Nepean Blue Mountains Primary Health Network
Care Finder Program

Supplementary Needs Assessment Activities
Section 1  Narrative

1.1  Actions to determine additional activities

Nepean Blue Mountains Primary Health Network (NBMPHN) undertook a variety of activities to identify the local needs of the community to inform the commissioning and requirements of providing care finder support to the population cohort.

These activities commenced with an initial review and analysis of the 2021 needs assessment to identify specific areas of focus for further analysis to ensure a robust understanding of the care finder target population. Additional focused quantitative analysis was undertaken including but not limited to the 2021 ABS Census Data, to establish the local population needs and how they would best be supported by the care finder program. Details of the data analysis is included as part of this supplementary needs assessment.

To further support the quantitative analysis NBMPHN commenced community consultations to ensure a qualitative assessment to support the needs assessment. This qualitative consultation identified the following key areas of priority for the population cohort:

➢ Trauma survivors
➢ Culturally diverse communities
➢ Geographically isolated communities
➢ Older people unable to use, or without access to information technologies
➢ People experiencing housing insecurity
➢ People with sensory impairments that affect access to information
➢ People with cognitive impairment and those at risk of including dementia, older people who may be living alone and socially isolated

It is important to note that whilst the analysis established some key areas of difficulty for the population cohort, there was a general lack of understanding of the challenges with this group not connecting with the service system in any substantial way. To further support the triangulation of analysis, review of the existing service system and available reports identified current service gaps in the NBMPHN region outlined within this needs assessment. It was identified that care finders will need to be in each local government area across the region and embedded within the community ensuring a local presence, enhancing the opportunity for assertive outreach within the area. This will maximise reach for the most vulnerable population groups.

NBMPHN consulted with other PHNs as part of the NSW/ACT Aged Care Network and participated in the co-design process facilitated by COTA. Regular consultation with other PHNs will continue to support the implementation of care finders and manage any potential service issues which may occur where PHN boundaries may impact care finder services.

The supplementary needs assessment clearly outlines the activities undertaken by NBMPHN to develop an evidence base through quantitative and qualitative assessment and analysis of findings to inform the commissioning of care finder services.
1.2 Additional activities undertaken

NBMPHN have undertaken a range of consultation and scoping activities to recognise the needs of our local communities as outlined above. This included regional data analysis, and a series of focus groups and consultation activities with our local service provider and community. The outcome of these activities is discussed below.

Data analysis - profile and needs of the local population in relation to care finder support

Geographic Distribution

The Nepean Blue Mountains Region covers four local government areas including Blue Mountains, Hawkesbury, Lithgow, and Penrith and is home to approximately 387,026 people. Of these, 58,472 people, or just over 15% are aged over 65 years. When we consider the median age of people across NSW, being 39 years old (and 38 years old Australia wide), we can see pockets of our region house a significantly older population. In Lithgow, the median age is 46 years old, followed by the Blue Mountains (45 years), with relatively ‘younger’ populations in Hawkesbury (39 years) and Penrith (35 years). Recent census data (2021) also indicates a high proportion of the population in our region aged over 65 years with 24.5% of residents in Lithgow aged over 65 years, followed by the Blue Mountains (22.5%), Hawkesbury (16.6%) and Penrith (12%).

The regional ‘active patient’ data extracted for May 2022 (from 98 General Practices who have data sharing arrangements with the PHN (72.5% of total practices in the region)), indicates an active patient number of 67,597 people aged over 65 years. Interestingly, of these, nearly 50% live in the Penrith Local Government Area, recognising that while rates of older people, as a proportion of the total population in other LGAs is greater (as shown in broader census data), due to greater population numbers in the Penrith LGA, a significantly higher number of older people reside there. It is important to note however, that the higher number of active patients in the Penrith LGA could also be accounted for due to a higher availability of GPs in this area. Therefore, residents from outlying areas may be seeing a GP in Penrith due to supply issues in their own place of residence.

Census data (2020) indicates that the NBM region has a population of 2,154 Aboriginal and/or Torres Strait Islander Peoples. The median age of Aboriginal and Torres Strait Islander Peoples in our region is lower than that of the general population (also reflected in state and national data), with a median age of 26 years.

The active patient population data indicates that active Aboriginal and Torres Strait Islander patients over the age of 55 years comprise just over 12% of the total Aboriginal and Torres Strait Islander

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1 PHIDU 2022 Social Health Atlas of Australia, June 2022, Torrens University.
6 ibid
7 NBMPHN (Nepean Blue Mountains Primary Health Network) (2022a) Disease prevalence for Active patients, 65+ years [data set], patcat.nbmphn.com.au.
residents in the region\textsuperscript{10}. Proportionately, the older Aboriginal and Torres Strait Islander population is highest in Lithgow, followed by the Blue Mountains, Hawkesbury, and then Penrith.

A relatively high proportion of residents were born in Australia (75.6\%)\textsuperscript{11}. This represents a higher percentage of Australian-born residents than both the NSW and Australian populations (65.5\% and 66.7\% respectively)\textsuperscript{12}. Of those residents born overseas, 7.3\% were born in predominantly English-speaking countries, with 10.9\% in non-English speaking countries. The highest number and percentage of residents born in a non-English speaking country reside in Penrith (28,983 people, or 14.8\% of the population)\textsuperscript{13}.

**Socio-economic Disadvantage**

According to the 2016\textsuperscript{14} Socio-Economic Indexes for Australia (SEIFA)\textsuperscript{15}, Lithgow is the most socio-economically disadvantaged LGA in the Nepean Blue Mountains Region followed by Penrith, Hawkesbury, and the Blue Mountains.

Lithgow is the 19\textsuperscript{th} most disadvantaged LGA in NSW out of a total of 130 LGAs, and the 105\textsuperscript{th} most disadvantaged LGA in Australia out of a total of 455 LGAs\textsuperscript{16}. In NSW, Lithgow sits at the 15\textsuperscript{th} percentile, meaning that 75\% of NSW LGAs are less disadvantaged, whilst Australia wide Lithgow sits in the 20\textsuperscript{th} percentile\textsuperscript{17}.

Penrith ranks 95 in NSW and 370 in Australia, and whilst still more socioeconomically disadvantaged than Hawkesbury and the Blue Mountains, and less disadvantaged than Lithgow\textsuperscript{18}. In NSW, Penrith is in the 73\textsuperscript{rd} percentile, compared to the 68\textsuperscript{th} percentile in Australia. Hawkesbury is ranked 105 in NSW and 451 in Australia and sitting in the 81\textsuperscript{st} percentile for NSW and the 83\textsuperscript{rd} percentile in Australia\textsuperscript{19}. The least socio-economically disadvantaged LGA in our region is the Blue Mountains, with a rank of 110 in NSW and 486 in Australia\textsuperscript{20}. In NSW, the Blue Mountains sits in the 84\textsuperscript{th} percentile and the 90\textsuperscript{th} percentile for Australia\textsuperscript{21}.

This data indicates that there is significant variability of socioeconomic status across our region. The high relative disadvantage in Lithgow, compounded further by the geographic isolation residents experience and reduced access to services, indicates the required resourcing considerations for this area.

**Housing Arrangements, Housing Stress and Homelessness**

The 2016, census data\textsuperscript{22} demonstrates that home ownership for residents aged 65 years and over in the Nepean Blue Mountains region is relatively high. The Blue Mountains has the highest rate of

\textsuperscript{10} NBMPHN (2022b) Disease prevalence for Active Indigenous patients, 55+ years [data set]. patcat.nbmphn.com.au.


