Care finders

Brisbane South PHN Supplementary Needs Assessment

1.1 Background

CARE FINDERS PROGRAM

Brisbane South PHN is in its sixth year of operation at a time of significant change, challenge and opportunity. Our operating environment is becoming more complex and more fluid; and we continue to build our maturity as a commissioning organisation.

This Care Finder Supplementary Needs Assessment (needs assessment) provides a deep understanding of the health and service needs of [1]older people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) throughout the Brisbane South region, to:

- Identify service needs of older people who require specialist and intensive assistance to connect with relevant supports and services
- Inform organisation approaches, including priority populations and geographies for care finder target market
- Provide a platform for communities, health and other system partners to understand and respond to the needs identified through the care finder program and to enhance integration between systems
- Support transition of the Assistance with Care and Housing (ACH) program
- Support the integration of the care finder network into the local aged care system which is complex and rapidly changing.

The care finder program forms part of a significant investment in aged care reform in response to the recommendations of the Royal Commission and is one of the first aged care programs to be delivered through PHNs.

1.2 Methodology

Prior to the initial commissioning of care finder services, Brisbane South PHN has undertaken additional activities, to supplement its existing Needs Assessment and to identify local needs in relation to care finder support.

These additional activities provide the evidence base for Brisbane South PHN's initial commissioning approach to care finder services and will therefore determine the services that the PHN will commission alongside the existing Assistance with Care and Housing (ACH) providers who will be offered a contract as care finders.

1.3 Purpose

The Once-off Report on Supplementary Needs Assessment Activities will:

- Provide information on the additional activities undertaken by Brisbane South PHN to identify local needs in relation to care finder support
- Set out the evidence base for Brisbane South PHN's initial commissioning approach to care finder services
- Be a stand-alone update to Brisbane South PHN's existing Needs Assessment
- Inform development of Brisbane South PHN's amended Activity Work Plan due by 31 August 2022.

Following the Once-off Report on Supplementary Needs Assessment Activities, Brisbane South PHN will report on the outcomes of needs assessment activities relevant to the care finder program as part of its annual updated Needs Assessment.

SUPPLEMENTARY DATA, QUALITATIVE CONSULTATION AND ANALYSIS

The demographic and geographic regional profile was refreshed as appropriate with 2020 ABS Census or AIHW data and custom reports from advocacy groups and providers in our region. In lieu of missing data regarding certain target populations, appropriate health literature and reports were used to build a robust evidence base.

Consultations were held with (2) ACH and (9) Organisational Providers, (3) Community Groups and responses were collected from members of both the (9) Clinical and Community Advisory Councils.

Provider feedback (ACH and Organisational) was gathered in a two-part process including the initial distribution of a custom subset of questions in online survey format and a follow up interview to clarify context, nuance and gather anecdotal feedback more informally.

Community consultations were conducted with existing community groups in a face-to-face format in various locations in our region, varied in contact length (30min-1 hour) with ~30 attendees, adequate sex and age distribution and some target population self-identification across the sessions.

Lastly, a custom subset of questions in an online survey format were distributed to members of the clinical and community councils with appropriate branching in each.

In total ~18 hours of consultation feedback were collected, coded and analysed for this report using the Qualitative Analysis Software 'NVIVO'.

1.4 Evidence Base

QUANTITATIVE

Broader regional demographics were extracted from the current organisational HNA data for consistency across BSPHN reporting. Where available, the Project Data lead accessed and updated the demographics of older persons in our region (updated 2022 geography boundaries were applied) from the most recent 2020 ABS Census data. This included refreshing the Estimated Residential Populations (ERP), areas of geographic need and available updated demographics of at-risk populations. There was little change in the geographic clusters of older residents generally, including distribution of First Nation or CALD populations, with focused areas of need remaining stable. There was however, an increase in our regions estimated population size, particularly in First Nations identification and in regards to average age.

QUALITATIVE

Qualitative data was collected through structured surveys and verbal feedback via scribe template in the instance of face-to-face consultations. A primary pool of questions addressing the DoHAC stipulations were customised for the various groups that were engaged for consultation. This same primary question pool guided the themes for the thematic content analysis of this qualitative data.

LIMITATIONS

In regards to accessing quantitative data on the identified care finder target populations there are numerous considerations regarding availability, reliability, validity and predictive relevance. Aggregation of minority data relies on sample populations that are not truly representative of need and the majority of the required datasets either do not exist, rely solely on sample populations, aggregations, incomplete models as collection or standardisation of these variables is not prioritised, represented or captured at the population level of public health research.

Furthermore, there are limitations in consultation of reluctant, diverse and intersectional target populations, specifically in attaining voluntary perspectives from marginalised or often persecuted populations.

As referenced by providers, advocates and community members across our consultations, engagement across certain cultural or diverse older communities requires membership within those groups, and where reluctant at-risk groups were not able to be consulted directly, relevant local and national qualitative literature was used to aide in the prioritisation and subsequent commissioning of appropriate services.

1.5 Outcomes

The unique geography of our region establishes a consistent need for continued engagement and specialised care of the Southern Moreton Bay Islands (SMBI)and North Stradbroke Island (Minjerribah), as these SA2's still contain some of the highest number of intersectionally at-risk older residents.

ACH and Providers referenced workforce training as the most ardent need and gap in aged care services, followed by references of 'system engagement fatigue', need for intensive case management and the issue of high wait-times for CHSP. The most frequently proposed solution was consequently increased education and training on services and healthcare pathways for both clients and clinicians, with added clarity around the costing of services.

Community consultations most frequently referenced the need for consistent and accessible in-home care as a need, including the gap of immense CHSP wait-times and the recent decline in service type and provision. It was also highly referenced that the aged care system was inconsistent and complex with arbitrary age restrictions and general lack of communication with clients, from clinicians and providers alike. In similarity to provider feedback, the community members referenced the solution of education; particularly on digital literacy, privacy, and for clinicians on complex comorbidities; trauma and disability accessibility practices, alongside the dire need for workforce provisions and a return to face-to-face care.

From a clinical advisory perspective, the most referenced need or gap was a lack of resources, particularly funding for primary care to provide aged care services. There were also references to the need for social support or counselling services, education on service delivery within the health system, and the need for a complete overhaul and suggested co-design of the referral process. Their most referenced solutions were the implementation of social support programs and hubs, the establishment of GP and provider relationships, need for funded care leave and primary care programs, and the consequent need for systemic review including direct consultation with older persons themselves.

1.6 Priorities

Five (5) priority areas have been identified where sufficient qualitative evidence, breadth of consultations, regional data and supporting evidence was identified to inform the commissioning process for care finders in the region.

Priority 1: Multiple barriers for SMBI, Stradbroke Island and Logan residents

Priority 2: Workforce provision, composition and competency

Priority 3: Culturally and Linguistically Diverse Populations

Priority 4: Disability Accessibility, Education and System Integration

Priority 5: At-Risk, Isolated or Homeless Older Residents

2. About our region

Figure 1. Brisbane South PHN Region

Located in South East Queensland, the Brisbane south region is home to over 1.2 million residents, making the region the most densely-populated PHN region in Queensland.

Extending from south of the Brisbane River through the Scenic Rim region to the New South Wales border, the Brisbane south PHN region is predominantly metropolitan with pockets of regional (Beaudesert SA3) and remote (Redland Islands SA2) areas. The region covers a total area of 3,770 square kilometres, and spans four local government areas – Logan and Redland (100% coverage each), Brisbane (approximately 54% coverage), and Scenic Rim (approximately 34% coverage). Brisbane south is a geographically diverse region – with areas of high density metropolitan residential populations, to regional and rural areas from Beaudesert to the northern New South Wales border at Mt. Barney, and remote areas of our Redland Islands which are accessible only by boat.

The Brisbane south PHN population is very diverse, with over one-third of the population having been born in a country that is predominantly non-English speaking. The region is also home to the largest urban First Nations population in Australia, and large and growing Pasifika and Māori communities. With this great diversity comes great strength in community cohesion and resilience, making Brisbane south a remarkably unique Queensland region.

Due to increased health risks and complexity of needs within this vulnerable older population cohort, this growing population within the region will experience increasing barriers to health services, difficulties accessing high-quality care, and poor health literacy resulting in poor health and wellbeing outcomes for the individual and the population as a whole.

2.1 Geographical Distribution of older people in the Brisbane South PHN region

In 2016, 13% of Brisbane south's population were aged 65 years or older ('older people'), slightly lower than Queensland's 15%. Scenic Rim and Redland LGAs had the highest proportion of older people within the region with 20% and 17% respectively. The greatest number of older people were located in Brisbane LGA, approximately 74,241 persons when scaled to the area located in the PHN region (54%)

At a sub-regional level, the Cleveland - Stradbroke SA3 had the largest population of older people, with 16,100 individuals making up 20% of the total SA3 population (QGSO 2018). Like many areas in Australia, the number of older persons residing in Brisbane south is expected to grow considerably in the coming years. By 2041, it is estimated that 305,528 older persons (more than two times that of the 2016 population) will live in the region, making up 19% of the total population. This is an increase of approximately 6,506 older people per year. Scenic Rim and Redland LGAs are expected to exhibit the highest rates of growth, 29% and 28% respectively. Jimboomba is projected to experience 52% compound annual growth of older people by 2041, almost 2 times higher than the next fastest growing area, Beaudesert (29%) (QGSO 2018).

2.2 Socio-economic and remote geographical disadvantage

The Brisbane south PHN region generally reflects the wider Queensland rates of socio-economic disadvantage. On several of the indicators, Brisbane south PHN reported more favourable rates than Queensland (education, welfare receipt, digital accessibility), and slightly less favourable in others (financial stress, homelessness) (QGSO 2021). At the LGA level, data shows relatively higher levels of financial stress in Brisbane and Logan, lower levels of education outcomes in Logan and Scenic Rim, a greater number of aged pensioners in Logan and Redlands, and higher rates of people experiencing homelessness in Brisbane (QGSO 2021).

The Cleveland – Stradbroke SA3 had the highest number of older persons within the region. Of particular consideration within this population group are those older persons residing on the SMBI and Minjerribah. The population on these islands had a considerably higher median age compared to the wider Cleveland – Stradbroke SA3 population, Queensland and national median ages, and higher proportions of residents aged 65+ years. These figures indicate an increasing need to optimise transportation and health service availability to an ageing population in these remote, low-service areas.

In 2016, the Southern Moreton Bay Islands score on The Index of Relative Socio-Economic Disadvantage (ABS 2016), indicated that it is a very comorbidly disadvantaged area in Redland City. Additionally, the SMBI has a significantly higher ageing population than the Greater Brisbane region, with 63.2% of the population recorded as over the age of 50 during the 2016 census. This is in

comparison with 30.6% of the Greater Brisbane population recorded as over the age of 50 (QGSO 2016).

The resident communities of the Southern Moreton Bay Islands experience disproportionate health and social outcomes compared to people living on the mainland, with the largest resident populations of the region's remote islands being Russell and Macleay Islands, followed by North Stradbroke Island. An external specific needs assessment of these communities identified an ageing population (over 70% aged 45 years and over) who are living longer, reduced birth rates, low educational attainment and high levels of housing insecurity and poverty (Griffith University 2019).

Information collected from these stakeholder conversations noted in a previous SMBI consultation indicate many unique challenges and opportunities on the islands including;

- The impact of seasonal changes to residents on the Islands, this is noted in particular on Minjerribah and for carers/care recipients living on the Islands
- Small population size makes having multiple service providers providing similar services unviable. This results in limited choice for clients and results in fewer service providers keen to invest in providing Island based services
- Lack of coordination and communication of the service providers, assessors and health care providers on the Island. This poses an opportunity where service providers, council, assessment and health care workers could share resources such as transport options on the Island or meeting spaces
- Phone and internet connection are noted as a concern for community members and service providers. Optus network connections can be particularly unreliable and result in concern for safety of service providers visiting the islands and result in drop outs during non-face-to-face assessments and health visits
- Volunteer participation has been identified during several provider conversations as an opportunity to support SMBI residents to develop connections and relationships with lasting benefits beyond those of traditional government funded services. Support to encourage new or younger residents to engage in volunteer work is needed to ensure ongoing viability of community groups on the SMBI. Many current volunteers are ageing and participate in multiple volunteer roles with much of this work being done by a few key members of the community. The risk identified is where these volunteers become unable to continue their role or move from the Islands. Much of their knowledge and experience is lost and not adequately captured to pass on to new potential volunteers.

2.3 Living arrangements of older residents

According to GEN Aged Care data, in 2020-2021 in the Brisbane south PHN region, 41.7% of seniors accessing home care services lived alone. Despite this, the vast majority of care and support for older people is provided by relatives and friends. It has also been estimated that 80% of older Australians will access some form of government funded aged care service in their lifetime (AIHW 2018h).

At a state level, women over 55 years of age are the fastest growing group to experience homelessness, however this is often experienced as staying with family and friends, living in over-crowded dwellings or in unsuitable housing for their physical and social needs and therefore not clearly captured in population datasets. Older women experience homelessness as a result of a number of factors including domestic violence, relationship breakdown, financial difficulty and limited

superannuation. It has been shown that homelessness or insecure housing, specifically in older people, can take a toll on the individual's health and emotional wellbeing (Australian Human Rights Commission 2019).

2.4 Social engagement, family and community support

There is consistent literature demonstrating that increased rates of social engagement have positive outcomes for a number of health outcome measures including mortality (Berkman and Syme 1979) disability, cognitive function (Aartsen 2002), cognitive decline and dementia (Bassuk 1999). Within our Brisbane south PHN region, community and sector representatives involved in local consultations highlighted that COVID-19 pandemic-related lockdowns and restrictions have increased social isolation and negatively impacted the mental health of older people in the Brisbane south community. Some of the key factors that were identified as impacting social engagement in our region included;

- Visitation restrictions during COVID-19 negatively impacting the mental health of people in aged care facilities, resulting in an escalation of negative behaviour
- Home Care providers reported a 57% drop in volunteer participation in home aged care during the 2019-2020 financial year (Aged Care Workforce Census 2020)
- Reduced travel between family and friends due to the COVID-19 pandemic
- Closure/suspension of all centre-based respite and group social support outings and activities in the Brisbane South region during the COVID-19 pandemic

Additionally, the 2015 Social characteristics of older Queenslanders report identified that disability of seniors is another factor impacting social engagement and the extent to which older Queenslanders left their home as often as they would like. Only 77.6% of older Queenslanders with a disability indicated they left their home as often as they would like to, compared to 94.6% without a disability.

- Many older Queenslanders contribute their time, service or skills to an organisation or group within their community, with 1 in 5 (19.9%) having spent time doing unpaid voluntary work through an organisation or group in the twelve months prior to Census night (ABS 2016). It is important to note that the care finder workforce is not expected to include volunteers or a peer workforce, taking into account that clients require intensive support and may often have complex needs.

2.5 Health and disability status

In the Brisbane south region there are 66,503 persons (or 5.6%) in need of assistance with a profound or severe disability (defined as needing assistance in areas of self-care, mobility, communication, disability or old age) with the Southern Moreton Bay Islands SA2 (13.4%) exhibiting the highest proportion of persons in need of this high level of assistance, followed by Bethania – Waterford (10.9%), Eagleby (10.5%), Beenleigh (9.4%), Beaudesert (8.9%) and Cleveland (8.5%) (QGSO, 2021).

Key themes raised by community and sector representatives during local consultation regarding older people with a disability included:

- The complexity of the NDIS system and obtaining Specialist Disability Accommodation (SDA) for older people, especially those with psychosocial disability, posing accessibility challenges

- difficulty identifying GPs that specialise in disability
- Lack of care coordination and service navigation support for adults with disability
- Lack of communication and understanding of consumer's needs
- Older people receiving NDIS support not having consistent/regular staff
- Lack of understanding and expertise amongst the aged care workforce with regards to psychological services, especially regarding intellectual disability
- The need for workforce training (especially amongst GPs) regarding disability with key focus areas to include communication, gap payments, providing information in an appropriate manner, and building trust and rapport.

