared for her husband. She needed to go into acute care urgently, but I didn't know what services and supports were out there to support the husband whilst the wife was away. I ended up calling the district nurse as I have a good relationship with her. She was able to help out."
When asked whether the GP knew about services from the Carer Respite Centre, he stated no. "*You have to have heard about it to know it exists."*

The increasing complexity and expectations of older people and their families make it more time consuming to ensure the best care is made available. GPs state they are not remunerated for this extra work.

The rise in Personal Care Attendants (PCAs) in RACFs also acts as a challenge for GPs, who claim that it is more difficult to have a shared understanding of the health goals as the PCAs don't have the appropriate health training. It is also common that PCAs have English as their second language. GPs stated this makes it harder for them – and the residents – to communicate.

GPs stated the patient gets better support when nurses are involved, but RACFs are struggling to recruit nurses. GPs report variability from one RACF to another in the quality of care, with inadequate experienced staffing being nominated as the biggest issue. For example, they noted that there can be a lot of agency staff in some facilities who do not know the residents. It was also noted that residents often don't have any choice in the allied health they see, because most facilities have visiting allied health who see anyone in need.

The further challenge raised in consultation with GPs was the mixed funding available for them. Review of a care plan attracts a payment, although the work tends to be more opportunistic than planned. Meanwhile, the review of medication and scripts attracts no remuneration through Medicare, although it can be a common reason for seeing someone.

A variety of client management systems at different RACFs can be challenging for GPs. They are often dealing with up to seven different systems and it can take time to adjust to and navigate around each of the these. *"I have to learn all the systems and trying to find information – time and headache."*

A GP related how, when consulting with a patient in a RACF, she needed to update the medication chart. This RACF had all its client management files completely computerised. The GP was not familiar with the system, so sought help from a staff member. No one on duty knew how to navigate the system so the GP was unable to update the chart, resulting in the patient having delayed access to the medication.

4.2.5 Suggestions

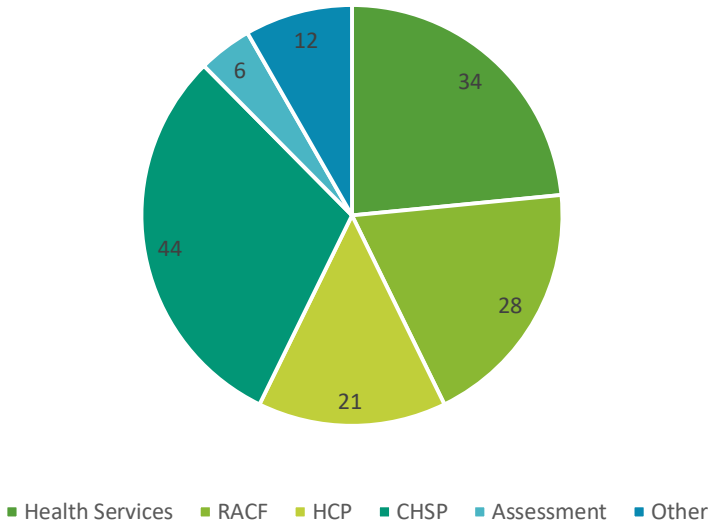
GPs suggested improvements or innovation in four key areas:

1. The implementation of 'care navigators' to assist older people, carers, GPs and service providers get access to information, support people to navigate and access what they needed. This could include emergency or urgent care and be located where older people might be best able to access this support.
2. Resources to support GPs, including the development of:
    - Health pathways to assist GPs navigate community options with older people, including a service directory where you can enter information about where the patient lives and what they need.
    - A community of practice or forum facilitated by the PHN – a conversation between GPs, allied health, nursing, RACFs and other providers working in the field. Participants could meet quarterly to stay updated, compare notes and problem solve.
    - The contracting of 24 hour medical services to provide GP services to RACFs, so residents get more consistency in who they see and how they are managed.
3. The development of a workforce strategy aimed at attracting more people to work in aged care and developing new models of care for supporting people in RACFs.
4. Better resourcing of the aged care system including:
    - More packages and support for people remaining at home.
    - Better staffing ratios and professional development in RACFs.
    - Better access to psychological and allied health services across the sector.
    - Support for neighbourhoods or communities where people look out for and help each other.
    - Initiatives such as matching university students with older people who may have a spare room, whereby they can exchange labour for board.

4.3 Service providers

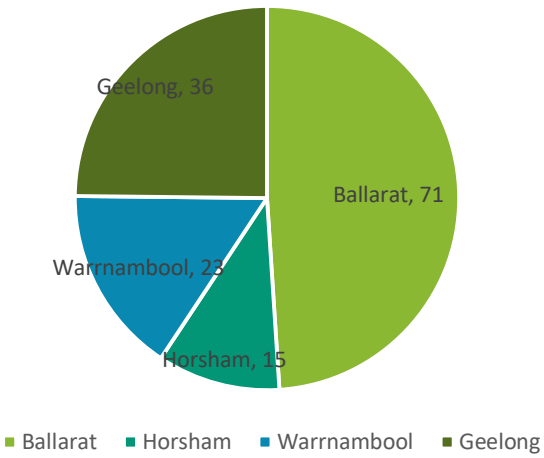
In total, 145 representatives from the range of aged care providers participated in the consultations (n=92) or survey (n=53). Thirty-four are employed in health services; 28 in RACFs; 21 in HCP; 44 from CHSP (including two Aboriginal and Torres Strait Islander controlled organisations and one multicultural specific provider); six from assessment services; and 12 identifying as other.

Figure Three: Number of participants per sector



The majority (n=71) work in the Ballarat sub region; with 15 working in the Horsham sub region, 23 in the Warrnambool sub region and 36 in the Geelong sub region.

Figure Four: Number of participants per sub region



4.3.1 Access

The majority of providers talked at length about the challenges that the introduction of MAC has caused. Issues and concerns raised by providers included:

- The number of consumers who are unable to access MAC without support. As one provider stated, *"We were finding that people were reluctant to access services through My Aged Care and so were accessing services later when they needed more support. They're often in crisis by this stage."*
- How difficult it is for consumers to find information. Only eight of the 53 respondents (15%) to the survey thought that information was easy for older people to access; six (11%) agreed that the information available was easy to understand; and, only 9 (17%) believed that it was easy for older people to access accurate advice.
- That MAC has slowed access to services for many people. Only eight respondents to the survey agreed that it was easy for people to get access to services when they needed them and even less agreed (n=3) that services were accessible after hours and on weekends.
- Seventy-nine per cent (n=42) agreed that once people got to the assessment phase, the process identified a broad range of needs.
- That it relies on the consumer and/or their family (if available) having a good knowledge of how to access and navigate the internet, supported by good connectivity.
- It is much harder to support a person to access MAC due to the stringent privacy and consent procedures. Providers cited many examples of how this has got in the way of assisting people to connect, especially those with hearing, language and verbal communication challenges. *"It is difficult to guide people when they contact Council as we need to be neutral. They are calling at a time of high levels of stress…"*
- Some consumers equate the name 'My Aged Care' with residential care. The title itself can act as a deterrent, especially for those who are cautious that, *"everybody wants to put them in a nursing home."*
- The distrust many older people have with the *"faceless system"*. MAC staff can ask many intrusive and personal questions and also call clients on a non-identified phone number.
- The variability in the ability of the call centre staff to competently screen a person's needs and provide accurate advice. As one provider stated, *"If I don't like the response, I call back again and try another operator."*
- That the descriptions on the MAC website about what services are available in a local area and what they can provide can be misleading for consumers. For example, it was noted that gardening and transport are not readily available across most of western Victoria, although the website indicates that they are.
- That MAC is likely to be useful once the bugs are ironed out of the system, but it is probably a generation or two ahead of the way older people prefer to interact.
- Concern about the skills and knowledge of the people staffing MAC and the impact this has on the accuracy of information provided to consumers.

Providers state that up to one third of consumers seeking support do not make contact with My Aged Care, as it is seen as too hard and acts as a barrier

- That it poses huge challenges to already vulnerable people, with too many steps and unfamiliar processes.
- That MAC is not culturally sensitive and in fact, is inhibiting people who identify as Aboriginal or Torres Strait Islander from seeking support.

When trying to assist a person to register with My Aged Care, one staff member reported that she had to register as an approved advocate for the consumer. In doing this, she had to provide her private residential address in front of the consumer

- Concern about the pressure that will be put on the acute sector as people slip through the gaps and are unable to find their way to MAC.
- That MAC will attempt to contact the consumer three times and if the person is unavailable, their referral will be cancelled. In these instances, the referee is rarely informed of this outcome.
- Staff state that if they don't use MAC regularly, that it is easy to forget all the steps and to make a mistake. This often results in the person *"…sitting in limbo in the system and there is no trigger to say it's wrong or not been acted upon."*
- One provider talked about how they provide community information sessions and how many older attendees are highly confused.
- That once people are assessed and deemed eligible for a particular service, they then struggle to choose from the panel of providers available on MAC. *"It's difficult to work out which ones are going to work best for them when they are not used to having choice. Now there's too much choice."*

Many providers do see the value of a central gateway that can offer more equitable access but believe there is a long way to go before MAC hits the mark.

4.3.2 Availability

The Ballarat and Horsham sub regions were concerned about the long wait for ACAS assessments and thus the delay in getting people with more complex needs into services or residential care. This issue is exacerbated by the shortage of level 3 and 4 HCP, leaving very vulnerable people with inadequate supports.