\textsuperscript{12} ibid

\textsuperscript{13} ibid

\textsuperscript{14} Please note, data from the 2021 Indexes has not yet been made available


\textsuperscript{16} ibid

\textsuperscript{17} ibid

\textsuperscript{18} ibid

\textsuperscript{19} ibid

\textsuperscript{20} ibid

\textsuperscript{21} ibid

\textsuperscript{22} https://profile.id.com.au/nbmphn/households-without-children?SeifaKey=40002

Care finder program: Once-Off Report on Supplementary Needs Assessment Activities 4
outright home ownership (66.8%), whilst a further 11.6% own their home with a mortgage, and 7.4% rent. Lithgow has the second highest rate of outright home ownership (64.1%), a further 7.9% own their home with a mortgage, while 10% rent. In the Hawkesbury, 61.3% of residents over the age of 65 own their home outright, a further 13.9% own their home with a mortgage, whilst 10% rent. Finally, Penrith has the lowest rate of outright home ownership (58.7%), a further 11% own their home with a mortgage, whilst 13.7% rent. In June 2021, 18.9% of households in rental accommodation in the region were receiving rent assistance\(^23\). This was close to the state average of 18.3%.

National Specialist Homelessness Services (SHS) data from 2020-2021\(^24\) identified that 8.6% of their client base was over 55 years of age. The most common reasons older people face homelessness included housing crisis, for example, due to eviction (18%), domestic family violence (18%) and financial difficulties (15%). There has also been an increase in older women experiencing homelessness due to lower lifetime incomes, less superannuation and domestic family violence. Specialist Homelessness Services were provided to 5,216 clients in NSW during 2020-2021.

The following data from the Department of Communities and Justice website\(^25\) reflects wait times for social housing in our region, reflecting the significant under-supply facing residents:

<table>
<thead>
<tr>
<th>Expected waiting time for general applicants</th>
<th>Blue Mountains</th>
<th>Hawkesbury</th>
<th>Lithgow</th>
<th>Penrith</th>
</tr>
</thead>
<tbody>
<tr>
<td>Studio/1 Bedroom</td>
<td>10+ years</td>
<td>10+ years</td>
<td>5 to 10 years</td>
<td>5 to 10 years</td>
</tr>
<tr>
<td>2 Bedroom</td>
<td>5 to 10 years</td>
<td>5 to 10 years</td>
<td>5 to 10 years</td>
<td>5 to 10 years</td>
</tr>
<tr>
<td>3 Bedroom</td>
<td>5 to 10 years</td>
<td>10 + years</td>
<td>5 to 10 years</td>
<td>5 to 10 years</td>
</tr>
<tr>
<td>4 Bedroom</td>
<td>5 to 10 years</td>
<td>5 - 10 years</td>
<td>5 to 10 years</td>
<td>5 to 10 years</td>
</tr>
</tbody>
</table>

SHS data also reveals that 20.3% of clients they assisted were also experiencing mental health issues, a further 15.7% were experiencing domestic family violence, 6.8% were experiencing both domestic family violence and mental health issues. 32% were experiencing mental health and problematic alcohol and other drug use.

**Social Engagement and Family/Community Support**

The Nepean Blue Mountains Region has a slightly higher percentage of residents that live alone, in comparison to state and national data. As such, 9.8% of residents over the age of 65 live alone, this is higher than Greater Sydney (8.7%) and been subject to increase from previous years. Data from the 2021 Census has also indicated that the Nepean Blue Mountains Region has a higher rate of older people without children (9.7%) compared to Greater Sydney (8.6%), and this rate has also risen compared with previous years. While it is difficult to definitively know whether this has any implication for aged residents, one potential impact could be a relative lack of informal care options within families compared to previous years and generations. Also, for older people without children, potentially, they may be more limited scope for advocacy and support in seeking services, a role that is often assumed by children of the older person.

Data from the General Social Survey\(^26\) in Australia, has recognised the specific social and physical isolation experienced by the general population, only exacerbated by the COVID-19 pandemic.

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\(^23\) PHIDU 2022 Social Health Atlas of Australia, June 2022, Torrens University.
Australians had less face-to-face contact with family or friends living outside their household in 2020 than in previous years of this survey. Some groups of community, namely recent migrants and temporary residents and people with a mental health condition, were identified as having even less social contact than the broader population. From the consultations, these already marginalised groups experienced further marginalisation when compounded with social isolation. There was also an identified decrease in the proportion of Australians involved in social groups, community support groups and civic and political groups from 2019 to 2020.

**Health and Disability Status**

The growing needs of the ageing population increase pressure on primary care services, particularly the need for coordinated care and services to keep people at home longer. This is particularly relevant for people living with dementia. Approximately 6,453 people in the NBM region are living with dementia, and this figure is expected to increase to 16,075 persons by 2058, with the highest prevalence in Aboriginal and Torres Strait Islander people. Dementia services outside of Penrith are limited and Aboriginal and LGBTIQ+ persons with dementia have poorer access to services. The proportion of persons with mild dementia in NBM between 2016 to 2045 is expected to reduce from 55% to 42%, while those with moderate will increase from 30% to 37% and those with severe dementia will rise from 15% to 20%. People living with dementia require higher levels of care and assistance particularly with activities of daily living, support for cognition and behaviour, and complex health care needs. The increasing number of people with dementia will increase the demand for aged care services and support.

Despite the number of older Australians increasing, the prevalence of disability in the Australian population appears to be relatively stable (49.6% of older people in 2018 compared with 50.7% in 2016). Of these people, just over one third was identified as experiencing a profound or severe limitation, approximately 15% with a moderate limitation, and just under half (40%) with a mild limitation.

The 2018 data identified that 86.5% of older people in Australia reported having at least one long term health condition. The most common long term health conditions were arthritis and related conditions (15.6%), hypertension (9.1%) and back problems (8.7%). When considering the local data, based on active patients with our registered primary care providers, we note that arthritis and related conditions (osteoarthritis, inflammatory arthritis, and other musculoskeletal conditions) were experienced by a significant number of older people aged 65 years or over in NBM region (22.5%, 3.93% and 7.16% respectively). Hypertension was the most commonly identified condition in the local data, with the condition identified for 45.7% of our active older patient population. Hyperlipidaemia (or high cholesterol), a potentially associated condition, was identified for 34.2% of this older active patient population. While this local data cannot be directly compared to the national data (as it is for a specific active patient rather than whole population group), there are clear commonalities expressed by the most common chronic conditions.

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30 Ibid
31 NBMPHN (Nepean Blue Mountains Primary Health Network) (2022a) Disease prevalence for Active patients, 65+ years [data set], patcat.nbmphn.com.au.
Multiple Barriers (Service Access)

Data collected in 2020[32] identified that there were 419 General Practitioners (GPs) within the Nepean Blue Mountains Region. This sees approximately 108 General Practitioners per 100,000 people, which was lower than the state (122/100,000 people) and National (126/100,000 people) rates. There were 441 Specialist Practitioners identified in the region in 2020, which represented a rate of approximately 114 per 100,000 residents. Again, this rate fell short of state and national rates (146.2/149.2 per 100,000 respectively). This pattern remained consistent when considering the number of Registered Nurses identified in the region (3,385), reflecting a rate of 874.6 per 100,000 people, compared with state and national rates of 1028.5 and 1137.2 per 100,000 people respectively. This data collectively, demonstrates the relatively lower availability of health professionals within the region, and based on data alone, may lead us to consider whether there are challenges relating to the supply and demand, and timely accessibility to health care in the region.