2.6 Multiple Barriers

Key themes raised by community and sector representatives during local consultation regarding older people with multiple barriers included;

- Challenges regarding the perception of mental health within CALD communities including recognising it as a spiritual issue or not recognising it at all
- Lack of access to culturally, disability safe and LGBTI needs trained appropriate aged care services
- Challenges providing accessible health information and education
- The importance of engaging trusted community advocates
- Additional challenges in navigating the aged care system
- Increased reliance on families caring for their elders
- Challenges accessing language and hearing interpreter services, especially in Logan LGA

3 Analysis of care finder workforce

3.1 Distribution and conceptualisation of workforce

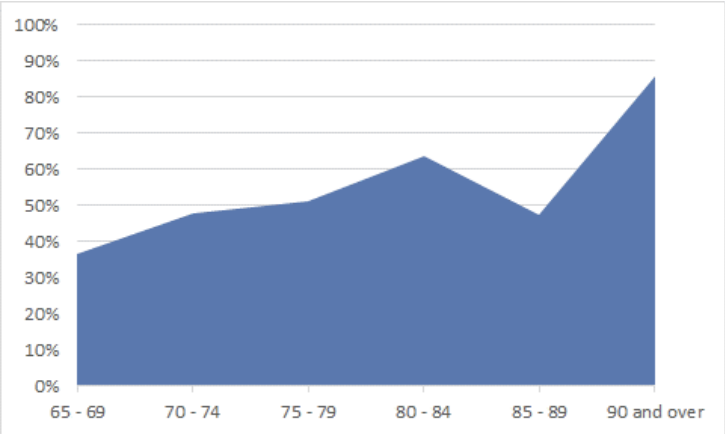
The care finder workforce will require the ability to be mobile, agile and readily integrated into existing active outreach. To support this, care finder organisations will be required to employ care finders and supply them with adequate access to motor vehicles and portable devices to complete their work. Ideally, the care finder workforce will reflect similar characteristics of the populations they are caring for, for example, live in the local community and identify with a CALD group.

The following demographic data regarding diversity of need and experience, supports the need for region-specific conceptualisation of the future care finder workforce.

According to GEN Aged Care data, in 2019-2020 seniors who were reported as accessing home aged care supports in the Brisbane south PHN region were made up of the following demographics: 31.8% were born overseas, 10.2% speak a language other than English and 2.3% were First Nations (AIHW 2020).

The 2015 survey of disability, ageing and carers (ABS 2016b) in Queensland provides the following statistics for ages within the care finders catchment who experience a disability:

Graph 1. Queensland reported percentages of experiencing disability across age bands



ABS 2016

Additionally, the rate of severe or profound disability amongst Aboriginal and Torres Strait Islander people was highest amongst those in the older age groups reaching 14.4% in the 65 years and over age group.

This data reflects the need for care finder workforce recruitment to target a broad range of care specialists to ensure knowledge across multiple disciplines engaged with caring for both those who are ageing and those who experience a disability. This will be of an even greater importance for our First Nations seniors who experience disability as they age at higher rates than that of the general population.

3.2 Region-based workforce considerations for care finders

With consideration of this evidence, it is imperative that the potential care finder workforce be made up of professionals with experience working with, supporting and caring for our target populations in similar percentages as those they will be supporting. Equally, care finders with experience working with seniors living with a disability such as hearing, vision or mobility loss, will be best placed to support this priority group in our region.

Some areas of the Brisbane south region which are more remote, such as the SMBI and Minjerribah which are only accessible by ferry, will also require specialised service provision considerations. Ideally, a care finder who resides on and understands the unique challenges and opportunities on the SMBI or Minjerribah would be employed to support this region. Equally, a care finder located in the Beaudesert region would be recommended to reduce possible travel impacts and ensure that these more isolated communities are adequately serviced by an appropriate and culturally competent care finder.

3.3 Capacity and capability for recruitment

According to the Aged Care Workforce Census report (ABS 2020c), in 2020 there were a total of 12,596 employee vacancies within home aged care service delivery across Australia. This was across multiple sectors of allied health, nursing and personal care and direct care staff. On a state level, there were an estimated 2500 vacancies in the same period. While the care finder workforce is likely to be recruited from a number of specialities; experience and a background knowledge in working with aged care clients will be a vital component for successful applicants.

It is foreseeable that, similar to the recruitment issues plaguing the wider aged care system, there may be difficulty in recruitment for care finder staff. Additionally, the need to have care finders who have experience or knowledge working with and supporting our priority communities may mean that recruitment is even more complex. To support this specialised need for recruitment, it is imperative that Brisbane south PHN and the commissioned providers whom they choose to work with, assertively outreach to the communities and employers within our identified priority care finder groups. In addition, building relationships to support ongoing training of all care finders to work with the diverse needs of our care finder population will be vital in not only ensuring strong positive outcomes for our care finder participants but also long-term staff retention due to higher rates of job satisfaction and progression due to ongoing training opportunities.

4. Supplementary Quantitative Evidence Base

4.1 An Update on Older Resident Population Demographics for the Brisbane south PHN region

As of June 2021, the estimated resident population of the Brisbane south PHN region is 1.21 million persons, our region comprising just over 23% of Queensland's total population (QGSO 2022). Within our region, it is estimated that 37.1% of these residents are between the ages of 45 and 65+. The median age increase of the Brisbane South population is representative of our nationally ageing population with an estimated increase in median age from 36.2 (2021) to 39.2 years by 2041. In regards to sex, our region has a higher number of females over 65 years of age (54.1%), identifying as Aboriginal and/or Torres Strait Islander (50.8%) and reporting a need for assistance (53.3%) when compared to the rest of our state (QGSO 2022).

Table 1. 2020 Estimated Resident Population for Older Persons in the BSPHN Region

2020 CENSUS Age Bands	Sex	Age Range ERP* Totals
45 - 54	M	74,230
	F	78,178
	Total	**152,404**
55 - 64	M	62,238
	F	66,229
	Total	**128,468**
65 - 74	M	47,091
	F	52,096
	Total	**99,164**
75 - 84	M	24,695
	F	28,566
	Total	**53,258**
85+	M	7,606
	F	12,765
	Total	**20,386**
45 – 85+ Total		***453,680***

(ABS 2022)

4.2 First Nations Identification in Older Residents

In 2020, Queensland experienced a 27.3% growth in First Nation's population, due to both increased identification and births within our state (ABS 2022). In the 45-75+ age ranges we saw an increase across each age group with the largest increase in the 55-64 (1.7%) and 65-74 (1.6%) age bands. Of this larger population, an estimated (ERP) 7,827 Aboriginal and/or Torres Strait Islander aged between 40 – 70+ reside in our BSPHN region (QGSO 2022).

According to self-identification in the 2020 Census, 33,019 (or 2.8%) person identified as Aboriginal and/or Torres Strait Islander, with the highest proportion of the resident population (16.1%) recorded in the SA2 of North Stradbroke Island (Minjerribah). Statistically, the largest percentage of residents is in the SA2 of Wacol, however this is capturing persons remanded or sentenced to adult custodial corrective services, who currently reside in the 16 units of the Brisbane Correctional Centre in this area, not necessarily residential areas of need. Other SA2's with a high-density percentage of First Nations residents includes Kingston (7%), Yarrabilba (6.9%), Slacks Creek (6.5%), Beaudesert (6.4%), Woodridge (6.2%) and Logan Central (6.1%) (QGSO 2022).

4.3 Care Finder Target Populations

4.3.1 Quantitative Limitations; Intersectionality, Comorbidity and Aggregation of At-risk Populations

Quantitative population demographics are imperative and functional in the commissioning and planning cycles of PHN regions. However, capturing the true nature, geography or need of the diverse care finder target groups is not without some consideration of deficits in reliability, validity or predictive relevance. Aggregation of minority data relies on sample populations that are not truly representative of need and there is the imperative need to support movements toward dis-aggregation and models that identify the actual, not predicted experience and assumed needs.

Nationally, there has been a shift toward collecting accessible and current data on cultural and linguistic variation, however there is still a dire lack of data on the regional identification of the at-risk sexual, gender, neurodiverse, cultural, reluctant or institutionalised populations. Across the spectrums of minority health research, there is understanding of the complexity, intersectionality and trauma that self-identification can present, particularly with the added barrier of generational trauma experienced by older minority populations. The majority of the required datasets either do not exist, rely solely on sample populations, aggregations, incomplete models as collection or standardisation of these variables is not prioritised, represented or captured at the population level of public health research.

The added difficulty in attaining this niche data from older populations include their deficits in digital literacy or access to safe and anonymous spaces for providing feedback, lack of willingness to self-identify, building distrust of government systems, including healthcare. In light of this lack of consensus and consistent variables, the need for applied spatial analysis local area estimates and geographical patterns of Australia's minority populations is key to future planning for service delivery and guidance for policy and for refined information regarding true comparative need (Wilson and Temple 2021).

4.4 Culturally and Linguistically Diverse Older Residents (CALD)

In the Brisbane south PHN region, 371, 160 persons (or 31.1%) were born overseas, which is relatively higher than at the state level of 22.7% (QGSO, 2021). A total of 275,677 persons (or 23.1%) stated they spoke a language other than English at home which again, is comparably higher than the state level of 13.5%.

Table 2. 30 Year National Comparison in Top LOTE spoken in Australia

Top LOTE (National)	1991	2021
1	Italian	Mandarin
2	Greek	Arabic
3	Cantonese	Vietnamese

4	Arabic	Cantonese
5	German	Punjabi

(ABS Census Data Seminar 2022)

Table 3. 2021 BSPHN Region CALD Snapshot

	Top NESB Backgrounds	Top Non-English languages spoken at home
1	China excludes SARs and Taiwan (2.5%)	Chinese Languages (5.4%)
2	India (2.3%)	Indo Aryan Languages (3.5%)
3	Vietnam (1.3%)	Vietnamese (1.8%)
4	Philippines (1.1%)	Southeast Asian Austronesian Languages (1.0%)
5	Taiwan (0.8%)	Korean (0.9%)

(QGSO 2022)

Within the Brisbane south PHN region, the SA2's with the highest percentage of residents who speak a language other than English are Calamvale – Stretton (59.6%), Macgregor (57.8%), Sunnybank (57.2%), Eight Mile Plains (56.1%) and Runcorn (55.2%). Similarly, the SA2's in which residents rated their English-speaking proficiency as either "Not well" or "Not at all" were Sunnybank (16.1%), Inala – Richlands (15.8%), Macgregor (14%), Robertson (13.4%) and Durack (12.8%) (QGSO 2022).

4.5 Older LGBTIQA+ and Gender Diverse Peoples

Accurately estimating the number of people who are lesbian, gay, bisexual, trans and gender diverse and intersex (LGBTIQAP+) in Australia is a critical gap in research. The lack of current population-level data limits understanding of health and wellbeing needs of LGBTIQ people, and the development of policy and programs for LGBTIQ communities. In large population-based surveys there is an absence of adequate questions or variables to describe sex, gender and sexuality that allows for quantification at a population level, not just aggregation from national estimates (Rainbow Health Australia 2020).

Health data for diverse sexual and gender identities is rarely and inconsistently collected at standardised geographical levels. Smaller population sample surveys such as the General Social Survey (GSS), The Household Income and Labour Dynamics in Australia survey (HILDA Wave 16) and The Second Australian Study of Health and Relationships (ASHR2) include adequate identity measures however, even the largest sample is only representative of 0.1% of the households in Australia (12,932 dwellings were counted in the 2020 GSS versus the 10.8 million private dwellings counted in the 2020 Census). Noting limitations, in 2020, national data on LGBTIQAP+ residents reported that 4% of the sample described themselves as gay, lesbian or bisexual compared to 3% in 2019 (ABS 2020b). This same cohort (773,000 residents) also reported lower levels of trust in others, the healthcare system and judicial systems in general and less frequent contact with family and community and self-reported lower levels of health status (ABS 2020b). Though the majority of LGBTIQAP+ participants in the 2020 GSS were younger, over 25% of respondents were aged between 40 and 70+.

4.5.1 Residential aged care fears for older LGBTIQAP+ residents

A qualitative study on the perceptions of residential aged care for older gender diverse persons in Australia, revealed the key fears and factors regarding reluctance in seeking care as the constant potential for abuse, discrimination as a result of being trans, and not having access to appropriate treatments (Waling et al 2022). Participants indicated a range of alternatives to using services, such as renovating the home, relocating to areas with greater access to trans-inclusive services, and potential euthanasia. Participants also perceived that service providers were not adequately trained for trans and gender diverse needs and highlighted a number of ways aged care services could better support their diverse community. These findings provide important information to assist health professionals as well as residential care service providers, in supporting the health and well-being of older trans women.

A similar study into the experience and perception of residential and in-home care was conducted on older lesbian women and gay men in 2019 (Walling et al). The 33 interviews queried the populations preparedness for using aged-care services. Similar concerns regarding lack of inclusivity, concerns regarding discrimination and hostility, and the imperative loss of access to community and same sex partners alongside more general concerns regarding loss of autonomy and fear of elder abuse were also reported by this cohort. These participants noted numerous strategies to avoid residential aged-care, including use of in-home services, renovating their homes for increased mobility or even moving to areas of greater access to these in-home services if lesbian-gay specific housing or residential-care options were not available.

4.5.2 Housing insecurity of older LGBTIQAP+ residents

Further considerations are required for this target population, regarding the specific demographic and psychosocial factors associated with diverse gender or sexuality, particularly in older age. Alba et al (2019) examined housing security among older (60+) lesbian women and gay men in Australia, which found correlations between increasing age, recent experience of discrimination and lack of social support and lower rated levels of housing security. It demonstrated particular vulnerability for certain groups of LGBTIQAP+ older persons who heavily rely on in-home care however, may have reduced housing security due to discrimination, are less likely to have support from biological families and/or less likely to have a partner than the general older population (Alba et al 2019).

4.6 Older People with Disability

In the Brisbane south region there are 66,503 persons (or 5.6%) in need of assistance with a profound or severe disability (defined as needing assistance in area of self-care, mobility, communication,

disability or old age) with the Southern Moreton Bay Islands SA2 (13.4%) exhibiting the highest proportion of persons in need of this high level of assistance, followed by Bethania – Waterford (10.9%), Eagleby (10.5%), Beenleigh (9.4%), Beaudesert (8.9%) and Cleveland (8.5%) (QGSO 2022).

4.7 Housing trends for older people

Housing is an imperative aspect to consider in regards to accessing consistent aged care – it is fundamental for all other services, health, well-being and continued care. Though a national trend, specifically for the older population there is a marked decrease in housing security, with a decrease in outright home ownership, increasing rates of renting with mortgage and older people residing in private rentals increasing 45% in the last 5 years (HAAG, 2022).

In 2021 26% of Brisbane south PHN region residents own their homes, 37% are being purchased, 34.1% rent whilst 1.5% have other arrangements (QGSO 2022).

Table 4. Brisbane South PHN Region household tenure by age (65+) and sex

2016 ABS Dwelling Tenure Type	Female (n)	Male (n)
Owned Outright	43,491	37,994
Owned with a mortgage	8,867	8,611
Rented: Real Estate Agent	3,470	3,218
Rented: State housing authority	3,048	1,950
Rented: Person not in same household	2,387	2,196
Rented: Other	1,041	863
Other Tenure Type	1,786	1,065
Total (n)	**69,062**	**60,060**

(QGSO 2016)

The 2016 Census identified that 75.8% of women and 77.6% of men 65+ in the Brisbane south PHN region owned their own home either outright or with a mortgage. 4.4% of women and 3.2% of men 65+ rented a property from a state housing authority whilst 12.6% of women and 12.2% of men 65+ rented a property either from a real estate, another person not in their household of other tenure arrangement (QGSO 2016).

In regards to household composition in our region and those over 65 years of age, males reported higher levels of co-occupancy with a husband, wife or partner in their residence (56.3%) compared to 43.6% of females. Similarly, 68.2% of women reported sole occupancy of their residence compared to 31.9% of men.

At the population level in 2016, 54.5% of persons who rented via a state or territory housing authority who identified as Aboriginal and/or Torres Strait Islander were female, compared with 45.2% for males (QGSO 2016). Female Indigenous identifying respondents reported higher levels of co-occupancy (husband, wife or partner) and group household membership and lower levels of single

occupancy households compared to the non-indigenous identifying population. This relationship was inverse for male Indigenous residents who were less likely to live with their husband, wife or partner, in group households and more likely to live alone than the non-indigenous population.

Of the Brisbane south region residents who reported a disability status, 53.8% owned their homes outright and were female (46.2% for males). Out of those who reported need for assistance and rented through a real estate agent, 47.6% were female and 53% were male (QGSO 2016).

Across the Brisbane south population, women born overseas from a non-English speaking background (NESB) report the highest rates of co-occupancy with their husband, wife or partner at higher rates than those of born of English-speaking background ESB or born in Australia. Men with NESB backgrounds reported the lowest levels of co-occupancy with husband, wife or partner. Similarly, women with a NESB background report lower rates of living alone than those born in Australia whilst NESB men report the highest levels lone occupancy (QGSO 2016).