Non-residential providers regularly raised the concern about the high incidence of psychological distress for residents in an RACF and the challenge of getting this support to them. People living in RACFs are not able to access psychological services through Medicare. This is compounded by the shortage of geriatricians, mental health services, primary health care and allied health staff to consult with people, as well as private spaces in RACFs to conduct consultations.

Not all residential providers in the Geelong area agreed with this and cited many instances of brokering psychological and allied health services, while GPs talked about being able to consult with geriatricians. There were some regional differences, with Ballarat, Horsham and Warrnambool sub region RACFs more likely to agree that mental health supports were lacking. Barwon Health (the largest residential provider in the PHN catchment) said that they utilised Dementia Support Australia for secondary support, although they found that this was often inadequate for people with significant behavioural challenges. They thought that the availability of a specialist mental health team would better support residents and reduce presentations to emergency departments.

Access to mental health supports for older people was seen as challenging by providers, with 70 percent also agreeing to this in the survey. This was also raised in the Ballarat and Warrnambool area consultations. Both Aboriginal and Torres Strait Islander Co-ops who participated in this project reported the challenges of getting any mental health services, let alone those that are culturally sensitive and meet the needs of Elders.

"We had someone who needed residential care and because there was nothing local that was culturally suitable for him, he had to move to Ballarat. This resulted in a disconnection from family, community and country."

The Aboriginal and Torres Strait Islander Co-ops also talked about how hard it is to find a suitable RACF for Elders, especially for those with dementia. They say there are long waiting times for the few that are suitable.

Access to GPs was seen as good in the Geelong and Warrnambool sub regions for community based older people, but more challenging in Ballarat and – more especially – in the Horsham area. The more rural areas talked about bringing in overseas trained staff and the high costs associated with this. Small rural health services rely on GPs to staff their emergency and urgent care units, as well as provide clinics to the general population and RACFs. Most RACFs stated getting adequate GP coverage for all residents was becoming more challenging, especially with the increase in paperwork with the new standards.

Where once a district nurse may have assisted a consumer to make their breakfast whilst they were visiting to attend to wound care, this is now frowned upon and *"…not seen as being within the scope of my role. Everyone has become more insular and just doing what they are funded to do. No more and no less."*

Local government CHSP providers stated they now have less ability to move funding around to meet demand. Under the previous state government management of the system, they used to be able to reallocate their funding more easily from low demand to high demand services. Other providers talked about how their job had become much more task focused under the new arrangements.

Transport was commonly raised as the biggest gap in the system at nearly 87%, both by consultation and survey participants. Transport is seen as vital for people to be able to access health supports, social opportunities, complete activities of daily living and participate in civic life.

Other gaps in availability noted by providers included:

- continence support;
- emergency residential respite;
- a reduced focus on prevention;
- adequate Medicare funded sessions under Enhanced Primary Care;
- adequate resourcing for specialist geriatricians in RACFs;
- lack of a post-acute care system for people exiting private health services;
- poor access to interpreter and translation services in more rural areas;
- the uptake of new technologies to support better care;
- the focus on healthy ageing and wellbeing becoming lost;
- access to residential respite care; and
- the operation of two separate systems that do not interface: that is, My Health Record and MAC.

4.3.3 Workforce

Providers were proud of their workforce and described staff as skilled, dedicated and passionate. The majority of providers agreed that staff are competent (64%) as compared to 21% who did not agree. Many CHSP providers were also able to describe the transition that has been occurring in the workplace culture to that of supporting people to be as independent as possible by applying a wellness approach. Over 80% believe that staff treat older people with respect.

Every provider talked about recruitment, retention and shortages of well qualified and skilled staff. Typically, the further west you travelled, the greater the challenge for providers to attract and retain quality staff, including:

- Payment for travel between jobs for CHSP support workers (especially in more rural areas where there are longer distances between consumers) varies from provider to provider. This can equate to a significant proportion of the unit cost being inadequately funded. One medium size provider stated that travel was unfunded in their organisation to the tune of $300 000 per annum.

- That you need a certificate level qualification to work in aged care and that this limited attracting staff who are attaining other relevant qualifications such as nursing, medicine and allied health. It was suggested that opening up opportunities could assist in attracting younger people to work in aged care once they finished their training.
- Staff are generally lowly paid and have unclear or no career pathways.
- Casualisation of the workforce impacts on consistent remuneration, job security and the ability to apply for personal and home loans.
- That it can be hard to meet the balance between consumer needs and security of employment for staff.
- That *"…the sector is growing at a faster rate than workforce availability."* Seventy-two percent of survey recipients either disagree or strongly disagree that there are sufficient staff available to deliver services.
- That there is very limited funding and non-contact time built into targets to allow for training and upskilling of staff.
- It is an undervalued and *"not very sexy"* profession.
- That CPI is not meeting the rising costs of delivery.
- That imported labour is likely to be one of the solutions, but there are concerns as to how older people will accept this. One provider stated it cost about $8000 to recruit an overseas staff member, plus the costs of organising visas.
- That the work can be confronting, especially for workers in a community setting. Staff might be exposed to people living in squalor presenting with complex medical issues, or find people dead in their homes.
- That it is even more challenging to recruit in the more rural areas.
- That it is more about the skill level of staff in RACFs than the ratios. One provider talked about how hard it is to recruit skilled and experienced nurses and personal care attendants.

Many providers have an ageing workforce, with some expecting around 60% to exit in the next five years

One of the specialist Aboriginal and Torres Strait Islander providers talked about how case managers are juggling too many clients on HCPs and are unable to keep up with the workload. The provider finds that they are frequently acting as the liaison between the client and the case manager, but are not funded to do this work. They also stated that most mainstream services expect them to do this for nothing. They frequently find themselves helping clients understand how to read the statements about how their funds are being spent.

Four examples of how providers are collaborating to better attract staff to work in the aged care sector were discussed in the consultations:

- Beaufort and Skipton Health Service talked about how they have worked with a university to develop some nursing units specific to ageing. This allows graduates to qualify with a graduate certificate as well as a bachelor's degree.
- Ballarat Health Service has been collaborating with Federal University so that psychology students spend time in the general medical wards and gain skills in gerontological practice.
- Barwon Health have a range of programs to encourage staff into aged care, including: employing allied health students as allied health assistants; having a supported enrolled

nurse program providing eight weeks of clinical support from a registered nurse; and graduate and undergraduate nursing programs.

- BUPA are developing a scholarship or incentive program for nurses to undertake a masters program, opening up career pathways such as nurse practitioners.

The increased reliance on personal care assistants in RACFs and less registered nurses was seen as a significant concern by many providers. There is a limit to the scope of work that these assistants can be expected to undertake. Some providers are calling for these staff to have national registration so that performance can be reported and monitored, as it is for most other health professionals.

4.3.4 Facilitators

One provider talked about how they assign practice nurses to develop annual care plans with residents and coordinate allied health, which are then approved and signed off by the GP. They stated that RACFs preferred this and residents were getting more comprehensive and coordinated responses to their needs. This also assisted in making the limited availability of GPs working with residents in RACFs in the Ballarat area reach more people.

Most providers in the Ballarat area agreed that Short Term Restorative Care is being well utilised, but is being held up by the waiting times for ACAS to assess and set up this service.

Assessment is generally well regarded by providers and most can see the sense in having one assessment entity when it is introduced in 2020. However, there are concerns about local government withdrawing from assessment and service provision, and with this the consequent loss of local knowledge and expertise. ACAS was mentioned on numerous occasions as being professional and helpful.

A couple of examples where organisations have merged to increase their chances of being more viable were discussed. The co-location of an RAS Assessment Officer in an Aboriginal and Torres Strait Islander controlled organisation paved the way for building trust and smoother access for Indigenous people to services. This was valued by both the assessment provider and the consumers, affording more accessible information and soft transfer and connection to the MAC, when required.

Another Aboriginal Co-op reported that they have an agreement in place with the local services, to offer support when anyone identifies as Aboriginal or Torres Strait Islander. This allows the Elder to be assisted in a culturally sensitive way and provide the additional support many Elders require due to historical practices.

Bellarine Community Health Service have self-funded a person to act as a navigator to support people to understand, make decisions about and access the system. Another example of where people are well supported is the provision of key contact staff in the Hospital Admission Risk

Program for people who have frequent presentations to emergency departments. These staff help people coordinate the care a person needs.

Intergenerational care was well regarded, and highlighted as a new and emerging model for many providers. This approach means people are grouped together around interest rather than age.

Providers talked about how much better a service the person gets when staff have time to actually engage with them as well as deliver the service. This little bit 'extra' can make an enormous difference to people and assist them to connect to other supports they may need.

A staff member who completed their work with time to spare, sat and talked to the person. They noted how the person looked different and was not their usual self. The staff member suggested the person go and see their GP. The GP provided intervention for depression. The family later rang to thank the staff member, believing that this little bit of extra care probably prevented the person from taking their own life.

Local networks and opportunities to share knowledge and discuss individuals were seen as good practices that helped to reduce gaps between services and increase coordination. This may or may not be supported through formal agreements or protocols (as established between ACAS and RAS or the Grampians Region Personal Care protocol). The MAC portal has been identified as being able to facilitate coordination if used well by all providers involved with each person.

4.3.5 Challenges

As with GPs and consumers, providers were also very concerned about the long waiting times for HCP, especially levels 3 and 4. Providers talked about consumers going into residential care against their wishes, as they were not able to be sustained on lower level packages while they waited for 18 months. Providers also discussed the pressure this puts on frontline staff, as they see the person struggling and want to help them, but do not have the funding to assist.

