

Wollondilly Health Needs Assessment and Future State: 2025

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Contents

Glossary	3
Introduction	4
Purpose	4
Aim	4
Objectives.....	4
Background	4
Methodology	5
Data Gathering Phase.....	5
Discovery Phase.....	5
Data Gathering	6
Population data (current and projected)	6
Health status (current and projected)	8
Health workforce and services (current and projected)	9
Data Discovery	14
Health concerns.....	14
Barriers to accessing healthcare	17
Healthcare system strengths.....	24
Opportunities to support health service navigation	27
Appendices	30
Appendix A: Community survey participant demographic data	30
References.....	34

Glossary

Term	Definition
Aged Care Planning Region – South Western Sydney (ACPR SWS)	In Australia, aged care services are funded and delivered across the 73 ACPRs. ¹ ACPRs are based on Statistical Area Level 2 (SA2).
After-hours period	Monday to Friday 6:00pm to 8:00am; Saturday from 12:00pm; and Sunday and public holidays all day. ²
Focused Psychological Strategies (FPS)	Specialised mental health training delivered by GPs under the Better Initiative Scheme. ³ FPS falls within two categories: <ul style="list-style-type: none"> • Cognitive behaviour therapy (CBT) • Interpersonal therapy (ITP)
Local Government Area (LGA)	A Local Government Areas cover legally designated parts of a state or territory for which incorporated local governing bodies have responsibility.
Mental Health Skills Training ACPR (Level 1)	Specialised mental health training for registrars and medical professionals working within general practices in Australia. ⁴ Training focuses on the assessment, treatment, planning and review of mental health conditions.
National Diabetes Services Scheme (NDSS)	An Australian Government Initiative administered by Diabetes Australia. ⁵ People diagnosed with diabetes can register to receive subsidised support and supplies to better manage their condition.
Qlik Cloud	Platform utilised by South Western Sydney Primary Health Network (SWSPHN) to develop and view health data within dashboards. Dashboards used for this Health Needs Assessment include: <ul style="list-style-type: none"> • After-hours emergency department presentations (LHD data) • SWS workforce (SWSPHN data)
South Western Sydney (SWS)	South Western Sydney is a region comprising of several LGAs, including: Canterbury-Bankstown Camden Campbelltown Fairfield Liverpool Wingecarribee Wollondilly
South Western Sydney Primary Health Network (SWSPHN)	The South Western Sydney Primary Health Network covers seven LGAs of Camden, Campbelltown, Fairfield, Liverpool, Wingecarribee, Wollondilly and of the former Bankstown, now part of Canterbury-Bankstown LGA.
Statistical Area Level 2 (SA2)	Statistical Areas Level 2 are medium-sized general-purpose areas. Their purpose is to represent a community that interacts together socially and economically. There are 2,310 SA2 regions covering the whole of Australia without gaps or overlaps.
Statistical Area Level 3 (SA3)	Statistical Areas Level 3 (SA3) are geographical areas. SA3s in SWS include: Bankstown Fairfield Penrith Bringelly-Green Valley Liverpool Southern Highlands Camden Merrylands-Guilford Wollondilly Campbelltown

Introduction

Purpose

The Wollondilly Health Alliance (WHA) initiated this health needs assessment to inform regional planning activities and priorities.

Aim

This document has two distinct aims:

- To better understand the unmet health needs of people currently residing in the Wollondilly Shire and explore health service utilisation at primary, secondary and acute level.
- To better understand the impact Wollondilly's rapid growth will have on the region, including changing demographics, health needs and demand for services.

The findings documented in this report will inform targeted health service priorities and preventative health initiatives for the region.

Objectives

The objectives of this health needs assessment were to identify:

- Health concerns of people residing in Wollondilly
- Barriers to accessing health services.
- Health system strengths.
- Opportunities to improve care coordination and continuity of care to improve the patient experience.
- Mechanisms to support health service integration.

Background

The WHA is a partnership between SWSPHN, South Western Sydney Local Health District (SWSLHD) and Wollondilly Shire Council (WSC). The primary goals of the WHA are to:

- Address health concerns in Wollondilly
- Develop innovative ways to connect health services within Wollondilly
- Improve health outcomes for residents of Wollondilly

The WHA funded this health needs assessment in 2024 to inform the health and service needs of the region. This report will directly influence future projects including the social impact assessment.

Methodology

This needs assessment used co-design methodology which was delivered systematically. A combination of consultation methods (including surveys, focus groups and structured interviews) were utilised to engage community members and service providers within Wollondilly.

Data Gathering Phase

An extensive review of population and health data of Wollondilly residents and their utilisation of health services was undertaken to inform this report.

Discovery Phase

The discovery phase included a community survey, community focus groups, community semi-structured interviews, a service provider focus group and semi-structured interviews with service providers across Wollondilly.

Community consultations

The WHA facilitated multiple consumer consultations between June and August 2024 with the following cohorts:

- General population
- First Nations
- Males (late aged)
- Retirees
- Young families

Consultations were held across different suburbs within Wollondilly: Appin, Bargo, Tahmoor and Wilton. A total of 77 community members were engaged via consultations.

All consultations were held face to face except for one which was facilitated via telephone interview.

Community survey

A consumer survey was available for completion between June and August 2024. It was developed and disseminated via WHA partner organisation communication channels and facilities. A total of 16 people completed the survey online. However, due to an identified risk, the online survey was closed. The survey was promoted to existing community groups across Wollondilly and completed by 75 people.

A total of 91 people completed the consumer survey; however, 2 responses were removed on the premise of not being eligible for inclusion. **Refer to Appendix A for demographic data.**

Service provider consultations

Mental health professionals and service providers were invited to participate in semi-structured interviews. Expressions of Interest (EOIs) were distributed online, via WHA partner organisation communication channels, in-person communication and emails. A total of 8 health professionals were engaged via semi-structured interviews including: GPs (5), pharmacists (1) and mental health providers (2). A total of 3 interviews were conducted face-to-face and 5 were held virtually. A service provider focus group was held on 14 August 2024 at Picton Town Hall. A total of 22 providers attended the session. The service provider focus day was advertised through the existing communication channels of each partner organisation of the WHA.

Service provider survey

A survey targeting health professionals service providers was administered to 4 participants. The survey was developed and delivered via WHA partner organisation communication channels.

Data Gathering

Population data (current and projected)

In 2021, the estimated resident population in Wollondilly LGA was 53,961. The median age of residents was 37 years old. This is lower than the median age of people living in NSW (39 years old). Residents were primarily born in Australia (84.2%) and English speaking (89.6%); Wollondilly has the highest proportion of residents in SWS who identify as Aboriginal or Torres Strait Islander (4.4% or 2,365 people). Wollondilly has a higher proportion of children and older people as residents compared to the NSW average (1).

By 2041, the population of Wollondilly is expected to more than double to 126,529 residents. This predicted growth rate (4.32%) is 58% higher than the predicted average growth across NSW (2.77%) and is concentrated in the greenfield development areas of Wilton and Appin (see table 1).

Table 1: Population forecast by region in Wollondilly Shire Council (2021 to 2041) (1)

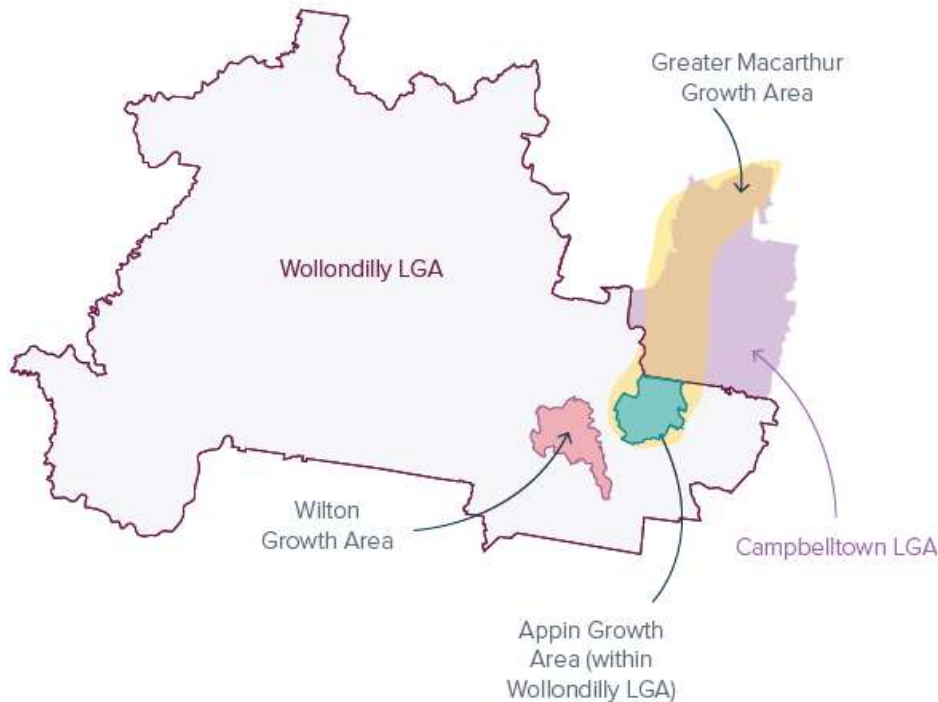
Population summary				
Area	Forecast year		Change between 2021 and 2041	
	2021	2041	Total change	Avg. annual % change
Wollondilly Shire	54,228	126,529*	+44,173*	+4.32*
Appin - Cataract - Darkes Forest	3,273	31,502*	+28,299	+12.38
Bargo - Yanderra - Pheasants Nest	5,968	6,362	+394	+0.32
Buxton - Couridjah	2,254	2,236	-18	-0.04
Camden Park - Mount Hunter - Cawdor	3,299	3,139	-160	-0.25
Douglas Park - Wilton	5,156	39,163	+34,007	+10.67
Menangle - Razorback	2,404	3,280	+876	+1.56
Oakdale - Nattai - National Park	2,127	2,637	+510	+1.08
Orangeville - Werombi & District	3,288	4,227	+939	+1.26
Picton - Mowbray Park - Maldon	5,417	6,874	+1,456	+1.20
Tahmoor	5,785	7,779	+1,994	+1.49
The Oaks - Belimba Park - Glenmore	3,667	4,031	+363	+0.47
Thirlmere - Lakesland	5,538	7,461	+1,923	+1.50
Wallacia - Warragamba - Silverdale	6,053	7,838	+1,785	+1.30

