

# Sydney South West Area Health Service

## Aged Care & Rehabilitation Clinical Services Plan 2007 – 2012



**Front cover photographs:**

Thanks are extended to current and past clients, carers and staff of SSWAHS Aged Care and Rehabilitation Services, and other services, who gave permission for these pictures to be used on the front cover.

**First Row (left to right):** John Layton, Harley Davidson and Ernest Metcalfe (Picture 1); Ruth Nangle and Bertha Whatman (Picture 2); Paul Pilellis (Picture 3); Merren Kelly and Monica Medina (Picture 4); and Brian and Yvonne Gleeson (Picture 5).

**Second Row (left to right):** Vicky and Lazaros Kafcaloudis (Picture 1); Ronald Breach (Picture 2); Linda Karp (Picture 3); and a group including Ronald Breach, Bertha Whatman, Ruth Nangle, May Garner, Brian Garner, Alf Channell, Frank Gronow, and Janet Margin (Picture 4).

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**ISBN No:** 978 1 74079 092 5

**Date:** 2008

**HEALTH SERVICE PLANNING REPORT NO:** 2008/01

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## TABLE OF CONTENTS

<b>CHIEF EXECUTIVE'S MESSAGE</b> .....	<b>1</b>
<b>EXECUTIVE SUMMARY</b> .....	<b>3</b>
<b>1. INTRODUCTION</b> .....	<b>10</b>
1.1 THE STRUCTURE OF AGED CARE AND REHABILITATION SERVICES IN SSWAHS .....	11
1.2 SCOPE OF THE AGED CARE AND REHABILITATION CLINICAL SERVICE PLAN .....	11
1.3 PRINCIPLES GUIDING THE AGED CARE & REHABILITATION CLINICAL SERVICE PLAN .....	11
1.4 THE PLANNING PROCESS .....	12
<b>2. POLICY CONTEXT</b> .....	<b>14</b>
2.1 NATIONAL POLICY CONTEXT .....	14
2.2 NEW SOUTH WALES POLICY CONTEXT .....	14
2.3 SSWAHS POLICY CONTEXT .....	17
<b>3. THE POPULATION OF SSWAHS</b> .....	<b>20</b>
<b>4. TARGET GROUPS – INCIDENCE AND PREVALANCE</b> .....	<b>24</b>
4.1 THE AGED CARE CLIENT .....	24
4.2 THE REHABILITATION CLIENT .....	27
4.3 CARERS .....	29
<b>5. SERVICE DELIVERY MODEL</b> .....	<b>30</b>
5.1 CORE SERVICES .....	31
5.2 SUPRA-REGIONAL SERVICES .....	33
5.3 PARTNERSHIP/ASSOCIATED SERVICES .....	33
5.4 UNDERSTANDING AND INTERPRETING THE AC&RS DELIVERY MODEL .....	33
<b>6. CORE SERVICES</b> .....	<b>34</b>
6.1 COMMUNITY AND NON-INPATIENT SERVICES .....	34
6.2 INPATIENT SERVICES .....	49
<b>7. SUPRA-REGIONAL SERVICES</b> .....	<b>58</b>
7.1 LIVERPOOL BRAIN INJURY REHABILITATION UNIT (TRAUMATIC AND NON-TRAUMATIC) .....	58
7.2 BURNS REHABILITATION .....	59
7.3 NON-TRAUMATIC SPINAL CORD INJURY REHABILITATION .....	60
<b>8. PARTNERSHIP AND ASSOCIATED SERVICES</b> .....	<b>61</b>
8.1 HEALTH PROMOTION .....	61
8.2 MENTAL HEALTH .....	61
8.3 OTHER SUBSPECIALTY MEDICINE AND SURGERY .....	63
8.4 ALLIED HEALTH .....	63
8.5 COMMUNITY HEALTH .....	65
8.6 PALLIATIVE CARE .....	65
8.7 BIOMEDICAL ENGINEERING .....	66
8.8 PROGRAM OF APPLIANCES FOR DISABLED PEOPLE .....	66
8.9 CARER SUPPORT SERVICES .....	66
8.10 VENTILATOR DEPENDANT QUADRIPLEGIA PROGRAM INCLUDING CHILDREN'S HOME VENTILATION PROGRAM .....	67
8.11 GENERAL PRACTITIONERS .....	67
8.12 RESIDENTIAL AGED CARE .....	69
8.13 COMMUNITY CARE PROVIDERS .....	70
8.14 ABORIGINAL HEALTH SERVICES .....	71
8.15 INTERPRETER SERVICES AND MULTICULTURAL SERVICES .....	71
<b>9. INFRASTRUCTURE AND SUPPORT REQUIREMENTS</b> .....	<b>72</b>
9.1 PHYSICAL INFRASTRUCTURE .....	72
9.2 INFORMATION TECHNOLOGY AND TELEHEALTH .....	73