Others talked about the limited funding attached to the lower level packages and how this could disadvantage some consumers who were probably better off remaining in the CHSP system. Most packages struggled to provide adequate funding to cover weekend and after-hours support. Many complained about the amount of money that was taken up to cover travel costs for those living in more rural areas. Additionally, it was noted that people with diabetes could spend all their package on getting support to manage their condition, leaving nothing left for other necessary services. It has become too cost prohibitive for some consumers. People with lower level needs are getting HCP, whilst people with higher and more complex needs are missing out on the support they need. One provider talked about the administration fees and that, *"People can be burnt by hidden costs, particularly in the package space."*

The accumulation of unspent funds in some people's HCPs was raised as a concern. Some consumers are sitting on money they don't know how to spend, whilst others receive inadequate services and are put at risk. The HCP guidelines are open to interpretation and some providers cite examples of where families or consumers are requesting funds be spent on what they see as extravagant purchases such as air conditioners in holiday homes.

Transition from CHSP to HCP can see consumers lose or change their connection to some services (such as social support) as they cannot always afford to continue this out of their package allocation.

The MAC system has reportedly made coordination amongst providers more challenging. Providers state that they only have access to information to the services they provide and are not always aware of other services available to the consumer. This can make it difficult to collaborate and work together to support the person to achieve the outcomes they are seeking. Some cited examples of how consumers have had to repeat the same information to a variety of providers.

> *"The reforms are breaking down collaborative relationships and service coordination and the ability to meet up and refer between ourselves. We used to be more focused on the client, now it seems like we are more focused on the system and our individual roles. Holistic care is going out the window."*

The lack of funding for practice nurses and the low remuneration rate for allied health under Medicare add to the challenges of getting adequate coverage in RACFs for residents. Providers also noted that there is an increased demand for pharmacists to be involved with residents in RACFs, as the personal care workers are not able to assist.

Although reablement is seen as a great idea in theory, RAS report that it is difficult to coordinate and to find providers who have the interest, skill and availability of services to respond in a timely fashion. They also state that the lack of allied health services impacts on the uptake of reablement and wellness.

Once people have been assessed, they are given 'identifier codes' for the services they have been approved for. Providers report that consumers are often confused about the codes and how to use them.

Some providers were bothered about their viability, especially given the higher costs to deliver services in smaller, more rural, communities. Specialist agencies – such as those for Indigenous clients – were also concerned about how they will be able to support their community, as much of their activity goes unfunded and they are spending a lot of their time just trying to keep up with the changes. The reporting demands have added to the diversity of required skill sets that

smaller providers are also grappling with. Providers also noted the withdrawal of local government and their co-contribution into the sector as worrying.

The same level of skill and resources to accommodate compliance and reporting is required in both small and large organisations. This is demanding investment in training, back of house systems and operations, and, a change in the skill sets of people sitting on the boards for some providers.

One provider talked about trying to attract board members with *"…more business skills like lawyers and accountants. Without it, I would be very surprised if agencies like ours keep going."*

The number of people who are either at risk – or are – socially isolated, came up again and again. There seems to be a growing recognition of the impact that loneliness can have on a person's health and wellbeing. Although the focus is on a person's goals, it has been observed that these are still described in terms of what services or clinical skills are available to meet them, and do not necessarily reflect the person's motivations. HCP providers also stated that people who move onto a package are often left with little money to purchase social support. This is a particular issue for people who have been going to CHSP-funded social support groups where they have built rapport and friendships, but can no longer afford it once they move across to HCP.

Like GPs, providers stated that the communication and coordination between the acute and community/residential sectors could be improved. Providers reported that people were often discharged too early, with inadequate discharge summaries and supports, and some bounced back into the acute sector within hours of being discharged. RACFs raised this concern more frequently than community providers and thought that the acute sector believed that people's acute health needs could be managed in the RACF.

People in palliative stages can be unnecessarily inconvenienced by having to go through MAC and assessment to get supports. Providers stated that their needs are often already well understood, and it is a duplication of effort to assess them again. One RAS provider demonstrated how they act flexibly to reduce this duplication by accepting the information from referring agencies.

Across the board, providers were concerned with a pervasive sense of uncertainty as the system adapts to the reform agenda. This included retaining staff who are starting to look for more secure employment and concerns about what we are having to give up in Victoria to comply with a national approach to aged care.

4.3.6 Suggestions

Service providers contributed suggestions that come under nine main themes:

1. Mechanisms to support collaborative practice amongst providers and with community. This could be achieved by co designing services and building the capacity of the community to

influence these services. At one consultation, it was suggested that collaboration could focus on delivering healthy ageing, with a community plan supported by memorandums of understanding between providers, as well as vision, passion and leadership.

2. Exploring ways that assistive technology and ehealth could complement service delivery, particularly in more rural communities.
3. That innovative models of integrated care could be developed. Suggestions included: placing health professionals in community settings such as community centres; and that the PHN become the contractor for assessment across the catchment (as Brisbane PHN has done).
4. That an aged care workforce strategy be developed and implemented to attract, recruit, train and retain staff. This could include stronger collaboration/partnering between providers to share workforces to meet the needs of the community.
5. Easier access to quality information for community and providers.
6. Greater access to mental health services and supports, particularly in the RACF setting.
7. Developing innovative programs to reduce social isolation and primary mental health issues (anxiety, grief, loss, depression) in both the community and RACFs.
8. Navigators to support people to transition and access supports. This may also include future planning, Wills, powers of attorney, etcetera. Many saw this as possibly an interim measure until the majority of older people were more comfortable with using faceless and online systems.
9. Adequate funding be made available to provide the supports older people want, including:
    - transport and gardening;
    - reduction of HCP waiting times and allied health waiting lists;
    - advocacy for subsidies to HCP for things such as travel (in more rural locations) and chronic disease (where people need extra support to manage this at home); and
    - investment and seed funding in local solutions.

4.4 Service mapping

The mapping exercise across the Western Victoria PHN catchment has identified where services are based, the range of funded aged care services they provide and to which areas. The location and number of RACF, HCP, CHSP and health service providers are demonstrated on the four sub regional maps in Appendix One.

4.4.1 Assessment services

Assessment is currently delivered by a two-tiered system. For people with entry level needs (and likely to be adequately supported by CHSP services), assessment is provided through one of the 21 outlets that make up Regional Assessment Services. Currently there is one outlet in each of the 21 local government areas.

For people with more complex or higher needs and who may be best supported through a HCP, or who need to access residential care for permanent or respite care, assessment is provided

by one of four ACAS teams. The Grampians Regional ACAS operates from two sites across 10 of the 11 local government areas in the Ballarat and Horsham sub regions. The exception is the Central Goldfields Shire, which is serviced by the Loddon Mallee ACAS.

An ACAS located in Warrnambool services people in the Warrnambool subregion. The Geelong sub region is serviced by the Barwon South Western Regional ACAS.

4.4.2 Residential Aged Care Facilities

Across the entire catchment, there are 122 RACFs providing 7453 beds, with 81 012 people aged 70 years and over. The greatest proportion of the beds are in the regional cities, with the Geelong sub region accommodating for half of all beds at 50.1%. The Commonwealth government has a current target of providing 88 beds per 1000 people aged 70 and over and are aiming to reduce this to 80 beds per 1000 by 2021/22. The average bed per 1000 people aged over 70 across the PHN catchment is 90.5, above the Commonwealth target.

The Ballarat subregion has a total of 1636 beds across 29 RACFs in the five local government areas, with 68% of these sitting in the City of Ballarat. The average number of beds in this region is 88 per 1000 people aged 70 years and over. Ballarat local government areas are over the federal government target of funded beds per 1000, Hepburn Shire is currently on target, whilst all the others are under. Figures have not been calculated for the Shire of Moorabool, as only part of the Shire is included in the Western Victoria PHN.

Sub region	LGA	No. of RACF	No. of beds	No. 70+*	Per 1000
Ballarat	Central Goldfields Shire	4	199	2 576	77
	City of Ballarat	16	1110	12 271	90
	Hepburn Shire	5	220	2 504	88
	Moorabool Shire	2	51	?	?
	Pyrenees Shire	2	56	1 161	48
		29	1 636	18 692^	88^

^ without Moorabool

The Horsham sub region has a total of 898 beds, provided by 27 facilities. The average is 94 beds per 1000 people aged 70 years and over, which is significantly over the federal target in all areas except the City of Horsham and Rural City of Ararat.

Sub region	LGA	No. of RACF	No. of beds	No. 70+*	Per 1000
Horsham	City of Horsham	6	213	2 754	77
	Hindmarsh Shire	7	146	1 112	131
	Northern Grampians Shire	4	193	1 915	101
	Rural City of Ararat	4	141	1 830	77
	West Wimmera Shire	3	62	674	92
	Yarriambiack Shire	4	143	1 299	110
		27	898	9584	94

The sub region of Warrnambool averages out at 81 beds per 1000 people aged 70 and over, just slightly above the federal government target for 2021/22. Overall, there are 1181 beds provided by 23 facilities. Both Corangamite and Glenelg have a higher ratio and Moyne is significantly under.