4.7.1 At-risk and homeless older residents

The current post-pandemic housing instability increases the rate and proportion of older persons classified as 'at risk', whether this is due to unsuitable housing, overcrowded condition or renting a home that is too expensive, unsuitable, temporary or in poor condition. It is equally important to note that there is an increase in older people experiencing homelessness;29% for people aged 55+ and a 47% increase for people aged 65-74, compared the 12% average across all age groups (HAAG 2022).

Between May 2019 and mid-June 2022, the Micah Project's Brisbane Zero Campaign (2022a) assertively reached out to 133 First Nations people over the age of 45 in the Brisbane LGA, where 75 (56%) were sleeping rough at the time of survey. It was reported that the streets, parks, cars, bushland, beaches and riverbeds as some of the most frequented places to stay. The majority of this surveyed group were late 40's or early 50's, with one individual reporting to be over 75 years of age, resulting in an average age of 52 years. From the cohort of 133 at-risk or homelessness First Nations older residents, 68.4% identified as male, 30.8% identified as females and 0.8% identified as transgender. Of these First Nations individuals, 92.5% identified as Aboriginal, 4.5% as Torres Strait Islander and 3% as both. As part of their assessment, Micah Projects also use the Vulnerability Index Service Prioritisation Decision Assistance Tool (VI-SPDAT) to assign individuals to three categories of increasing vulnerability (acuity) with 74% of First Nations identifying contacts being high acuity and in need of housing, health care and community support services.

On the granular level of comorbidity and associated health risks, 91 (68%) reported at least one chronic health condition, 107 (80%) at least one mental health condition and 93 (70%) reported substance use. In this population, only 3% had access to Aged Pension, whilst majority relied on Unemployment Benefits (51%) or Disability Support Pensions (42%). This same sample of older First Nations residents reported an average of 6.5 years of living on the streets or in emergency accommodation and an average of 4 years since their last instance of stable housing. Approximately 50% reported having experienced discrimination based on age, race, appearance, disability or gender and sexual identities in their access to housing. The majority also reported having experienced physical

5 Qualitative Analysis – Provider, Community and Clinical Consultations

5.1 Quantitative Limitations – Reluctant, Diverse and Voluntary Engagement

violence, physical or verbal abuse during homelessness, exploitation by force and fear of further threats by a certain individual and owe money (68%) and specifically gambling debts (79.7%)

Micah Projects (2022b) prepared a similar report on non-first Nations identifying population across the same timeframe and geographical confines with an adjusted age threshold of 50 across a cohort of 318 surveyed older residents. Comparatively, 148 (46%) of the individuals were sleeping rough at the time of survey, citing similar, but slightly lower rates of sleeping on the streets, in parks and other outdoor areas. The majority of the surveyed group were in their 50's with one individual reporting being over 85 years of age, resulting in an average age of 57. Out of this non-first nations cohort of 148 at-risk or homeless older residents, 69.5% identified as male and 29.6% identified as female with 91.2% reporting that they are neither Aboriginal or Torres Strait Islander, with 6.3% being unsure and

5.2 Market Analysis and Service Landscape

2.5% declining to answer. The majority (71%) were born in Australia, followed by New Zealand (10.7%) and approximately 5% from European countries with just under 2% CALD identification (China and Iran). On the VI-SPDAT vulnerability scale, 61% were classified as high acuity.

In regards to comorbidity and health risks, 225 (71%) reported at least one chronic health condition, 253 (80%) at least one mental health condition and 162 (51%) disclosed substance abuse. Comparatively, there were higher rates of Disability Pension (41.2%), access of Aged Pension (11.32%), lower averages of years spent living on streets or in emergency accommodation (5.2 years) and time since last stable housing (3.7 years). This cohort also reported that the majority has experienced physical violence, physical or verbal abuse during homelessness, exploitation by force and fear of further threats by a certain individual and owe money (73.9%) and specifically gambling debts (86.5%) however reported that 91.8% had regular income.

The general population of older residents captured in the Micah Projects Brisbane Zero Campaign outreach reported lower rates of sleeping rough, a wider and older age range, less high acuity and less time spent living on the streets or without stable housing than First Nations identifying individuals captured in their contact. Though there are measurable differences across identities, and this an important prioritisation consideration, this at-risk population as a whole, captures the imperative need for care finder integration into assertive outreach programs, particularly for access to transient, reluctant or isolated older residents.

In similarity to the caveats surrounding quantitative datasets on the care finder target populations, there are numerous limitations in consultation of reluctant, diverse and intersectional target populations, specifically in attaining voluntary perspectives from marginalised or often persecuted populations. A Market Analysis identified 17 Provider organisation with the capacity to expand and provide specialised services for the care finder target populations, of which nine (9) agreed to participate in our two-step consultation process. Among the three (3) ACH providers funded to provide CHSP in-home care in the BSPHN region who would transition to care finders, two (2) participated in our survey consultation.

As referenced by providers, advocates and community members across our consultations, the ability of engagement across certain cultural or diverse older communities requires membership within those groups. Where reluctant at-risk groups were not able to be consulted directly, relevant local and national qualitative literature was used to aide in the prioritisation and subsequent commissioning of appropriate services.

Average consultation and response times indicated that the Project Team compiled and analysed a comparative ~18 hours of qualitative data across provider, service, advocacy, workforce, community and clinical perspectives. This will provide an adequate basis for successful prioritisation of the felt, expressed and normative needs required to commission the implementation of care finder navigators in our region.

A market analysis of key stakeholders providing care, services and information to our identified care finders target groups in our region was developed. Twenty service providers (including our three Assistance with Care and Housing providers for our region) were contacted with an expression of interest letter to invite them to take part in our consultation work. A total of 12 provider consultations were completed as a result of this expression of interest, with a further 3 community consultations also conducted. The providers consulted included;

- Better Hearing Australia (low hearing advocacy, advice and education services)
- Meals on Wheels QLD (Government subsidised home delivered meal program)
- Micah Projects (Housing and Homelessness health services)
- Lotus Place (Program within Micah Projects focused on supporting senior care leavers or ‘Forgotten Australian’s. Australians who experienced childhood institutionalisation)
- Legacy Brisbane (Services supporting the widows and families of deceased veterans)
- Queensland Council for LGBTI health (Aged Care navigation for senior LGBTI Queenslanders)
- Vision Australia (Services supporting Brisbane South seniors experiencing low vision and blindness. Education and vision aids, advocacy and social support
- ADA (Aged disability advocacy, QLD’s primary advocacy services for seniors in home and residential aged care)
- Islamic Women’s Association Australia (Encompass Program: Peer support and aged care navigation services for seniors from culturally and linguistically diverse communities in Brisbane)
- Footprints QLD, Ozcare, Star Community Services (Assistance with Care and Housing providers covering services for seniors experiencing homelessness, hoarding and squalor and associated complexities as a result of these issues)

5.2.1 Aged Care Supports and other Services

A review of available CHSP services in the Brisbane South PHN region on 20 June 2022 shows the following availability by service type:

Allied Health

Five providers open for referrals from a total of 18 providers in the region. (Note: not all available providers service all allied health types).

Assistance with Care and Housing

Three providers available in our region, all open for referrals. Each provider services clients based on different geographic and complexity levels

Centre Based Respite

Three providers open for referrals from a total of five providers in the region. Each centre-based respite service in our region specialises in care for clients with complexities including vision loss, dementia and CALD seniors.

Cottage Respite

Two providers available in our region, one open for referrals across two sites, Alzheimer's QLD which specialises in care for client with dementia

Domestic Assistance

Seven providers available in our region with only one open for referrals. Domestic assistance availability levels have been an ongoing issue within our region with little to no capacity recorded for most providers for the last two years

Flexible Respite

Nine available providers with two open for referrals.

Home Maintenance

Four available providers with one open for referrals. Home maintenance is another area with ongoing low service availability in our region. Often clients report confusion between state home assist funding and My Aged Care funding. Many providers hold funding for both programs with a focus on equitable access and clearer eligibility requirements an ongoing concern for seniors.

Home Modifications

Two available providers, both open for referrals. Home modifications funding is another area of confusion for many clients who may previously accessed support under the home assist program. Additionally, clients report that support for basic modifications is often delayed by poor availability of occupational therapists in our region. This is particularly problematic for clients who are at a falls risk or seeking discharge from hospital but are delayed due to modification installation wait times.

Meals and Food Services

Meal delivery to the home is typically well serviced in our region, primarily by a number of Meals on Wheels outlets. Meals on Wheels is a well-known provider and reported as a trusted, reliable service within aged care. Additional meal preparation in the home services is provided by some CHSP services to support clients who prefer meals made to a culturally or personal preference.

Nursing

Four available providers with three open for referrals. Nursing service availability can be problematic in our region. It has been identified, particularly with consultation with hospital discharge planners and GP's that service navigation for clients needing urgent nursing care in the home can be difficult. The time taken to find an available provider and link this with a client discharge can be lengthy and complicated by needing to contact multiple providers and outlets. This often leads to delays in seniors receiving care.

Personal Care

Five providers available with two open for referrals. As with nursing above, personal care services are most often sought after a significant decline in client function or hospital discharge and are usually sought urgently. Service availability in our region and navigating to an available service for a client can cause delays and frustration for clinical and home care referrers.

Social Support (Group)

Twelve providers available with six open for referrals. Social support group services most often service small areas of geographical areas in our region. Many providers offer transport to and from their service within a limited catchment area with seniors outside this area required to find their own transport. COVID-19 impacted all social support group services with extended closures of these programs; however, this provided an opportunity for these providers to redesign the way their programs were delivered with many successfully trialling online classes and social groups. Grants to support the supply of devices and internet connection to seniors were reported as a vital link to continuing to support isolated clients in our region during COVID-19 lockdowns.

Social Support (Individual)

Nine providers available with two open for referrals. This service type has increased in popularity and need for seniors in our region during the COVID-19 lockdowns. Usual family arrangements to manage shopping needs in the community were disrupted with travel limitations as was usual social interactions between peers. Social support individual services provided a valuable support to seniors not wishing to leave their homes but still needing support to attend to appointments and shopping needs.

Specialised support services

Five providers available, all open for referrals. Each available provider in our region specialises in either vision services, continence advisory or dementia advisory support services.

Transport

Three providers available with 2 open for referrals. Each provider services a specific geographical area within our region. Transport services are the second most popular service type in our region, second to domestic assistance services

The primary gaps identified within current Commonwealth Home Support Service providers in our region are reported as:

- Little/no service availability for any service type across primarily CALD focused organisations (Cathay Community, Evergreen and IWAA are the primary providers, however, their capacity for new clients is very limited).

- Limited client choice for most service types with Blue Care or Anglicare the only available providers in the region for nursing, personal care, social support individual, home maintenance, flexible respite (Vision Australia offering services specific for vision impaired clients, AQ offering services to clients experiencing dementia), continence advisory, other food services and domestic assistance (Logan ACPR only) at the time of report.
- Limited specific services for First Nations clients. For example, Burringilly, First Nations provider in Logan, has very limited availability for their services and waitlist.
- Limited availability/client choice of services on the SMBI, Blue Care listed as the only provider currently open for new clients for most service types. Star Community services provides some limited support for transport and home maintenance.
- Minjerribah respite centre and Yulu-burri-ba provide limited CHSP services on Minjerribah (North Stradbroke Island).

5.3 Current Service Users in the Brisbane South PHN regions

5.3.1 Home Care Package Program Level Summaries

Home Care Packages are designed for those with more complex care needs that go beyond what the Commonwealth Home Support Programme can provide.

Table 5. HCP Level 1 for BSPHN

	Age Bands	n
Level 1 Home Care Package - Basic care needs – $9,179.75 a year	50-54	2
	55-59	0
	60-64	2
	65-69	44
	70-74	89
	75-79	99
	80-84	127
	85-89	99
	90-94	48
	95-99	9
	100+	1

Sex	**Female**	309
	Male	211
First Nations Status	9	
Preferred language	**English**	408
	Other	94
	NS	18
Born in Australia	281	
Born in other English-speaking country	60	
Born in a non-English speaking country	171	
Total (n)	***520***	

Table 6. HCP Level 2 for BSPHN

Level 2 Home Care Package - Low care needs – $16,147.60 a year	**Age Bands**	**n**
	50-54	0
	55-59	6
	60-64	8
	65-69	110
	70-74	292
	75-79	400
	80-84	489
	85-89	521
	90-94	338
	95-99	59
	100+	8
Sex	**Female**	1493
	Male	737
First Nations Status	23	
	English	1888

Preferred language	**Other**	297
	NS	46
Born in Australia	1325	
Born in other English-speaking country	279	
Born in a non-English speaking country	596	
Total (n)	***2231***	

Table 7. HCP Level 3 for BSPHN

Level 3 Home Care Package - Intermediate care needs – $35,138.55 a year	**Age Bands**	**n**
	50-54	2
	55-59	8
	60-64	10
	65-69	112
	70-74	268
	75-79	321
	80-84	421
	85-89	389
	90-94	245
	95-99	53
	100+	5
Sex	**Female**	1204
	Male	629
First Nations Status	39	
Preferred language	**English**	1522
	Other	276
	NS	36
Born in Australia	1082	
Born in other English-speaking country	211	

Born in a non-English speaking country	515
Total (n)	***1834***

Table 8. HCP Level 3 for BSPHN

Level 4 Home Care Package - High care needs – $53,268.10 a year	**Age Bands**	**n**
	0-49	5
	50-54	3
	55-59	17
	60-64	27
	65-69	111
	70-74	243
	75-79	290
	80-84	332
	85-89	345
	90-94	215
	95-99	66
	100+	14
Sex	**Female**	1044
	Male	624
First Nations Status	38	
Preferred language	**English**	1355
	Other	274
	NS	39
Born in Australia	944	
Born in other English-speaking country	208	
Born in a non-English speaking country	596	
Total (n)	***1668***	

According to the Home Care Package Data Report 2021-2022 (Quarter 2) in the Brisbane south PHN region, the following numbers of seniors were waiting on allocation and provision of a HCP at their approved level at 31 December 2021, and have yet to be offered a lower-level HCP:

Table 9. Number of BSPHN Residents Awaiting Approved HCP

Level 1	Level 2	Level 3	Level 4	Total
56	423	409	41	929

This total is the third highest for a PHN region in Queensland (Sunshine Coast - 1150, Cabool 1027). Seniors in Brisbane south PHN waiting for a HCP at their approved level represents 11.2% of the total of all Queenslanders on the HCP queue.

5.4 Consultation and Targeted Engagement

Representatives from community, Assistance with Care and Housing Providers, external organisations and the Clinical and Community Advisory Councils were approached via an expression of interest process. Initial project planning for the Once-off Report on Supplementary Needs Assessment commenced in April 2022. This included the Program Manager approval of a high-level project plan, and the initial stages of market analysis in relation to needed consultations. The initial tasks the Project Team included was the proposed structure for collection and organising data for analysis as it relates to the template provided by the Department of Health and the co-design of a varying pool of stakeholder engagement survey questions.

The Project Team drafted a set of standard survey questions to service all formats of proposed consultation (Community groups, Assistance with Care and Housing (ACH) Providers, targeted Provider Organisations and both Clinical and Community Advisory Councils to be distributed in the varying forms (identified and non-identified). This included an online survey distributed through the Survey Manager platform, with tailored face-to-face meetings to help in clarification, gathering of feedback regarding the data collection process and formats and initial partnership building with the various stakeholders. The resulting large-scale qualitative dataset will then undergo a thematic content analysis by the care finders Project Team as the foundation for establishing the regional priorities (Phase 3) of the care finder program.

An overview of the engagement process and activities were envisioned to occur across four sectors:

1. Community Member Consultation – face to face group interviews

A set of questions was developed for engaging a range of community members and advisors to assist in a targeted approach to subsequent stakeholder engagement. Approximately 30 responses were received from these community consultations. Thematic analysis was undertaken on the results.

2. Targeted Engagement (Assistance with Care and Housing Providers)

A series of meetings were held with the three (3) ACH providers who are transitioning to the Care Finder Program with quarantined funding. These are noted as follows:

- Star Community Services meeting on 9th June 2022
- Footprints meeting on 27th June 2022
- Ozcare meeting on 29th June 2022

6 Provider, Community and Clinical Consultations Analysis

Notes were transcribed and an accompanying online questionnaire (via Survey Manager) from our flexible set of questions was supplied to each of the three providers on 29th June 2022 for completion. Of the three ACH providers, two completed the consultation process and were included in this report.