* Figures altered to account for Wollondilly Shire Council Appin land release projections to 2034 and extended to 2041 to match ABS forecasts.

There is a higher proportion of young people living in the Wollondilly Shire Council region than there are older people. Overall, 21.7% of the population was aged between 0 and 14, and 15.3% were aged 65 years and over. Forecasts for Wollondilly Shire Council indicate the distribution of younger people, people of working age and old people will remain relatively steady as the population increases; however, indications from other greenfield sites indicate an increase proportion of families with young children. This may indicate pockets of Wollondilly with disproportionately higher numbers of older residents. **See appendix 1 for descriptive statistics of Wollondilly's population.**

To accommodate this increase in population, it is expected that the number of dwellings in Wollondilly will grow 18,907 to 40,790. This growth in housing will mainly occur within the Appin and Wilton greenfield development sites. The Wollondilly Shire Council Socio-Economic Index for Areas (SEIFA) score does not indicate the region is socio-economically disadvantaged. This is unlikely to change over the next twenty years.

Figure A – Projected Growth Areas



The future Wilton Strategic Centre will not only become the strategic centre for Wollondilly LGA but also for neighbouring areas, including people living in the Campbelltown LGA. Wilton presents an opportunity to demonstrate best practice approaches to the delivery of networked social infrastructure to achieve a healthy, resilient and socially sustainable new community within a mixed-density greenfield site.

The cultural diversity is expected to change from the current 11.1% of its population born overseas to 35-40% by 2041. Considering changes in cultural diversity occurring across Greater Macarthur greenfield expansions, the largest population groups moving into the region are Indian, Bangladesh, Filipino and Nepalese. However, it is expected that these community groups will be English-speaking communities reducing the potential need for translation services to support the health needs of these populations (2).

The Wollondilly Cultural Precinct in Picton is positioned as a transformative community asset, providing contemporary community and cultural facilities for the wider Wollondilly Shire. It is currently in stage 2 of planning, and it is to serve as a community and cultural hub, the construction of the Precinct is expected to generate local economic stimulus, create construction jobs, and provide ongoing employment opportunities, further supporting local businesses and the broader community. The vision for the Precinct is to establish it as the civic, cultural, and economic heart of Wollondilly (3).

Alongside the development of the Cultural Precinct, there are further future implications for community and health services:

- Programs to foster social cohesion and support integration may be beneficial,

particularly for smaller but emerging cultures, who may face social isolation or lack of culturally specific support services.

- Migrants and minority populations may experience higher rates of stress, isolation, or discrimination.
- Targeted mental health initiatives, including culturally sensitive counselling and community outreach, can address these challenges.
- CALD residents are actively engaged in the local community, from small business ownership to roles in healthcare, education and retail sectors.
- Integrated services deliver models of care which include culturally sensitive health care services. These include translation and interpretation services to increase accessibility, service integration to deliver culturally sensitive healthcare. (4)
- Importance of considering cultural practices, beliefs and behaviours may also have profound impacts on both physical and psychological health and wellbeing to be accounted for in future projects.
- Health literacy is a major challenge and would be alleviated through building the workforce capacity to effectively communicate with CALD patients and consumers through increased promotion, support and appropriate use of health care interpreters/existing educational opportunities. (5)

Wollondilly experiences high rates of domestic violence-related assault (319.4 per 100,000 population in 2024-2025) with nearly a quarter of these incidents involving alcohol (6). Evidence coming out of other greenfield sites within Greater Macarthur indicate an increase rate of domestic violence prevalence in new communities due to the increased number of young families moving into the area.

Health status (current and projected)

Health risk behaviours

The Population Health Information Development Unit (PHIDU) modelled estimates in 2022 revealed the overall quality indicator for risk factors in adults in Wollondilly was “good” (7), with most health risk behaviours either being slightly above or below the NSW and national averages. The exception to this is obesity which was significantly higher than the average and higher than average alcohol consumption.

Table 2: Modelled estimates (%) of health risk behaviours of people aged 18 years and over, by LGA (ASR per 100), 2022.(7)

	High Blood Pressure	Overweight but not obese	Obese	Current smokers	More than five alcoholic drinks per day*	Adequate fruit intake	Did not meet physical activity guidelines **
Wollondilly	25.3	35	34.5	11.3	22.7	45.0	77.2
NSW	23.0	33.6	30.7	11.6	18.0	44.7	76.7
Australia	23.3	34.0	31.7	= 12.2	19.7	44.3	76.9

*Modelled estimates for persons aged 15 years and over who consumed 5 standard drinks (on any day within a 12-month period on a monthly basis)

** Modelled estimates for persons aged 15 years and over who did not meet 2014 guidelines for physical activity

First 2000 days of life

Between 2020 and 2022, the number of mothers giving birth in Wollondilly steadily increased from 676 to 810 (8). This upward trend is expected to continue as population growth accelerates in areas like Wilton and Appin, placing additional pressure on Campbelltown Hospital’s Antenatal

Clinics and Birthing Unit.

This growth may further exacerbate existing challenges faced by Wollondilly women in accessing comprehensive antenatal care by 14 weeks gestation. Currently, only 70.4% of mothers in Wollondilly receive antenatal care by this critical timeframe which is 13.5% lower than the national average of 79.9%. Among the South Western Sydney (SWS) LGAs, Wollondilly ranks fourth in early antenatal care coverage, behind Camden (84.4%), Campbelltown (79.9%), and Fairfield (72.4%) (8).

Routine antenatal care before 14 weeks gestation can improve both maternal and child health outcomes (9) It can also increase access to necessary health interventions during pregnancy.

As of June 2024, the Wollondilly childhood immunisation rates are as demonstrated below.

Table 3: Childhood immunisation coverage by age group and immunisation type, as of June 2024 (10)

	DTP	Polio	HIB	HEP	Pneumo	MMR	Men C	Varicella	Fully Vaccinated
1 year olds	93.13%	93.13%	93.13%	93.55%	94.25%	0%	0%	0%	92.17%
2 year olds	90.04%	95.93%	91.02%	96.07%	94.39%	90.60%	94.53%	90.60%	89.06%
5 year olds	95.01%	94.87%	0%	0%	0%	0%	0%	0%	94.87%

Following birth, PHIDU data (7) indicates that Wollondilly children are more on track than other regions regarding child development, physical health and wellbeing. However, with an increasing number of young families living within Wollondilly over the next twenty years, the demand for paediatric specialist and allied health services will increase substantially.

Chronic and preventable diseases

Wollondilly has lower rates of residents registered with NDSS (5.41%) compared to the national rate 5.44% (10). In 2022-23, 84 people in Wollondilly (SA3) received an annual diabetes cycle of care (0.18 services per 100 people) (11). This is higher compared to the national and SWSPHN rates (0.14 and 0.14 services per 100 people respectively). Wollondilly had the second highest rate of people receiving an annual diabetes cycle of care compared to other SA3s in the SWS region.

However, Wollondilly residents have a higher than NSW average cancer incidence rate 11% compared to NSW for all cancers (standardised incidence rate of 1.11) for 2017-2021, despite high participation rates in breast and bowel screening (but lower rates of cervical screening) (12)

Health workforce and services (current and projected)

Transport and Infrastructure to support access to health services

A population of this magnitude requires strategically located local, district, shire-wide and regional social infrastructure to support residents in leading healthy, happy, and socially connected lives. With significant distances to traverse, a dispersed settlement pattern and many workers needing to leave the Shire for employment, the community is heavily reliant on the road network. Additionally, public transport options in the Shire are limited and do not meet the

current demands of the population.