Sub region	LGA	No. of RACF	No. of beds	No. 70+*	Per 1000
Warrnambool	Corangamite Shire	7	221	2 513	88
	Glenelg Shire	3	268	2 978	90
	Moyne Shire	3	122	2 017	60
	Southern Grampians	6	221	2 602	85
	Warrnambool City	4	349	4 555	77
		23	1181	14 665	81

Lastly, the Geelong sub region has 42 RACFs providing 3738 beds, and averages 98 beds per 1000 people aged 70 and over. All local government areas are over the target, with the exception of the Shires of Golden Plains and Colac Otway. There has been significant growth in the number of RACFs in this sub region in the past few years.

Sub region	LGA	No. of RACF	No. of beds	No. 70+*	Per 1000
Geelong	City of Greater Geelong	29	2748	31 049	89
	Colac Otway Shire	3	235	3 144	75
	Golden Plains Shire	1	120	1 730	70
	Queenscliffe Borough	1	90	481	187
	Surf Coast Shire	8	545	1 847	295
		42	3738	38 251	98

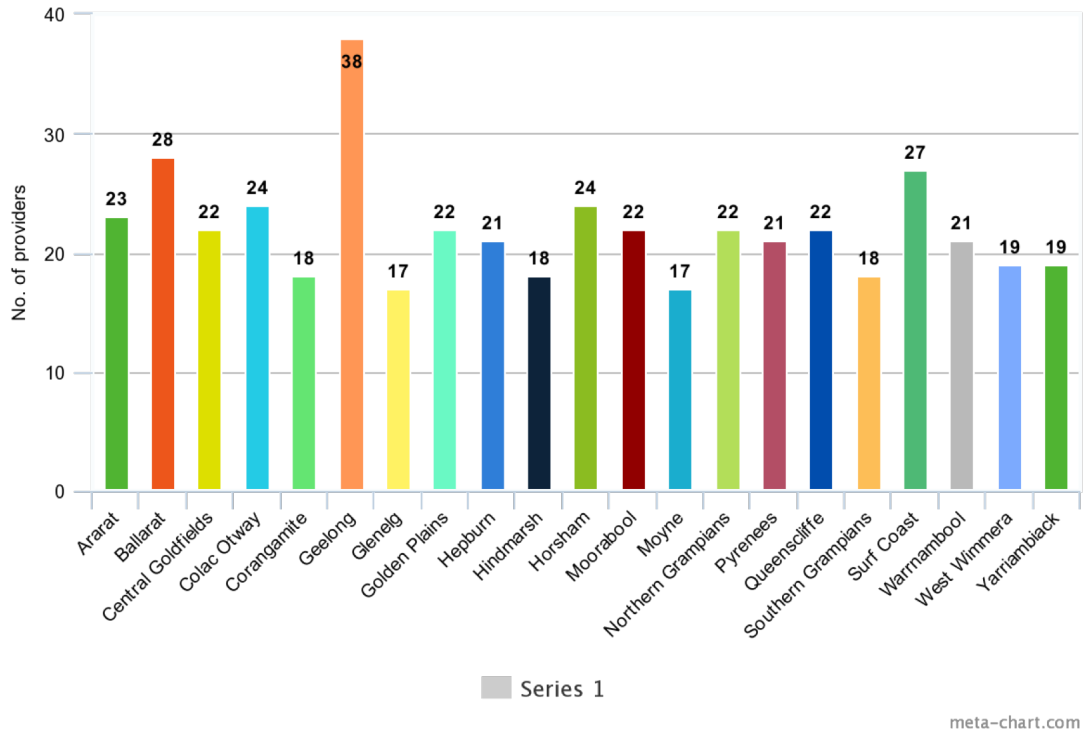
(* Australian Bureau of Statistics 2019)

4.4.3 Home Care Package providers

There are 62 HCP providers which nominate as supplying services in the region, with approximately 18 of these stating they cover the whole region. It is difficult to be highly accurate with the number of providers, as some say they service a particular area, yet local providers are unaware of their presence. When these unknown providers are contacted directly, they tend to state that they can operate in the area, although whether they are or not is difficult to quantify. As the HCP is attached to the client and not the provider, there is no cap on the number of packages that can be operating in the region.

If we believe that all the HCP providers are actually operating as reported, then the consumers living in western Victoria have a good range to select from. The Geelong area has the most providers with 38 and Glenelg and Moyne Shires with the least choice at 17 providers. With the exception of Aboriginal and Torres Strait Islander specific organisations, most of the specialist or culturally specific HCP providers operate in the Ballarat and Geelong sub regions.

Figure Five: Number of HCP providers per local government area



4.3.4 Commonwealth Home Support Program

There are 15 different service types funded under the CHSP, all of which are delivered to some degree in the Western Victoria PHN catchment. Domestic assistance, allied health, social support, district nursing and home maintenance tend to be the most commonly used.

The table below provides an overview of the number of providers currently funded to supply each service type per local government area. There is only one provider funded for the new service type of Goods and Equipment and they are an Indigenous provider that services five local government areas. Transport is not available in almost half of the areas and is generally not available across the whole shire or city for those that do have funding. Victoria is recognised as being historically underfunded in transport compared to other states and territories.

Social support has the most funded providers across nearly all local government areas. Two of the services funded to provide support to people who are homeless or at risk of homelessness are state-wide organisations, that do not have an office-based location in western Victoria. It is also worth noting that in most local government areas, one to two of the allied health providers are funded to supply one allied health type only. For example, Vision Australia is a state-wide service that can provide occupational therapy to any person with low or no vision.

Local government area	Domestic assistance	Personal care	Social support	Transport	Home maintenance	Goods & equipment	Home modifications	Meals	Nursing	Allied health	Centre based respite	Cottage respite	Flexible respite	Homelessness .	Specialist support
Ararat	3	4	7	0	2	0	2	1	4	6	1	0	4	3	6
Ballarat	3	5	7	0	2	0	1	2	5	9	1	1	4	3	4
Central Goldfields	1	1	3	0	1	0	1	1	1	2	0	0	1	2	1
Colac Otway	3	2	9	2	3	0	1	2	2	4	4	2	6	2	4
Corangamite	2	3	5	1	3	1	1	2	2	3	1	1	2	2	2
Geelong	2	1	9	0	2	0	1	3	2	4	5	2	7	2	6
Glenelg	4	5	6	1	4	1	1	1	2	3	2	1	2	2	1
Golden Plains	1	4	4	0	1	0	1	1	4	5	1	0	4	2	4
Hepburn	1	4	5	0	1	0	1	2	5	6	1	0	4	2	4
Hindmarsh	4	5	6	2	2	0	0	2	2	4	2	0	5	3	7
Horsham	4	5	7	2	3	0	0	1	2	4	1	1	4	3	6
Moorabool	1	4	4	1	1	0	1	1	3	5	0	0	3	3	4
Moyne	3	7	5	1	4	1	1	2	3	5	2	1	4	2	1
Northern Grampians	3	4	5	0	2	0	1	1	2	3	1	0	5	3	4
Pyrenees	2	3	7	0	0	0	2	1	3	4	1	0	5	3	4
Queenscliffe	1	1	6	1	2	0	1	1	2	2	5	2	6	2	4
Southern Grampians	1	3	4	2	2	1	1	1	2	3	1	1	3	2	1
Surf Coast	1	1	7	1	2	0	1	2	2	3	5	2	6	1	4
Warrnambool	3	4	6	0	4	1	1	2	1	4	3	3	5	2	2
West Wimmera	4	5	8	2	2	0	0	2	3	4	2	0	5	2	7
Yarriambiack	3	4	6	1	2	0	0	1	2	5	2	0	3	4	6

4.3.5 Health services

There are 26 health services across western Victoria. The Warrnambool sub region has the most with nine, although many of these are smaller regional services. The Geelong sub region has the least with four, but also contains the largest with the multiple campuses of Barwon Health. All of the health services provide urgent care, RACF, allied health and community care.

	Health service	Location
BALLARAT	Ballan District Health and Care	Ballan
	Ballarat Health Service	Ballarat
	Beaufort and Skipton Health	Beaufort and Skipton
	Hepburn Health Service	Daylesford, Clunes, Creswick and Trentham
	Maryborough and District	Maryborough
HORSHAM	Dunmunkle Health	Rupanyup
	Edenhope and District Hospital	Edenhope
	East Grampians Health Service	Ararat and Willaura
	East Wimmera Health Service	St Arnauld
	Rural North West Health	Warracknabeal, Hopetoun and Beulah
	Stawell Regional Health	Stawell
	West Wimmera Health Service	Nhill, Goroke, Kaniva, Minyip, Murtoa, Natimuk, Rainbow, Rupanyup
	Wimmera Health	Horsham
WARRNAMBOOL	Casterton Memorial Hospital	Casterton
	Cobden Health	Cobden
	Heywood Rural Health	Heywood
	Moyne Health Services	Port Fairy and Koroit
	Portland District Health	Portland
	Southwest Health	Warrnambool, Camperdown, Lismore, McArthur, Portland, Hamilton
	Terang and Mortlake Health Service	Terang and Mortlake
	Timboon and District Healthcare Service	Timboon
	Western District Health Service	Hamilton, Coleraine, Merino, Penshurst
GEELONG	Barwon Health	Geelong
	Colac Area Health	Colac, Birregurra
	Great Ocean Road Health	Apollo Bay and Lorne
	Hesse Rural Health Service	Winchelsea, Bannockburn, Beeac, Rokewood, Moriac

5. Discussion

The philosophy behind Australia's aged care system and service delivery is one of autonomy and wellness; that is, supporting older people to age well in their own environment. Some of the key phrases used in this context include 'maximising independence', 'consumer choice and control', 'person directed care', 'strengths-based', 'goal-directed' and 'flexible'. The vision that underpins the reforms is *"…an aged care system that is simpler, more consumer-driven, market-based, affordable and sustainable, responsive to diverse needs, and focused on promoting wellness and independence"* (Department of Health, 2017 p5).