9.3	DATA MANAGEMENT -----	73
9.4	ACCESS TO MOTOR VEHICLES, PATIENT TRANSPORT AND AFFORDABLE/ACCESSIBLE PARKING -- -----	74
9.5	GOVERNANCE -----	74
9.6	WORKFORCE -----	74
9.7	RESEARCH AND EDUCATION-----	76
<b>10.</b>	<b>IMPLEMENTATION, MONITORING AND EVALUATION -----</b>	<b>78</b>
	<b>ACTION PLAN -----</b>	<b>79</b>
	<b>LIST OF ABBREVIATIONS -----</b>	<b>91</b>
	<b>REFERENCE LIST -----</b>	<b>93</b>
	<b>APPENDIX 1 PRINCIPLES, FRAMEWORK FOR THE INTEGRATED SUPPORT AND MANAGEMENT OF OLDER PEOPLE IN THE NSW HEALTH CARE SYSTEM 2004 – 2006-----</b>	<b>95</b>
	<b>APPENDIX 2 CONTRIBUTORS TO THIS PLANNING PROCESS-----</b>	<b>96</b>
	<b>APPENDIX 3 THE WAY FORWARD – PROGRESS-----</b>	<b>98</b>
	<b>APPENDIX 4 DISTRIBUTION OF AGED CARE &amp; REHABILITATION SERVICES IN ACUTE AND COMMUNITY SETTINGS, SSWAHS-----</b>	<b>99</b>
	<b>APPENDIX 5 DISTRIBUTION OF RESIDENTIAL CARE AND RESIDENTIAL TYPE CARE IN SSWAHS-----</b>	<b>102</b>
	<b>APPENDIX 6 BRIEFING PAPER: AGED CARE WORKFORCE ISSUES 9 (CLINICAL REDESIGN) -----</b>	<b>103</b>

## CHIEF EXECUTIVE'S MESSAGE

The demands on our health care system are increasing. Over the next ten years it is expected that the population in Sydney South West will grow to 1.52 million people. At the same time, the number of older people will increase, with almost 200,000 people aged over 65 years and approximately 25,000 people over 85 years by 2016. The number of people with disabilities will also increase with the ageing of the population.

Most people will remain healthy and active throughout their lives. However, some people particularly as they age, will find it increasingly difficult to manage due to chronic or persistent health problems, an injury or a disability, or a combination of these. At that stage, they will require additional health care, and may require admission to hospital due to acute or chronic health problems. They will also find it difficult to manage at home, requiring additional assistance, care and support. Although this support will be provided by community services, relatives, friends or neighbours may also need to take on an additional role of carer. These are the clientele of SSWAHS Aged Care and Rehabilitation Services.

It is important that there is a service such as the SSWAHS Aged Care and Rehabilitation Services which can work with all parts of the health and community care system, and support and care for people with complex needs at this vulnerable time and into the future. It is also essential that there is a service that can reach people where ever they need help - in hospital, at home, or in a residential care setting.

The environment in which SSWAHS Aged Care and Rehabilitation Services and related health services operate is complex. There are a large and growing number of health and community services which can help those with greater frailty or disability, funded through different government departments and programs. The cultural and linguistic diversity of the Sydney South West community adds another dimension to this complexity. SSWAHS services and staff need to be flexible in how and where they deliver their services, knowledgeable about the services available, respectful in how they work with clients and their carers, and adaptable in addressing and coordinating care, so that clients and their families have their needs appropriately met.

The SSWAHS Aged Care and Rehabilitation Clinical Services Plan provides direction for health services to maintain the quality of life of older people with complex needs and people requiring rehabilitation, for the period 2007 - 2012 and beyond. The recommendations are based on extensive consultation, analysis of evidence based practice, and interpretation of the available data. The Plan is consistent with NSW Health's vision of delivering high quality services responsive to the needs of health consumers and the community.

This Plan provides an appropriate balance of structure, foresight, vision and compassion, for the challenges ahead. I would like to thank the staff and service providers who have been involved in its development, many of whom will continue to work with and support clients and their carers in addressing complex health and support needs.



Mike Wallace  
**Chief Executive**



## **EXECUTIVE SUMMARY**

### **Background to the Plan**

The Sydney South West Area Health Service (SSWAHS) Aged Care and Rehabilitation Clinical Services Plan provides direction for the development of Aged Care and Rehabilitation Services (AC&RS) across Sydney South West in the period 2007 – 2012, with a broader view to 2016.

The Plan has been developed to ensure SSWAHS is able to comply with the policies guiding the delivery of AC&RS at a national and state level, meet the growing demand for AC&RS, and provide an equitable and accessible service system across the Area. A set of principles has been described which outline the basis for this Plan and the future delivery of AC&RS across SSWAHS.

Plan development was overseen by a small steering committee comprising senior AC&RS managers and clinicians. Commencing early 2005, various consultative and participation opportunities have been arranged for clinicians and community members across SSWAHS (Refer Appendix 2).

### **The Target Groups**

The population of Sydney South West, along with that of most developed countries, is rapidly ageing. In 2001, approximately 10.6% of the population were aged over 65 years and approximately 1% aged over 85 years. By 2016, the population over 65 years is projected to rise to almost 13% and the population aged over 85 years to almost 2%. Although these percentages appear small, projections indicate that there will be approximately 200,000 people over the age of 65 years in Sydney South West by 2016. People in this age group are the highest users of health, particularly hospital, services and will place extensive demands on all services over time, particularly if current health service utilisation patterns continue.