With the planned growth to come in Wilton, the deficit in transport options will become even more pronounced unless addressed by public transport solutions. The Community need healthy built environments and liveable places with better access to health care services and programs. Much of the community is required to leave the Shire for health and education services as there are limited options available. With the population forecast to potentially triple in the next 20 years, planning for important community services is required now. Council's full policy on managing growth and change is captured in Council's Local Strategic Planning Statement "Wollondilly 2040" (13).

The Capital Works Program for 2024/25 - 2027/28 is provided on the basis that funding will be approved for the various programs. Wollondilly Council annually adopts a four-year plan to maintain and improve the road network. This plan focuses on the highest priority areas based on road conditions, traffic volume, and other important data (14).

Wollondilly Council has worked consistently with other local councils and allies to secure a bipartisan election commitment for \$1 billion towards a rail corridor from Macarthur to the new Western Sydney airport in the lead up to the 2025 Federal election (14)

The extended master plan area will be a significant new part of metropolitan Sydney, and in addition to residential uses will provide and develop into an important employment corridor utilising city shaping corridors – major trunk road and public transport corridors providing higher speed and volume connections between the cities and centres that shape locational decisions of residents and businesses (14).

Primary Care

As of April 2024, there are 18 General Practices in Wollondilly LGA (36), including: (15)

- 2 solo, 9 small practices (2-5 GPs) and 7 large practices (6+ GPs)
- 16 practices (88.9%) have a registered nurse
- 10 practices (55.6%) have a GP registrar
- 15 practices (83.3%) bulk-bill and 3 practices (16.7%) both bulk and privately bill
- 17 practices (92.4%) are accredited

The number of GPs in Wollondilly increased from 65 GPs in 2023 to 95 GPs in 2024. There are 18 GP registrars, which increases the number of GPs to 113. In the 2022-23 financial year, the GP Full-time Equivalent (GP FTE) in Wollondilly was 62.8 with 112.6 GP FTE per 100,000 residents. This compares with a rate of 127.3 GP FTE per 100,000 residents across SWS, and a NSW rate of 116.9 GP FTE per 100,000 residents. Despite an increase in the number of GPs since 2023, Wollondilly continues to have the lowest rate of GP FTE compared to other LGAs in SWS (16).

In 2025, there were 12 pharmacies located in Wollondilly LGA (17).

Between 2021 and 2023, the rate of Medicare subsidised GP attendances (all ages) have decreased from 1,184.35 services to 893.71 services per 100 people. Women and older people had higher rates of GP attendance. At the same time, there has been an increase in residents using Medicare subsidised GP After-hours service usage (18).

To support the increased population over the next twenty years, Wollondilly will require a further:

- 127 GPs
- 22 new General practices
- 15 pharmacies

These additional primary care services will need to be located within or close to the Wilton and Appin to support these larger population centres.

Many general practices in SWS report it is difficult to recruit GPs to work in the area. NSW legislative council 2020 report highlighted anecdotal evidence from medical professionals that it was difficult to get health care workers to live and work in SWS, as opposed to areas of Sydney. Many medical professionals working in SWS live in other parts of Sydney and face long commutes to work. Other reasons identified were poorer and stressful working conditions compared to other health districts, including heavy workloads, lack of resources and limited career paths.

Allied Health Care

An analysis of allied health services in the Wollondilly region indicates that dietetics, nutrition, chiropractic, and psychiatry services are limited or not readily available locally.

While some dietetic services are accessible via telehealth, such as Active Nutrition, and Camden Hospital dietetics services in the broader area, there is no evidence of locally based chiropractic services. This gap highlights the need for improved access to these specific allied health services within the Wollondilly region.

Table 5: Allied Health Services, Wollondilly (LGA) (19)

Allied health facilities	Number	Numbers needed by 2041
Speech pathology and language therapy clinics	4	9
Podiatry	1	2
Physiotherapy	5	12
Optometry	4	9
Occupational Therapy	3	7
Hearing clinic	2	5
Exercise physiotherapy clinics	3	7
Psychology	3	7
Pharmacies	11	26

Specialists

Similarly with specialist services in the Wollondilly region highlights limited local availability across several key disciplines, including cardiology, diabetes care, endocrinology, ear, nose and throat (ENT), gastroenterology, geriatrics, gynaecology, haematology, nephrology, orthopaedics, paediatrics, psychiatry, and rheumatology services essential to meet the needs of a growing population.

In Wollondilly (SA3 level), Medicare subsidised specialist attendances (all ages) have slightly increased to 130.71 from 126.96 services per 100 people in 2022-23 (19).

As a result, residents are often required to travel to surrounding areas such as Bowral, Campbelltown/Camden, and Liverpool to access timely and appropriate specialist care.

For instance, psychiatric services are largely concentrated in regional centres, with the Campbelltown Community Mental Health Centre serving as a primary hub. Currently, psychiatric service provision within the Wollondilly LGA remains minimal.

Table 6: Specialist Services in the Macarthur region to support growth areas (19)

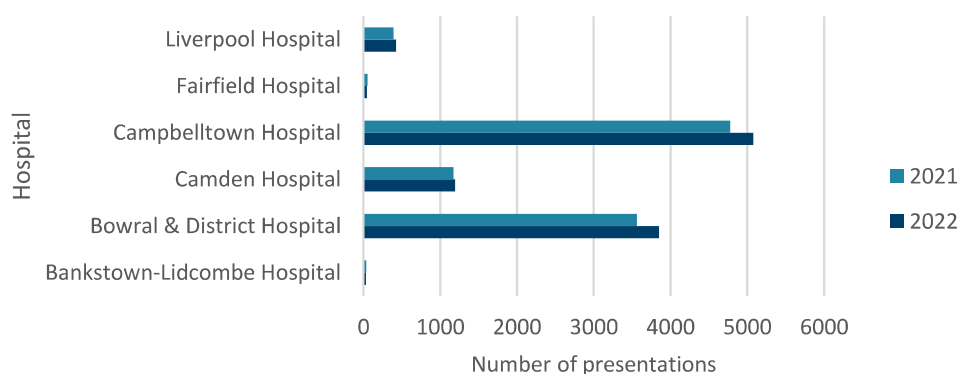
Specialists	Number	Numbers needed by 2041
Cardiologists	30	70
Diabetes Specialist	4	9
Endocrinologist	9	21
ENTs	12	28
Gastroenterologists	31	73
Geriatricians	5	12
Gynaecologists/Obstetricians	9	21
Haematologists	1	2.3
Nephrologists	10	23
Orthopaedics	24	56
Paediatricians	17	40
Psychiatrists	12	28
Rheumatologists	3	7

Acute and tertiary care

Wollondilly does not have public or private hospitals. Residents need to rely on acute and tertiary services at either Bowral, Camden, or Campbelltown Hospitals (20). This includes presentations to Emergency Departments (ED) or outpatient specialty clinics. These facilities can be up to forty minutes' drive to reach or significantly longer if public transport is required.

In 2022, Wollondilly residents presented 15,640 times to an ED, with the majority presenting at Campbelltown and Bowral hospitals. (see Figure B). The closest Urgent Care Centre is in Campbelltown and Gregory Hills.

Figure B: ED presentations to SWS Hospitals, Wollondilly residents, by facility, 2021-2022 (20)



Based on current growth projections, and with Wilton and Appin residents more likely to present to Campbelltown Hospital for emergency and outpatient care, this significantly increases the potential demand for services within this hospital. This is further exacerbated by large population growth in Camden and Campbelltown also contributing to greater service demand.

In response to the growth within Wollondilly Shire and surrounding growth areas identified Greater Macarthur and Appin Growth Areas, Council is actively collaborating with the SWSLHD and SWSPHN to plan for critical health infrastructure to support the community's expanding needs.

Council, SWSLHD and key stakeholders meet regularly to collaborate on health services

planning. At present, planning is focused on integrated community health hubs with several locations being considered for future horizons. This planning aligns with broader development activities in the Greater Macarthur region, where substantial growth is anticipated.

This work is particularly timely, given ongoing negotiations on Voluntary Planning Agreements (VPAs) between landowners and the Department of Planning, Housing, and Infrastructure to secure enabling infrastructure for the region (21).

Aged care

Wollondilly has three Residential Aged Care Facilities (RACFs)

1. Durham Green Manor at Menangle
2. RSL LifeCare Taara Gardens in Thirlmere
3. RSL LifeCare Queen Victoria Park in Picton

Almost 6% of older people (70+) in Wollondilly were in residential care and more than 60% of people using permanent residential care had a dementia diagnosis. Of those living in the Southern Highlands and using home supports in 2021-2022: (22)

- 20.51% (208 people) had a carer
- 2.86% (29 people) identified as Aboriginal and/or Torres Islander
- 3.65% (37 people) spoke a language other than English
- 24.66% (250 people) were born overseas
- 19.33% (196) had a disability
- 38.17% (387) lived alone

Mental health services

Community Links Wellbeing (CLW), including the ReFrame (headspace) program, has observed a rise in mental ill-health presentations across the Wollondilly region. The LGA's rural and dispersed geography, similar to areas such as Wingecarribee, presents ongoing challenges to service access. Barriers in relation to mental health, housing, legal support, specialist services, and essential government services such as Centrelink and Medicare persist in the region.