While these aspirations are worthy, consultations with older people and carers completed by COTA in preparation for a response to the Royal Commission found that:

> *"Older people often felt disempowered by the current aged care system and 'worthless'. They say the system is confusing and set up to provide a basic level of care that reacts to people's health deteriorating rather than proactively considering their well-being" (p. 2).*

Furthermore, it was evident when consulting with older people yet to enter the system that they feared it, thinking aged care meant being shipped off to a nursing home. The COTA consultations also found that older people feel ageist attitudes pervade the system, both within institutions and broadly throughout the community.

Older people make up a considerable proportion of Australia's population. In 2017, over 1 in 7 people were aged 65 and over. This is expected to grow to 1 in 5 by 2037, and 1 in 4 in 2057. The health of this increasing number of older Australians is an important social and economic challenge facing the country. Older people account for 20% of presentations to emergency departments (AIHW, 2018).

The undertaking of this project is timely, given the national aged reforms underway and still pending, and the increase in the number of older people expected to access these services in the future. Already, these changes are impacting the way people find out about, are assessed for, access, and experience services designed to support older people in the community or in residential care.

The reforms are still relatively new and there are still a lot of changes that both consumers and providers are adjusting to. This is important to bear in mind when considering the findings of this report. Some of the participants' comments probably reflect this necessary adaptation and – if canvassed again in 3-5 years – may reveal different opinions and experiences. Whilst these times are challenging, they also present opportunities to be innovative and build upon the strengths of the existing sector.

Overall, 225 contributions were made to this project, with 72 being from consumers, carers and family members (32%); 9 from GPs (4%); and 144 from service providers (64%). There were significant consistencies in participants' experiences when interfacing with the aged care sector, whether as consumers, carers or providers. There was also a noticeable uniformity across the sub regions, with some local variation regarding the availability of allied health, GPs and psychology supports.

5.1 Access and navigation

Access and navigation are currently causing considerable challenges. Up until several years ago, consumers entered the system via multiple access points. The introduction of MAC as the central point of information and access is regarded by both providers and consumers as unsuitable for the current cohort of older people. MAC operates as a telephone and internet-based system. Many older people prefer face to face contact and are challenged by handing over personal information on the phone. In addition, MAC is less suitable for people with hearing loss or people from a CALD background. The written communication received by consumers from MAC is also proving overly technical, making it hard to understand the content and what they need to do next.

> *"Aged care is a failing system. There is too much red tape, it is hard to navigate the website, everything. It is designed to erode your confidence. All of it is so confusing that I can't get to first base. I lose confidence and just give up." Graham, Ballarat workshop, 20 June (COTA, 2019 p.3)*

Organisations and consumers report that the idea of a 'soft 'or 'warm' transfer to MAC is too difficult.

It is reported that up to one third of consumers who are directed to MAC do not follow through with it. Organisations are expected to assist people to navigate and connect to MAC, but many stated this is extremely time consuming (especially specialist organisations such as those supporting people from an Aboriginal and Torres Strait Islander or CALD background). When organisations do assist, the processes put in place by MAC on how and when another person can speak on behalf of an older person are proving challenging.

The Aged Care Act designates 'people with special needs', as follows:

- people from Aboriginal and Torres Strait Islander communities;
- people from culturally and linguistically diverse (CALD) backgrounds;
- veterans;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged;
- people who are homeless or at risk of becoming homeless;

- people who are care-leavers;
- parents separated from their children by forced adoption or removal; and
- lesbian, gay, bisexual, transgender and intersex (LGBTI) people (Department of Health 2015, p. 78).

These special needs groups are identified as such because they are at risk of being left behind. Providers supporting people from CALD and Aboriginal and Torres Strait Islander backgrounds report how these groups are particularly disadvantaged by the MAC process and generally require additional support to access and take up services. This is particularly concerning, as reduced access to services is suggested as one of the reasons for the health gap between Indigenous and non-Indigenous Australians, with almost a quarter of Indigenous people reporting problems accessing services before MAC was introduced (AIHW, 2018). It is estimated by providers of services for Indigenous people that this is figure now far exceeds 50 percent.

MAC is a national system and therefore it is not easy for local providers to influence its design and function. Being in the early stages of development, it is anticipated that MAC will become more user-friendly as it evolves. Right now though, it is a challenging interface for both consumers and providers to interact with.

At every consultation – and across all groups who contributed to this project – the most suggested strategy to combat the shortcomings of MAC was the provision of independent navigators to assist consumers, families, GPs and providers. Some suggested that these navigators could be located in community facilities such as libraries or information centres, whilst others suggested navigators could also assist people to enter and exit the acute sector, as needed. Bellarine Community Health has taken a lead on this and invested in employing a staff member to act as a navigator for consumers.

Recommendation One

That additional investment is considered to provide face to face support to the current cohort of older people in accessing and navigating the system, paying particular attention to at risk or 'special' groups (as identified by the Department of Health).

5.2 Social isolation

The benefits of implementing strategies to improve social connectivity are evident and can reduce pressure on health and aged care services. This was seen as a priority across the consultations, and also an opportunity for collaborative work between providers, benefitting people living both in the community and in RACFs.

Social isolation and loneliness are recognised as major negative contributors to a person's health and wellbeing. Loneliness has been linked to premature death (Holt-Lunstad et al. 2015), poor physical and mental health and general dissatisfaction with life (Australian Psychological

Society 2018). Healthy ageing involves more than just promoting good physical health, with social and mental wellbeing also identified as important determinants for a high-quality life into older age (AIHW, 2018).

Holt-Lunstad et al. (2015) identified that social isolation has the same impact on a person's health as obesity or smoking 15 cigarettes a day. It has also been linked to mental illness, emotional distress, suicide, the development of dementia, premature death, poor health behaviours, smoking, physical inactivity, poor sleep, and biological effects, including high blood pressure and poorer immune function (Holt-Lunstad et al. 2015).

Men over the age of 85 are one of the highest risk groups for social isolation, loneliness and suicide

Living alone and not being in a relationship with a partner are substantial risk factors for loneliness (Flood, 2005). Many older people find themselves alone, often experiencing loss of friends and changes in their health.

Recommendation Two
That programs to improve social inclusion be considered, with the trialling and implementation of strategies across the community and in RACFs.

5.3 Mental Health

Access to mental health services and supports was seen as inadequate for older people, both in the community and in residential care. The Australian Institute of Health and Welfare (2018) state that the majority (86%) of residents in RACFs were diagnosed with at least one mental health or behavioural condition, with depression as the most commonly diagnosed mental health condition (49%). They also note that over half of all residents have a diagnosis of dementia (AIHW, 2018).

Providers in the Ballarat and Warrnambool sub regions were concerned about the lack of access for residents to psychological supports and the barriers to such access via the Medicare scheme. Some RACFs in Geelong confidently discussed how they arrange access to psychologists, geriatricians and other health professionals as needed by residents, whilst others saw this as being inadequate for the range of mental health needs of their residents.

Providers in the Ballarat sub regions suggested that multi-disciplinary teams could be formed to assist people living in RACFs, including geriatricians and neuropsychologists.

Recommendation Three
Multi-disciplinary mental health supports be made more readily available, particularly for people living in RACFs.

5.4 Community supports

There was considerable discussion across all forms of consultation in relation to gaps and strengths in community supports. The long wait for HCP (especially levels 3 and 4) – resulting in people being left for long periods of time with inadequate supports – was identified as being of high importance to consumers, GPs and providers. Concerns were also raised about the safety risks for people and how some were being forced into residential care prematurely or against their preference to stay at home. This is also putting pressure on providers of acute care, GPs, and CHSP services, which further reduces availability of these services for people who would be best supported by them.

In December 2018 there were 1904 people on a HCP in the Barwon South West area and 1051 in the Grampians. At the same time, there were 1702 people awaiting a HCP at their approved level in the Barwon South West area and 1045 in the Grampians region. The number of HCPs released in this quarter was 447 in Barwon South West and 326 in the Grampians. These figures clearly demonstrate that demand outstrips current supply and there are significant numbers of people with inadequate support for a considerable time. Some providers quote 18 months as being the common waiting time. The Department of Health states the wait is over 12 months.

At one consultation, consumers talked about older people they knew who were still driving when they shouldn't be, but who believed they had no other option.

The most commonly identified gap is the provision of transport. Only 12 of the 21 local government areas in the PHN catchment have some sort of funding for transport and this generally only reaches parts of their community. Transport is a precursor for consumers to access health, community-based care and social opportunities. Consumers in more rural areas stated that if they had to stop driving, then they would have to consider moving into residential care or closer to amenities. Whilst many may continue to drive for life, a significant number are likely to reach a point where they consciously limit the amount of driving that they do and/or cease driving altogether. Research underlines how essential transport is for healthy ageing:

"Transport accessibility is a key determinant of the ability of older people to remain healthy and active in their old age and to access services and programs. As such transport is central to the health of older people" (Browning and Sims, 2007).