The Aged Care component of this Plan does not address the health needs of all older people, but has focussed rather on those who specifically require aged care services. This is based on the premise that older people with a single system disease are best treated by that sub-specialty, and do not require a comprehensive multi-disciplinary approach to treatment. Aged care clients are defined in this Plan as those with either an acute or chronic illness, who have particular physical or mental disabilities, issues with care, accommodation and support, or with multiple medical or polypharmacy problems. Particular attention is given to people with dementia and people who have experienced falls or are at risk of falling.

The Rehabilitation component focuses on adult rehabilitation only, giving particular attention to the needs of people who have had a stroke, have a chronic disease, an intellectual disability, brain injury, spinal cord injury or severe burns. Clients of the Rehabilitation Service have unique physical or mental disabilities and are also often in need of assistance with care, accommodation and/or support. Services for people with disabilities are also being addressed through the SSWAHS Disability Plan.

Given that both Aged Care and Rehabilitation clients usually have a strong reliance on carers, the needs of carers are also considered. Carers' needs are considered in greater detail in the SSWAHS Carers Action Plan.

### **The Aged Care and Rehabilitation Service System**

The AC&RS system is complex from both a service design and delivery perspective, with funding and guidance for the delivery of programs coming from multiple sources at an Australian and State government level, as well as direct from the Area and through other partnership arrangements. The system includes a range of health promotion initiatives (particularly focused on injury prevention), through to early intervention and diagnosis, community care, acute care and residential care. A range of providers operate within the system including public services, non-government organisations and private providers, such as General Practitioners. Both generalist and specialist services are provided in inpatient, outpatient, community and home based settings.

Within SSWAHS, inpatient AC&RS are provided at Royal Prince Alfred Hospital (RPAH), Balmain, Concord Repatriation General Hospital (CRGH), Canterbury, Bankstown/Lidcombe, Liverpool,

Fairfield, Braeside and Camden Hospitals. Outpatient, community based and home based services are provided differently across the Area, subject to a range of local factors. The complexity of the service system highlights the need for excellent communication and cooperation across all providers, to ensure integrated service delivery for the client and family.

### **The Aged Care and Rehabilitation Service Delivery Model**

The service delivery model for AC&RS incorporates three key aspects:

- **Core Services** – services provided to targeted clients which need to be available consistently and equitably across SSWAHS. Core services are available along the continuum of care and are categorised as being either community/non-inpatient or inpatient services. Some of these services (generally in the community) are externally funded whilst others (generally in the inpatient setting) are funded by the Area Health Service.
- **Supra-regional services** – specialised services catering for a small number of people with specific health needs. Such specialised services are to be concentrated on one site to facilitate access to specialist expertise and equipment;
- **Partnership/Associated Services** – services which provide extensive assistance to AC&RS clients and/or are operated cooperatively between AC&RS and other clinical services. This includes services provided by the non-government sector, such as community and residential care.

#### Core AC&RS

Core AC&RS have demonstrated effectiveness in responding to the needs of clients in community/non-inpatient settings and hospital settings. Many of these services are externally funded, and should this funding cease, their role in the AC&RS service delivery system would require review.

Without a set of core services being consistently and equitably available across SSWAHS, difficulty will be experienced in adequately responding to the increasing demand projected as a result of the Area's rapidly growing and ageing population. Many initiatives are now being implemented to streamline services and improve effectiveness and efficiency, and will assist in meeting demand. However, they will be insufficient to respond to the anticipated demand without genuine AC&R service expansion. Refer to Section 6 and the recommendations below.

#### Supra-Regional Services

Supra regional services which form part of the AC&R service delivery system include the Liverpool Brain Injury Rehabilitation Unit (traumatic and non traumatic), Burns Rehabilitation and Non-Traumatic Spinal Cord Injury Rehabilitation. Given the scope of these services is beyond SSWAHS, planning needs to be undertaken in conjunction with a state-wide planning process, in which SSWAHS is an active participant. However, it is anticipated that demand for these services will continue to increase with population growth. Refer to Section 7 and the recommendations below.

#### Partnership/Associated Services

AC&RS clients and patients receive support and care from a wide range of partnership/associated services, without which the AC&R service delivery model could not comprehensively be provided. These services, and their links with aged care, are essential to the delivery of an effective and efficient Aged Care and Rehabilitation service system. Partnership/associated services described herein include other clinical streams of SSWAHS such as Area Mental Health Services and Allied Health Services, as well as external partners such as general practitioners, residential aged care facilities and community care providers. Refer to Section 8 and the recommendations below.

### **Infrastructure and Support Requirements**

Given the complex funding and service delivery environment in which AC&RS operate, and the frailty and functional restrictions of many clients, AC&RS have particular infrastructure and support requirements. These relate to the physical infrastructure of inpatient and community services, and supporting infrastructure such as motor vehicles, IT systems, workforce, research and education.

Increased capacity of infrastructure and support requirements will be necessary as clinical services expand to meet the needs of the growing population of older people and people with disabilities across the Area. Without this expanded capacity, AC&RS will not operate at optimum efficiency.

## Recommendations

The recommendations following are based on extensive consultation, analysis of evidence based practice, and interpretation of the available data. They relate closely to the national, state and local policy context in which AC&RS operate, including the State Plan, the State Health Plan, the SSWAHS Strategic Plan *A New Direction for Sydney South West Health Towards 2010*, the *Framework for the Integrated Support and Management of Older People in the NSW Health System* and the *SSWAHS Older Persons and Aged Care Services Clinical Redesign Project*.