Service access across geographical boundaries is a recurring theme in the region, with residents in northern parts of Wollondilly, such as Warragamba and Silverdale, frequently utilise services within the Nepean catchment. In the southern villages, including Yerrinbool, Buxton, and Hill Top, there is a pattern of accessing health and community services in Wingecarribee. This has been acknowledged through existing arrangements such as the alignment of Wollondilly South with the Wingecarribee Community Mental Health Team. Monthly mental health forums held in Bowral also reflect cross-boundary engagement, with regular participation from local stakeholders and community members. These patterns suggest a level of functional integration with neighbouring regions that may have implications for service planning and coordination.

SWSPHN commissioned services

Since July 2017, SWSPHN mental health programs have delivered 19, 059 service contacts to 3,489 distinct clients in Wollondilly (23). Data has dramatically increased in recent financial years because programs previously not captured on SWSPHN Qlik are now included, for example headspace+.

Table 7: Overview of SWSPHN Mental health contacts and clients by financial year (23)

Financial Year	Service contacts	Distinct clients
2020-2021	3, 446	806
2021-2022	1,944	621
2022-2023	3,578	890
2023-2024 (6 months only)	1,775	455

Key insights

Of clients who accessed PHN commissioned mental health programs in Wollondilly in 2022/23 FY:

- 79.7% reside in Wollondilly, 10.1% reside in Wingecarribee, 8.3% reside in Camden, the remainder reside in other LGAs
- The average number of contact hours per client was 4.4
- Majority were aged between 12-26 years (32%)
- 71% identified as female
- 6.7% identified as indigenous
- The most common diagnosis is mixed anxiety and depression
- 52.7% of clients were referred by a GP

According to POLAR data on RACGP active patients (generally defined as someone who has had at least three clinical encounters or activities within the past two years), there have been approximately 4,100 instances of Mental Health Care Plans (MBS item 2715) initiated within the Wollondilly Local Government Area (24). This number reflects the demand for primary mental health support in the region and highlights the important role general practitioners play in facilitating access to mental health services, particularly in semi-rural areas where specialist services may be limited.

Data Discovery

Health concerns

Health and service provider consultations

All health professionals, allied health and service providers that participated in consultations were asked to identify the primary health concerns among Wollondilly residents.

Findings from the service provider focus group (22 participants), and health professional and service provider semi-structured interviews (8 participants) were analysed using thematic analysis. Primary health concerns identified are outlined below.

Table 8: Consultation outputs, primary health concerns among Wollondilly residents

Focus groups	Interviews
Service accessibility (29.2%)	Mental health & AOD (71.4%)
Mental health & AOD (15.7%)	Preventative care (28.6%)
Access barriers (35.2%)	Service accessibility (28.6%)

Key health concerns:

- **Mental health:** A dominant health concern raised was mental health and alcohol and other drugs (AOD), especially youth mental health. Many participants emphasised the need for increased mental health services to meet regional demand.
- **Preventative care:** Consultation findings with health professionals highlighted that preventative care is disproportionately accessed by residents due to factors, such as poor health literacy, lack of awareness and poor help seeking behaviours (particularly among young people).
- **Service accessibility:** Refers to the limited or lack of services available within

Wollondilly to meet the health needs of residents. Prime examples included Geriatricians, Paediatricians, falls prevention services, mental health services, and domestic violence supports.

- **Access barriers:** Inclusive of all barriers pertaining to the logistical and financial access of required services. These barriers included transport and distance, affordability, technology and wait lists. Access barriers can be detrimental to a resident’s health. For example, medication affordability and the reduction in bulk-billing GPs can lead to poor medication and care compliance, thus impacting health outcomes.

Table 9: Health professional and service provider consultation outputs, primary health concerns

Health concern	Consultation outputs
Mental health & AOD	<p>Emerging mental health concerns among victims of domestic violence. In young persons, there is a growing trend of self-harm and suicidality. Increasing numbers of children presenting with behaviour and complex conditions.</p> <p>There is a lack of mental health support available to meet the needs of the community, especially a lack of after care services following discharge which result in delayed follow-up care.</p> <p>There are high rates of suicide within the community but there is limited access to counsellor, specialised and psychiatric services.</p> <p>There is a high incidence of parents seeking mental health assessments as a support for challenging behaviours in their children, especially those with ADHD.</p> <p>Youth mental health concerns include a high incidence of anxiety and depression.</p> <p>In adolescents specifically, there are increased rates of self-harm and suicidal ideation which has eventuated from depression, school refusal and anxiety.</p>
Preventative care	<p>GPs identified that in Wollondilly, there are high rates of preventative care refusal. For example, patients are not accessing flu vaccinations. This could come down to personal beliefs or low health literacy,</p> <p>There is a larger number of undiagnosed chronic diseases that could be a result of poor service accessibility to support the working population, or people aren’t aware of preventative health strategies. Ultimately, these delayed presentations have led to instances of malignancy or end stage organ damage.</p>
Service accessibility	<p>Overall, there are not enough health services available within the region and the extensive wait lists are preventing people from seeking help with their health.</p> <p>Mental health in children is an emerging concern, however paediatrician and support service access is lacking.</p> <p>Some providers emphasised the need for more visible outreach services, especially youth mental health including intervention within schools.</p> <p>In vulnerable populations, when a person reaches out for support and that service is full, this discourages a person from seeking help again. The current availability of health services is not meeting the current population growth. Antidotally, this was observed with the Oran Park</p>

	<p>expansion where the rapid population growth outpaced the availability of health services, resulting in limited support for the rising incidence of domestic violence.</p> <p>There needs to be more referral pathways for domestic violence services to support those without transportation or means to travel into Macarthur. Furthermore, there needs to be increased support for teenagers disclosing strangulation among sexual partners.</p> <p>Public appointments are difficult, even when urgent.</p> <p>Growing need for increased local women's health services focused on menstrual health.</p>
Chronic conditions	<p>GPs and Pharmacists highlighted the following conditions as primary health concerns among their patient cohorts:</p> <ul style="list-style-type: none"> Diabetes Atrial Fibrillation Pain (chronic pain more prevalent within the elderly population) Osteoarthritis Asthma Obesity Hypertension
Patient barriers	Addressed later in this document
Aged care	<p>GPs and Pharmacists indicated that mobility was a concern among the elderly which is further exacerbated by the lack of appropriate service, such as falls prevention clinics.</p> <p>Mobility issues restrict the elderly in physically accessing their primary care provider. In some instances, there is a concern of inappropriate telehealth consultations among this cohort.</p> <p>In isolated regions, such as Warragamba, there is growing concern for elderly patients unable to sustain their license which significantly impacts healthcare accessibility.</p>

Community member consultations

Community members engaged by survey were asked to select health risk behaviours applicable to themselves or the person they care for (Question 7). There is high incidence of poor health behaviours among Wollondilly residents. Noteworthy findings include:

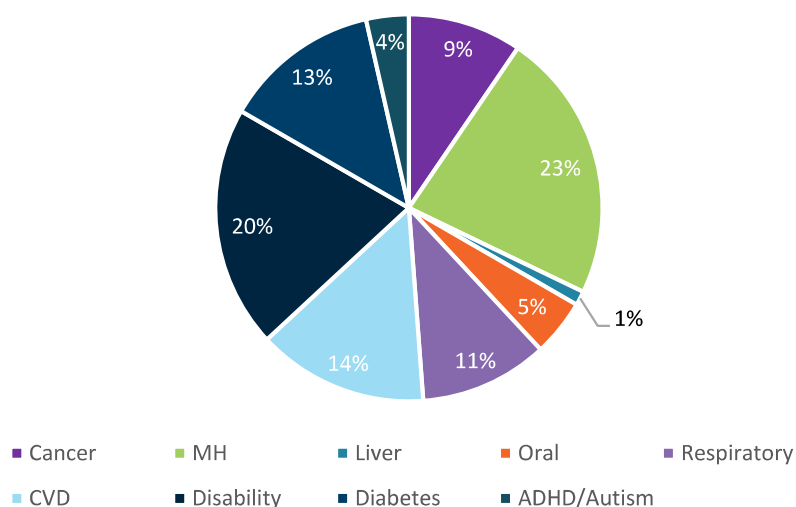
- 44% of respondents reported inadequate fruit and vegetable intake (<5 service per day).
- 40% of respondents are overweight or obese.
- 40% of respondents do <2-3 hours of exercise per week.
- Nearly half of respondents (45%) partake in 2 or more health risk behaviours.

More than one third of respondents (33%) indicated that themselves or the person they care for take 1 to 2 regular medications. Polypharmacy (>5 regular medications) was reported by 24% of community members.

Community members were also asked to indicate if they or the person they care for have any health concerns. Mental health has the highest prevalence among survey respondents (23%).

- 20% of respondents reported disability as a health concern.
- 31.5% of respondents have co-morbid health concerns.

Figure C: Community survey, question 6, health concerns of residents or the person they care



In all communities, health professional and service provider consultations, participants were asked to identify the barriers in accessing healthcare within Wollondilly. Thematic analysis was utilised to determine key themes. These are outlined below.