In 2016 it was estimated that 39,000 (51.5%)[33] residents of the Nepean Blue Mountains region aged over 45 experienced a time where they needed to attend a GP in the preceding 12 months but did not attend. The most common reasons include unable to secure timely appointment (52.71%), cost (6.5%) and no GPs nearby (1.98%).

In 2016, 15,985 (21.1%) residents of the NBM region aged over 45 experienced a time where they needed to attend a specialist in the preceding 12 months but did not attend. The most common reasons include cost (53.31%), unable to secure a timely appointment (29.76%), no GP referral (10.02%) and no specialists nearby (6.96%).

As of 2020, the Nepean Blue Mountains Region had 64.5 residential aged care places per 1000 older people aged over 70 years, the lowest rate of aged care places than any other region in NSW[34]. While we recognise that the care finder population are people within the community (not residential care), this data is relevant as it demonstrates a significantly lower number of aged care places for the ageing population in our region compared to other regions. This potentially indicates a higher number of residential-eligible older people continuing to live in the community due to lack of access. Additionally, within the region, there was significant disparity in the allocations by area, seeing, for example, 209.4 places per 1000 older people in Werrington/Penrith, compared to no places in several locations (Yarramundi, Glenmore Park, Erskine Park, Cambridge Park and Blaxland). When compared to the proportion of older people in various parts of our region, for example the highest rates of older people per the broader population in Lithgow, it is noted that around a quarter of the allocation found in Penrith were allocated in Lithgow. This data is considered relevant, as it is reflective of broader community feedback about the relative lack of services in Lithgow.

Projected Population Changes

Australia’s population is projected to grow to between 30.9 and 42.5 million people by 2056[35]. By 2056 there will be a greater proportion of people aged over 65 years and a lower proportion of people aged 15 and under. In 2007, 13% of Australia’s population was aged over 65 years, this is projected to increase to between 23% and 25% by 2056. The number of people over the age of 85 is...

34 PHIDU 2022 Social Health Atlas of Australia, June 2022, Torrens University.
35https://www.abs.gov.au/ausstats/abs@.nsf/Previousproducts/3222.0Main%20Features12006%20to%202101?opendocument&amp;tabname=Summary&amp;prodno=3222.0&amp;issue=2006%20to%202101&amp;num=&amp;view=...
also expected to dramatically increase. In 2007, people aged over 85 years made up 1.6% of the population; this is projected to grow to 7.3% by 2056.

In the Nepean Blue Mountains Region, people aged over 65 years are projected to increase from 15.2% of the population in 2020, to 17.4% of the population in 2030\(^{36}\). Lithgow and the Blue Mountains are projected to see growth rates in population aged over 65 years in the same period of 22.9%-27.8%, and 20.9%-24.4% respectively.

In the next 20 years (2021-2041) Lithgow’s population is projected to decline from approximately 21,477 to 21,174 people, with an annual negative growth of -0.07%, whilst Hawkesbury’s population is set to increase by nearly 10,000 residents (67,472 to 77,211), with an annual growth of 0.68%\(^{37}\). The Blue Mountains is also predicting an increase by nearly 4,500 people (79,373 to 83,951) residents with an annual growth of 0.28%. Penrith is set to see the biggest increase in residents with from 216,075 to 270,477 residents (increase of 54,402) with an annual growth of 1.13%\(^{38}\).

**Stakeholder and community consultations to identify local needs for care finder support**

A range of consultations, expert interviews and service provider discussions were undertaken as a component of the care finder needs analysis. This built on NBMPHN’s previous regional needs assessments to understand the specific needs, priorities, barriers, or challenges faced by our community in relation to access to, or delivery of, effective aged care supports.

The interviews conducted involved stakeholders from the following groups: aged and social service providers, advocacy services, neighbourhood services, local Police, specialist service providers, primary care providers and health sector stakeholders.

While a wide range of perspectives were shared, key themes in stakeholder feedback were noted. These themes were reflective of both the needs of the community, as well as the associated barriers based on these needs, to access support. These themes are also reflective of where the greatest need is to target our care finder workforce.

**Trauma Survivors**

Throughout our community consultations, various participants discussed previous and current experiences of trauma as a complexity for older people seeking (or considered needing) aged care supports. ‘Trauma’ in this context was discussed in a broad way, including childhood trauma (for example Care Leavers or other traumas incurred during childhood), trauma relating to war or circumstances in home countries (for example, refugees, or migrants from countries with current political crises), relationship trauma (for example family violence) or victims of crime. Discussions relating to trauma also extended to situational trauma, for example: trauma occurring due to homelessness (for example, accepting unhealthy relationships in exchange for shelter); post war/post armed services trauma (returned Veterans or ex-police experiencing post-traumatic stress disorders); or other trauma experienced at the hands of institutional systems. Racism and other cultural or race-specific trauma were also discussed and explored further under ‘cultural diversity’. Trauma, in this context, also extended to negative past experiences of services or systems that strongly influenced the way people engaged (or were fearful of engaging) with aged care and other services.


\(^{38}\) ibid
Many interviewees spoke about how these diverse experiences of trauma had a major impact on people accessing aged care services. Whether this be due to their own fear or resistance (often due to deep mistrust of the system), or, due to attempts to access services that had not been successful, reinforcing fear and distrust.

Some examples of these discussions included:

“Some of our clients have come from situations where it is not preferable or safe for institutions (or governments) to hold a lot of their personal information. People are nervous about governments having so much of their information, so even getting to the assessment stage can be very difficult”.

ACH Provider

“We often have clients who have been previously involved in the child removal systems. Where their children have been removed in the past, and they still have a fear of people making judgements, or of there being some consequence (like thinking they cannot live at home independently anymore) because of how they are living. So, they don’t allow services into their homes”.

Aged Care Provider

“We come across people who have family members living with them from other countries (war-torn or political unrest) who may not have legal Visas. They might be helping to run properties and farms for owners who are ageing and do not want to have to leave their properties. They are reluctant for any ‘systems’ getting involved and potentially resulting in deportation or a decision that they are unable to maintain their properties anymore”.

Local Council

“We have many residents who have been victim to domestic violence or childhood institutionalisation, where the level of mistrust is so deep and entrenched. They have not had good experiences with systems. As older people now, it is difficult to reassure them that the system may be able to help”.

Housing Provider

“Some of our clients have been in ‘disability homes’ or other institutions back in the day where their treatment was not good. Often, back then, these institutions were church based. We still find many of our older clients who are resistant to church-based providers, which is hard when sometimes they are the only option”.

Disability Provider

“More recently we have had some transgender women who have experienced quite a lot of community backlash up here. They do not feel safe in a lot of places. This can be a reason why people may be reluctant to get support, like they do not know if the service is going to be accepting and supportive of their unique circumstances”.

Community Centre

While it was clear from the consultations that there were some specific population groups where targeted knowledge about their trauma was needed by service providers (for example, understanding the experiences of Care Leavers, and specific triggers that may create distress within a service environment). There was consensus that every individual’s experience of trauma was different, and that the skillset required related generally to an ability to practice trauma informed care. Participants spoke of the need for care finders to have an underlying capacity to practice
trauma informed care, while taking the time to build trust, relationships and understanding of an individual’s specific experience of trauma.