3. Targeted External Stakeholder Engagement of Organisations (Multimodal Approach)

The third subset of the engagement process involving provider organisations, occurred in a two-step process:

1. Provision of consultation questions in a standardised online survey format (via Survey Manager). Of the 17 provider organisations, 10 responded favourably and volunteered their expertise across a set of project specific demographic, geography and gap and service need orientated questions (included in Appendix).
2. Follow-up meetings were organised with each participating stakeholder representative to discuss the questions and their answers in more depth, clarify context and to gather feedback regarding the consultation process, format and focus.

4. Community and Clinical Advisory Council Engagement

All sources of surveyed engagement, consults and interview transcripts were transcribed and analysed for Thematic Content Frequency by the Project Team via the use of NVivo (Qualitative Data Analysis Software). This collaborative analytic process aims to remove individual bias and establishes a robust methodology to analysing and utilising the variety of open-ended responses collected across the numerous consultation processes. This analysis, alongside the quantitative data surrounding demography, geography and services will enable the initial prioritisation and triangulation processes to guide both care finder concentration and need for workforce diversity and skillset.

The analytic process grouped the thematic coding and subsequent dissemination of this engagement content into three parts; 1. ACH and Provider Organisations, 2. Community Consults and Community Advisory Feedback and finally, 3. Clinical Advisory Feedback. Each phase utilised the overarching themes of gaps and needs, potential solutions, health system integration feedback and key feedback regarding Aged Care generally and in the specific focus of care finders, to allow for cross-referencing and analyses across the different stakeholder groups, and to guide the overarching triangulation and prioritisation process.

6.1 Part 1 – Provider Perspectives

Table 10. ACH and Organisational Provider Regional Coverage and Demographics

ACH Providers (2)	% BSPHN	Target Population (selection)	Total (n)	Male	Female	Age Range	Readiness Scale Rating (1-10)
Footprints	100%	1,2,3,4,5,6,7	148	66	82	45-100	10
STAR Community Services	98%	1,2,3,4,5,6,7	101	38	63	50 - 95	9
Organisations (9)	**% BSPHN**	**Target Population (selection)**	**Total (n)**	**Male**	**Female**	**Age Range**	
Aged and Disability Advocacy Australia	100%	1,2,3,4,6 and 7*	1000	N/A	N/A	All ages	
Better Hearing Australia Brisbane	100%	3	300	Higher prop.		60-80 (avg.65)	
Islamic Women's Association of Australia (IWAA)	100%	2,3 and 5	200	50	150	65 - 95	
Legacy Brisbane	90%	1, 4 and 7	5,300	N/A*	99.80%	65 - 104	
Lotus Place (Micah Projects)	100%	1,2,3,4,5,6,7	200	70	130	50+	
Meals on Wheels Queensland	100%	1,2,3,4,5,6,7	2704	N/A	N/A	All ages*	
Micah Projects (Brisbane Zero Campaign)	80%	1,2,3,4,5,6,7	63	46*	15*	65-87	
Queensland Council for LGBTI Health	100%	1,2,3,4,5,6,7	60	N/A*	N/A*	60 - 90+	
Vision Australia	100%	1,2 and 4	235	88	147	66 - 102	
Totals/Average	*98%*		*10000~*			*45-104*	

6.1.1 Assistance with Care and Housing Providers (ACH)

- Footprints
- STAR Community Services

Out of the three suitable ACH providers identified in the Market Analysis of the BSPHN region, two responded to the call for consultation. This included a subset of questions regarding geographical service parameters that were mapped to our region at an SA2 concordance level (average of 99% coverage), a summary and estimated demographics of care finder target population that they already service, region and target population specific service gaps and clientele needs, proposed solutions for these shortcomings and feedback for wider systemic health integration, including a rating of their readiness to transition to the care finders program.

ACH providers Footprints and STAR Community Services and their chosen representatives were contacted by the Project Manager and provided with a link to the identified online subset survey and providers were given 3 weeks to respond to the survey through the Survey Manager platform. Contact information of the nominated ACH representative were collected in case of need for clarification of population estimates or concordance mapping to our region.

ACH providers were asked to select from a list of 7 examples, representative of the variety and scope of the care finder population, and how many of these groups they already service. Both consulted providers indicated they already serviced all example populations (see Appendix).

Similarly, when asked to rate their capability and capacity to expand their service model and broaden their focus to the care finders population on a scale from 1 (No) to 10 (Yes) both ACH providers rated as 'Yes' (9.5 score average). All respondents estimated a higher proportion of female clients and a service age range from 45-100 years of age (Refer to Table 1) which aligns with the trend of sex identification of the older person ERP of our region (QGSO, 2022). The surveyed ACH providers estimated an average of 125 clients in our BSPHN region within the last 12 months.

6.1.2 Organisational Providers

- Aged & Disability Advocacy Australia (ADAA)
- Better Hearing Australia
- Islamic Women's Association of Australia (IWAA)
- Legacy Brisbane
- Lotus Place
- Meals on Wheels Queensland (MoWQ)
- Micah Projects (Brisbane Zero Campaign)
- Queensland Council for LGBTI Health (QCLGBTIH)
- Vision Australia

As these provider organisations and their specialised populations of service provide the best proxy to accessing data of certain care finder target populations in our region, the provider consultation was designed as two-step process in which the survey questions were reviewed in an informal interview

with two members of the Project Team (including a Data Analyst). This allowed for expansion, clarification of answers, context, estimations in demographic data and the capture of nuance, anecdotes and specificity across the gaps, needs, solutions and systemic propositions for the care finder implementation in our region. Both the Project Team and the provider recognised the importance of this follow-up and all respondents rated this multi-modal process as easy, accessible and valuable.

6.1.2.1 Provider Geography and Brisbane South PHN Area Coverage

The nine consulted Provider Organisations were sent a specific, modified subset of survey questions and given two weeks to respond to the survey, during which in parallel the follow-up interviews were scheduled and conducted. Similarly to ACH providers, the organisations and were consulted on a subset of questions regarding geographical service parameters that were mapped to our region at an SA2 concordance level (average of 97% coverage), a summary of their own target population and estimated demographics of care finder target population that they already service, region and target population specific service gaps and clientele needs, proposed solutions for these shortcomings and feedback for wider systemic health integration.

A specific nuance to note regarding regional service coverage is geographies that rely on residential data are not applicable to all care finder target populations. For example, Micah Projects (area coverage concordance of 80%) who run the Brisbane Zero Campaign for active outreach to at-risk and homeless persons, only have data on the location of the individual at the point of initial contact. It was noted that this geographic data is unreliable as this highly transient population are not able to be classified in the same manner as residential populations.

It was described that, as their office is in West End, and the majority of resources for homeless or at-risk persons cluster around the CBD, their data captures high contact in these two areas, however may not indicate the specific need in these locations. It was also raised that there is need for collaboration across Brisbane south and Brisbane north PHN regions and care finder programs, as the arbitrary regional boundaries that intersect the Brisbane LGA. In particular the CBD division, are problematic schemas in the care and continued navigation support of non-residential, at-risk and transient populations.

6.1.2.2 Providers Servicing Target Populations in Brisbane South PHN region

In the consultation with the organisational providers, there was larger variance in the number of target populations that they service, as each service has higher specificity in their own advocacy or target group. For example, 44% (4) of the organisations (Lotus Place, Meals on Wheels, Micah Projects and The Queensland Council for LGBTI Health) responded that they serviced all the target populations (see Appendix for question format). The remaining 5 providers had higher specificity in regards to their

own target populations, and either required self-identification or referral or did not engage in active outreach (Aged & Disability Advocacy Australia, Vision Australia and Better Hearing Australia), worked with specific cultural and religious groups (Islamic Women's Association of Australia) or worked with a very niche population subset such the Widows of Veterans services offered by Legacy Brisbane. This variance in client populations is indicative of the complexity and intersectionality of the care finder target population and it is imperative to note that clients could access more than one service or be comorbid and individually diverse in their needs and care as they exist across the spectrum.

It is important to note this measure was intended to indicate the breadth of population specific services and there was no expectation or need for organisations to service each and every subtype as specialised services and community connections are key to providing ongoing and successful aged care navigation. It was noted by organisations with specific target populations that the need for integration of care finders into existing processes, communities and with the guidance of representatives already engaged with certain minorities was the key to success, adoption and continued engagement from their clients.

When asked to estimate the number and demographics of care finder population clients serviced in the last 12 months, the majority of organisations estimated and aggregated from their national data. Micah Projects (of which Lotus Place is subsidiary), Vision Australia and Meals on Wheels were able to filter their data to our specific BSPHN region (See Table 1). Each of the providers consulted provide service and support to First Nations people as business as usual.

Brisbane South PHN will aim to work closely with Aboriginal and Torres Strait Islander community controlled health services and the Trusted Indigenous Facilitators (once commenced). Brisbane South PHN, in its planning for care finder commissioning and implementation will work with First Nations services providers (in particular TIF) to meet the needs of all diverse groups that form part of the target population in their region, including older First Nations people.

Similarly, age ranges are estimated from national client datasets but across the organisations ranged from 45 – 104 years of age, noting that some organisations, particularly advocacy and care provision services, do not have any age thresholds for service so do not collect data on this granular level, however were able to elaborate on this in the follow-up interview. For example, Meals on Wheels service clients of all ages but 85% of their clientele are over 65+ years of age and Better Hearing Australia were able to report an average client age of 65 in lieu of more specific regional data. Out of the 11 providers, 6 (54%) reported that their client age range started at 45 years of age. This flexibility in prerequisites in services allows for inclusion of populations with differing lifespans ands rates of ageing, including those who have experienced trauma, disability, LGBTIQAP+ or First Nations older persons.

Estimations of sex demographics were equally varied as some services (e.g., Legacy) only service women and others have higher presentations of certain impairments among males, such as higher proportions of hearing loss (Better Hearing Australia), homelessness (Micah Projects) whilst others were more prominent in females such as vision loss/impairment (Vision Australia) or survivors of forced institutionalisation (Lotus Place). This is very much representative of with the risk-taking behaviours and varying lifespan of each sex as demonstrated in the larger national and even global populations.

It was raised in the feedback portion of consultation with Queensland Council for LGBTI Health, that male and female sex identities were too restrictive for their specific sub-group population. The Project Team decided to omit collection of variables of gender identity or alternative sexual identities (such as intersex individuals) within the demographic estimates due to the trauma, generational hesitancy and current inconsistencies surrounding collection and definition of these variables. However, Micah Projects was able to provide data that revealed that 2% of their clients over 65+ identified as 'other' in regards to their sexual identity.

6.1.3 NVivo Thematic Content Analysis

The thematic content analysis coding process was initiated by the Project Team as a diverse group, prior to finer analyses being conducted under their guidance, by the Senior Health Data Analyst. Four main thematic areas of investigation were identified across all consultations that align to the needed further investigations outlined by DoHAC for this Supplementary Needs Assessment. Each individual response across the consultations was coded under the following themes to track frequency of certain references, clustering of themes and sub-themes and to aggregate feedback to aide in prioritisation of regional needs:

Theme 1: Identified gaps in service and system and unmet client needs
Theme 2: Proposed solutions or implementations to overcome the gaps and needs
Theme 3: Perceived changes in Health systems (Last 12 months)
Theme 4: Overarching Health System integration solutions or feedback

Aggregation of these codes was conducted under the guidance of the Project Team and frequency of codes and their associated reference are explored below. Sub-themes or deviations that emerged during consultation or subsequent analyses were also explored.

Due to the overlap in their perspective, role and question subsets, the ACH and organisational providers were analysed as a composite group. Each surveyed provider (11 in total across ACH and organisational consultations) was asked to describe their organisational target population in their own reference terms. This was then coded against care finder sub-groups to identify commonalities, high-prevalence and deficits across different populations. The most frequently reported client sub-groups were CALD (63%) and isolated older persons (54%), followed people with disability (54%), First Nations (36%) and those reluctant to seek care (36%). Providers were primed (see Appendix for question pool) that the identification of subsequent gaps and needs were to be identified with specific reference to these care finders target populations in our region.

Table 11. ACH and Organisational Provider Target Population Groups

Target Population Codes	Code Frequency across Responses

CALD*	7
Isolated	6
People with Disability**	6
First Nations	4
Reluctant to seek care	4
At-risk or Homelessness	3
LGBTIQAP+	2
Veterans ***	1
Forgotten Australians***	1

Notes: Each target population was only coded to an individual response once, but due to intersectionality of these sub-groups, providers were coded as multiple target populations if identified in the survey response or interviews. *CALD population was coded to response when organisation has multiple languages if service/had need for interpreters across multiple language groups. **People with Disability was aggregated to include populations with physical (e.g. vision and hearing) and decision-making. impairments People with Disability. ***Veterans and Forgotten Australians were not aggregated due to complexity and intersectionality of these populations.

6.1.3.1 Theme 1: Identified gaps in service and unmet client needs

Table 12. ACH and Organisational Provider Gaps and Needs

Gaps in Service/Unmet Needs Codes	Code Frequency across Responses
Workforce lacks training*	19
Supporting Autonomy	*5*
Trauma Awareness	*4*
Disability Awareness	*2*
Inclusivity and Safety	*1*
Cultural Competency	*1*
Consistency of contact	*1*
System Engagement Fatigue	6
Intensive case management/navigation	6
Wait Times for CHSP	4
Crisis Support Access**	4
Provider at capacity/exceeding targets	4
Post-hospitalisation in Home Care	3
Keeping clients informed on system changes	3
Referrals limited/lost***	2
Affordable Disability Aides	2
Reluctant clients not identified	2
Better Partnerships with Community	2
More LOTE Services	1
Fair Work changes not reflective of need	1
Affordable Disability Aides	1

Notes: Gaps and Needs were coded across multiple questions so the frequency total exceeds the number of individual responses. * 'Workforce lacks training' was aggregated to include Trauma and Disability awareness, 'supporting autonomy' and 'inclusivity and safety' but as these both have two individual references this was expanded and included in the table to retain nuance. **'Crisis Support Access' is aggregated to include 'high costs of allied/mental health' and 'at-risk of homelessness', 'mental health' and 'immigration/visa' crises. *** 'Referrals limited/lost' is aggregated as both 'Referrals getting lost' and 'Referrals only though My Aged Care'.

The most frequent reference across the services gaps and unmet needs of the care finder population were concerning the composition, training and competency of the Aged Care navigation workforce.

Each individual provider consultation mentioned the specific provision, integration and training needed for successful adaptation of the care finder implementations. Most frequent references were regarding the general lack of specificity training of aged care support staff including "*communication skills and technology (aides and devices)*".

More specifically there were references regarding reinforcing the autonomy of the client, awareness of trauma, sexuality, gender diversity, disability and cultural competency. Some specific references included "*Fear of Aged Care and institutions is immense*", "*trauma regarding removal and institutions*", "*Safety, inclusivity of language and service require continued training*", "*lack of disability accessible information available, and the difficulties they experience in engaging with it requires trained assistance*", "*Older Australians who have recently lost their sight…will struggle to access printed or electronic information and need a trained navigator for these processes*" and the overarching need for "*understanding behaviours and their triggers*".

The next most frequent references were in regarding the System Engagement Fatigue experienced by those with specific needs that the general health and aged care systems are not providing. Organisations who work in the disability advocacy space flagged that the resulting lack of disability awareness and resources means that "*inability for communication is the key barrier"* and that consequent "*lack of support around intake*" and the "*need (for) support but don't know how to access it*" for their specific intersecting needs was the cause for this fatigue and anecdotally the catalyst for disengagement from care. For the less impaired populations it was raised that "*explanation of the system as a whole is lacking*" and specific and that navigation itself causes fatigue in high-risk or reluctant clients. Along a similar vein, the need the need for intensive navigation was raised "*to avoid double dipping…to navigate and choose the correct services*" for their needs. There a specific mention of keeping clients informed regarding changes in their Aged Care from a top-down perspective so this onus does not sit with or erode trust with the provider, especially in cultural or trauma-based reluctant communities. Similarly, the identified issues with referral pathways relate to the "*large referral rates of at-risk people*" or being limited to official referral channels where "*we cannot identify the gaps, or does who do not engage with My Aged Care*".

From a client-centric perspective, the lack of crisis support was also identified by multiple providers (4) as a key gap in the current provision of care and included references across need for at-risk homelessness support, mental health and immigration or visa cancellation risks.

Providers were also asked to reference the evidence for their gaps and needs and identified their Casework as the most frequent (>50%) with survey feedback, complaints, community consultations and research, policy and generational attitudes as other sources.

Overall, there was immense breadth and consideration in the references regarding the gaps in service and client needs and subset of highlight the specific regional considerations regarding an adequately trained workforce, need for intense navigation and the overall urgency of the care finder navigation implementation.