The recommendations have been designed to deliver the AC&R service delivery model across SSWAHS by 2012. Further planning will be required to respond to the demands of population growth and ageing beyond this timeframe.

Rationale	Recommendation
<b>Centralised Intake</b>	
Centralised intake provides a single point of contact for AC&RS. This model has been demonstrated to improve access to the range of services, improve customer satisfaction, and the quality and consistency of referral information collected, reduce inappropriate referrals, and enhance service effectiveness and efficiency.	1. Expand the centralised community intake model across the Area through the Older Persons and Aged Care Services Clinical Redesign Project
<b>Aged Care Assessment Team (ACAT)</b>	
ACAT are jointly funded by the Australian Government and SSWAHS. The primary role of ACAT is to assess people to determine their eligibility to receive residential level care. As the population ages, demand for this service is increasing, in both the community and inpatient setting.	2. As funding permits, expand the accessibility of ACAT services in hospitals and community settings, including the development of an Area-wide rapid response capacity
<b>Emergency Department Aged Care Services</b>	
SSWAHS operates aged care services emergency teams to respond to the unique needs of older people in Emergency Departments (EDs). Across NSW new models are being trialled to determine their effectiveness and efficiency. Aged Services Emergency Team (ASET) in SSWAHS have improved ED responsiveness to older clients and diverted admissions. However the service is generally only available during core business hours and is not available at all sites. Projections indicate a significant increase in ED presentations in the older age cohorts over the next few years.	3. Expand existing ASET services to cover extended hours according to demand.
	4. Review existing and develop new models for the care of older people presenting to Emergency Departments.
<b>Outpatient Clinics – Geriatrics and Rehabilitation</b>	
Outpatient clinics are available to varying degrees across SSWAHS, subject to resource availability. As hospital avoidance strategies and post-acute care services become more widely available, there will be an increased demand for outpatient clinic services, of both a generalist and specialist nature.	5. Outpatient geriatrics clinics are established at Camden and Bowral Hospitals by 2010 and all outpatient clinics are expanded across the Area in line with population growth and ageing
<b>Day Hospitals and Outpatient Therapy Services</b>	
Day Hospitals and outpatient therapy services provide alternatives to inpatient care, using a comprehensive and multidisciplinary model. These services provide opportunities to avoid hospital admissions and to provide intensive post-acute care, whilst maintaining or improving functioning and independence. There is limited availability of these services in SSWAHS at present.	6. Day Hospital and outpatient therapy services across SSWAHS are expanded at appropriate sites, in line with population growth and ageing
<b>Home Based Therapy</b>	
Some AC&RS clients would benefit most from the delivery of targeted therapy services in the home. A reduced length of stay in hospital would be expected if home based therapy services were available to people with mobility restrictions. Functional gains will also be made within the most relevant environment.	7. Home based therapy services are reviewed across the Area, in association with the proposed review of HACC services, to develop a consistent model of care and to inform future service planning and funding applications

Rationale	Recommendation
As improvements in functioning occur, recipients can be transferred to alternative services.	
<b>ComPacks</b>	
ComPacks provides short term, low level, post acute support to patients discharged from acute care hospitals. The availability of ComPacks has been shown to reduce length of stay.	8. As funding permits, expand ComPacks services across the Area, consistent with population growth and demand
<b>Transitional Aged Care Program</b>	
The Transitional Aged Care Program (TACP) is jointly funded by the Australian and NSW Governments to June 2008, pending evaluation. It provides short term, post acute support and therapy to facilitate functional improvement and reduce or delay residential placement. It facilitates timely discharge of patients who are medically stable, but require a coordinated program of services for a short term to regain independence.	9. Monitor Transitional Aged Care Program activity to determine the most appropriate client mix and service structures for ongoing program management
<b>Community Dementia Teams</b>	
Community Dementia Teams is a new model which has been proposed to assist the Area to respond better to the increasing incidence and prevalence of dementia associated with population ageing. The teams will address early, the health and behavioural needs of people with dementia and their carers, with a view to providing sustained support and reducing avoidable hospital admissions/reducing lengths of stay.	10. Pilot two Community Dementia Teams in SSWAHS (at Concord and Liverpool) staffed by Registered Nurses and Clinical Psychologists, linked with ACAT and the Specialist Mental Health Service for Older People
<b>Centre Based Day Care</b>	
Centre Based Day Care (CBDC) provides low level support for older people and respite for carers. This type of service is now predominantly funded through the HACC program and largely provided by the non-government sector in NSW. There is a need for SSWAHS to review how CBDC services are provided across the Area and to develop a focus on providing specialised rather than generalist services.	11. Undertake a comprehensive review of Centre Based Day Care in SSWAHS, including governance, operations, funding, staffing, policies, procedures, client mix, opportunities for expansion and clinical service delivery
<b>Dementia Advisory Services</b>	
Dementia Advisory Services (DAS) play a key role in supporting people with dementia and their carers through both direct support and service development. This complementary service is funded by DADHC.	12. Seek additional HACC funding through DADHC to extend the capacity of the existing Dementia Advisory Services and their capacity to service culturally diverse communities
<b>Respite and Support Services</b>	
Funding for the range of respite and support services provided by SSWAHS is usually not recurrent, but based on short/medium term agreements. The ancillary nature of these services and the lack of comprehensive availability across SSWAHS, raise questions about the role of SSWAHS in the provision of these services.	13. Review the role of SSWAHS in the provision of externally funded respite and support services
<b>Inpatient Beds – Acute and Sub-Acute Aged Care and Rehabilitation</b>	
Demand for AC&RS inpatient beds, both acute and sub acute, will increase in response to population growth and ageing. In particular the increasing prevalence of dementia (and associated long lengths of stay) and the impact of falls will be considerable. Additional inpatient capacity is required to respond to this demand.	<p>14. As funding permits, expand the bed capacity of AC&amp;RS through the creation of additional units and/or the colocation of outlier patients to improve inpatient management</p> <p>15. Review issues associated with after hours medical coverage at sub-acute/stand alone facilities to determine appropriate service and staffing models</p> <p>16. Investigate the feasibility of developing specialist inpatient bed capacity, such as transitional living units and specialist units for younger people with a disability</p>