Table 10: Dominant healthcare access barriers identified through consultations

Community consultations	Community survey	Health professional and service provider consultations	Service provider focus group
Service availability barriers (42.3%)	Logistical barriers (83%)	Logistical barriers (31.8%)	Service availability barriers (85.7%)
Logistical barriers (41.5%)	Service availability barriers (61.8%)	Patient experience barriers (27.3%)	Financial barriers (71.4%)
Patient experience barriers (11.7%)	Financial (57.4%)	Systemic barriers (20.5%)	Logistical barriers (71.4%)
Financial barriers (10.1%)	Patient experience barriers (25.8%)	Financial barriers (13.6%)	Patient experience barriers (42.9%)
Systemic barriers (3.23%)		Service availability barriers (9.1%)	Systemic barriers (14.3%)

‘Service availability barriers’ refer to the identified service gaps impacting accessibility to timely and appropriate healthcare among Wollondilly residents. These services included GP, specialist, allied health, mental health, after-hours and other services. The lack of hospital infrastructure was not captured within this theme. ‘Patient experience barriers’ refers to factors pertaining to

how a resident interacts with healthcare services which may prevent them from receiving optimal care. These could include barriers such as stigma, lack of options and negative interactions, health literacy, and awareness of available services.

- **Stigma:** discourages people from accessing both preventative and reactive healthcare services, thus impacting health outcomes. Stigma was only addressed as a barrier in consultations with service providers. There is a sense of ‘pride’ among the older generation which inhibits help seeking behaviours.
- **Lack of options and negative interactions:** residents can have trouble accessing alternative care within Wollondilly following poor initial experiences with a service. There was significant concern raised in community consultations around the lack of trust with some health providers including Community Health and GPs. It was reiterated by many participants that finding a reliable and trustworthy GP that utilises active listening can be difficult.
- **Health literacy:** is an indicator of poor health outcomes. Some health professionals identified health literacy as an obstacle among residents in accessing preventative health care, such as immunisations and screenings. It was further reiterated that health literacy can influence delayed intervention at their GP, leading to disease exacerbation and significantly poorer health outcomes (e.g., end-stage organ damage from unmanaged diabetes or hypertension).
- **Awareness of available services:** this included poor community awareness of services (health and support services) available within Wollondilly and how to access them. It was raised in community consultations, that in the event of becoming unwell in the after-hours period, many residents would not know what services could be accessed. Further community education is imperative to enhance help seeking behaviours.
- **Financial barriers** include the associated costs with accessing primary care, specialist care and medications. The number of bulk-billing GPs is reducing across the district, further exacerbating healthcare access with patients needing to pay gap payments.

Consultation findings emphasised limited-service availability as the dominant barrier in accessing healthcare within Wollondilly. The key services identified as having poor access included GPs, allied health, specialists, hospital services, mental health services and other support services.

There is significant concern among consultation participants that the population growth in Wollondilly is rapidly outgrowing service availability.

Table 11: Key consultation outputs by service type

Service	Consultation outputs
Allied Health	<p>Access within Wollondilly is limited, especially Occupational Therapy and Speech Pathology</p> <p>75% of provider survey respondents reported allied health access in Wollondilly as poor or very poor.</p> <p>There is a lack of infrastructure to support more allied health rooms across the region.</p> <p>Health professionals require trust with new allied health services before referring patients, this further exacerbates access issues.</p> <p>GPs identified that there is a significant lack of falls prevention services, especially in outer suburbs like Warragamba.</p>
After-Hours	<p>There is no available after-hours or urgent care service within the region.</p> <p>The existing GP After Hours deputising service is not as beneficial for patients</p>

Services	<p>compared to physically being seen.</p> <p>The lack of after-hours access to pharmacy was raised in community consultations.</p>
Community health	<p>GPs acknowledged that there are community health services available within the region but are uncertain on what services are specifically provided, this is hindering appropriate referral pathways. There needs to be greater transparency between health professionals on the criteria for community health referrals to better support residents.</p>
GPs	<p>Many participants did not have a preferred GP and would often see the next available. This leads to poor continuity of care. However, continuity of care was mentioned as being difficult with decreased GP supply and population growth in Wollondilly.</p> <p>Access to preferred GP is influenced by wait times (could be between 2 to 3 weeks).</p> <p>Same day appointments are difficult to obtain in some clinics.</p>
Specialists	<p>49% of consumer survey respondents reported specialists not being available in their region as a barrier in accessing healthcare.</p> <p>There is high reliance on specialist care being provided outside of the region which fragments patient care.</p> <p>There are not enough psychiatrist appointments to support the mental health demand.</p> <p>Geriatrician and Paediatric access is not available within Wollondilly. Outreach services (including case conferencing models) were raised as potential opportunities to mitigate this.</p>

Table 12: Key consultation outputs for targeted populations

Population group	Consultation outputs
General population	<p>The absence of home visiting services is a big service gap within Wollondilly.</p> <p>Access to required specialists in other LGAs, such as Campbelltown for Dermatology.</p> <p>Transiency of GPs- continuity of care is difficulty to achieve when some GPs only come into Wollondilly for a short period of time.</p>
First Nations	<p>Access to Paediatricians is insufficient within the region, leading to a significant dependence to travel to adjacent LGAs, including Campbelltown.</p> <p>There is difficulty finding GPs that residents believe meet their needs (being reliable and trustworthy)- resulting in fragmented patient care and poor patient experiences.</p> <p>There is no Aboriginal Medical Service (AMS) or outreach within Wollondilly with First Nations people needing to travel to Campbelltown. However, there are systematic barriers that further compounds access to appropriate healthcare, especially among foster children without the required documentation.</p>
Males (late aged)	<p>Availability of pharmacies across the region varies. Those situated in rural areas of Wollondilly are required to travel to Appin pharmacy.</p> <p>Continuity of GP care is a challenge, especially when principal GP</p>

	<p>appointments are limited, and patients are seen by registrars. The preference is to see a primary care provider, however with some wait times reaching up to 3 weeks, residents need to see the first available which further fragments patient care. This instance was specific for a resident travelling in Campbelltown LGA for their preferred GP.</p>
Retirees	<p>There is high utilisation of specialists within this cohort. In most cases, residents need to access specialists across multiple regions. In some regions, such as Tahmoor, there is poor continuity of primary care due to many GPs working part-time and increased patient loads.</p>
Young families	<p>Consultation findings with young families (predominantly mothers) demonstrate need for:</p> <ul style="list-style-type: none"> Increased counselling and support services for younger mothers More psychologists to decrease the wait times Increased telehealth options- this is especially beneficial for those with multiple children Local paediatrician access to minimise the impact of travel and distance, people are requiring days off work for their child to receive specialist care in other regions After hours pharmacy - some parents mentioned that access is available only when you “plan to get sick” in business hours Improved access to GPs

Service utilisation barriers

The patterns of service utilisation were collected through the community survey (Questions 9 and 11). Key insights include:

- 53% of residents saw a GP more than 6 times within the last 12 months.
- 84% of residents access GP services within Wollondilly, albeit 8% reported accessing GP services across both Wollondilly and Campbelltown.
- 36% of residents saw a specialist 1 to 2 times within the last 12 months.
- 49% of residents access specialist care in Campbelltown and 39% in Southern Highlands.
- 21% of residents access specialist care in other regions such as Westmead, Sydney, and Liverpool.
- 87% of residents did not require access to community health services.