"What happens when you have to stop driving – how do you get to medical appointments or hospital visits or to see a friend in aged care?" Wilma, Portarlington workshop, 17 July (COTA, 2019, p. 4)

Mileage came up as a major cost for services delivered in more rural areas. Sometimes this cost is borne by the provider. For example, one organisation said this amounted to around $300 000 per annum and was not covered by the unit cost provided through their funding. Consumers on HCP talked about how the impost of travel meant that their package did not stretch as far as it would for more regional city-based consumers, and they were having to opt out of some services as they could not afford them. Across the board, contributors to this project would like to see advocacy for rural subsidies for travel.

Two other CHSP service types that are clearly unavailable for most people in western Victoria are gardening and goods and equipment. No CHSP agencies are currently providing a full gardening service, and only one provider is funded under goods and equipment. After-hours access to services and access to specialist services for people with dementia were identified as gaps across the whole region.

Consumers and providers both rated their confidence in staff as high and believed that they are generally well trained and treat older people with respect. Consumers who participated in this project largely agreed with this.

Assessment is seen to be working well and can be used to identify a broad range of needs. The only concern raised was the waiting times required to access ACAS in Ballarat and Horsham.

A lack of suitable housing options for older people was identified in a couple of consultations and this can contribute to people entering residential care prematurely. People in more rural areas suggested they would like to see the development of accessible cluster housing where they can share service support, as needed.

There is concern as to what the sector will look like in the coming years as block funded service types in CHSP give way to competition-based funding. Some providers are questioning their viability and whether they will continue to provide the current suite of services. Some local government providers have already declared their intention to stop being a provider once their block funding ceases in June 2021, whilst others are still considering their position. In the larger regional cities, there is likely to be a range of other providers who will join the marketplace, but whether this extends to the smaller and more rural areas is yet to be seen. Most providers in the more westerly local government areas are not expecting an influx of new providers as it is not an economically viable proposition. Availability of staff and the costs of travel impose greater challenges for the more rural communities.

Recommendation Four

That the PHN leads advocacy around the gaps and impediments in service provision. Areas could include: transport; goods and equipment; rural subsidies for travel costs; HCP subsidies for people with complex diabetes management needs; increased availability of HCP; and adequate unit cost funding.

Recommendation Five
Consideration be given to exploring the unmet need for after-hour service options.

5.5 Residential aged care facilities

There is an adequate supply of RACFs and beds in most areas of the PHN catchment – in fact there is an over-supply in some areas. This will dwindle as the number of older people increases and the ratio of beds per older person decreases. Empty beds are common at the present moment, with some facilities reporting as much as a 20% vacancy rate. There has been an influx of new facilities in the Geelong area, alongside population growth.

RACFs are currently in an interesting place, with both the increase in HCP to help keep people in their own homes and adverse findings arising from the Aged Care Royal Commission impacting upon them. Negative images of residential aged care creates a social stigma about aged care and a fear of this life stage. Participants in the COTA consultations remarked that RACFs are people's homes and as such should move away from the medical model. They suggested that staff not wear uniforms and there should be more engagement with the local community (COTA, 2019).

Concerns were raised about the decreasing numbers of registered nurses in RACFs – especially on the floor and interacting with residents – and the increased employment of personal care attendants as the majority workforce. GPs stated this made it harder to have shared goals implemented, and families raised concerns that the staff were overworked and under-skilled for the complexity of resident needs that presented in RACFs. Some providers said the issue was not just about ratios, but also about attracting experienced and mature staff that can meet the needs of residents.

Mercy Place in Ballarat is identified as an innovative example of an RACF, with its provision of a village like approach of cluster housing, a grocery store and a pub. Residents are able to participate in a variety of activities, such as helping with the cooking and washing, and exercise classes

Some of the smaller and/or older facilities are contemplating how viable they are, with increased compliance requirements and difficulties attracting staff to the more rural areas. These facilities are valued by the community, allowing people to remain connected to their hometowns.

Recommendation Six
That the PHN advocates for improved staffing ratios and ongoing training for staff working in RACFs.

5.6 General practitioners

Consumers talked highly of the support they get from their GPs. Older and more socioeconomically disadvantaged people see their GP more frequently (The Royal Australian College of General Practitioners, 2019). Accessibility to GPs in the regional cities is reported as good, although this changes in the more rural zones. Availability of GPs in the smaller, more rural areas is reported as challenging. One small health provider talked about how they recruit overseas GPs and nursing staff to fill the gaps. This is costly yet necessary to ensure that the community have access to the medical services they need.

Some GPs also raised their concerns regarding their availability to work with people in RACFs. They stated they have more patients than they can adequately service and think that the financial incentives to do this work are inadequate. One RACF said that GPs have told them that the changes in the Medicare payment made in July (for GPs to attend residents in RACFs) is lacking for the travel and amount of work that is required. This acts as a barrier rather than an incentive.

One large RACF in the Ballarat area told of how they have one GP who works in their facility. This GP is about to retire and despite months of trying to recruit local GPs, they have had no success. This could leave 130 residents without medical care.

According to data released by the Australian Institute of Health and Welfare (2019a), people living in RACFs average one GP attendance per fortnight. The Royal Australian College of General Practitioners is calling for more support to improve care provided in RACFs, noting that GPs are as vital as the primary providers of medical care to residents of RACFs.

The four top priority health policy issues the Australian Government should focus on as identified by GPs in the General Practice: Health of the Nation report (2019) are:

1. Medicare rebates (51%)
2. Mental health (43%)
3. Obesity (30 per cent)
4. Aged care services (26%).

Three of these priorities correlate with the findings of this project, both reported by GPs and providers.

The Residential in Reach program operated by Barwon Health is cited as good practice due to its system of rostering GPs to cover RACFs when a person's usual GP is unavailable.

HealthPathways was raised as a useful tool that assists GPs to navigate supports for patients. It was suggested that more pathways could be developed to guide GPs through the aged care system. An example included where to get support if a carer needed to be hospitalised.

One clinic discussed how the practice nurses prepare and coordinate annual care plans for people in RACFs. These are overseen by the GP and are highly valued by the RACFs.

Recommendation Seven
That the PHN advocates for better Medicare rebates for GPs providing services to people in RACFs.

Recommendation Eight
The development of HealthPathways to assist GPs navigate community options with older people.

5.7 Workforce

As with the rest of Australia, having an adequate supply of skilled staff to meet the service demand for older people is increasingly seen as a significant challenge. The Productivity Commission (2011) predicted that 3.5 million Australians will be accessing aged care services every year by 2050, requiring a workforce of almost one million direct care workers.

With an ageing workforce, one RACF provider stated that they expect around 60% of current staff to retire in the next five years. This is not an uncommon scenario for providers who employ certificated staff, such as personal care attendants and home support workers (who make up a significant proportion of aged care staff).

Working in aged care tends to be something that people stumble into, rather than set out to do. Attracting people to a sector that is not seen as 'sexy' a prospect as other areas of community and health care is a conundrum that needs attention. The lack of consideration within undergraduate and specialised aged care training programs across many health professions is a barrier to building a future workforce. Two examples of good practice discussed at the consultations include working with universities to increase the exposure of health students to aged care (as described in section 4.3.3). Another suggestion included the employment of students studying for health-related degrees as support workers or personal care attendants. This would serve the double purpose of exposing students to the rewards of working in aged care, whilst opening up a supply chain of staff that is currently unavailable.

Aged care is one the nation's fastest growing job markets, yet there are considerable challenges within the industry associated with:

- high employee turnover, including significant movement between organisations;
- poor employee engagement and enablement;
- difficulty in attracting staff;
- ineffective and inefficient design of work organisation and jobs;
- undervalued jobs with poor market positioning;
- suboptimal workforce planning;
- casualisation of the workforce, particularly in home-based care;

- leadership effectiveness gaps;
- key capability gaps and skills and competencies misalignment;
- career progression bottlenecks; and
- ineffective recruitment, induction and on-boarding processes (Department of Health, 2018, p. 8).

Providers contributing to this project are wanting to see a local workforce strategy that can consider opportunities to innovate, share resources, market the sector, and create career pathways and security for staff.

Recommendation Nine
That a local workforce strategy be developed to strengthen recruitment, training and retention of all parts of the workforce across the catchment.

5.8 Collaboration and coordination

Universally, the concept of collaborative practice and coordination between services was discussed. Providers felt that a more 'siloed' approach was evolving with the introduction of the reforms and a competitive marketplace. Used to working in a more collaborative style, many were concerned about losing this approach and the impact it would have on consumers and the community. GPs discussed how they could see the benefits of having a community of practice whereby they or the practice nurses could come together with the broad range of providers that interact with the older patients they see.

Some suggested that a locally focused acute and community-based providers network would be beneficial, to improve collaboration and better support older people to move more seamlessly between the sectors.

Recommendation Ten
That opportunities to collaborate around a localised focus of projects and strategies to strengthen healthy ageing, clinical practice and innovation be provided and supported.

5.9 Innovation

There are a lot of pressures on the aged care sector with the policy reforms, Royal Commission, introduction of new standards and planning for increases in demand. Consumers talk about trusting the local providers and wanting help to navigate the system and be supported to remain at home for as long as possible. Whilst this is a tricky time to be operating in, it also presents opportunities to innovate and redesign parts of the system so it can function sustainably into the future.

In the United Kingdom, we are seeing new models of service delivery emerging in community care. One example is that of self-managed or wellbeing teams (Helen Sanderson, 2019), whereby a group of workers essentially operate as a team to support a group of consumers. These teams organise their own work schedules, fitting in with the clients and their own needs. This provides flexibility to both the consumers and the staff. It also allows clients to receive some continuity when staff go on leave, as they are familiar with other members of the team (addressing one of the biggest areas of complaint in community care).