**Cultural Diversity**

Diverse cultural needs, perspectives or even concepts relating to help-seeking, was also a key theme of the consultations. While our general conceptualisation of ‘culture’ often relates to race, the discussions held in consultation covered this, as well as a broader consideration of ‘generational cultures’ and finally ‘culture’ as it applies to family and gender diversity.

Cultural diversity related to race was discussed as a potential barrier or complexity for seeking and accessing aged care services. While some of this was practical/logistical (for example, information that is translated, use of interpreters, ability to get information in an appropriate form), participants spoke more of cultural barriers that may be more related to cultural norms, protocols, constructions of caring or of care giving. The former (the more practical access considerations) will be explored in the following section on *Practical Barriers to Support Seeking*.

Cultural norms or protocols were identified as a potential barrier for support seeking, access and/or delivery. The consultations provided insight into these areas. While participants noted that there is not extensive cultural (race) diversity in the Nepean Blue Mountains region, they did note that for many residents, where there was this diversity, it did often have an impact on their access to aged care. Participants also noted, that in areas where there were pockets of concentrated cultural groups, there was often a preference for inter-community care and support, rather than seeking outside support. Participants also observed differences in help-seeking behaviours (for example, perspectives about accepting help as a weakness, or aversion to accepting government help); perceptions relating to receiving and giving care (for example, perspectives relating to the role of children or other family as care givers over the role of the state); and cultural preferences for how care is delivered (for example, perceiving the ‘recipient’ of care as a couple or family group rather than the individual). In some cases, it seems that perspectives are shaped by home country norms, in others, due to past experiences (or stories of others’ experiences) that influence care seeking.

*Some examples here included:*

“I work with families that definitely see accepting help from governments as a weakness. This is a cultural thing that stems from the role of government in their own countries. The next generation (their children) who may have even been born here, don’t understand the resistance. We need good information to bust some of these stigmas”.

“In some families, and for some cultural group, it can be the children that are resistant too. In some families, not allowing your children to take care of you can be quite offensive. Like, it is an important cultural role to provide care”.

**Multicultural Service**

“In some communities, there are tight circles of trust that can influence service access. Community members often trust each other more than ‘outsiders’. So, if there have been some bad experiences within the community, often everyone hears about it and this can make people less trusting to accept support”.

**Aged Care Provider**

Where service systems were not able to accommodate cultural preferences, this also became a barrier to support seeking. Examples of this could include: how services included or accommodated the preferences/requests or involvement of extended family, how questions were asked about
deficits or inabilities that caused shame (or in some cases fear, that the assessor may deem the person unable to care for themselves); where there were gender considerations (for example, asking questions about physical bodies or gender-specific experiences that were not comfortably discussed with a person of the opposite gender); or in a broader sense, where there was a level of stoicism or culturally-based communication approaches that don’t focus on inability (resulting in, for example, assessments not adequately identifying need, despite family or friends knowing support was needed).

‘Culture’ was discussed in a broader sense as well, beyond race. Generational culture was raised as an issue for support seeking and acceptance. Specifically, the post war generation was identified as a group that were very stoic, non-complaining and self-sufficient, a ‘Silent Generation’ that were used to putting others’ needs before their own. ‘Battling on’, this generation was discussed as needing more time, information, and support to encourage their acceptance of services, that is often not afforded within the current system.

“I see so many older residents who clearly need help. But there are so stoic and it is hard to get them to accept it. I think some of them are concerned about people coming in and deciding for them that they cannot cope, so they just battle on”.

NSW Police Community Liaison

“People have been out there, running their properties all their lives. They are resilient and self-sufficient people. As they get older, as well as not being used to accepting a lot of help, I think they worry that people will come and try to get them to move off their properties, you know, assume they cannot cope. So, they avoid services coming in and seeing what is going on sometimes”.

Local Council

Finally, the concept of ‘cultural diversity’ was used to recognise a theme around family and gender diversity. While not recognised as a large population, there were pockets where people identifying with gender diversity identified barriers to support seeking (this issue was mostly raised in the Blue Mountains discussions). Older generations who did not experience acceptance of gender diversity in their younger years (including those who may not even have disclosed their gender identifications until older adulthood), fear of judgement, discrimination and of their needs not being appropriately assessed/responded to, was a barrier for some community members. Place-based discrimination of people from the LGBTIQ+ community was also identified, further instilling anxiety and mistrust in the broader service system. While some of these barriers are also trauma-based, there was a general theme relating to systemic understanding of diversity which manifests in similar ways to barriers experienced with other diverse populations.

Some examples of comments supporting this theme included:

“Unfortunately, the transgender community do experience quite a lot of backlash here. They are often fearful about accessing mainstream services, unsure about how they will be received”.

Blue Mountains Women’s Resource Centre

“For some of our older client’s identifying in the LGBTIQ+ community, they may have ‘come out’ later in life, or even not at all to family and friends. Accessing services can be daunting, unsure whether their needs will be supported, if they haven’t even received that acceptance and support from their close circle”.

Catholic Healthcare
‘Culture’ and ‘diversity’ was a clearly identified barrier in the consultations. Even where some consultation participants told us that the ability to respond to culture and diversity was a more generic rather than community-specific skill (others felt that community specific knowledge and responses were very important). There was clearly a need for care finders to possess skills in engaging effectively with diversity. Skills in this space included being able to understand cultural or historical motivators, build trusted relationships, provide effective information in gentle ways to challenge stigmas, and/or to be able to work effectively with not only the older person, but their (sometimes extended) families and communities.

Logistical Barriers

The final and somewhat broad theme identified in the consultations, relates to a range of logistical barriers to care finding, access to information, and ultimate service delivery. This can be further categorised into the following sub-themes, including barriers relating to:

Sensory impairments and access to information: This includes the Deaf community, as well as people who experienced vision or hearing impairments. Various consultation participants identified the lack of timely and purpose-developed communication resources for these populations. Where these resources were only available online, participants noted an older person’s ability to use information technology as a compounding barrier.

Cognitive impairments, particularly for older people who may be living alone and socially isolated: Many participants also noted cognitive impairments as well as unmanaged mental illness as a potential barrier for help seeking. Particularly where an older person experienced these impairments and lived alone, or were otherwise socially isolated (or where, in some cases, another person in the household also experienced a lack of insight or other cognitive impairment), these issues were more pronounced.

Geographic isolation: This was described by many as both a difficulty to access services due to geographic distance, but also a lack of consistent service providers in more remote areas (for example Lithgow, where rather than having established providers, services may ‘visit’ from more central localities). And additional costs associated with their location, for example, having to pay higher rates for services to cover travel. In some cases, geographical isolation meant that vulnerable communities remain ‘hidden’ where they are not actively coming forward for support, and service providers come in and out without an established presence in the community. For others, it meant that there was an inability to form meaningful relationships and trust, so service access was avoided altogether.

Inability to use information technologies: Time and time again, communities raised the difficulties older people had accessing information that may be online. There were many reasons identified for this: basic lack of access to information technologies; inability to use computers or mobile devices; limitations in ability to access information on the devices (for example, due to sight or hearing impairments); and/or inability to navigate the information effectively. Where there was also financial disadvantage or stress, accessing the internet or having available data was also identified.