Figure D: Community survey, question 9, service utilisation in past 12 months

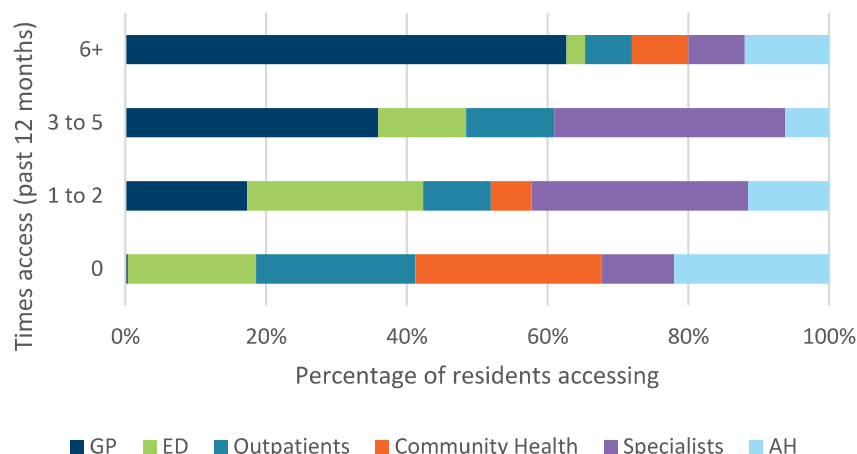
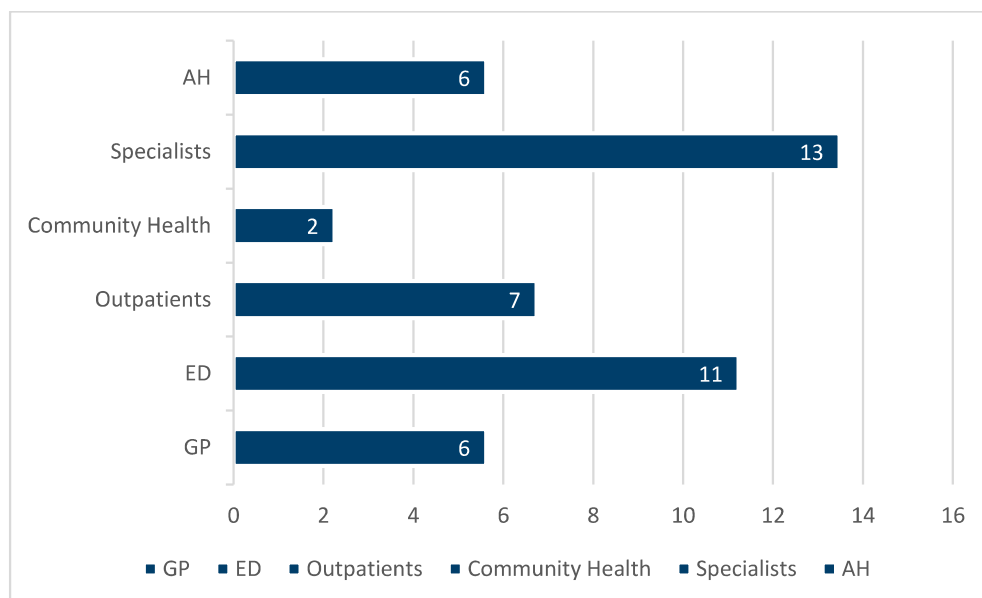


Figure E: Community survey, transport as an identified barrier to access healthcare services



Travel and wait times

Service accessibility in Wollondilly is exacerbated by the distance and travel required by residents to access services in adjacent regions. From the community survey (Question 10), 30% of respondents reported travel as a challenge in accessing specialist care.

Long wait times and wait lists were reported as a barrier when accessing different services, including GPs, specialists, allied health and emergency.

Table 13: Key consultation outputs for targeted populations (travel and wait times)

Population group	Consultation outputs
General	Having to travel to access Cancer Services at Campbelltown or Liverpool whilst experiencing discomfort. Further exacerbated by barriers

population	<p>experienced with Community Transport.</p> <p>There are pharmacy options within the region, however residents in the outer villages must be prepared to travel to suburbs with pharmacists (e.g., Picton).</p> <p>For those requiring carer support, additional carers are needed when travelling to access out of area services.</p>
First Nations	<p>It was reported that travel was a barrier especially to access Tharawal Aboriginal Medical Service (located in Campbelltown LGA), public immunology clinics, and paediatric services.</p> <p>Travel is also required when after-hours care is needed with residents needing to travel to Bowral or Campbelltown Hospital.</p> <p>Paediatricians have extensive wait lists.</p>
Males (late aged)	<p>Some participants stated that travel is required to other regions to access providers with established trust and quality of care.</p> <p>Wilton was mentioned as having poor access to allied health with residents travelling into Campbelltown for services such as Podiatry.</p> <p>However, access to services in adjacent regions is dependent on availability of transportation.</p> <p>There is heavy reliance on family support among people with the inability to drive or don't have a car.</p>
Retirees	<p>Many participants require specialist services at Liverpool Hospital in which travel combined with waiting times are burdensome for the elderly population.</p> <p>Travel is also a barrier when patient care sought across multiple regions.</p>
Young families	<p>It was emphasised that travel to other regions for paediatrician access was a significant barrier as it impacted work commitment.</p> <p>This challenge is further compounded by the absence of a car and multiple modes of public transport to access this care.</p> <p>Access to public allied health for children is available at Campbelltown Hospital, albeit the distance is burdensome when travelling with multiple young children.</p> <p>There are long wait times for:</p> <ul style="list-style-type: none"> Regular (and trusted) family GP Paediatrician access in SWS Mental health services across Wollondilly Antenatal care at Campbelltown Hospital After-hours care at Campbelltown Hospital Emergency Department

Health professionals and provider consultations emphasised the financial burden residents are experiencing when accessing required healthcare services. With the rising cost of living, some residents are not prioritising their health more than their basic needs, such as stable housing and food. The predominant services with perceived high costs include:

- **GPs and Mental health services:** including psychology, psychiatry and other mental health services with limited bulk-billing options.
- **Specialists:** there are high gap payments associated with private specialist access. Especially, for those requiring multidisciplinary care.

Community consultation findings highlighted many services in which initial and continued access are impacted by financial challenges. Noteworthy insights included:

- Associated costs of medications can be a barrier, particularly among families with young

children requiring sustained care.

- For residents on low incomes, GP accessibility is steadily declining in Wollondilly with the introduction of mixed and private billing options, as well as the elimination of financial aids, such as the single parent \$5 fee and Medicare levy. There was a proportion of residents that indicated their 'preferred' GPs are in adjacent LGAs and there are high out of pocket fees to access the service (e.g. \$70-80 per visit) in conjunction with petrol and parking costs.
- Specialised mental health treatment is often difficult to access through public mental services and are often at capacity, private options can be very costly. This was emphasised for Autism diagnosis and assessments.
- Despite the convenience of telehealth consultation, especially among families with multiple sick children and retirees with restricted means of transport, there has been the introduction of fees to access these services (approximately \$40-\$60) with is further limiting access to timely and appropriate healthcare.

Systematic barriers

A systematic barrier refers to the structural and bureaucratic factors preventing access to prompt and appropriate patient care within the health system. Factors associated with systematic barriers included tertiary referral pathways and inadequate infrastructure within Wollondilly.

Inadequate infrastructure: the absence of a hospital or urgent care service in Wollondilly was reinforced in consultations. Wollondilly residents have access to service within the Macarthur area however noted there are no hospitals or urgent care centres in the Wollondilly area. Acute hospital service needs are currently accommodated by Campbelltown Hospital. Health service planning will continue to consider population growth and the health needs of the community.

Tertiary referrals: providers and community members are experiencing bureaucratic barriers in accessing tertiary services. Residents in outer suburbs, such as Warragamba, are facing significant tertiary care access barriers.

Key insights raised in health professional consultations were:

- Residents in Warragamba are required to access Campbelltown Hospital (~40 minutes) despite Nepean Hospital being closer.
- There have been instances in which Warragamba residents have accessed Nepean Hospital for antenatal care but requiring perinatal mental health services at Campbelltown Hospital. This is fragmenting patient care, creating additional barriers to timely care (travel and distance) and causing poor patient experiences within the healthcare system.
- There are significant concerns among health professionals regarding poor referral pathways into Campbelltown Hospital. It was identified that often referrals are rejected but GPs are unable to discuss patient suitability with the relevant department.
- GPs have emphasised the importance of a GP liaison to mitigate this issue and to ensure that there is effective coordination between primary and tertiary care providers.

Service providers engaged via survey were asked to indicate the level of impact (1= least impact, 5= highest impact) for healthcare access barriers:

- 100% reported logistical and workforce barriers as high impact (4-5)
- 50% reported lack of culturally appropriate care as low impact (1-2)
- 50% reported health literacy as medium to high impact (4)

- 75% reported difficulty navigating the health as medium impact (3)
- 75% reported lack of required health services as high impact (4-5)

Healthcare system strengths

In all community consultations, residents were asked to identify the enablers to timely and appropriate access to healthcare regions within Wollondilly. The purpose of this question was to determine the aspects that are facilitating ease of access and good health outcomes, and to further develop them through WHA initiatives.

Anecdotally, the overall service availability in Wollondilly is inadequate to meet the health needs of residents. However, community consultations emphasised that there are existing services that significantly enable access to prompt and suitable healthcare, thus achieving better health outcomes.