Rationale	Recommendation
<b>Aged Care Inpatient Consultation</b>	
Not all older patients need to be, or will be able to be, under the care of AC&RS. However, to ensure the multidimensional needs of the target group are met, additional capacity to provide aged care inpatient consultation is required.	17. Develop the capacity of aged care inpatient consultation services, consistent with population growth and ageing, whilst strengthening the capacity of non-AC&RS wards to respond to the needs of older people, people with a disability and their carers
<b>Rehabilitation Inpatient Consultation Service</b>	
Given the increasing prevalence of disability associated with an ageing population, there will be an increased demand for rehabilitation inpatient consultation services. Early delivery of these services enhances the patient's recovery and can assist in reducing length of stay.	18. Expand the capacity of inpatient rehabilitation consultation services consistent with population growth and ageing
<b>Dementia and Gerontology Clinical Nurse Consultants (CNCs)</b>	
Dementia is increasing in prevalence with the ageing of the population. Delirium is also highly prevalent in hospitalised older people. Gerontology/Dementia CNCs will improve the responsiveness of facilities to the needs of people with dementia and their carers in hospital, potentially decreasing length of stay.	19. Expand the availability of Dementia and/or Gerontology CNC positions, ensuring a presence in each facility to support inpatient management of people with dementia and/or delirium
<b>Brain Injury Rehabilitation</b>	
Brain Injury Rehabilitation is a state-wide service provided at Liverpool Hospital. The service caters for people with a traumatic brain injury; and has limited capacity to respond to increasing demands for tertiary services for people with a non-traumatic brain injury.	20. Consistent with state-wide planning for brain injury, develop an additional 10 beds to expand the existing Liverpool Brain Injury Rehabilitation Unit, and to facilitate provision of services for targeted people with a non-traumatic brain injury, supported by outpatient and community support services, as part of the Liverpool Hospital Stage 2 redevelopment
<b>Burns Rehabilitation</b>	
Concord Hospital operates a state-wide acute burns service. Development of specialist burns injury rehabilitation capabilities would enhance this service and facilitate alternatives to inpatient care and an associated reduced length of stay in the acute unit.	21. Contingent on the outcomes of the state-wide planning for Burns Services, establish a four bed Burns Step Down Unit at CRGH in the style of a transitional living unit, supported by non-inpatient services
<b>Non-Traumatic Spinal Cord Injury Rehabilitation</b>	
There is increasing demand for rehabilitation services for people with a non-traumatic spinal cord injury, particularly associated with the ageing of the population. Local delivery of these services would support patients and carers and enhance the specialist capacity of rehabilitation services in SSWAHS.	22. Subject to the outcomes of state-wide planning for Spinal Cord Injury Services, investigate the development of a 14 bed non-traumatic spinal cord injury/post-acute injury rehabilitation unit within SSWAHS, supported by outpatient and non-inpatient therapy services
<b>Partnership/Associated Services</b>	
Partnership/associated services are integral to the provision of a comprehensive care and support system to meet the needs of AC&RS clients. AC&RS and partner/associated services working collaboratively, will improve the service system, in relation to responsiveness, flexibility and capacity to meet ever increasing demand. Services include: <ul style="list-style-type: none"> <li>– Health Promotion;</li> <li>– Mental Health;</li> <li>– Other Sub-specialty Medicine and Surgery eg. orthopaedics;</li> <li>– Allied Health;</li> <li>– Community Health;</li> <li>– Palliative Care;</li> <li>– Biomedical Engineering;</li> <li>– Program of Appliances for Disabled People;</li> <li>– Ventilator Dependent Quadriplegic Program;</li> <li>– General Practitioners;</li> </ul>	23. AC&RS participate in the implementation of the Falls Prevention and Management Program and other relevant Health Promotion initiatives 24. Establish collaborative processes to improve the coordination and integration of Aged Care and Specialist Mental Health Services for Older People, particularly in the management of people with behavioural and psychological symptoms of dementia 25. Implement a range of initiatives to improve the responsiveness of SSWAHS to the needs of older people, people with a disability and their carers 25. Further develop and implement collaborative systems for responding to the allied health needs of AC&RS clients and expand the availability of specialised allied health services across the Area 27. Improve the accessibility of AC&RS by delivering targeted services in Community Health Centres where possible 28. Develop improved systems for end of life care in inpatient and community/residential settings, including