Housing insecurity: The lack of secure housing was also identified as a key theme in our consultations. This theme will be explored in more detail in other areas of our report, however in summary, where people did not have secure housing, accessing care seemed to be significantly more difficult. The lack of affordable housing was identified in the consultations repeatedly, particularly in areas where affordable rentals were being converted to Airbnb accommodation, or where demand exceeded supply, pushing up rental prices. Where older people were in transient accommodation cycles, staying with friends or family, ‘couch surfing’ or even staying in unsafe or unhealthy
relationships rather than finding themselves homeless, care access and delivery proved difficult. Where older people were in marginal housing, people also identified older people’s reluctance to invite services in, for fear of being judged or deemed unable to live in that environment. Participants also identified that for some residents in social housing, who may be struggling to maintain that property; or where there were issues, such as hoarding, squalor, substance use or others staying with them experiencing challenges, people were often reluctant to accept in home help for fear of losing their accommodation.

**Health literacy:** The World Health Organisation identify health literacy as being a significant factor in an individual’s health outcomes and their ability to seek health services\(^\text{39}\). In work done by Choudhry et.al, they quote data that indicated that 60% of Australians have low health literacy, which has an impact on their ability to access health services, manage chronic conditions and their medication management. This was identified as being an even greater issue in rural and remote locations. Primary health providers in the Nepean Blue Mountains region concurred with this study, recognising the link between low health literacy and health and social care outcomes for older people in our region. The data in this research indicates a greater need for collaborative and coordinated approaches for improving health literacy within our population, with the need to ensure a health literate lens for all health-related communication and interaction between the consumer and health professionals\(^\text{40}\).

What was clear from the consultations, was that these physical/logistical barriers, either experienced alone or with other compounding factors, greatly influenced vulnerable older people’s ability or willingness to access aged care supports.

**Analysis undertaken to understand the local service landscape as relevant to care finder support**

The Nepean Blue Mountains PHN has been able to utilise new and previous needs analysis information, systems, and stakeholder engagement to understand the local service landscape and to establish where gaps exist. Specifically, the following service system characteristics have been identified that directly impact the care finder cohort and new care finder program\(^\text{41}\):

- Placement of older people into residential aged care, potentially prematurely, due to the lack of appropriate community-based care to support their needs.
- Exceptionally long waiting lists for Aged Care Packages in the region, as well as lack of availability of services through the Commonwealth Home Support Programme (CHSP).
- Limited parking availability and parking costs, limiting access to essential services.
- Unsuitable and high-cost public transport, in particular private bus company services in the Lithgow LGA and lack of transport options altogether in some parts of the region (for example, North-South public transport between Hawkesbury and Penrith).
- Unreliable community transport due to undersupply of drivers and consequent cancellations, increasing social isolation and limiting access to essential services.
- Confusion and difficulty navigating the service system, knowing who the providers are, how to get assessment, eligibility and accessing of service information generally.
- Limited choice in providers, at times resulting in members of the population with specific care needs not feeling confident in accessing care they do not feel will meet their needs.

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\(^{40}\) Ibid.

➢ Perceived lack of service coordination, clear referral pathways or clear eligibility for some service types.

**ACH Providers**

NBMPHN was advised by the Department of Health and Ageing of four Assistance in Care and Housing (ACH) providers who were operating in the Nepean Blue Mountains region. Meetings with each provider was undertaken to establish the level of interest in continuing to provide a service through the care finder program. These discussions were in two parts, an initial conversation detailing the care finder program including the quarantined funding available and the policy guidelines that were circulated by the Department. The second discussion was focused on feedback from the ACH Providers and allowing some time to develop an understanding of the care finder program and how they intended on proceeding.

Of the four ACH providers, one has elected to withdraw due to the limited funding. Two of the ACH providers were interviewed as part of the consultation process. The providers highlighted a high level of need for the care finder target population. This vulnerable population can be hard to reach, and both currently employ an assertive outreach model. This work would see them visit RSL clubs, church groups and neighbourhood centres to ensure they reach those people who are not accessing the service system in any way.

The ACH providers advised the areas in which they were conducting most of their work and collectively it was determined that up until this point there had been a focus on Penrith and Hawkesbury LGAs but limited focus in the Blue Mountains and Lithgow LGAs with only one organisation being funded to cover Lithgow at 0.2 FTE.

The ACH providers also indicated that there were previously limited relationships between each ACH provider as they would individually respond to the client’s needs directly, with limited engagement with other ACH providers. They identified better coordination and collaboration as an opportunity under the new program.

**Primary Health Network NSW/ACT Aged Care Network**

The NSW/ACT PHN Aged Care Network meets quarterly to discuss shared opportunities, issues and solutions to any barriers impacting all PHNs across the aged care sector. The network was established to allow an opportunity for each PHN in NSW/ACT to share examples of innovation and best practice and explore key integration enablers with a view to identifying opportunities for collective approaches to shared knowledge and resource gaps. This meeting is chaired by Nepean Blue Mountains PHN Executive Manager - Primary Care Development. Since the release of the care finder policy guidance, the network has met more frequently with a priority focus on discussing and sharing lessons learned for the care finder program. Subsequently, a dedicated working group has been established to develop a standard contract schedule for all NSW/ACT PHNs led by the network Chair. The network has been critical in sharing information regarding care finder across PHNs.

**My Health Connector**

The ‘Improving Social Connections for Older People’ pilot project aimed to reduce isolation and loneliness through the implementation of a compassionate community approach in the Hawkesbury region. The program involved linking a ‘Health Connector’ to older people to help them find local services, activities, or support strategies to help them feel more connected and less isolated. The Health Connectors needed a directory of local supports available, therefore a key element of this program involved the development of a comprehensive online community directory, *My Health*.
An extensive asset mapping process was undertaken initially in the Hawkesbury region and has since been expanded to encompass all the Nepean Blue Mountains region. This online directory lists local health and lifestyle services including social groups, wellbeing activities and community services for older people. There are currently over 600 services listed which provide a comprehensive awareness of and understanding of the existing services and supports available within the Nepean Blue Mountains region for older people. This resource also indicates any transport, cost and booking requirements, along with hours of operation, and how the service is provided e.g. in home, telephone. As with any database, there can be concerns with the ongoing maintenance and currency of entries, however this is addressed by allowing services to ‘claim their entry’ and update directly.

The following table shows the service mapping represented within the My Health Connector Directory:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Blue Mountains</th>
<th>Hawkesbury</th>
<th>Lithgow</th>
<th>Penrith</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community and Aged Care</td>
<td>130</td>
<td>129</td>
<td>81</td>
<td>108</td>
</tr>
<tr>
<td>Dementia</td>
<td>26</td>
<td>26</td>
<td>19</td>
<td>23</td>
</tr>
<tr>
<td>Social Groups</td>
<td>93</td>
<td>118</td>
<td>29</td>
<td>70</td>
</tr>
<tr>
<td>Support Groups</td>
<td>84</td>
<td>52</td>
<td>36</td>
<td>56</td>
</tr>
<tr>
<td>Health and Wellbeing</td>
<td>124</td>
<td>124</td>
<td>64</td>
<td>107</td>
</tr>
<tr>
<td>Transport</td>
<td>24</td>
<td>19</td>
<td>14</td>
<td>21</td>
</tr>
<tr>
<td>Housing and Accommodation</td>
<td>28</td>
<td>24</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>Multicultural Groups</td>
<td>18</td>
<td>12</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Aged Care</td>
<td>85</td>
<td>86</td>
<td>59</td>
<td>72</td>
</tr>
<tr>
<td>Disability</td>
<td>48</td>
<td>41</td>
<td>32</td>
<td>46</td>
</tr>
</tbody>
</table>

The ongoing regional consultation and needs and gaps identification processes identified the following regional circumstances in relation to service access and utilisation.