Table 14: Consultation outputs associated with health system enablers

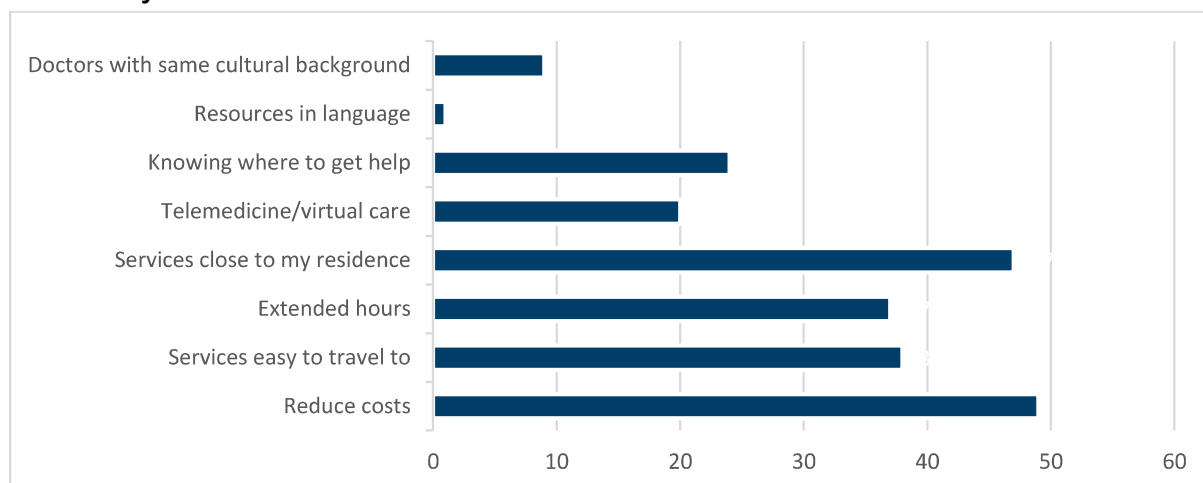
Identified theme	Consultation outputs
Allied Health	Among retirees residing in Bargo and Tahmoor, allied health outreach (home visits) was reiterated as a substantial strength. Podiatry was specifically mentioned multiple times.
Dental	Dental access is good across the region and is highly regarded by retirees.
GP	38% of participants reported both GP access and experiences across Wollondilly were good. GPs are generally well regarded, especially among males (late aged) and retirees. Trust, effective communication and post treatment follow up were specific traits mentioned. Access to 'preferred' GP was identified as easy in Appin and Bargo (2-3 days).
Pathology	Access in Bargo was highly regarded among retirees. It was specifically mentioned that local pathology provides home visit services.
Pharmacy	39% of participants reported pharmacy access and experiences across Wollondilly was good. Pharmacists provide information about medications, including side effects and advice. Pharmacists provide excellent support and are sometimes an alternative to seeing a GP for some conditions. Scripts can generally be filled at a single pharmacy, with most having access to a variety of medications or having the capacity to compound medications. Among the elderly participants, access to pharmacy home delivery services was a significant enabler to healthcare (particularly within Bargo and Tahmoor).
Hospital	Strengths in the hospital system included: Better wait times at Bowral emergency compared to Campbelltown. Positive relationships with staff at Campbelltown Hospital including nurses, Doctors and ICU team. Positive experiences with paediatric care at Bowral.

Opportunities to enhance service accessibility

Community members were asked to select opportunities to improve healthcare access for

themselves or the person they care for via survey (Question 12). The reduction of service costs was the highest reported (22%), followed by proximity of healthcare services (21%)

Figure F: Community survey responses, opportunities to improve healthcare access in Wollondilly



Opportunities for enhancing care coordination to improve patient experience

During consultations with consumers, health professionals and service providers, participants were invited to identify ways to enhance care coordination and continuity of care in Wollondilly. The purpose of this inquiry was to assess the opportunities the community believes could improve patient experiences, strengthen connections between people, services, and the wider community, and support individuals in achieving optimal mental health and well-being. Care coordination refers to the integration of patient care activities between two or more participants involved in a person’s care, to facilitate the appropriate delivery of health care services.

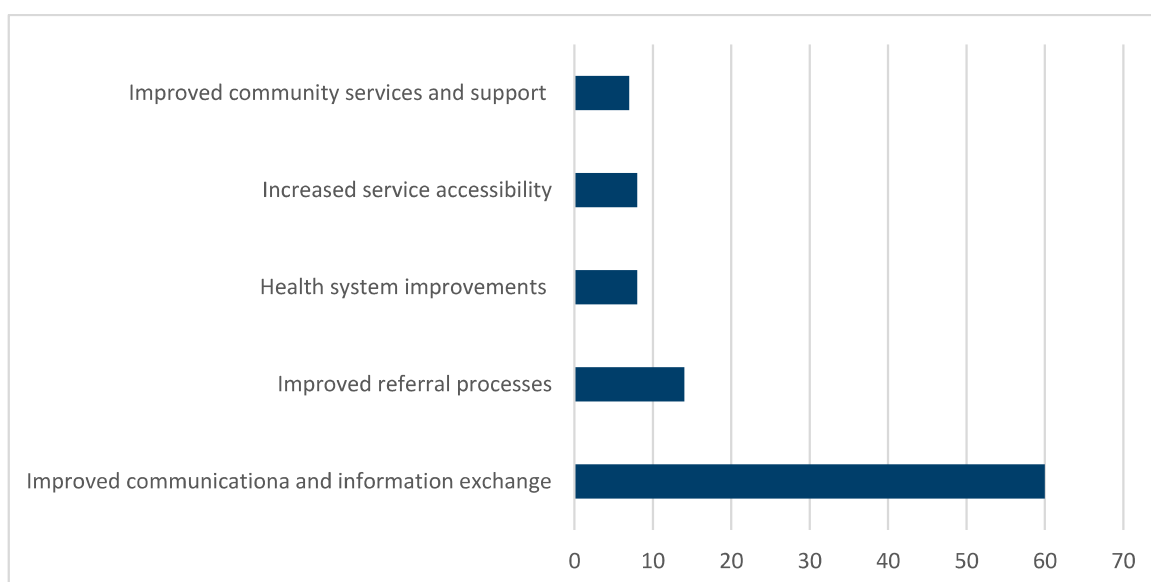
Table 15: Key themes from consultations with health professionals and service providers focusing on enhancing care coordination

Identified theme	Key consultation outputs
Increase provider awareness and access	<p>Respondents highlighted that increasing awareness of available health service providers in Wollondilly would significantly enhance the experiences of both patients and providers.</p> <p>Interagency meetings, events and networking opportunities that include health staff, GPs and local services were identified as valuable for fostering connections and collaboration among providers.</p> <p>Education for GPs/health providers to enhance knowledge and understanding of available resources and services.</p> <p>Leveraging existing services to improve accessibility e.g. Dilly Wanderer with consideration for expansion.</p>

Established referral processes	<p>Increasing awareness of appropriate referral pathways to ensure patients are directed to the most suitable services</p> <p>Improved understanding of patient eligibility criteria to minimise referral knockbacks.</p> <p>Enhance access to service providers for obtaining detailed information about their services.</p> <p>Availability of up-to-date information online or via phone to enable GPs to support patients adequately and provide timely advice.</p> <p>Addressing the fragmentation of the referral process, ensuring that GPs receive timely updates on the patients progress at any stage of their service journey.</p>
Strengthen supports	<p>Council networking programs aimed at addressing loneliness and fostering a stronger sense of community.</p> <p>Opportunities for connection to help alleviate mental health burdens, particularly for individuals experiencing financial hardship, homelessness, or those in need of support.</p> <p>Strengthening local support networks for individuals without family assistance.</p> <p>Ensuring proper compensation and support for informal carers, recognizing their contributions and providing the resources they need.</p>
Improve integrated care	<p>A strong need for an established care coordinator or GP liaison to support patient health by ensuring continuity of care for chronic and complex conditions linking patients to appropriate primary care and community service providers and improving patient follow ups – particular mentions for paediatric, geriatric and palliative patients.</p> <p>Reduce siloed working by enhancing relationships and communication between care teams GPs, specialists, allied health and service providers.</p> <p>Increase involvement from councils and advocacy groups in promoting programs focusing on preventative health and health promotion initiatives.</p> <p>Improve follow-up and communication to patients to prevent them from getting lost in the system and to maintain continuity of care.</p>
Establish data integration software	<p>Patient health information is fragmented- requiring navigation through multiple software systems – There is a need to streamline access to discharge summaries from hospitals, specialists and allied health to make them easily accessible.</p> <p>Enhance the timeliness and effectiveness of access to patient information and health records to reduce delays in obtaining essential data and minimize the need for follow-ups for time poor GPs/health care providers.</p>
Strengthen workforce	<p>Emphasize the importance of employing community nurses and social workers to ensure adequate follow-up care for patients after hospital discharge.</p> <p>Enhance GP education on providing comprehensive information to patients during consultations to improve patient understanding and engagement.</p> <p>Address the issue of under-resourcing among nurses, GPs, and healthcare services to strengthen the overall quality of care.</p>

The consultation findings from consumers underscore the critical need for enhanced communication, information exchange, referral processes, and overall health service improvements to strengthen care coordination within Wollondilly. The significant emphasis on communication and information exchange reveals a pressing opportunity for enhancing care coordination, which is vital for improving patient experience.

Figure G: Consumer survey responses to opportunities for enhancing care coordination in Wollondilly



Opportunities to support health service navigation

Participants were invited to identify improvements and opportunities for supporting health service navigation in Wollondilly. Potential strategies for enhancement were explored in collaboration with the community, service providers, and health professionals.