6.1.3.1.1 Sub-theme: Referrers

As a specific question subset, the 9 organisational providers were also consulted on their current referrers and asked to rate their relationship to these other organisations or bodies. All organisation providers rated their relationship with their referrers as positive. 4 providers (ADAA, IWAA, Micah Projects and Lotus Place) were also involved in assertive outreach to expand and service their target sub-groups. 2 providers also utilise community development officers (ADAA and Legacy) and volunteers (Legacy) in their outreach and identification of clients.

Table 13. Organisational Provider Referrers

Referrers	Code Frequency across Responses
Community Services	4
Client Self-Referral*	3
My Aged Care	2
Hospitals/Specialists	2
Other Providers	1
Department of Communities, Housing and Digital Economy	1
Department of Housing	1
Queensland Police Service	1
Queensland Ambulance Service	1
Department of Veterans Affairs	1
Veteran's Homecare	1

Notes: * 'Client Self-Referral' includes referrals made online or made by family, community or friends and was treated as client-initiated referral directly to the organisation.

This variety of referrer types, including government, judicial, health, private and social support providers, demonstrates the active effort and necessity of building specific relationships with community, engaging in outreach and the expand their workforce for the practice of identifying at-risk individuals. This adaptability, including the 100% agreement across consulted providers to remain flexible in their service boundaries to be able to attend to clients in need, is important to note in regards to commissioning of services who will be tasked with identification of care finder target population residents in the BSPHN region.

Some example references in regards to, the Community Services that were being utilised as referrers were "*we seek out local supports and services in client's region*", "*legal centres*", "*Audiology Association network that is linked in well with the deaf community*" and "*volunteers to have set visits with widows to identify them in the community*".

6.1.3.2 Theme 2: Proposed solutions or implementations to overcome the gaps and needs

Table 14. Organisational Provider Proposed Solutions

Proposed Solutions	Code Frequency across Responses
Increased Education on Services*	13
System Pathways	6
Clients	4
Clinicians	3
Costing across services	1
Workforce Training	6
Health System Integration	4
Navigation Support	4
Funding based on need**	3
Mobile Outreach/Repeated Engagement	3

The most referenced of proposed solution across the provider responses was the need for "*education for clients and clinicians and systemic understanding of pathways*." A reference from MoWQ summarised that "*Communication and Referral pathways are the key issue - lack of awareness, education, understanding of existing and appropriate services"* including the "*clearer understanding of which services provide what and the specific costs involved.*" There was a high number of references on the proposition of further "*investment in workforce training*" with particularly the nuance of "*training in trauma) informed care and policies regarding asking questions (and how to ask and how to explain aged care from that perspective)*" including consideration of the diverse experiences across multiple cultural groups, identities and sexualities with the key goal of "*building trust and safety*" for all.

More broadly, there was repeated reference to the need for "*building awareness, partnerships and collaboration"* and integration across different health systems, including relationships with other providers, specialist health services, GP's, government funding bodies and community services.

In regards to education, of the nine organisational providers, 6 (>60%) referenced providing training, with 5 providers providing this directly to consumers (Better Hearing Australia, IWAA, QCLGBTIH and Vision Australia), clinicians (Lotus Place and Vision Australia), online via web modules or training videos (QCLGBTIH, Better Hearing and Vision Australia) and to private businesses (QCLGBTIH, Better Hearing and Vision Australia).

6.1.3.3 Theme 4: Organisational Provider Opportunities for Enhanced Integration of Care

Table 15. Organisational Provider Opportunities for Enhanced Integration of Care

Opportunities to Enhance Integration	Code Frequency across Responses
Education	10
Training providers	2
Educating clients	2
Health literacy	2
Digital literacy	2
Confidentiality	1
Understanding Patient Journey	3
Integration with health services (pathways)	9
Advocacy Partnerships	7
Workforce Provision	1

Education of providers and clients at systemic level was identified as particularly important for reluctant clients, as referenced by QCLGBTIH that "*providing information to the LGBTIQ+ communities on appropriate services is also essential to gain trust and understanding*." It was also referenced that clinicians need education regarding "*assistive technology*", "*isolation and new impact of impairment*" and "*to build the capacity so culturally appropriate services are provided*" at a systemic level. Both disability advocacy providers referenced the importance of "*forms and confidentiality*", the need for health and digital literacy education and consequent improvement of policies and procedures regarding instances of breached confidentiality for clients that require assistance in accessing care.

The "*increased integration with health services as an active project*" was referenced as the second most frequent opportunity for enhanced integration where particularly the need to, "*integrate pathways and referrals to follow through entire patient journey*" and the "*hospital integration of CALD assistance*", by "*running sessions in hospital settings*" were referenced. There was agreement from all providers that "*Strengthening care pathways would be essential*".

The references coded for 'Advocacy Partnerships' highlighted the opportunity to "*work with advocacy groups to better understand patient journey and improve patient outcomes*" and to attend "regular coordination meetings". "*It's all about spreading the word and building relationships*" and "attending network meetings" and from a perspective of cultural advocacy, "*Removing stigma around accessing aged-care supports*" and improving the need for accessibility in health spaces generally by "*advocating with the department in Canberra around the needs of this group of people.*"

6.1.3.3.1 Sub-theme: Other Relevant Codes and Feedback from Providers

Any other noteworthy idiosyncrasies captured during the survey or interview process were coded as 'Other'. These references included that one provider offers phone support for reluctant or hard to reach clients (Lotus Place) and another provider functions as 24-hour mobile service during peak times of need (Micah Projects). Five (45%) providers (both ACH and Organisational) offer services in LOTE (Footprints, STAR Community Services, ADAA, IWAA and MoWQ). ADAA provide advocacy across the disability spectrum but in the Brisbane South region have a particular focus on First Nations advocacy in the aged care disability space, including an implementation lead for practitioners for intersectional accessibility for CALD, LGBTIQAP+ and cases of Elder Abuse. Better Hearing and Vision Australia also both offer advocacy services state-wide. As per Section 5.10 of the care finder policy guidance, the primary role of care finders is to support people to understand and access aged care services and connect with other relevant supports in the community. While this may involve discrete elements of individual advocacy, such as support to resolve a problem with a provider, individual advocacy will not be a primary role of care finders and care finders will not be funded as advocates.

Upon completion of each follow-up interview all organisational providers were asked to give feedback regarding the data collection process, the structure, questions and accessibility of the survey and the informal follow-up interview process. All providers agreed that the "*the collaborative format is helpful*" with specific praise of the ability to clarify on context and elaborate on answers to the often broad, free-text questions. References stated that the "*method with follow-up was very useful for clarification*" and "*allowed time for consideration with colleagues*" and that the majority free-text format "*survey was easy to use*" and "*very accessible for a blind person*".

6.2 Part 2 – Community Perspectives

Table 11. Community Consultation Demographic Summary

Community Consultations (3)	**n**	**Female**	**Male**	**Sex %**	**55-60**	**60-64**	**65-70**	**71-75**	**76 -80**	**80+**
Donald Simpson Centre	7	5	2	70% female	0	1	2	1	1	2
Amputees & Families: Healthy Ageing Hub	18	14	4	77% female	0	2	2	6	4	2
First Nations Elders Consult for BSPHN	3	3	0	100% female	1	0	1	1	0	0
Totals	*28*	*22*	*6*		*1*	*3*	*5*	*8*	*5*	*4*
Community Advisory Council (4)	**Located in BSPHN**	**Female**	**Male**	**Sex Split**	**59 & <**	**60-64**	**65-70**	**71-75**	**76-80**	**80+**
All Responses (Totals)	100%	2	2	50%	2	0	0	2	0	0

Community consultations were conducted with targeted groups in our region, utilising a client experience centric set of questions (see Appendix for specific question subset). The same four overarching themes, in alignment with DoHAC stipulations, were utilised for coding of second portion of the thematic content analysis. As with provider responses, community consultation data and community advisory council responses were analysed as a composite group due to their overlap in perspective and focus.

The process of the Community member consultations involved a designated speaker and a scribe would initiate an informal 30-minute interview with the groups of older residents, during which self-identified demographics and responses to a subset of broad prompting questions were collected (see Appendix for question subset). These interviews remained anonymous, informal and were not recorded in any format and participants were briefed and reminded of their ability to withdraw consent at any time during the process. Contact details were left with group or centre facilitators to allow for later withdrawal of consent.

Face-to-face community member consultations were predominantly comprised of female participants (82% average across 3 groups), including the First Nations consult being comprised of only female elders. Group sizes varied, with the largest (18 participants) being the Amputee consult, capturing the views of family members in attendance. From community advisory council members, we received 4 responses with 50% sex split of male and female.

The most common self-reported age band for our community member consultations was 71-75 (28%), followed by 65-70 and 76-80 years of age. This median clustering was largely consistent across the different consultation groups, with a significant gap of insight from the 55-60 age range, which only included one respondent. It was noted that two participants in the Amputees consultation did not disclose their age. The most common age for our community advisory respondents was split between the 71-75 age band and a custom 59 and under selection (adjusted from set bands to accommodate the varying age range of advisory council members who wanted to respond to our survey).

6.2.1 Geographical distribution of community members and consultations

All Community member consultations were conducted face to face at various events in the BSPHN region (Redlands, Logan Central, Eight Mile Plains) however, attendees were varied in their places of residence (this was not collected due to the identifying nature of this in a face-to-face group setting). Responses from the Community Advisory Council survey subset were mapped against their postcodes of usual residence (as these were non-identifiable) with all residing within our region. The four respondents resided across Coopers Plains, Murarrie and Tarragindi.

6.2.2 Target populations in the community

Table 16. Community Consultation Target Populations

Target Populations	Self -Identification by Participant (instance)
First Nations	3
People with Disability	2
CALD and NESB	2
Cantonese	1
Sinhalese	1

Note: this data does not include the Amputees and Families Consultation – identity demographics were not collected from this group due to sensitivity, mixed attendance and group size.

During community consultations, one participant identified themselves as CALD and NESB, noting Cantonese as their language other than English spoken at home. Furthermore, two participants identified themselves as people with disability and three participants identified as Aboriginal. Within the community advisory survey responses, one respondent identified as CALD and NESB and noted Sinhalese as their language other than English spoken at home.

At a higher level of specificity, two participants in the Donald Simpson Centre group noted that they were disabled, with one participant specifically describing their experience of being almost profoundly deaf and other as physically disabled. Both participants had disabled partners (one profoundly deaf, the other with a form of paralysis), so their references were coded with the contextual nuance of this experience. During consultation with the Amputee and Families group, disability identification was not directed collected, due to the nature of the group and attendance of family members. During the First Nations community consultation, all three participants identified as Aboriginal, with one participant also identifying as a person with disability, who resided in respite care with specifically mobility issues and the consistent need for specialist haematological care.

. Brisbane South PHN will aim to work closely with Aboriginal and Torres Strait Islander community controlled health services and the Trusted Indigenous Facilitators (once commenced). NACCHO (including QAHIC) have been approached by Brisbane South PHN and are considered a significant part of the Care Finder program delivery. Brisbane South PHN, **in its planning for care finder commissioning and implementation will work with First Nations services providers (in particular TIF) to** meet the needs of all diverse groups that form part of the target population in their region, including older First Nations people.

6.2.3 Theme 1: Identified gaps in service and unmet client needs

Table 17. Community Consultation Gaps and Needs

Gaps in Service/Unmet Needs Codes	Code Frequency across Participants/Responses
Lack of in-home care*	11
CHSP Wait Times	3
Maintenance	3
CHSP Wait Times	4
Disability Isolation	1
System inconsistency/complexity	8
Age restricted access	2
Lack of communication	4
Specialist care lacking locally	5
Travel	3
Unaffordability of living**	4
Lack of social spaces/mental support	3
Lack of holistic/person-centred care	3
Workforce training	2

Note: Due to the varying size of group consults, the informal setting and the inclusion of community advisory responses each reference was coded as one instance of response or mention to best capture frequency and priority of feedback. * 'Lack of in-home care' was coded to include references regarding isolation. ** 'Unaffordability' was codes were aggregated to include references that include housing, travel, aides, socialisation or volunteering costs.

The most frequent reference across our community member consultations was the lack, inconsistency and difficulties in accessing in-home care, that resulted in isolation, lack of engagement, frustration and potentially dangerous behaviours in attempts to self-managing certain aspects of maintenance and home care. It was referenced that "*funding wait times are extensive and often health declines while waiting for support*" and that when a service does attend their home, the "*service providers focus on coming in to do a job but don't spend time with clients, get to know them or socialise with them on a visit*" and that specifically in our region, "getting a provider out to Redlands is next to impossible". Alongside the need for more timely service, it was identified that there was an overarching "general lack of knowledge within the Aged community who remain in their own home" and that there was large gap in "*Support to make initial contact, know where to start and who/how to follow up after assessment or services start*" It was referenced by majority of participants at the Donald Simpson Centre that they "*have to travel out of area for specialist care*" and across all

consulted groups there was general consensus that the "*Aged Care system is complicated, no continuum of care, providers or support worker*" with little to "*no focus on holistic care*."

Across all three groups of community members, all participants (100%) reported direct contact or knowledge of isolated older person within their community. It was referenced that "*they are isolated due to cognitive or mental health concerns and do not have capacity to navigate the current systems*." It was referenced that the community will assist these individuals themselves, with a participant reporting having "*successfully acquainted a number of friends and relatives into home-based services*". A reference directly demonstrated the need for additional specialised navigation support for high-risk persons and the failures of the system by sharing the following harrowing anecdote: "*I have a family member who has been trying to get a mental health care plan to access psychological treatment – they were having suicidal ideation. Their appointment was cancelled three times in a row and they eventually had to book with a different doctor outside Brisbane South. This could have resulted in their death.*" During the consultation with the First Nations Elders, it was noted that a specific cluster of isolated older community members were residing within Logan, and referenced that "*we all know someone isolated, particularly other Aunties*" and provide further evidence that communities currently self-manage these reluctant or high-risk populations, and reinforce the need for a viable, supported and long-term intervention. It was also noted by the Elders that "*Medical centres more sterile due to the virus – these used to be communal and gathering site for yarning*" and without this social aspect of health, their community was delaying and stagnating in their willingness to seek out care.

6.2.4 Theme 2: Proposed solutions or implementations to overcome the gaps/needs

Table 18. Community Consultation Proposed Solutions

Proposed Solution Codes	Code Frequency across Participants/Responses
Education	12
Clients on services	4
Digital health literacy and privacy	3
Clinicians on comorbidities/accessibility	3
Workforce Provisions	5
In-Home Care	2
Return to face to face	3
Maintenance/Home Assistance	2
Person Centred Approach	5
Assertive Outreach	2
Crisis prioritisation	2
Building relationships	1

The most frequent reference in regard to proposed solutions centered across the need for education, for clients, providers, clinicians at the macro, regional and systemic level. "*There has to be a better understanding and action towards integration of services and willingness to share information to cement relationships to get started*" and there was strong agreement from participants regarding the reference that "*there's a genuine fear of breaches of privacy which should be able to be addressed but an unwillingness to problem solve*" but simultaneously a lack in adequate sharing of health information across health systems was identified. It was referenced by the Amputee and Families group that there was a need for "*ensuring medical records are shared with relevant health professionals*" to facilitate the patient's journey within the healthcare system. It was noted that "utilising current contact and support relationships to engage in "*very extensive publishing and communication push using the (existing) services*" could aide in education clients on the services available in their immediate region, community or facility.

A participant who identified as hearing impaired referenced that there was a "*lack of consistent awareness of individual accessibility needs across other practitioners"* and that one of the driving needs for return to face to face was to ensure that necessary "preference for vision and hearing impairments" could be accommodated. Furthermore, it was referenced that the current "*telehealth solutions for **mental health counselling being problematic due to partner/spouses or family members being around."***

Overall, the need for "*treating patients in a holistic manner - not piecemeal*" was referenced in the need for person-centred care across all consulted groups. It was referenced that in specific regard to care finder target populations, the role of assertive outreach to assist in "*actually locating them in parts of the community*" was met with strong agreement from participants (Donald Simpson Centre).

6.2.5 Theme 3: Perceived changes in Health Systems (Last 12 months)

Table 19. Community Consultation Perceived System Changes

Perceived Changes (Last 12 months) Codes	Code Frequency across Participants/Responses
Overloaded Health Services	7
GP's overloaded	3
Increased wait times for primary care	3
Specialist services overloaded	1
Assertive Outreach decline	4
Telehealth appointments	3
Fear and Comorbidities emerged	3
Medical supply chain issues	2

In regards to perceived changes that community members had experienced or witnessed in the 12 months, the most frequent references were in regards to the overloaded state of health services. The Elders noted that even First Nations specific health centres (ATSICH) were overloaded and reported similar issues with increased wait times across all aspects of accessing care. This included anecdotal references that "doctors refused to take on new patients if the patient is seen as too complicated" and that the pandemic revealed gaps in the "workforce and medical supply chains" and consequently the ready "availability of diabetes medications".