**Penrith**

The data presented in Penrith City Council’s ‘A Snapshot of the Ageing Population in Penrith’ demonstrates the diversity in older people in Penrith in terms of where and how they live, the kinds of services they require and how they access information about those services. A considerable proportion of older people in the city are more likely to use entry-level aged care than home care packages and residential aged care facilities. The rate of people utilising these funded services in Penrith is lower than other comparative regions. This could be an indicator of the complexity and challenges experienced by marginalised communities to navigate and access the aged care system, Penrith has pockets of CALD communities, homelessness, and low socio-economic populations groups.

The Penrith community profile highlighted some challenges with servicing the older population:

- The proportion of Aboriginal and Torres Strait Islander people in the older age range increased by 244.6% for people aged 65 years and over since 2006 to 2016.
- 2 in 5 people aged 65 years or older have a disability as the likelihood of living with disability increases as you get older.

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The rate of home care assistance for Penrith residents was 56.7 people per 1,000 (higher than Greater Sydney rates at 54.7); 36.0% of home care clients lived alone; 3.2% of clients identified as Indigenous and 9.6% were from a non-English speaking background.

As previously noted, there are a range of issues faced by older people living in the Penrith region which include an increasing need for access to GPs, higher rates of injuries and hospitalisations due to falls, difficulties in navigating the aged care system electronically; and lack of appropriate services to support independent living, chronic pain management and end of life care.

Blue Mountains

The 2017 Aged Care Strategy of Blue Mountains City Council\(^{44}\) identified eight key areas that require action of which the following four are of relevance and importance to this needs assessment and the care finder population:

*Transportation*: There is a lack of reliable and age-friendly transport in the Blue Mountains. Transportation is a big issue for service providers with a lack of connection between Blue Mountains train stations, no direct service to Westmead hospital and poor connection between the Mountains trains and inner-city trains. Additionally, public/community transport to medical services and social activities is limited and costly.

*Housing*: There are various issues specifically related to housing accessibility and supports, including:

- A lack of suitable housing
- Lack of mental health support and public housing provision
- Demand for more retirement housing

*Social participation*: The Blue Mountains Council, in association with Charles Sturt University, conducted a study into vulnerability and resilience in the Blue Mountains (2014)\(^{45}\). This study indicated that age is a factor in social isolation and is often associated with chronic illness and lack of community networks. Loneliness and exclusion are also factors associated with depression and anxiety for older people. Activities are not always affordable, and transport can be difficult.

*Community and Health Services*: Access to medical services is a major issue for older people in the Blue Mountains – and one of the most frequent service offerings for community providers. There is a high cost for people to remain at home and access domestic care support.

There are a variety of health issues affecting Blue Mountains residents and increasing numbers requiring complex care. Respite care and permanent care needs to be located in the area close to social supports.

Hawkesbury

In 2019 NBMPHN conducted workshops\(^{46}\) with over 100 community participants in the Hawkesbury which were designed to create an opportunity for community engagement with the aim of improving social connectedness for socially isolated people in the Hawkesbury region. Since that time, the wide-scale natural disasters including floods and bushfires along with the COVID-19


\(^{45}\) https://www.researchgate.net/publication/301655119_Community_Connections_Vulnerability_and_Resilience_in_the_Blue_Mountains

pandemic faced by this region has further increased the stress on the vulnerable populations in the Hawkesbury with many unable to access the services they need.

The workshops highlighted the following issues and opportunities:

➢ Service providers working together – services lacking integration with the need for improved understanding of the demands of the community to ensure appropriate funding for services that are suitable.
➢ Connection with the socially isolated – not all people who are socially isolated necessarily want help and technology can be a barrier for older people in accessing information.
➢ Improving transport – given the geographic nature of the Hawkesbury it is difficult to service in terms of transport and more options need to be available for access to social activities, not just medical appointments.
➢ Respite and support for carers – with limited respite beds, carers are struggling for support in the community.

The subsequent Improving Social Connectedness of Older Australians project pilot Evaluation Report (2022)\(^47\) identified:

➢ Transport as a major barrier to social connection, especially for older people in more outlying areas of the Hawkesbury LGA.
➢ That many older people either did not have a digital device, the skills to use it or could not afford internet access, which is a significant barrier to participating in virtual social connection activities and reduces access to community activities that rely on online registration for participation.
➢ That community stakeholders perceived social connectedness as an important issue in the community and they need to be engaged in this process.
➢ The need for an intersectoral approach that integrates and connects relevant health, aged and social care service providers is required to address the needs of vulnerable populations.
➢ The need for culturally appropriate supports specifically for Aboriginal and Torres Strait Islander peoples.

Whilst this pilot focused on improving social connections, decreasing social isolation and loneliness and improving mental health outcomes for older Australians in Hawkesbury, there were significant learnings that can be applied across the region applicable to the care finder population.

**Lithgow**

There are significant geographical and economic factors that impact service provision in Lithgow. The Lithgow Community Mental Health and Wellbeing Report (2018)\(^48\) highlights some of the structural issues as outlined below:

➢ Unemployment - The impact associated with mines closures and workforce reductions along with a lack of diversity in economic opportunities, are a significant issue.
➢ Health Service Provision - Changes in the boundaries and structures for state and federal health services have resulted in Lithgow often missing out on health services.
➢ Service System Fragmentation - With changes in health service funding systems and NDIS implementation, many of the service providers are unaware of other services in the

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community resulting in lack of integration which potentially negatively impacts on patient outcomes.

➢ Outreach Services - Many of the services provided are not based in the community which is viewed as less than optimal and feelings of Lithgow being forgotten by health service decision makers. This view was duplicated during consultant interviews of service providers in Lithgow. Highlighting that service provision in Lithgow is often conducted by organisations who are based elsewhere and visit the region for a short period of time. With the geographical size of the LGA, this limits the services that can be provided.

1.3 Processes for synthesis, triangulation, and prioritisation

Nepean Blue Mountains PHN has considered a wide range of sources, including population data and projections, health system data, community and stakeholder consultation, and regional service system data to inform the implementation of the Nepean Blue Mountains care finder service.

Through data analysis, key population characteristics were identified to further explore in our qualitative project stages. From this initial analysis, various themes or characteristics were identified, including:

➢ The ageing population in our region, particularly within the Lithgow and Blue Mountains Local Government Areas.
➢ The relative socio-economic challenges experienced in pockets of our communities, specifically, in the Lithgow and Penrith Local Government Areas.
➢ Challenges in accessing secure housing, in particular the Lithgow and Blue Mountains areas.
➢ Geographic isolation, by distance and access to services, specifically in the Lithgow, Hawkesbury, and Upper Blue Mountains areas.