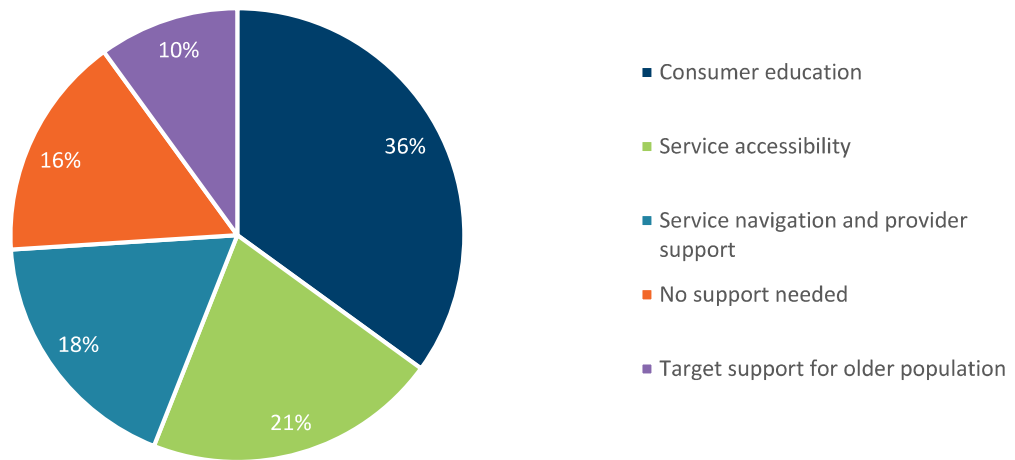
Service Navigation refers to the process of identifying appropriate health and support services available within Wollondilly through education and guided support. Furthermore, assisting with service entry requirements.

Table 16: Key themes from consultations with health professionals and service providers on opportunities to support health service navigation

Identified theme	Key consultation outputs
Service awareness and collaboration	<p>Service providers are often unaware of how to connect or link to other services effectively and thus there is a strong need in building service awareness and facilitating collaboration in Wollondilly.</p> <p>Service providers must become more aware of the availability of other services to enhance collaboration and support.</p> <p>Creating targeted support for diverse, vulnerable, or disadvantaged groups through specific initiatives, such as youth services and community halls.</p> <p>Providers should strengthen connectedness among providers by actively building robust referral networks and service entry</p>

	requirements.
Consumer education	<p>Addressing access barriers for digitally excluded populations by developing strategies to distribute information via a range of channels e.g. radio, mail, community outreach.</p> <p>Increased focus on consumer education is needed.</p> <p>Patients lack awareness about the services they receive or are eligible for; they require support to navigate the healthcare system and improve their health literacy.</p>
Outreach services	<p>Utilise spaces such as churches and art galleries to deliver multiple services to the community.</p> <p>Establish mobile services providing hot meals, washing machines, free health checks, and safe spaces for discussion.</p> <p>Service NSW buses should be deployed to enhance access to essential services like Centrelink in remote areas.</p> <p>Broaden the scope of outreach services, as they are currently limited in the region.</p>
Provider education and training	<p>Providers require training on key topics such as domestic violence (DV), mental health, aged care, family support, and assistance for culturally and linguistically diverse (CALD) and First Nations communities.</p> <p>Providers need a clearer understanding of their responsibilities when working with complex patients and must improve their knowledge of eligibility criteria.</p> <p>Providers should be educated on what makes other services eligible for referrals to ensure a smoother referral process.</p> <p>Raise the profile of currently available services while ensuring they have the capacity to handle increased demand.</p>
Address service barriers	<p>Better transport options for accessing initiatives e.g. Men's sheds and for older populations to access their health care appointments</p> <p>Road improvements are necessary to facilitate providers travelling to Wollondilly.</p> <p>Building trust among local services is crucial, as many individuals tend to seek care in Campbelltown, which is further away.</p>
Increased funding	<p>Advocate for government funding that targets the specific needs of the community.</p> <p>Collaborate with non-for-profit organisations (NFPs) to secure additional resources and support for local initiatives.</p>

Figure H: Consumer survey responses on health service navigation improvements



Note: 'No support needed' refers to patients reporting that healthcare professionals have provided the necessary information, with no indication of needing further assistance. For instance, services like pharmacists (Priceline), and GPs have offered sufficient guidance, and patients have also found it easy to access information online, such as through Google.

Appendices

Appendix A: Community survey participant demographic data

Table 1: Wollondilly Shire, 2021 demographic indicators

2021 profile.id data	Appin-Cataract-Darkes Forest	Bargo-Yanderra-Pheasants Nest	Buxton-Couridjah	Camden Park-Mount Hunter-Cawdor	Douglas Park-Wilton	Menangle-Razorbac	Oakdale-Nattai-National Park	Orangeville-Theresa Park-Werombi	Picton-Mowbray Park-Maldon	Tahmoor	The Oaks-Belimba Park-Glenmore	Thirlmere-Lakestead	Wallacia - Warragamba-Silverdale
Total pop.	3,229	5,947	2,248	3,254	5,146	2,419	2,118	3,278	5,387	5,766	3,663	5,469	6,009
Pop density (person per square km)	16.7	75.9	196.2	50.8	37.8	30.1	1.3	32.2	101.6	339.5	74.4	51.3	92.8
Age overview													
Median age	33	40	34	39	35	48	36	40	39	34	37	39	34
Housing overview (the following is based on enumerated data)													
Average household size (people/hh)	3.2	3.84	2.92	3.25	3.19	2.91	2.87	3.36	2.78	2.74	3.06	2.67	3.06
Couple families with children	49.6%	36.1%	39.9%	52.4%	51.3%	38.4	37.9	48.1	38	33.4	46.1	32.4	46.2
One parent families with	11.8%	10.9%	11.5%	8%	7%	3.9%	9.5%	6%	10.1%	15.8%	9.5%	10.8%	9.5%

disability																				
Live with long term health condition	28.4%	36.1%	33.2%	28.6%	28.4%	31.5%	30.4%	28%	33.9%	36.8%	31.4%	35%	31.1%							

Figure A: Community survey, question 3, age

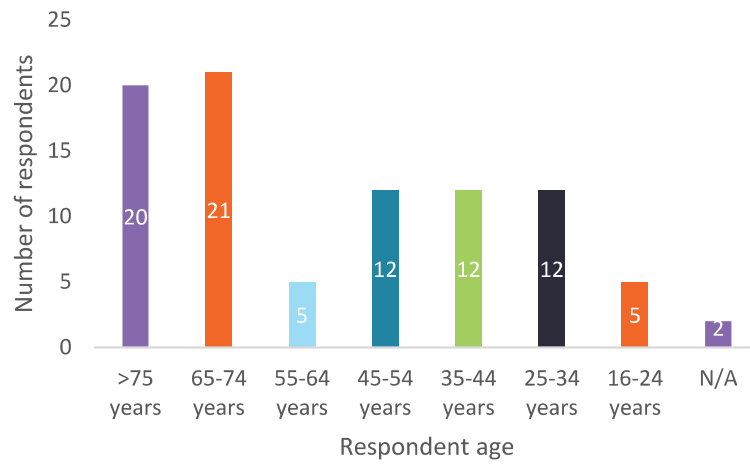


Figure B: Community survey, question 4, gender

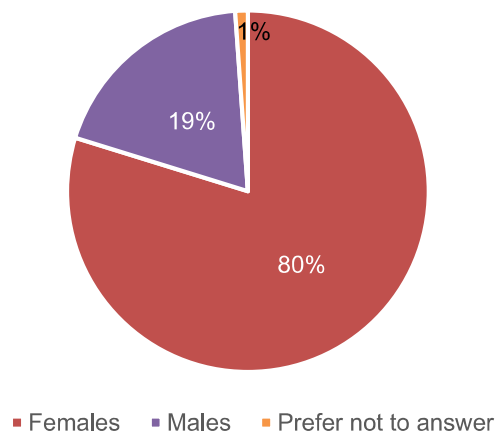
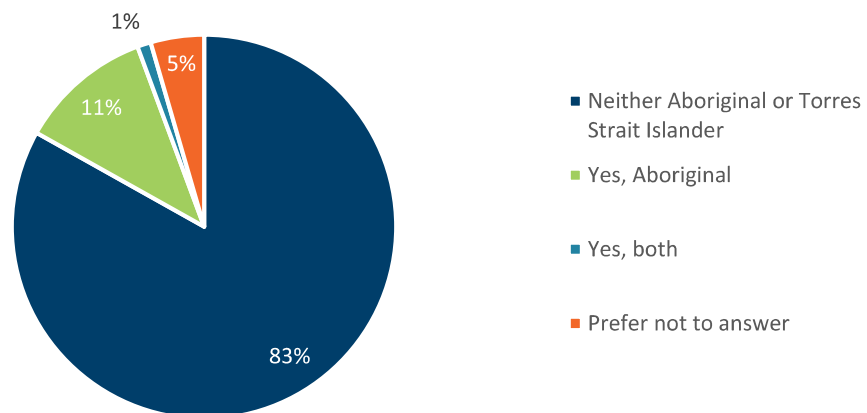


Figure C: Community survey, question 5, Indigenous Status



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The Executive Members of the Wollondilly Health & Planning Alliance formally endorse this document for publication and distribution to stakeholders and the broader community.


Signed on behalf of the South Western Sydney Local Health District by:

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Signed on behalf of the Wollondilly Shire Council by:

Signature of delegate	Name of delegate	Position
	BEN TAYLOR	CEO

Signed on behalf of the South Western Sydney Primary Health Network by:

Signature of delegate	Name of delegate	Position
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