Rationale	Recommendation
<ul style="list-style-type: none"> <li>– Residential Aged Care;</li> <li>– Community Care Providers;</li> <li>– Aboriginal Health Services; and</li> <li>– Interpreter Services and Multicultural Services.</li> </ul>	<p>through Advanced Care Directives initiatives</p> <p>29. As funding permits, expand the existing Biomedical Engineering service to develop a specialist rehabilitation role</p> <p>30. Participate in implementing recommendations of the NSW Health PADP Review</p> <p>31. Improve and expand carer support services, consistent with the NSW Carers Action Plan</p> <p>32. Review management arrangements of Ventilator Dependent Quadriplegia and Children's Home Ventilation Programs within SSWAHS</p> <p>33. Expand the range of services and supports offered in partnership with General Practice, to improve early intervention and reduce avoidable hospital admissions</p> <p>34. Expand the range of services and support offered in partnership with Residential Aged Care Facilities, to improve early intervention and reduce avoidable hospital admissions</p> <p>35. Expand the range of services and supports offered in partnership with community care providers, to improve early intervention and reduce avoidable hospital admissions</p> <p>36. Implement actions in the SSWAHS Aboriginal Health Plan which focus on Aboriginal people who are older or who have disabilities, and their carers</p> <p>37. Continue to develop systems and staff skills to ensure a culturally competent and appropriate service</p>
<b>Infrastructure and Support Requirements</b>	
<p>Infrastructure and support requirements for the development of AC&amp;RS to meet the projected increase in demand to 2012 and beyond include:</p> <ul style="list-style-type: none"> <li>– Physical infrastructure;</li> <li>– Information technology and Telehealth;</li> <li>– Data management;</li> <li>– Patient transport services and affordable, accessible parking;</li> <li>– Governance;</li> <li>– Workforce; and</li> <li>– Research and Education</li> </ul>	<p>38. Develop/redevelop physical infrastructure in AC&amp;RS consistent with guidelines and take into account the unique needs and circumstances of clients eg. people with dementia/delirium</p> <p>39. Upgrade IT systems across SSWAHS, to facilitate service integration and improved performance monitoring, and enable the expansion of Telehealth initiatives to facilitate communication across sites and reduce avoidable hospital admissions</p> <p>40. Develop improved data and performance management systems, including analysis, across AC&amp;RS, through the establishment of standardised processes and infrastructure</p> <p>41. Increase access for AC&amp;RS to appropriate transport services, including patient transport, accessible parking and fleet vehicles, to enable the delivery of centre and community based services</p> <p>42. Implement the recommendations from the SSWAHS Review of Clinical Streams 2007</p> <p>43. Strengthen the capacity of the SSWAHS workforce to respond to the needs of AC&amp;RS clients; in particular through the recruitment and retention of Advanced Trainees and other staff with specialist qualifications in aged care and/or rehabilitation</p> <p>44. Work with the Director Workforce Planning and Development to incorporate the needs of AC&amp;RS into the broader workforce planning initiatives within SSWAHS</p> <p>45. Develop a compendium document which focuses on workforce projections and infrastructure</p> <p>46. Strengthen the capacity of SSWAHS to undertake research and education in aged care and rehabilitation</p>