Engagement with key stakeholders provided more in-depth information on the themes identified in the data analysis. These consultations confirmed the identified issues, and provided greater clarity and specificity, including:

➢ Specific population groups who were subject to some of the aspects of disadvantage (such as socio-economic disadvantage or housing stress), including Care Leavers, people escaping family violence, and residents who experienced lack of access to affordable rentals with the influx of holiday rental transitions (i.e., previous rentals being used for Airbnb to maximise on tourist income).
➢ Pockets of cultural diversity that was not necessarily visible in broader population statistics, due to low numbers but concentrated residency. For example, pockets of cultural diversity identified in both Penrith and Blue Mountains locations, which saw more ‘out of system’ delivery of supports within informal care networks.
➢ Specific social and geographical challenges experienced by Hawkesbury residents in farmlands, who were nervous about the involvement of ‘the system’ due to perceived risk of loss of independence and ability to stay on the farms.
➢ Pockets of immigrant communities (generally afraid of deportation and/or historical relationships with governments in their home countries) in families on properties in more remote areas of the region, that resulted in them not accessing service support due to fear of deportation of family or friends in the area.
➢ A small, but concentrated population of gender-diverse older people in the Upper Mountains, who experience significant discrimination and fear of the same in accessing formal services (due to lived experiences of stigma within their existing communities).
Lack of information technology capability within older populations who also experienced geographic and social isolation.

These consultations enabled greater understanding of the practical implications of some of the population characteristics across the region.

Finally, the information was compiled to look at how the current service system responds, and the barriers identified. This process enabled a more specific identification of service level gaps and barriers that confirm the lived experience of residents who may need, but who are not accessing aged care supports. Some of these themes included:

- Relative lack of access to formal aged care services compared to need, and relative to broader state and national ratios.
- Lack of physical location of services in some areas of our region (namely Lithgow, more remote areas of the Hawkesbury and Upper Mountains), seeing more regional outreach service provision in these areas by services physically located in the Penrith and more ‘central’ areas of the region. This model of delivery proved difficult for specific groups of residents, particularly those with cultural or trauma-specific needs that required the development of trust and visibility to enable access.
- Lack of choice in some locations, between service providers who could offer (or who were perceived to represent) different philosophical foundations to care. For example, in areas that only had providers that were faith based, with community members who potentially had less than favourable experiences with the church (Care Leavers, members of the disability community), this proved to be a barrier to accessing necessary care; and,
- Perceived lack of collaboration between existing providers. This seemed particularly relevant where there were community members with multiple or complex needs requiring system level coordination and communication (for example, people experiencing homelessness and mental or physical health issues, or for people experiencing trauma and alcohol and other drug challenges, or people experiencing multiple hospitalisations and unstable housing).

Considering all the data, synthesising, and triangulating, this enabled clear recommendations for the Nepean Blue Mountains care finder program to respond to some layered complexities in the region.

1.4 Challenges encountered and reflections/lessons learned

Data issues

As a region located within the Greater Sydney statistical area, we have access to a wide range of data to assist us in our need’s identification. However, at the time of this report, there are a few limitations to note:

- The timing of the release of the 2020 Census has been staggered. With at times, access to some data sources with 2020 data, this led to some complexities in needing to use combinations of old and new data sources. In some cases, however, projection data from Torrens University was used in lieu of older data as it may not be as representative of contemporary circumstances. This difficulty in data continuity has meant it has been difficult to make comparisons or use different data to triangulate findings.
- Inability to secure localised data for some population groups or from issues identified in the consultations. For example, there was no data to represent some smaller population groups, those where there was significant need identified, but where the population data does not exist to represent it. Examples of this include information about the LGBTIQ+ community, small but concentrated culturally and linguistically diverse communities (i.e.,
those not identified as the main CALD communities in the census/Torrens data), and Care Leavers.

- Access to various data was visible with the active patient population, however, lack of visibility over older people who may not access registered GPs across the same data domains (for example, chronic illness, health service access etc). For ‘hidden’ or ‘hard to reach’ communities (the subject of the care finder program), it is anticipated this may constitute a data ‘black spot’; and,

- Difficulties in accessing local data on active community aged care packages. Whilst data was available relating to RACF places, community aged care data and CHSP utilisation data was difficult to assess.

With the full release of 2020 census data, it is anticipated this will assist the ability to effectively use the data to assess need. However, with such diversity in the region, and concentrated small community groups with specific need, these parts of the community may not be adequately reflected in broader population data.

**Additional challenges and lessons learned/reflections**

Potentially the most significant lesson learnt during this consultation stage, was the relative invisibility of the care finder client cohort. While this is consistent with their lack of access to support being the reason for the care finder program being needed, it did prove difficult to get specific information about the community from existing service providers.

Many providers could provide some detail about the client cohorts they felt they were not reaching, as well as those who, for various reasons, may have fallen out of formal service supports. However, there was a significant sense that they ‘didn’t know what they didn’t know’. Neighbourhood and drop-in services seemed to have better visibility over some of the population groups who found it difficult to access existing aged care supports. The consultations outlined that stakeholders with more specific local knowledge sat outside of the system; examples included shop or post office owners, Probus and Rotary groups, and/or church communities. These stakeholders may have had detailed information about small numbers of people accessing their services, however, not enough to get a more global picture of need for the local government area or region more broadly. Marginalised community groups were identified, with particular needs in specific locations, however some of this was limited in detail. An initial task of care finders will need to require re-engaging with these community stakeholders to form more holistic views of the needs and potential access pathways for marginalised communities and individuals.

This understanding reinforced how important it will be in the Nepean Blue Mountains region, for care finders to be located within, and working directly with non-traditional supports and service system access points.
Section 2 Outcomes

A summary of the activities undertaken to identify local needs, through triangulation of findings is in the table below:

<table>
<thead>
<tr>
<th>Identified need</th>
<th>Key issue</th>
<th>Evidence</th>
</tr>
</thead>
</table>
| Place-based access to care finder supports across is required to service      | The NBMPHN region covers a broad geography, where traditionally services to more remote areas are provided under an outreach model. Care finder cohorts need more place-based service delivery to build trust and optimise visibility and access to supports. | ➢ ABS regional data  
➢ PHIDU population data and projections  
➢ Community consultations  
➢ Current service system mapping data |
| communities across diverse geography                                         |                                                                                                                                                                                                          |                                                                                            |
| Assistance is required to access a GP and other primary health and community  | Parts of our region experience significantly lower rates of access to primary health and community services, based on regional, state, and national data. Lack of access results in poorer chronic care management and health outcomes, requiring higher levels of potentially avoidable service delivery. Better assessment, referral, linkage, and targeted coordination is required. | ➢ Active patient data  
➢ PHIDU regional service access data  
➢ Consultation with Primary Care  
➢ Consultation with service providers  
➢ Chronic illness data |
| services                                                                       |                                                                                                                                                                                                          |                                                                                            |
| Isolated groups of Culturally and Linguistically Diverse (CALD) communities    | There is small yet concentrated pockets of CALD communities with specific needs that can be overlooked due to a perceived low population in broader regional data. The need for targeted supports for some communities who may also be experiencing specific cultural barriers or past experiences with government or health systems, needs consideration. | ➢ ABS population data  
➢ Community consultations  
➢ Multicultural service provider consultation |
| can be overlooked due to broader population data                               |                                                                                                                                                                                                          |                                                                                            |
| People with unstable housing arrangements find it harder to access aged care   | The region is home to many community members experiencing homelessness, housing stress and/or housing instability. These residents find it difficult to access required services. Similarly, the service system finds it difficult to locate these residents and adequately understand needs. | ➢ ABS data  
➢ National Specialist Homelessness Services Data  
➢ ACH provider consultations  
➢ Community service consultations |
| support                                                                        |                                                                                                                                                                                                          |                                                                                            |
| Socially isolated older people are not receiving the care that they need       | Older residents are experiencing higher rates of social isolation due to COVID. With social isolation comes greater difficulty locating and supporting older people who may have previously been identified through social activities (i.e., attending groups or other community activities they are no longer attending). | ➢ ABS data  
➢ General Social Survey data  
➢ Community service consultations |
| Trauma survivors require tailored care from providers with specific trauma     | Survivors of trauma were identified in several consultations, with specific care needs. Care leavers, refugees, survivors of institutional abuse and people escaping domestic violence were examples of this                                                                             | ➢ Community consultations  
➢ Housing provider consultations |
<p>| informed care training                                                         |                                                                                                                                                                                                          |                                                                                            |</p>
<table>
<thead>
<tr>
<th>Identified need</th>
<th>Key issue</th>
<th>Evidence</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>cohort. Lack of trust in systems, and lack of place-based service provision to build relationships and trust in the most affected areas was identified.</td>
<td></td>
<td>Council and police consultations</td>
<td></td>
</tr>
<tr>
<td>Approaches to care that recognise the role of families and communities, rather than just the individual are required</td>
<td>Communities expressed challenges with care models that do not recognise the nuances and complexities that may exist inside specific communities when it comes to care giving. Models of care that could be culturally responsive to different perspectives on care giving and receiving were identified as fundamental for communities otherwise perceived as ‘difficult to engage’.</td>
<td>Community consultations</td>
<td></td>
</tr>
<tr>
<td>Care finders will require targeted cultural diversity training</td>
<td>Communities identified cultural diversity and understanding of cultural perspectives, histories, and past experiences as vital for culturally safe service provision.</td>
<td>Community consultations, ACH consultations, Aged Care Provider consultations</td>
<td></td>
</tr>
<tr>
<td>LGBTIQ+ communities are somewhat ‘hidden’ within the region, and find it difficult to access support through mainstream services</td>
<td>Concentrated pockets of residents from LGBTIQ+ communities experience discrimination and stigma. This makes it difficult for them to access services through traditional channels, particularly where there are limited choices of care providers.</td>
<td>Community consultations</td>
<td></td>
</tr>
<tr>
<td>Service information and access support needs to be provided in a range of languages and information formats</td>
<td>Access to information by special needs groups was identified as difficult. Specifically, access for Deaf people, and access for people with vision impairments was identified.</td>
<td>Community consultations</td>
<td></td>
</tr>
<tr>
<td>Communities experience low levels of health literacy that impact on care and wellbeing outcomes</td>
<td>Low levels of health literacy amongst community members were identified as contributing to poorer health outcomes and higher rates of chronic conditions. Coupled with other factors, this also led to lower levels of preventative health services or activities, and not only affected individuals, but families and communities.</td>
<td>Primary Health consultations, Literature review, ABS data, Service provider consultations</td>
<td></td>
</tr>
<tr>
<td>People with cognitive impairments that live alone are not accessing necessary services</td>
<td>Particularly in more regional areas, people who live alone, who have been previously independent but now experiencing the onset of cognitive impairments are not receiving timely assessments. This need was identified in broad areas across the region, but particularly, in more isolated communities where the availability of services was lower.</td>
<td>Police consultations, Council consultations, Community consultations</td>
<td></td>
</tr>
<tr>
<td>Farming communities were less likely to recognise need for, and accept, support</td>
<td>Across the Hawkesbury in particular, the needs of farming communities were identified. Specifically, reluctance to seek and accept support, concerns about being</td>
<td>Community consultations</td>
<td></td>
</tr>
</tbody>
</table>

Care finder program: Once-Off Report on Supplementary Needs Assessment Activities

22
### Identified need

<table>
<thead>
<tr>
<th>Identified need</th>
<th>Key issue</th>
<th>Evidence</th>
</tr>
</thead>
</table>
| forced to vacate farmlands, post-disaster recovery and concerns about deportation within migrant communities resulted in less trust in the service system. | A large proportion of consultations noted difficulties in the use of IT. These difficulties included lack of ability to use IT, lack of hardware (e.g., computers and smart phones), or financial difficulties resulting in lack of access to the internet or data. Inability to access IT made it more difficult for older people and families to receive information and access assessments or service support. Even lack of access to phone services (coupled with sensory or cognitive impairments) demonstrated a need for in-person assessment and information services. | ➢ Community consultations  
➢ Aged Care Provider consultations  
➢ Multicultural service consultations |
Section 3 Priorities

The Nepean Blue Mountains PHN has prioritised geographical reach across the four LGAs as a priority. The region is diverse, and the consultation process has highlighted the need for place-based service provision to ensure the most vulnerable population groups have access to a care finder. This process has been assisted by discussions with existing ACH providers. The placement of existing ACH providers, with quarantined funding, has been established. There are two providers who have requested to be based in the Penrith LGA and a third provider who requested a larger footprint.

Based on the available funding and prioritisation 8 care finder positions will be geographically located:
- Penrith – 3 (two already allocated to ACH providers)
- Blue Mountains – 2
- Hawkesbury – 2
- Lithgow – 1

The community consultation process combined with the data analysis has established key areas of need that will be prioritised by care finders within the Nepean Blue Mountains region. They include a focus on:

➢ Trauma survivors
➢ Culturally diverse communities
➢ Geographically isolated communities
➢ Older people unable to use, or without access to information technologies
➢ People experiencing housing insecurity
➢ People with sensory impairments that affect access to information
➢ People with cognitive impairment and those at risk of including dementia, older people who may be living alone and socially isolated

There will also be a focus on those experiencing homelessness which will continue to be the focus of the ACH providers.

To reach these vulnerable population groups, care finders will use an assertive outreach model. The consultations highlighted this target population is not currently hitting the health system in any way and there will be a requirement to implement a very different model to reach those in need. To assist care finders, the Nepean Blue Mountains PHN will prioritise additional training and upskilling as it is not expected that the successful applicants will necessarily have all skills and experience required to support the range of identified population groups. Instead, the focus will be on ensuring there is a strong mix of skills across all care finders with a willingness to support learning in communities of practice and other appropriate forums.

The Nepean Blue Mountains PHN expects, based on the existing needs assessment, there will be significant increases in the number of people over 65 years with moderate to severe dementia. It is expected that dementia will impact the care finder population group and present as a secondary issue. Consequently, there will be a focus on training and upskilling all care finders to ensure they are well skilled to support those clients with dementia.
To assist care finders with their assertive outreach activities NBMPHN will provide support in the following ways:

➢ Access and participation in local inter-agencies with representation from the local community services sector including community groups, not-for-profit organisations, charities, and government organisations.
➢ Promotion of care finder details on the NBMPHN website and My Health Connector directory and other local networks and relevant directories.
➢ Incorporation of referral pathways into Health Pathways.
➢ Promotion of the care finder network to general practice, allied health, and pharmacies.
➢ Continual enhancement of the PHN’s partnership with the Local Health District to understand the care finder program and ensure relevant stakeholders can make appropriate referrals for patients on discharge from hospital.

The NBMPHN Healthy Ageing Advisory Committee will provide direction and support to the care finder project team. This will include representation from key stakeholders in the region and subject matter experts involved throughout the course of the care finder program implementation and evaluation period.