Community members were also asked what they perceived to be the cause of these changes in the health systems. They referenced COVID-19, spikes in seasonal illness and recent natural disasters and how these resulted in "*health issues being ignored out of* fear" the self-awareness regarding our ageing population as referenced in "*the size of the business of aged care and the pressure for services beyond the capacity to provide*." It was also referenced from the perspective of accessibility that "*health staff not understanding impact of hearing loss and mask wearing*."

6.2.6 Theme 4: Opportunities for Enhanced Integration of Care

Community members were asked a variation of this question, to aide in more client-centric view and were asked to elaborate on what is most important regarding their access to aged care and community supports (see Appendix for specific question subsets).

Table 20. Community Consultation Aspects Important for Access to Care

Important for Access to Care Codes	Code Frequency across Participants/Responses
Timeliness of service	3
Consistency of care relationship	3
Cultural competency	2
Overview of local services	1

6.2.6.1 Sub-theme: Other Relevant Codes and Feedback from Community Members

There was full agreement in the community member consultations for the preference and increased accessibility of face-to-face engagement. It was recorded that one participant utilised a hearing loop device (Donald Simpson Centre) and that they noted their ability for nuanced group interaction without access to this type of aid is limited.

Each group of community members was asked to provide informal feedback regarding the consultation process and questions prompts and participants referenced that the Project Team "… *asked the right questions*" were "*glad someone is doing this important work*", "*relieved that someone noticed the gaps*" and praised that "*you came to us".*

6.3 Part 3 – Clinical Perspectives

Table 17. Clinical Advisory Demographic Summary

Clinical Advisory Council (5)	Located in BSPHN	Female	Male	Sex %	59 and under	60-64	65 - 70	71 - 75	76 - 80	80+
All Responses (Totals)	100%	4	1	80% female	*3*	1	0	0	0	0

6.3.1 Clinical identities and areas of practice

The Clinical Advisory Council subset of questions (see Appendix) received five responses of which the majority (80%) identified as female. It should be noted that demographics across the Advisory subset did have the option of disclosing gender identity but there was no deviation from their selected sex, nor free text responses in any of the nine cumulative responses. These clinicians or practitioners are either currently practicing and/or hold valid registration. These clinical respondents reporting residing and practicing across Loganholme, Birkdale, South Brisbane, Durack, Inala, Oxley and Sherwood. The majority of clinicians were aged 59 and under, with one respondent in the 60-64 age band and on who did not disclose their age. Two of these clinical respondents (50%) identified as Aboriginal.

6.3.2 Theme 1: Identified gaps in service and unmet client needs

Table 21. Clinical Advisory Gaps and Needs

Gaps in Service/Unmet Needs Codes	Code Frequency across Responses
Resource Shortage	3
Funding	2
Counselling and social support	1
Education on service delivery	1
Referral system overhaul	1

Clinicians themselves are aware of the "*Lack of services and funding available comparative to the need*," specifically referenced that "*Current My Aged care access and referral process needs a major review – this is an obscure process for GP providers,*" and acknowledged their own systemic

shortcomings in regards to client communication, and availability of information by referencing that there was a need for "*being more transparent on what is possible with service delivery rather than eligibility for service delivery*" and the need for inclusion of "*alternative models of health care*".

6.3.3 Theme 2: Proposed solutions or implementations to overcome the gaps/needs

Table 22. Clinical Advisory Proposed Solutions

Proposed Solution Codes	**Code Frequency across Participants/Responses**
Social support programs	4
Ageing and Health Hubs	1
GP and provider relationships	3
More Navigators	1
Funding for Aged Care	3
Flexible/funded carers leave	2
Funding for Aged Care within Primary Care	1
Systemic Review	3
Co-design of Aged Care systems	1

6.3.4 Theme 3: Perceived changes in Health Systems (Last 12 months)

Table 23. Clinical Advisory Perceived System Changes

Perceived Changes (Last 12 months) Codes	**Code Frequency across Participants/Responses**
Less face to face	2
No home visits	1
Lowered expectations	1
Higher wait times (GP)	1

Clinicians referenced that, in the last 12 months, there was a "*lowering of expectations*" across the health system, a marked increase in the "*time to getting an appointment*" and referenced the decline in face-to-face contact in the community. "*I stopped providing residential aged care support/home visits due to COVID and as I was losing money at every visit - which is a shame*".

7 Triangulation and Prioritisation

In regards to the cause of these changes the clinician respondents noted COVID-19, a general health workforce shortage which resulted in patients reporting "*fragmented care*", a specific "*lack of workers in aged care*" and "*an aging population which is requiring more time with GP's*" with problematic lack of funding and "*lack of investment in primary care*."

6.3.5 Theme 4: Opportunities for Enhanced Integration of Care

Table 24. Clinical Advisory Opportunities for Enhanced Integration of Care

Opportunities for Integration	**Code Frequency across Responses**
Co-design of Aged Care system	3
Systemic Review	1
Alternative Service Models	1
Utilising the Primary Care Workforce	1

It was reaffirmed in the clinical advisory responses that "*involvement of aged care clients in the direction of services*" and the need for "*links between multidisciplinary services being concretely established*". It was also noted that a systemic review and co-design process would initiate "*a major rethink of how we deliver service"* and highlight the need for "*with alternative models including peer support and social prescribing*". It was referenced that to aide in integration of care, we should "*use the existing GP/primary care workforce (but) don't expect us to do it for free*."

Triangulation describes the analysis of multiple sources of information to draw together an improved understanding of a particular issue or challenge.

The triangulation process was completed through the use of triangulation matrices that collated the evidence for each potential issue against each of the four need types defined by Bradshaw's Taxonomy of Needs (refer to Table 22). This process was repeated for each evident need identified during analyses.

The triangulation and prioritisation processes were collaboratively approached by the Project Team and utilised all aspects of the evidence base.

Table 25. Bradshaw's Taxonomy of Needs

Comparative Needs:	The "supply" side and equity. • Explores access patterns and barriers to access among different geographies • Comparison of a community or area to similar communities or areas • Also explores socio-demographic data and epidemiological data
Felt Needs:	What the community tells you is a need. • Community expectations • Patient experience surveys
Expressed Needs:	The "demand" for services. • Service usage data • Seen as felt need turned in to action • Can be problematic without context
Normative Needs:	What the expert tells you is a need. • Defined by the expert of professional • Clinical standards • Best practice guidelines • Standards for health and healthcare

7.1 Synthesis, Triangulation and Prioritisation

Table 26. Priority 1: Multiple barriers for SMBI, Stradbroke Island and Logan residents

Comparative Needs:	SA3s: Cleveland-Stradbroke, Beaudesert, Jimboomba and Loganlea-Carbrook. Cleveland-Stradbroke SA2 (Redlands LGA) has the consistent highest number of older persons in the Brisbane South region (QGSO 2016:2022) Highest self-identification of First Nations on SA2 North Stradbroke Island (QGSO 2022) Cleveland-Stradbroke has multiple barriers of remoteness, and consequent lack of service provision Cleveland-Stradbroke has socio-economic disadvantage (including housing insecurity and poverty) Number of aged pensioners and level of financial stress in Logan is the highest in region (QGSO 2022, ABS 2016) The Southern Moreton Bay Islands SA2 (13.4%) exhibiting the highest proportion of persons in need of this high level of assistance, followed by Bethania – Waterford (10.9%), Eagleby (10.5%), Beenleigh (9.4%), Beaudesert (8.9%) and Cleveland (8.5%) (QGSO 2022). Other SA2s with a high-density percentage of First Nations residents includes Kingston (7%), Yarrabilba (6.9%), Slacks Creek

	(6.5%), Beaudesert (6.4%), Woodridge (6.2%) and Logan Central (6.1%) (QGSO 2022).
Felt Needs:	• Community reported problems accessing provider services in Redlands LGA • Lack of specialised aged care health services or consistent transportation in Redlands LGA • Logan was referenced as area of need for isolated friends and community members during consults, particularly for community elders • Redlands LGA residents referenced Multiple barriers, comorbidity, cultural preference and disability accessibility of face-to-face care and engagement • Lack of language interpreter services for older CALD population in the Logan LGA • Lack of access to culturally safe and appropriate aged care Elders in community consultation referenced that in the last 12 months even First Nations specific health centres (ATSICH) were overloaded with increasing wait times to access care
Expressed Needs:	• Population figures in the Cleveland-Stradbroke SA3 indicate an increasing need to optimise transportation and health service availability in these remote areas. • Consultation in the Redland LGA found that SMBI islands residents are living longer, have low educational attainment, high levels of housing insecurity and poverty. • Limited specific services for First Nations clients. For example, Burringilly, First Nations provider in Logan, has very limited availability for their services and waitlist. • Limited availability/client choice of services on the SMBI, Blue Care listed as the only provider currently open for new clients for most service types. Star Community services provides some limited support for transport and home maintenance. • Minjerribah respite centre and Yulu-burri-ba provide limited CHSP services on Minjerribah (North Stradbroke Island).
Normative Needs:	• The referenced lack of Primary Care funding for GP's makes ability for home visits limited as clinician absorb coats themselves. This is particularly dangerous for area of pre-existing low service. • Referenced high wait-times for clients, CHSP and inability for consistent face-to-face care is compounded with geographical isolation and low service density in these areas. • Small population size makes having multiple service providers providing similar services unviable. This results in limited choice for clients and results in fewer service providers keen to invest in providing Island based services.

	• Lack of coordination and communication of the service providers, assessors and health care providers on the Island. This poses an opportunity where service provider, council, assessment and health care workers could share resources such as transport options on the Island or meeting spaces.

Table 27. Priority 2: Workforce provision, composition and competency

Comparative Needs:	Regional need for competency across cultures and languages – 31.8% of BSPHN older resident were born overseas, 10.2% speak a language other than English (AIHW 2020) Men with NESB backgrounds reported the lowest levels of co-occupancy with husband, wife or partner and regionally report the highest levels lone occupancy (QGSO 2016) Need for on-going training especially in the areas of trauma and cultural competency (2.3% of BSPHN older residents identify as First Nations) Lack of safe aged care options safe for Lesbians, Gays and Transgender individuals and reliance on in-home care for ageing. (Waling et al 2019a:2019b) In the Brisbane South region there are 66,503 persons (or 5.6%) in need of assistance with a profound or severe disability (defined as needing assistance in area of self-care, mobility, communication, disability or old age)

Felt Needs:	• Providers most frequently referenced the need for workforce training to alleviate system fatigue for these diverse populations.
	  ○ Referenced need for consistency with provider or health worker relationships, contact and navigation to remain rapport and alleviate system fatigue
	  ○ Highly referenced by providers, disability advocates and community that clinicians lack training in delivering accessible services - referenced for both visions, hearing and physical frailty and disability.
	• Community referenced the dire need for workforce provision and availability of services that are competent across different identities, complex comorbidities and are trauma aware.
	• Referenced consistently across providers, advocates and community that current workforce is not culturally competent, safe for all identities or trauma aware.
	• Highly referenced community need to treat patients “in a holistic manner, not piecemeal”
	• Highly referenced across providers, community and clinicians that on-going training of workforce is imperative to meeting across different target populations

	• Provider referenced need for integration of services into existing models (e.g., assertive outreach) or into remote, CALD or First Nations communities to build trust of health system overall.
	  o Specific geographic consultations referenced the needs to understand the specific challenges for older people living in remote communities
	  o Referenced lack of access to primary care where multiple co-morbidities exist
	  o Referenced difficulty accessing specialist care in a timely manner due to shortages

Expressed Needs:	• According to the 2020 aged care workforce census report, in 2020 there were a total of 12,596 employment vacancies within home aged care service delivery across Australia.
	  o This was for allied health, nursing and personal care work direct care staff.
	  o The number for Queensland is predicted to be approximately 2500 vacancies in 2020.
	• Providers repeatedly referenced being at capacity or exceeding targets, unable to take on new referrals' – particularly specialist organisations servicing clients with CALD needs, homelessness or disability advocacy needs.
	• Clinicians also referenced the noticeable lack of Specialist or Primary care availability, a decline in expectation and level of service in the health system generally, alongside a decrease in ability to conduct face-to-face and in-home visit care.
	  o Even First Nation specific primary care centres are at capacity
	  o No funding for in-home care (a necessity for this population) and the need to refer complex patients onwards.

Normative Needs:	• Advocates referenced need for system integration including need for assertive outreach for homelessness, CALD, LGBTI+ communities and transient populations (an integrated workforce). • Providers and advocates for CALD communities referenced ability to engage across cultural or diverse older people communities requires membership within those groups • The most frequent reference across consultations, workforce lacks training in supporting autonomy, trauma and disability awareness, inclusivity and safety. • Community Elders, clinicians and advisory experts referenced the need for specific and on-going workforce training • The most frequently referenced proposed solutions included increased education about services and pathways for clinicians, training and health system integration

	• The need to building awareness, systemic partnerships and cross-disciplinary collaboration was a repeated reference across clinical and other advisory consultations

Table 28. Priority 3: Culturally and Linguistically Diverse Populations

Comparative Needs:	• The BSPHN region has nationally comparative high cultural diversity, immigration and NESB residents (QGSO 2016:2022)
	  ○ 31.1% of people were born overseas, which is higher than the state level of 22% (QGSO 2022).
	  ○ 23.1% speak a language other than English at home, higher than the state level of 13.5% (QGSO 2022).
	  ○ In 2020, Queensland experienced a 27.3% growth in First Nation's population, both due to increased identification and births within our state (ABS 2022).
	• In the last 20 years, patterns of immigration and language groups in our region have changed, leaving existing services and collateral as consistently lagging and outdated (ABS 2022)

Felt Needs:	• Community consultations identified lack of in-home care service capacity and wait times as part of their needs and previous experience with the aged care system • Referenced challenges regarding the perception and consequent care of aged and mental health care within CALD communities Increased reliance on families caring for their elders and reluctance to engage with aged care for fear of community exile - cultural perspective on care differ immensely. ○ Providers and community referenced the lack of access to culturally safe and trained care providers • Prior consultation reported challenges accessing language and hearing interpreter services especially in Logan LGA
Expressed Needs:	Home Care Packages for those in a non-English speaking country (Home Care Package Data Report 2021-2022): • Level 1 – 171 (out of 520) • Level 2 – 596 (out of 2331) • Level 3 – 515 (out of 1834) • Level 4 – 496 (out of 1668) • 27.9% of all home care packages in Brisbane South region are allocated to people born in a non-English speaking country • In June 2022, 5 providers were open for centre-based respite in the region, tailored specifically to CALD seniors.

Normative Needs:	• CALD groups were the most frequently reported sub-groups with high commonalities across the ACH and Stakeholder consultations (reported 63% of the time)
	• Providers highly referenced need for providing culturally competent, inclusive and safe workforces was frequently referenced during consultations.
	  ○ It was referenced by multiple providers that due to changing language groups in region there was the need for more LOTE services required
	• CALD specific organisational providers who were consulted reported their referrer relationships as positive, their services at capacity and the need for providing assertive outreach.
	  ○ There was agreement across all (100%) of community consultations that they knew a friend, acquaintance or community member who was isolated and required outreach
	• It was referenced across various consultations that CALD specific assistance or navigators were needed to enhance overall health system integration.