Another Australian example is a newer organisation called Mable. Mable runs an online platform where vetted and credentialed staff advertise what services they offer and the rates they charge. Consumers and/or families can go online and select the staff member that most aligns with their preferences. Invoicing and payment are all handled by Mable.

Some providers are concerned about the viability of their current operating model and would benefit from support to explore options so they can make informed decisions about the future. There are opportunities to merge workforces and/or operations and this may be a useful consideration for the smaller or more rural providers.

Ultimately, everyone is in the same business and – where values align – there may be benefits for the community if organisations look to each other

One of the more rural communities talked about how healthy ageing could be an ideal platform to bring community and providers together to co design ways to support older, local people. This positive approach builds on community and individual older people's strengths; engages older people in designing solutions that are going to work for them; and brings providers, community and older people to that table as equals – ultimately breaking down ageism.

Others talked about the rise of assistive technology and eHealth and how there has been very little uptake, yet these innovations could be a useful way to target a workforce when a shortage is anticipated. Examples that are currently available and operational include:

- the use of a landline or mobile telephone to prompt people to take their medication;
- the use of sensors in a person's home to detect that they are up or if they have fallen; and
- remotely monitoring a person's blood pressure or other health signs which reports into an online system.

Service hubs from which a mixture of providers operate have also been identified as innovative. Such hubs would form a central point or 'one stop shop' for the consumer (rather than the consumer having to find their way from one provider to another in different locations).

With the upcoming contracting out of assessment, one provider suggested the PHN could act as the contractor, coordinating assessment across the region.

Recommendation Eleven

That providers be supported to explore new models of service delivery that are more sustainable, flexible and consumer focused, also allowing improved working conditions for staff.

Recommendation Twelve

That support be given to providers of high risk or vulnerable client groups to better understand and consider their business needs. This could include skill sets on boards, back of house functions, compliance and quality. There are opportunities to merge workforces and/or operations and this may be a useful consideration for the smaller or rural providers.

Recommendation Thirteen

That healthy ageing be given a stronger and more prominent platform across service provision in the Western Victoria PHN.

Recommendation Fourteen

Explore ways that assistive technology and eHealth could complement service delivery, particularly in more rural communities.

Recommendation Fifteen

Provide support to develop innovative models of integrated care. Suggestions include: placing health professionals in community settings such as community centres; and, that the PHN become the contractor for assessment across the catchment (as Brisbane PHN has done).

6. Conclusion and recommendations

This project has engaged with older people (both current and possible future service users), carers, families and providers of services that make up the aged care system. Whilst it is evident that many things are working well, there are also areas for improvement and gaps in service provision.

The current cohort of older people have confidence in providers but struggle to access and navigate the system, especially with the introduction of a centralised telephone and online platform. The policy shifts being introduced are disruptive as providers, older people and the introduced systems collectively struggle to adapt. This change is going to take some time to embed.

Interestingly, these changes also provide opportunities for innovation and a shift in focus from seeing older people as a physically and cognitively declining cohort who use up significant chunks of the available resources, to that of assets to the community. We need to create the right environment for this shift to occur, by taking a broader focus on healthy ageing. As the World Health Organisation states, *"Healthy ageing is about creating the environments and opportunities that enable people to be and do what they value throughout their lives"* (WHO, 2019). Age, disability or disease does not and should not preclude people from contributing, being valued and belonging to the community they live in.

Western Victoria has a lot of supports to enable older people to age well in place, including a good range of service providers across community and residential care, as well as access to health supports in the form of GPs, allied health, nursing and medical services. With a growing proportion of ageing community members, increased pressures are likely to be put on these systems if we don't innovate and focus on what we can do. The following summary of recommendations are drawn predominantly from contributions to this project, but also from national and international examples of good practice.

6.1 Summary of recommendations

a) That additional investment is considered to provide face to face support to the current cohort of older people in accessing and navigating the system, paying particular attention to at risk or 'special' groups (as identified by the Department of Health).

b) That social isolation be considered, with the trialling and implementation of strategies to strengthen social inclusion across the community.

c) That multi-disciplinary mental health supports be made more readily available, particularly for people living in RACFs.

d) That the PHN leads advocacy around the gaps and impediments in service provision. Areas could include: transport; goods and equipment; rural subsidies for travel costs; increased

availability of HCP; staffing ratios in RACFs; better Medicare rebates for GPs providing services to people in RACFs; and adequate unit cost funding.

e) Consideration be given to after hour service options.

f) The development of HealthPathways to assist GPs navigate community options with older people.

g) That a local workforce strategy be developed to strengthen recruitment and retention of all parts of the workforce across the catchment. Some innovation is evident (as documented in this report), but there is much more to be done.

h) That opportunities to collaborate around a localised focus of projects and strategies to strengthen healthy ageing, clinical practice and innovation be provided and supported.

i) That providers be supported to explore new models of service delivery that are more sustainable, flexible and consumer focused, also allowing improved working conditions for staff.

j) That further support be provided for providers to high risk or vulnerable groups to better understand and consider their business needs. This could include skill sets on boards, back of house functions, compliance and quality. There are opportunities to merge workforces and/or operations and this may be a useful consideration for the smaller or more rural providers.

k) That healthy ageing be given a stronger and more prominent platform across service provision in the Western Victorian PHN.

l) Explore ways that assistive technology and eHealth could complement service delivery, particularly in more rural communities.

m) Provide support to develop innovative models of integrated care. Suggestions include: placing health professionals in community settings such as community centres; and that the PHN become the contractor for assessment across the catchment (as Brisbane PHN has done).

7. Glossary

ACAS - Aged Care Assessment Services

Aged Care Assessment Services conduct comprehensive assessments to determine eligibility to access higher level services, including residential aged care, residential respite care, Home Care Packages, as well as the CHSP.

CHSP – Commonwealth Home Support Program

The CHSP provides entry-level home support for frail older people who need assistance to keep living independently and safely at home. The CHSP offers a range of short term or ongoing personal services, support services and clinical care.

HCP – Home Care Packages

The Home Care Packages (HCP) program provides older people with complex care needs who want to stay at home with access to a range of ongoing personal services, support services and clinical care that help them with their day-to-day activities. HCP fits between CHSP and RACFs. There are four levels of support:

- Level 1 – basic care needs
- Level 2 – low level care needs
- Level 3 – intermediate care needs
- Level 4 – high care needs.

MAC – My Aged Care

My Aged Care provides the main access point to the aged care system in Australia. A contact centre (online or telephone) provides information, screens and registers people for an assessment; determining whether a home support assessment through the RAS, or comprehensive assessment through the ACAS, is the best option.

PHN – Primary Health Network

PHNs aim to increase the efficiency and effectiveness of medical services, particularly for people at risk of poor health outcomes, and improve coordination of care to ensure people receive the right care in the right place at the right time.

RACF – Residential aged care facility

Residential aged care facilities provide a range of care options and accommodation for older people who are unable to continue living independently in their own homes. The type of care provided ranges from personal care to assistance with activities of daily living through to nursing care on a 24-hour basis. Residential aged care services are delivered by a range of providers, including not-for-profit, private and public sector organisations.

RAS – Regional Assessment Services

Regional Assessment Services carry out face to face assessments for people looking for entry-level support at home, generally provided under the Commonwealth Home Support Program.