### **Implementation of the Plan**

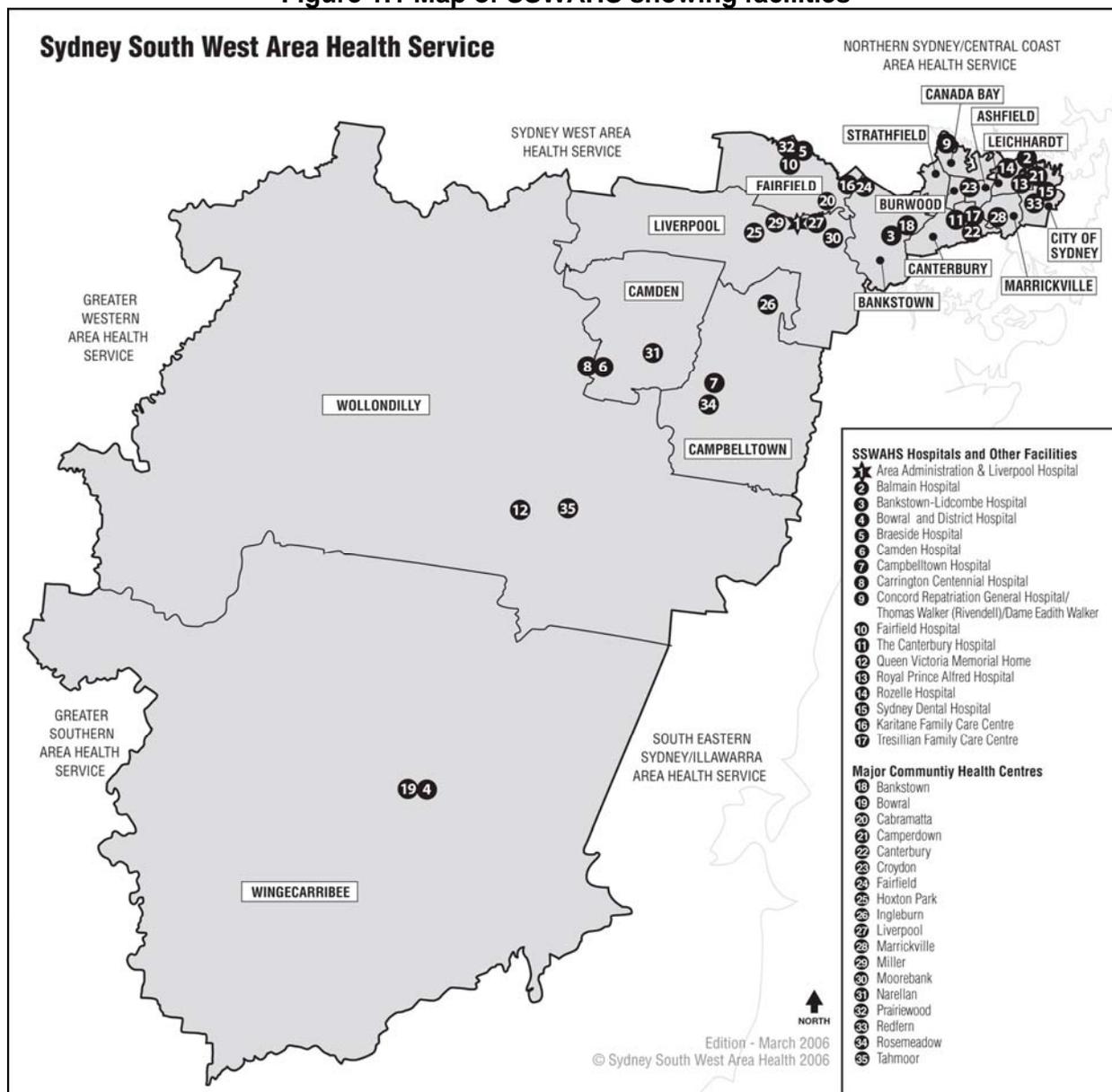
The Plan will be implemented flexibly in response to funding and service delivery opportunities. Processes such as the *Older Persons and Aged Care Health Services Clinical Redesign Project* and reviews of external funding may impact on the direction proposed. As such, this Plan should be considered a living document, subject to regular monitoring and review.

Implementation of the Plan will be monitored by the SSWAHS AC&RS executive, including the Older Persons and Aged Care Health Services Clinical Redesign Project Implementation Management Group. Reporting on progress will be undertaken on a six monthly basis, with progress reported to the SSWAHS Executive through the Director of Clinical Operations. The Plan will be comprehensively reviewed after five years.

## 1. INTRODUCTION

Sydney South West Area Health Service (SSWAHS) was established in January 2005 following the amalgamation of the former Central Sydney Area Health Service (CSAHS) which is in Sydney's Inner West, and is also known as the Eastern Zone (EZ), and the former South Western Sydney Area Health Service (SWSAHS) which is part of Sydney's south west, and is also known as the Western Zone (WZ). A map of SSWAHS is provided as Figure 1.1.

**Figure 1.1 Map of SSWAHS showing facilities**



The SSWAHS area comprises 15 Local Government Areas (LGAs) and covers a geographic area of 6,380km<sup>2</sup>. The eastern part of SSWAHS comprises the LGAs of City of Sydney (part), Leichhardt, Marrickville, Canterbury, Canada Bay, Ashfield, Burwood and Strathfield and is comparatively densely populated. By contrast, the south west, which accounts for over 95% of the geographic area of SSWAHS, comprises the LGAs of Bankstown, Fairfield, Liverpool, Campbelltown, Camden, Wollondilly and Wingecarribee. Settlement patterns in the south west are varied, including older centres, scattered rural townships, and new release areas.

The Aged Care and Rehabilitation Service (AC&RS) is a complex group of services provided in a range of settings including hospitals, community health centres, homes and residential aged care

facilities. Some services are provided on a consultative basis, whilst others are designated specifically as aged care or rehabilitation. Services provided in the full range of settings and to members of the identified target groups will be discussed in this Plan.

### **1.1 The Structure of Aged Care and Rehabilitation Services in SSWAHS**

Due to its history as two separate organisations, the AC&RS has operated under differing structures. In the eastern part of SSWAHS, AC&RS have been managed since 1993 through the General, Geriatric and Rehabilitation Medicine (GGRM) Clinical Stream with a single Area Director. In the south west of the SSWAHS, both Aged Care Services and Rehabilitation Services have been managed through the Complex Care and General Practice Stream, via an Area Director Aged Care and Area Director Rehabilitation. This structure has been in place only since late 2005 and considerable work is required to reorient the service away from its previously sectorised model.

With the development of clinical streams across SSWAHS, a single AC&RS clinical stream will be implemented in 2008. It is anticipated that AC&RS services will be grouped into three clusters: a Southern Cluster (Wingecarribee and Macarthur areas); Central Cluster (Liverpool, Fairfield and Bankstown areas); and Northern Cluster (Canterbury, Concord and Camperdown areas). An AC&RS organisational chart will be developed in 2008.