Table 29. Priority 4: Disability Accessibility, Education and System Integration

Comparative Needs:	In Brisbane south region there are 66,503 persons in need of assistance with a profound or severe disability with SMBI SA2 (13.4%) exhibiting the highest proportion of persons in need of this high-level assistance (QGSO 2022) From a socioeconomic perspective, Brisbane South PHN region generally reflected wider Queensland rates of socio-economic disadvantage (QGSO 2022) Identified lower levels of education outcomes in Logan and Scenic Rim (QGSO 2022)

Felt Needs:	• It was referenced across all consultation types that person centred, holistic and accessible care across all consultation groups was a highly referenced need
	• Community consultation referenced the complexity of the NDIS system and obtaining specialist Disability Accommodation
	• Providers and community referenced the difficulty identifying GPs that specialise in disability and in regards to specific needs of this population:
	  ○ The lack of care coordination and service navigation support
	  ○ The lack of communication and understanding of consumer's needs
	• Older people receiving NDIS referenced difficulty in building relationship, trust and rapport with high turnover of workforce – this induced systemic fatigue

	• Advocacy groups, providers and community all referenced need for workforce training regarding disability with key focus areas to include communication, gap payments, providing information in an appropriate manner and building trust and rapport. o Communities referenced inconsistencies and complexities in regards to age restricted access and lack of communication
Expressed Needs:	• People with Disability was the third most frequent identification encountered across all types of consultation. • ACH and Organisational provider gaps identified that workforce training, system engagement fatigue and issues with referrals across health providers were all issues raised in relation to integration. o Referrers to Providers that were referenced included Community services, MAC, Hospitals/specialists, Dept of Communities, Housing and Digital economy, QAS, Department of Veterans Affairs. • Provider's highly referenced proposed solutions included increased education about available spectrum of services, system pathways, costing across services, workforce training and navigation support • References regarding enhancing integration of care across consultations included education for providers, clients, health and digital literacy and understanding the patient journey whilst focusing on integrating health service pathways (was the second highest frequency of reference across provider consultations)
Normative Needs:	• Clinicians referenced resource and funding shortages as comparative to the need as the highest frequency gap in their provision of adequate aged care • This was echoed by providers, who consistently referenced that specific resources and funding for education and broader for health system integration were referenced as lacking. • Systemic shortcomings in regards to client communication, and availability of information • GPs and providers relationships was the 2nd highest rating proposed solution whilst increasing funding for Aged Care rated 3rd highest • Utilising the primary care workforce that already exists was identified as a potential solution for this priority area whilst co-designing the aged care system with alternative models including peer support and social prescribing.

Table 30. Priority 5: At-Risk or Homeless Older Residents

Comparative Needs:	• Housing costs and insecurity are on the rise nationally and within our region in particular (ABS 2022). • At LGA level, relatively higher levels of financial stress in Logan and Scenic Rim, a greater number of aged pensioners in Logan and Redlands, and higher rates of people experiencing homelessness in Brisbane (QGSO 2022). • Data available for QLD however indicates that women over 55 years are the fastest growing group to experience homelessness (Australian Human Rights Commission 2019). It has been shown that homelessness or insecure housing, specifically in older people, can take a toll on the individual's health and emotional wellbeing (Australian Human Rights Commission 2019). ○ HAAG, 2022 data indicates that there is an increase in older people experiencing homelessness - 29% increase in people aged 55+ and a 47% increase for people aged 65-74 compared to the 12% average across all age groups. • GEN Aged Care data, in 2020-2021 identified that in the Brisbane South PHN region 41.7% of seniors accessing home care services lived alone • Assertive outreach identified and profiled ~500 older residents sleeping rough in Brisbane LGA in the last 12 months, with immense comorbidity, in danger of violence and consistent lack of stable housing (Micah Projects 2022).
Felt Needs:	• Unaffordability of living included housing, travel, aides and socialisation was the 4th most frequently referenced gap noted by community members (this followed, Lack of in-home care, System complexities and lack of local specialist care) • Across all three groups of community members, all participants (100%) reported direct contact or knowledge of isolated older persons within their community. It was referenced 'due to cognitive or mental health concerns and they do not have the capacity to navigate the current system' ○ Consultation with First Nations Elders noted 'we all know someone isolated, particularly Aunties'. The Elders noted that communities are self-managing reluctant or high-risk populations but also reinforced the need for a viable, supported and long-term intervention.
Expressed Needs:	• 50% of at-risk or homeless population surveyed by Micah Projects (2022b) reported having experienced discrimination based on age, race, appearance, disability, gender, sexual identities in accessing housing.

	• The majority surveyed reported experiencing physical violence, verbal abuse during homelessness, exploitation by force and fear of further threats. 68% owed money with gambling debts the highest contributor to monies owed. • SPDAT vulnerability scale noted that 61% of homeless people reported by MICAH in 2022b were classified as high acuity. • ACH and provider who serviced homeless or at-risk populations referenced importance of seamlessly working across PHN regional boundaries (CBD in particular) to ensure consistency of support provided for this highly transient and service reliant older residents.
Normative Needs:	• As referenced by clinicians, the current My Aged Care and referral processes need a review as this was an obscure and outdated process for GP providers. • Clinicians referenced the need for social support programs (including example of Ageing and Health Hubs) as their most frequent solution • Providers who worked in the homelessness and housing space were adamant in referencing need for care finders to integrate into their viable and proven assertive outreach procedures and systems. ○ This includes the ability to be agile, mobile and have expanded hours to provide referrals to this population.

7.2 Issues encountered, reflections and lessons learned

7.2.2 Data Issues and Limitations

As noted above in the analysis, there are numerous general and more specific data limitations across the quantitative and qualitative evidence base. The specificity, diversity and intersectionality of care finder target populations presents numerous barriers in the traditional needs assessment process and across the different forms of necessary engagement needed to formulate an adequate evidence base. For nuances, please refer to the sections above, and for a general summary of data issues and limitations encountered during this process please see below:

- Generally, some data sets may present results at the Statistical Level Area Three (SA3) level, whereas others may report only at a Local Government Area (LGA) level.
- In regards to Data currency, limited 2020 Census data tables have been released, limiting the currency of some later planned release variables (particularly data on complex intersectional issues such as housing, identity or health comorbidity that require longer to prepare).
- There are limited national standards on the collection of data elements that allow identification of people from multicultural backgrounds health and service needs, where most data sets collect a country of birth and/or whether an interpreter is required. Other limitations include the lack of data related to sexual orientation and gender diversity, and people with particularly the need for standardisation of definitions particularly in regards to neurodiversity and disability.
    - For example: national population data agencies such as the ABS have stipulations on how to conceptualise variables surrounding gender or sexuality, but do not successfully or consistently collect this data themselves and still rely on aggregated samples, including the highly criticised attempt to include gender term ‘non-binary’ as an option in the 2020 Census sex variable measure.
- The qualitative data from these at-risk target minorities is largely aggregated from small samples, referential or modelled and lacking any sort of granularity at a geographic regional or even population level.
- At-risk populations require self- identification and the trauma, abuse or vilification associated with certain target groups limits the ability to collect data on these individuals.
- Quantitative data is best leveraged from local organisations (e.g. Micah Projects providing a custom parameter report on homelessness contact data in the larger Brisbane area) but relies on prior relationships or Data Sharing Agreements and the assumption that homeless or other transient populations neatly abide within geographical boundaries of PHNs.

The older age range of the care finders target population introduces further generational confounding variables in their lack of capture in research, lower levels of digital or privacy-based literacy and higher isolation and rates of reluctance to engage.

The most evident gaps were the ability estimate the true rates and geographic distribution of those with disability, neurodiversity, sexual and gender diversity or the direct engagement with CALD or transient communities. To bridge these gaps, we utilised regional health data, external organisational and clinical relationships and leveraged knowledge.

7.2.3 Additional (Non-Data) Limitations

The process of consulting with care finder populations was complex. The nature and sensitivity of many of the circumstances and topics surrounding the reasons why seniors become vulnerable, isolated or marginalised means that sensitivity and awareness of preventing trauma was incredibly important. While it is vital to locate and understand these populations, many may not self-identify, actively seek support or engage with services and consultations due to a history of stigmatisation and distrust of government services. The very reasoning behind the creation of the care finders program, that is to locate, support and engage with vulnerable populations, is the very real limitation surrounding the gathering of data about, and consulting with these groups.

The short time frame provided to complete the supplementary needs assessment further limited the scope of the consultations. The reliance on voluntary participation without the ability, in some cases, to build adequate rapport with certain organisations or population groups meant that we were either unable to engage or unable to build meaningful data around multiple interactions.

Consulted Providers reported further limitation surrounding the identification of specific populations. Estimations on location, number, sex and ethnicity were often not based on absolute data. Providers reported that due to short time frames, or they were unable to locate the specific data, the data was identified as too sensitive due to the small population set (for example, data of aged, disabled service users on the Southern Moreton Bay Islands could not be provided due to privacy concerns with small numbers of participants). To minimise the impact of these limitations as much as possible, a two-step consultation process was undertaken.

The online survey provided to organisations allowed them time to consult with data and others on their teams prior to a live, online consultation via Microsoft Teams. During these consultations, speaking through each question posed most often enriched the data or provided the additional context required to ensure all parties understood what was being sought. Furthermore, many providers submitted follow up material and data for more localised need once the distinction between regions was explained (i.e. the difference between Aged Care Planning Regions and Primary Health Network Regions)

While our consultations included a broad and varied representation of the majority of the care finder population target groups, there were a small number of priority groups for which greater localised knowledge would be of benefit to continue to seek out consultation with to support Brisbane South PHN in supporting our care finder population. The identified gaps and limitations are as follows:

- LGBTIQ+ seniors residing in the Brisbane South PHN region – A local LGBTIQ+ seniors aged care service provider (Rainbow Care) was contacted to support our consultation for this priority group. Following this, we were contacted by a representative from the Queensland Council for LGBTIQ+ health. While this consultation provided excellent insight on the needs of Queensland LGBTIQ+ seniors, it is noted that seeking consultation with local LGBTIQ+ seniors and providers would provide a much greater context for our work.

Additionally, none of the community members consulted advised that they identified as LGBTIQ+. Future consultations are recommended to have LGBTIQ+ status question as well as a wider range of gender options for identity.

- A number of providers who support clients in the Beaudesert and Southern Moreton Bay Islands regions were contacted for consultation to identify the specific needs of these remote regions with unfortunately no response. In order to ensure that the needs of these populations were explored, the use of recent data and consultations was referred to. These included recent consultations with Southern Moreton Bay Island

community and carer groups and consultations with Beaudesert care providers who are part of the Brisbane South PHN Home Care Provider Community of Practice.

- We note limitation in consultation work with community members who did not speak English. While service providers who support these communities were consulted, limited time, contacts and resources prevented the arrangement of interpreters to engage with non-English speaking community members

Section 2 Outcomes

Table 31. Summary of Outcomes for BSPHN

Identified need	Key issue	Evidence
Multiple barriers for SMBI, Stradbroke Island and Logan residents	Barriers identified are transportation, lower educational attainment, housing security and poverty. A limited availability of service providers specifically catering to First Nations people leading to lower levels of client choice and long wait periods.	Multiple barriers of socio-economic disadvantage, financial stress, lack of service provision, limited transport and services, high First Nations identification, and the consequently large geographic clusters of intersectionally at-risk older residents.
Workforce Provision, composition and competency	High numbers of aged care workforce currently, resulting in limitations of providers being able to accept new referrals. Lack of specialist and primary care available in locations that are easy to access for older people. General practice is experiencing workforce pressures, increased wait times and lower face to face appointments.	Highly referenced requirement across all types consultations: workforce who are able to competently support the breadth of cultural backgrounds, people with disability, LGBTIQA+ older persons and be trained in trauma informed response and care. High level of workforce shortages across aged care health disciplines.
Culturally and Linguistically Diverse Populations	CALD groups experience a lack of in-home care tailored to suit their needs which is culturally aware, community orientated and safe. Lack of navigation or translation assistance within the overall health system and aged care system.	The BSPHN region has nationally comparative high cultural diversity, first nations identification (27.3% growth in last census for the state) immigration and NESB residents, and a third of its population were born overseas which is comparatively higher than the rest of the state. Additionally, 23.1% speak a language other than English at home, higher

	CALD people have a high representation with Assistance with Care and Housing (Stakeholder consultations) within the Brisbane South region. As a high immigration region, language group frequencies change and populations who are ageing now are not catered for with current services and materials.	than the state level of 13.5% (QGSO 2021). The target population of CALD was the most frequently referenced serviced client target population across the local ACH and Provider consultation types.
Disability Accessibility, Education and System Integration	Complexity of NDIS system and lack of understanding the integration and overlap with the aged care system. A general lack of accessibility and aids in all parts of the health system, but of particular relevance in an aging and increasingly comorbidly impaired population. Difficulty building relationships with trust and rapport due to the high turnover of the workforce. Complexities and inconsistencies in regards to	In Brisbane South region there are 66,503 persons in need of assistance with a profound or severe disability with SMBI SA2 (13.4%) exhibiting the highest proportion of persons in need of this high-level assistance (QGSO 2021) It was also referenced that in-home services did not adequality consider impairments in their service provisions Across provider consultation it was highly referenced that accessibility requirement were not met in primary care, aged care or in the wider health system.

	age restricted practices in relation to aged care services. Difficulty finding GPs that specialise in disability care or complex comorbidities and high rates of referral to specialist hubs that are not in the immediate residential area.	
Older Residents at risk of Homelessness and Isolation	Discrimination based on age, race, gender, appearance, disability, sexual identity in accessing housing. Experience of physical violence or abuse, coercion, substance use whilst homeless. Geographic boundaries of service provision can cause inconsistency of support and need to be addressed with intensive navigational support that collaborates across BSPHN boundaries.	Housing costs and insecurity are on the rise nationally and within our region in particular (ABS 2022) At LGA level, relatively higher levels of financial stress in Logan and Scenic Rim, a greater number of aged pensioners in Logan and Redlands, and higher rates of people experiencing homelessness in Brisbane (QGSO 2021) All participants in community consultation referenced direct contact of knowledge of isolated persons within their community
Older people with co-morbidities	Finding a provider or health professional that specialises in older people who have one or more co-morbidities. Providers and health professionals working together	Inequality driving the most pressing unmet health needs with lower socio-economic communities reporting higher levels of people experiencing multiple conditions (Brisbane South PHN HNA)

	when there are one or more involved in the care of the older person.	
Health System Integration	More integration required including primary health lead team-based models of care (BSPHN HNA).	Care coordination services to support people to enhance their self-efficacy and management to avoid health deterioration (BSPHN HNA)

Section 3 Priorities

Five (5) priority areas have been determined through the additional activities undertaken by Brisbane South PHN in relation to local needs for care finder support.

Priority 1: Multiple barriers for SMBI, Stradbroke Island and Logan residents

Priority 2: Workforce provision, composition and competency

Priority 3: Culturally and Linguistically Diverse Populations

Priority 4: Disability Accessibility, Education and System Integration

Priority 5: At-Risk, Isolated or Homeless Older Residents

Locations prioritised for care finder support:

Location	Priority Number
Cleveland-Stradbroke SA3	1, 2, 3, 4 and 5
Loganlea-Carbrook SA3	1, 2, 3, 4 and 5
Beaudesert SA3	1, 2, 3, 4 and 5

Prioritised Target Population sub-groups:

- Older people at risk of homelessness and who are socially isolated due to lower levels of education, financial stress, mental health conditions, multiple co-morbidities, who are significant risk of a fall
- Older people from culturally diverse populations (limited literacy, do not speak English)
- Older people who have reduced access to transport
- Older people that due to disability have a reduced capacity for travel, have a lower health status and who are at risk of isolation
- Older people that identify as LGBTIQA+, gender diverse and may have had previous history with institutional care and are resistant to engage with aged care for any reason
- Older people with no support networks who have limited ability for decision-making
- Older people with limited communication
- Older people whose safety is at immediate risk who may end up in crisis

Prioritised approaches to meet needs of all diverse groups that form part of the care finder target population:

- Commissioning of care finder program based on gaps and needs identified in this Supplementary Needs Assessment
- Appointment of care finder organisations who have met the selection criteria and have pre-existing relationships with the target populations
- Recruitment by care finder organisations to meet the needs of the program
- Ensure education and training for all care finders, their managers and triage staff will be required to complete mandatory online care finder induction training, and training in cultural safety and trauma informed care.
- Engage with primary care, assessment organisations and health institutions to educate about care finder program, referral pathways and identifying care finder populations
- Through reporting and evaluation identify areas for continual improvement in delivery of the care finder program via an independent evaluator who is managing a national and ongoing evaluation of the care finder program
- Ensure face to face appointments occur by care finder organisations to support the client through the journey
- Ensure care finder providers provide culturally competent, inclusive and safe workforces was frequently referenced during consultations.
- The establishment of a Brisbane South region Community of Practice and Steering Committee
- From January 1 2023, ensure care finder organisations that have been appointed are able to assertively reach into the target populations to ensure navigation and support is provided

Prioritised activities to enhance integration between health, aged care and other systems in the context of the care finder program:

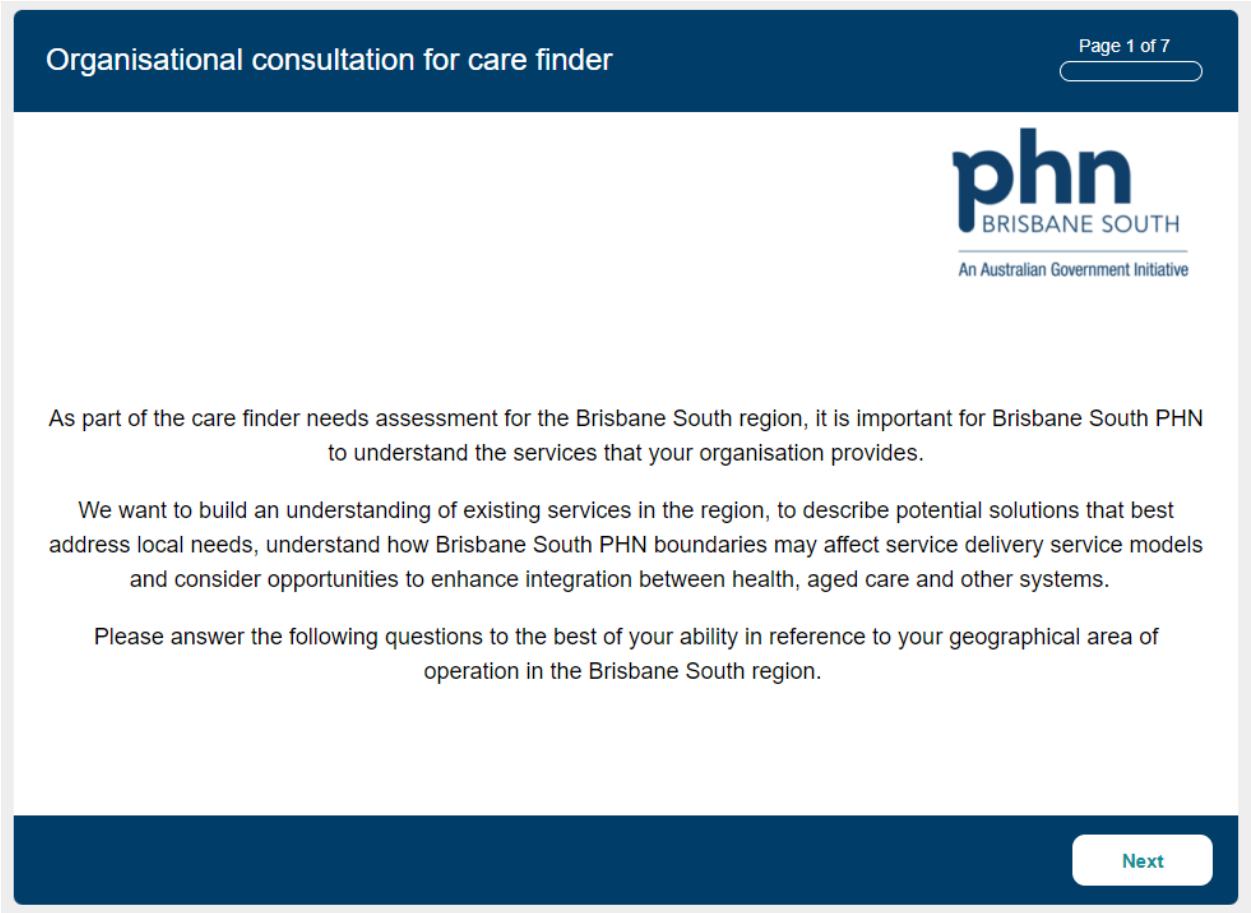
- Targeting HHS, Private hospitals, Community Health Centres, general practice and other health organisations with a comprehensive communications program to educate workforce regarding the care finder program inclusions and scope, referral processes and appointed organisations.
- Develop care finder quarterly meetings with hospital social workers, discharge planners, nurse navigators and assessors to network, build relationships, problem solve and ensure referral pathways are able to be followed.
- Include the Services Australia ASCO officers for the Brisbane South region in the above meetings.
- Brisbane South PHN Health Integration team to be involved in co-design of care finder programs on appointment of successful providers to assist with integration and communication with primary care.
- National Aboriginal Community Controlled Health Organisation (NACCHO) to be included in integration discussions and planning

Appendix

Survey Format

Consultation surveys were designed in the Survey Manager platform within the standard BSPHN template, with the inclusion of a suitable priming preamble (preview below). Each survey had appropriate branching for use with multiple groups and to maintain brevity (e.g. if 'no' is selected the subsequent related questions do not appear) and unique identifiable data (respondent contact details) needed for initial clarification or follow-up was discarded prior to analysis.

A direct unique link for each survey was distributed via email to ACH and organisational providers, and advisory council members for completion within a specific timeframe. The link was able to be accessed multiple times, but each click was recorded and responses were monitored for repeats with identifying information (e.g., provider/respondent name and email) as these were required to proceed.



Data Dictionary and Scribe Templates

Data dictionaries are presented below and the template for Community Consultation scribe notes is also included. Please note than in the data dictionary, question denoted with an Asterix (*) are compulsory.

Data Dictionary: Care Finders, Provider consultation for care finder program (ACH)

Survey ID: 1759
Created: 10/08/2022

Answer Rules

Answer Rule Key:

Section	*Question*	*Option*	*Matrix Response*	*Matrix Option Group*	*Quota*

Jump Logic Key:

Jump

ExclusiveOr Key:

ExclusiveOr

* Please select your ACH provider name:

- ○ Footprints
- ○ Star Community Services
- ○ Ozcare

* Contact details for the consultation respondent:

Name: *
Email *

What is your geographic reach? Please list **all** the suburbs, postcodes or LGA regions which you service:

* When considering Assistance with Care and Housing, who is your target population?

*

* Do you focus on any of these specific groups within the care finder **target population**?
Please select all options that apply to your organisation:

- [ ] People who have one or more reasons for requiring intensive support to interact with My Aged Care or other relevant supports in the community
- [ ] People who are isolated, at significant risk of a fall or they have no support person
- [ ] People with communication barriers including limited literacy skills, or does not speak English
- [ ] People with difficulty processing information to make decisions with no close family or friends
- [ ] People who are resistant to engage with aged care for any reason
- [ ] People whose safety is at immediate risk and they may end up in crisis
- [ ] People who have experiences that mean they are hesitant to engage with aged care, institutions or government
- [ ] None of these populations are serviced by our organisation

* How many clients are supported by your organisation each year?

Total Number: *
Male: *
Female: *
Age Range: *
Language(s) clients speak at home (other than English):

* Please list your referrers:

*

* Please list your intermediaries:

*

* How would you describe your relationship with the providers above (intermediaries and referrers) and other services?

*

* Do you provide other services, in addition to the navigation support that will be transitioning to the care finder program? If so, briefly describe these:

*

* What local needs in relation to care finder support are already being addressed? Please describe these briefly:

*

* Considering your answer above, what are the **gaps** in your service that need to be addressed?

*

* Considering your answer above, what is the **unmet need/s**?

*

* As an ACH provider transitioning to the care finder program, **do you have the capability and capacity to expand your service model / broaden your focus** (either within your current funding or as part of the Brisbane South PHN commissioning process) to meet other local needs in relation to care finder support? Please select the most relevant score from the sliding scale below:

* Please describe how your service offering would **meet the needs of the care finder target population:**

*

Data Dictionary: Care Finders, Organisational consultation for care finder

Survey ID: 1763
Created: 10/08/2022

Answer Rules

Answer Rule for Reffers
Does your organisation work with intermediaries or referrers?
= Yes

Answer Rule Key:

Section	*Question*	*Option*	*Matrix Response*	*Matrix Option Group*	*Quota*

Jump Logic Key:

Jump

ExclusiveOr Key:

ExclusiveOr

* What is your organisation's name?

*

* Contact details for the consultation respondent:

Name: *

Role within organisation: *

Email *

* What areas of the Brisbane South region do you service? Please list **all** the suburbs, postcodes or LGA regions that you service:

*

* The Brisbane South PHN boundaries are set by postcodes. How does your organisation work to deliver services across different LGAs or aged care planning regions?

*

* Organisationally, who is your target population?

*

* Do you focus on any of these specific groups within the **care finder target population**?
Please select all options that apply to your organisation:

- [ ] People who have one or more reasons for requiring intensive support to interact with My Aged Care or other relevant supports in the community
- [ ] People who are isolated, at significant risk of a fall or they have no support person
- [ ] People with communication barriers including limited literacy skills, or does not speak English
- [ ] People with difficulty processing information to make decisions with no close family or friends
- [ ] People who are resistant to engage with aged care for any reason
- [ ] People whose safety is at immediate risk and they may end up in crisis
- [ ] People who have experiences that mean they are hesitant to engage with aged care, institutions or government
- [ ] None of these populations are serviced by our organisation

Based on your experience, approximately how many clients from the **care finder target population** would you support each year?
This question is intended to be an estimation and is optional.

Total Number:
Male:
Female:
Age Range:
Language(s) clients speak at home (other than English):

* Can you identify **any specific identified needs or gaps in service** experienced by your clients?

*

* What **evidence** do you have that helps you recognise these needs/gaps?

*

* How could these issues/barriers be **overcome**?

Please list any potential solutions that might best address the needs identified above:

*

* Does your organisation work with intermediaries or referrers?

- ○ Yes
- ○ No

↓ ***QUESTION-RULE: Answer Rule for Reffers***

* How would you describe your relationship with the providers above (intermediaries and referrers)?

[ ] *

Lastly, can you describe any opportunities to enhance integration between health, aged care and other systems within the region?

[ ]

Data Dictionary: Care Finders, Advisory Council Consultation for care finders

Survey ID: 1770
Created: 10/08/2022

Answer Rules

If Community then display
Which Brisbane South PHN council are you a member of?
= Community Advisory Council

Answer Rule Key:

Section ***Question*** ***Option*** ***Matrix Response*** ***Matrix Option Group*** ***Quota***

Jump Logic Key:

Jump

ExclusiveOr Key:

ExclusiveOr

* Which Brisbane South PHN council are you a member of?

- ○ Clinical Advisory Council
- ○ Community Advisory Council

* Which area(s) of the Brisbane South region do you live or practice in?

Postcode(s): *

* What is your age range?

- ○ 59 years and under
- ○ 60 - 64 years
- ○ 65 - 70 years
- ○ 71 - 75 years
- ○ 76 - 80 years
- ○ 80+ years

* What is your sex?

- ○ Female
- ○

Male

- ○ Intersex
- ○ Other

What is your gender identity? (optional)

Do you speak any other language than English at home? (optional)

If so, which language(s)?

Do you identify as part of any of these groups?

Please select as many as apply (if any):

- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Maori
- ☐ Pasifika
- ☐ LGBTQIAP+
- ☐ Culturally and Linguistically Diverse (NESB)
- ☐ People with disability

* What do you feel is the **most significant gap or need** in accessing aged care services, health care and associated social supports in the Brisbane South region? Please describe briefly:

*

* How could these gaps/needs be **overcome**?
List potential solutions that might best address the gaps or needs identified in the previous question:

*

1 ***QUESTION-RULE: If Community then display***

Personally, what is most important for you when you are receiving support to access either aged care and other service?

Do you have any **friends, acquaintances or clients** who you feel are isolated and aren't able to access or benefit from aged care and health services in this region?

Please briefly describe their situation:

* Thinking about your interaction with aged care and the health systems, what do you feel is the **most significant change** in your engagement with these systems has been **over the past 6 – 12 months**?

*

* Considering your answer above, what do you think **caused** these changes?

*

Lastly, can you describe any opportunities to enhance integration between health, aged care and other systems within the Brisbane South region?

Care Finders Community Consultation (HNA)

Community consultation details

Date	
Location	
Facilitators	

Demographics

Number of attendees who self-identify in each group

Total number of attendees		
Age Range	60-64 years	
	65-70 years	
	71-75 years	
	76 – 80 years	
	80 years +	
Other	Male	
	Female	
Does anyone speak any other language (than English) at home?		
Languages		
Does anyone identify as part of the following groups (if any)?		
Aboriginal		
Torres Strait Islander		
LGBTQIAP+		
Person with Disability		

Care Finders HNA Questions

Forum discussion based on general guiding questions and their sub-thematic prompts

1. What do you feel is the most significant gap/need in accessing aged care services, health care and social supports?	
2. What do you think would have the biggest impact/effect on changing this gap/need?	
3. Thinking about your interaction with aged care and the health systems, what do you feel the most significant change in your engagement with these systems has been over the past 6 – 12 months?	
3a. What caused this?	
3b. Do you have any ideas or suggestions about opportunities to help improve integration?	
3c. What is most important for you when you are receiving support to access aged care and other services (e.g. aged care navigator support)?	
3d. Do you have any friends or acquaintances who you feel are isolated and aren't able to benefit from aged care and health services in this region?	

Care Finders HNA Questions

Forum discussion based on general guiding questions and their sub-thematic prompts

4. Is there any other feedback that you have regarding accessing aged care and health support?

Other Feedback

Facilitator or attendee general feedback surrounding structure of consultation, questions, complaints or notes regarding limitations or unforeseen events during consultation process. To guide future design and/or to be provided as feedback for the project evaluation.

References

ABS (Australian Bureau of Statistics) (2020a) *Estimated Resident Population, Regional Population but Age and Sex, Australia,* accessed 28/06/2022

—— (2016) *Census of Population and Housing: Socio-Economic indexes for Areas (SEIFA)*, accessed 22/07/2022

—— (2016b) *Disability, Ageing and Carers, Australia: First Results*, accessed 28/06/2022

—— (2019) *Indigenous and Non-indigenous Estimated Resident Population at statistical area level 2 (SA2) for Queensland*, accessed 28/06/2022

—— (2020b) *General Social Survey: Summary Results*, Australia, Accessed 20/07/2022

—— (2021) *General Community Profiles Datapack, statistical area level 2 (SA2) for Queensland,* accessed 29/08/2022

—— (2022a) Census National Data Seminar, YouTube, accessed 7/07/2022

—— (2022b) Census Data Seminar - Queensland, YouTube, accessed 10/08/2022

Alba B, Lyons A, Waling A, Minichiello V, Hughes M, Barrett C, Fredriksen-Goldsen K, Blanchard M (2019c) 'Demographic and Psychosocial Predictors of Housing Security in Older Lesbian and Gay Australians', *The International Journal of Ageing and Human Development*, 89 (1), 57-76, https://doi.org/10.1177/0091415019843449

Australian Institute of Health and Welfare, Home care packages program data report 1 October – 31 December 2021, accessed 28/06/2022.

Australian Human Rights Commission (2019), Older Women's Risk of Homelessness: Background Paper, accessed 28/06/2022.

Griffith University (2019) *Redland LGA Community Needs Assessment Social Provisioning, Griffith University and Redland City Council,* accessed 20/06/2022

HAAG (Housing for The Aged Action Group) (2022), '*Transition to Care finder: Assistance with Care and Housing (ACH) Program*', accessed 28/07/2022

Micah Projects (2022) Brisbane Zero Campaign, *VI-SPDAT Homelessness Report for First Nations (45+) from May 2019 to June 2022* (extract from 08/08/2022)

—— (2022b) Brisbane Zero Campaign, *VI-SPDAT Homelessness Report for General Population (50+) from May 2019 to June 2022* (extract from 08/08/2022)

PHIDU (Public Health Information and Development Unit) (2021), Social Health Atlas of Australia [data set], accessed 26/08/2022

Queensland Health Vaccination Taskforce, *Influenza Vaccination Coverage Report* (SPPD-SPB-HSRAM-COVID19-Vaccination dashboard), accessed 28/06/2022

QGSO (Queensland Government Statisticians Office) (2022a) Queensland Regional Profiles - Resident Profile for BSPHN Region (2021 ASGS), accessed 27/07/2022

—— (2022b) Queensland Regional Profiles – Women and Men Profile for BSPHN Region (2021 ASGS), accessed 29/07/2022

—— (2016) Queensland Regional Profiles – Resident Profile for BSPHN region, accessed 31/07/2022

Rainbow Health Australia, 2020, Research Matters: How many people are LGBTIQ+?, Rainbow Health website, accessed 20/07/2022

—— (2022b) Silver Rainbow Webinar: Older LGBTI people and accurate data collection, LGBTIQ+ Health Australia, accessed 20/07/2022

Wilson T and Temple J (2021) 'Local Areas Estimates and Geographical Patterns of Australia's Sexual Minority Populations', *Applied Spatial Analysis and Policy*, https://doi.org/10.1007/s12061-021-09416-0

Waling A, Lyons A, Alba B, Minichiello V, Barrett C, Hughes M, Fredriksen-Goldsen K, Edmonds S (2019a) 'Trans Women's Perceptions of Residential Aged Care in Australia', *British Journal of Social Work*, 50(5), 1304–1323, https://doi.org/10.1093/bjsw/bcz122

—— (2019b) 'Experiences and perceptions of residential and home care services among older lesbian women and gay men in Australia', *Health and Social Care in the Community*, 27(5), 1251-1259, https://doi.org/10.1111/hsc.12760