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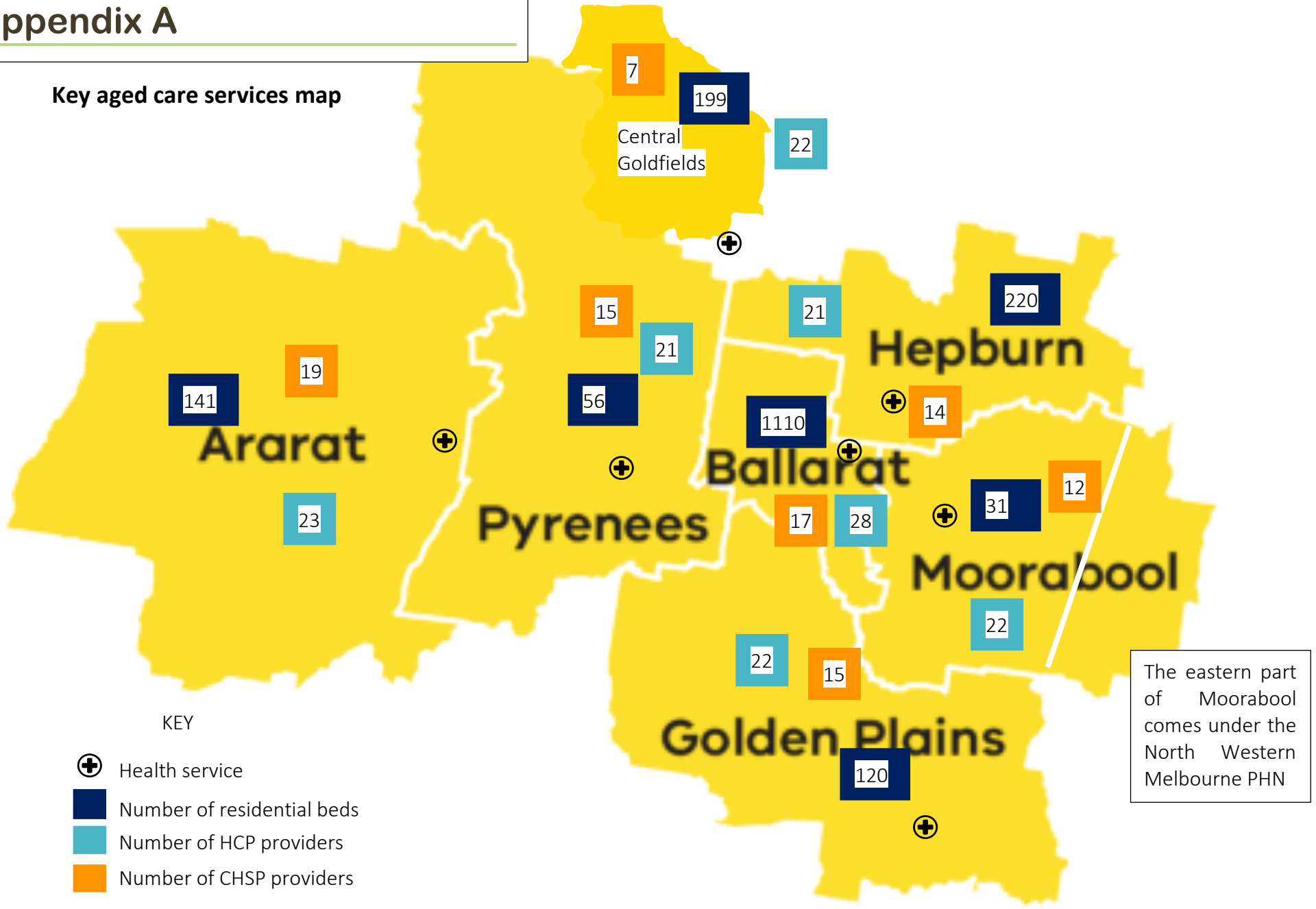
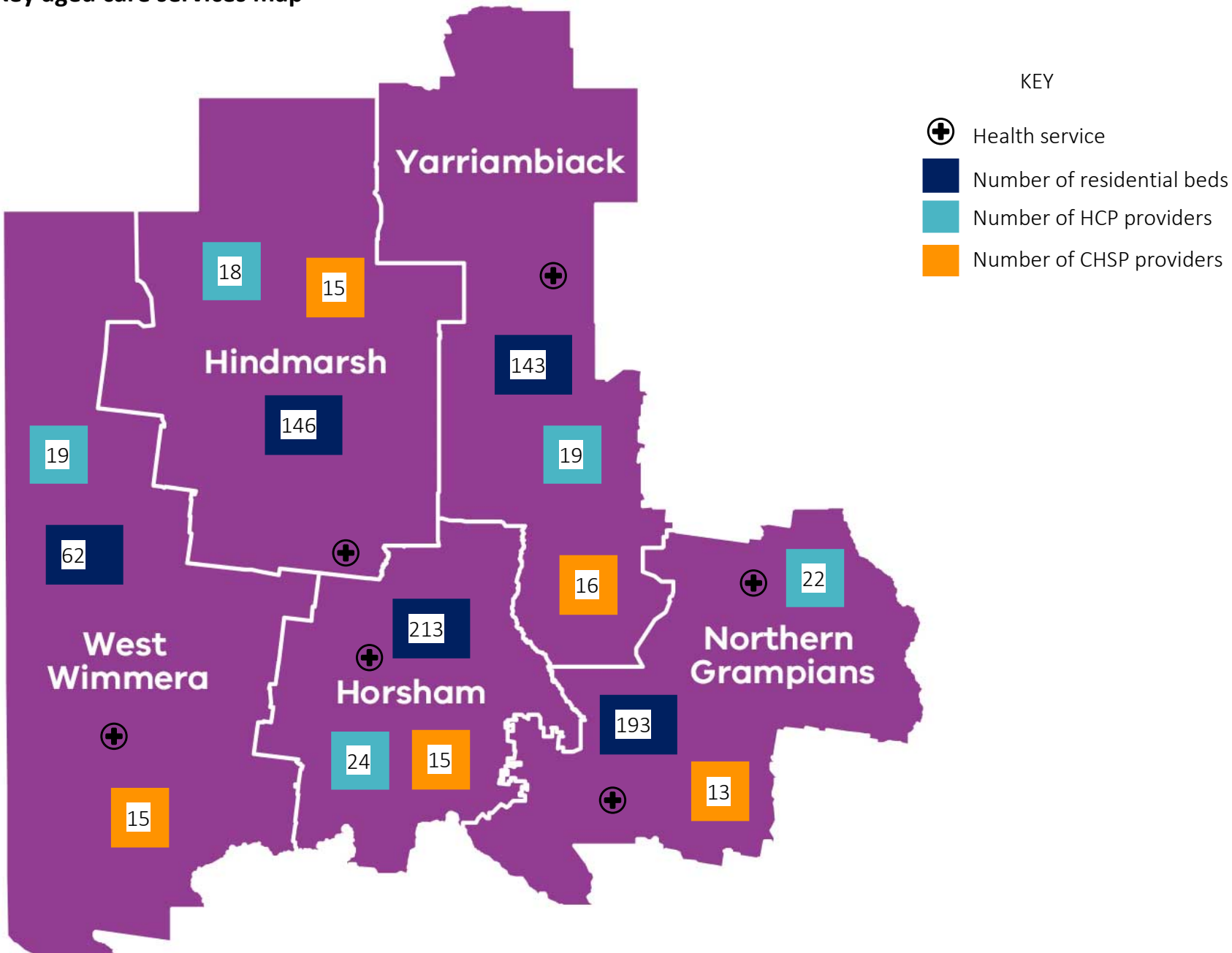
8. Appendix A

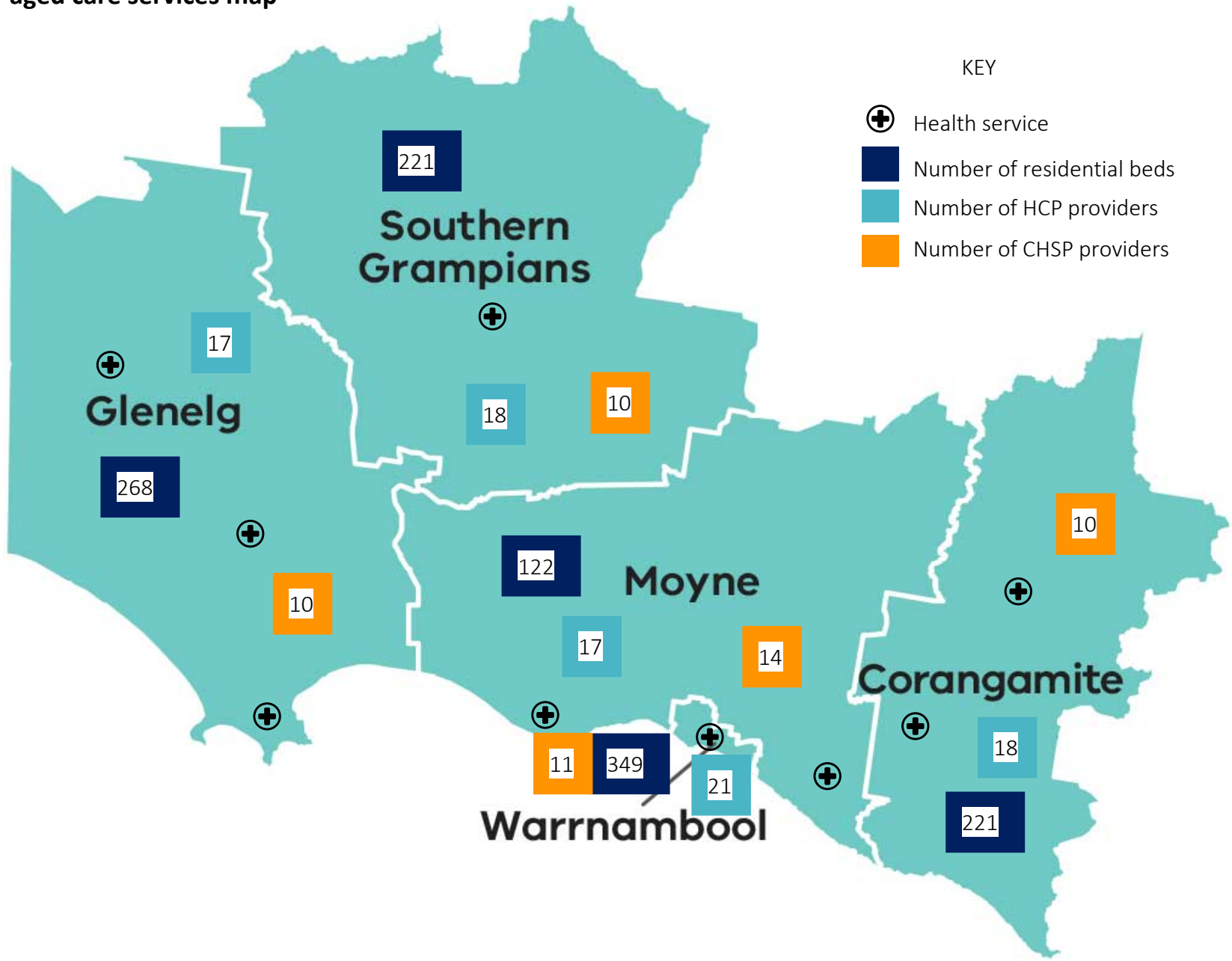
Key aged care services map



Key aged care services map



Key aged care services map



Key aged care services map