Further work has also been required to clarify the role of General Medicine across the south west, and relationships between AC&RS, Allied Health Services and Community Health Services.

Across SSWAHS, the Specialist Mental Health Service for Older People (SMHSOP) is to be jointly managed by AC&RS and the Area Mental Health Service. Further work is required to delineate roles and responsibilities across services, particularly in relation to the management of older people with complex co-morbidities and/or dementia with challenging behaviours.

### **1.2 Scope of the Aged Care and Rehabilitation Clinical Service Plan**

This Plan is focused on ensuring equity of access and outcomes for the elderly patient with multiple system medical, functional and psychosocial problems ie "the aged care client" and for all adults who require rehabilitation services. These target groups are defined in Section 4.

The Plan addresses in detail services managed by Aged Care and Rehabilitation Services. Partner services are identified and briefly discussed in the context of the overall aged care and rehabilitation service system, but this Plan does not project future needs for these services.

It identifies the service delivery model for AC&RS from 2007 and beyond. The model includes services across the continuum of inpatient, non-inpatient and community based services, including associated specialist services. The model recognises current clinical structures and service models, particularly in relation to the availability of general medicine, whilst also outlining a consistent approach for the future.

In respect to aged care, this Plan has used as its basis the NSW Health *Framework for Integrated Support and Management of Older People in the NSW Health Care System 2004-2006*. Rehabilitation is described in accordance with current guidelines produced by the Australasian Faculty of Rehabilitation Medicine (AFRM).

This Plan does not have a population health focus, with strategies to maintain and improve the health status of the well elderly addressed in other SSWAHS plans. In addition, the Plan focuses on people requiring multidisciplinary assessment and treatment, rather older patients with a single health problem or disease treated by other specialties.

Implementation of this Plan is dependent on factors including the external funding, policy environment and internal structures. As such, the Plan will be regularly monitored and reviewed to ensure it remains consistent with the operating environment of the services.

### **1.3 Principles Guiding the Aged Care & Rehabilitation Clinical Service Plan**

The provision of aged care and rehabilitation services in SSWAHS will be guided by a clear set of principles. These principles (following) are consistent with National and State policy.

### SSWAHS AGED CARE AND REHABILITATION SERVICE PRINCIPLES

- ❖ The majority of AC&RS clients can live independently within the community with varying degrees of support. AC&RS will support people in a variety of settings including hospitals, workplaces, community settings, or at home, in order to facilitate their independence.
- ❖ AC&RS clients and their families/carers have the right to choose what care and support they receive and who should be involved in the delivery of these services.
- ❖ Health treatment and care is respectful and recognizes the privacy of clients as well as their individual differences and specific needs, such as cultural, religious and sexual differences.
- ❖ AC&RS recognize that clients have complex needs. AC&RS will offer holistic treatment and support, recognizing that the needs of clients may not be solely related to their physical health, but also their social, emotional and economic circumstances.
- ❖ AC&RS clients and their families/carers are often long term clients of the service, who undergo many changes during their interaction with AC&RS. These changes occur in a variety of settings. Service consistency and reliability supports the patient journey through the lifespan and through individual episodes.
- ❖ AC&RS are based on strong evidence and have a focus on maintaining, improving and preventing deterioration in the health and quality of life of clients. Quality and safety is paramount to the delivery of all services.
- ❖ To enable smooth transition of clients between services provided by different organizations or in different settings, AC&RS health and support services will be well integrated and coordinated, with strong communication systems implemented to support clients and their families/carers.
- ❖ A range of hospital and community based AC&RS will be available locally to support local populations. These services will be delivered using a multidisciplinary model of comprehensive assessment and management and be easily accessible to the community and other care providers, with streamlined intake processes to reduce duplication of referral and assessment.
- ❖ Preventing hospital admission is a basic philosophy of AC&RS. However, inpatient services will continue to be available for clients who require specialist care in a hospital setting. Early discharge planning will occur to ensure that AC&RS patients are not hospitalized for unnecessary periods.
- ❖ AC&RS will work in partnership with clients and families/carers, other relevant clinical and support services in SSWAHS, and external stakeholders to improve services for clients.
- ❖ Information on AC&RS will be readily available through a variety of mediums to facilitate access to services and ongoing support.
- ❖ Carers are an integral component of the overall AC&RS system. Respect for all carers, along with specific services and supports for carers, is essential to the ongoing maintenance of AC&RS.

Source: Adapted from AHMAC 2004 and the Framework for the Integrated Support and Management of Older People in the NSW Health System. Original detail is contained in Appendix 1.

#### 1.4 The Planning Process

The process involved in the development of this Plan has been extensive, over a two year period 2005 – 2007. It commenced in early 2005, as part of the process of developing the draft SSWAHS Healthcare Services Plan. Planning involved workshops with clinicians, management and community representatives, to identify issues and develop the desired future model of care.

Considerable work has also been undertaken in the planning of AC&RS in the Liverpool Hospital Stage 2 redevelopment.

Since the initial development work was undertaken, consultation and development has continued to occur. This includes the preparation of SSWAHS Self-Assessment reports under the *Framework for*

*the Integrated Support and Management of Older People in the NSW Health System 2004 – 2006; and the Older Persons and Aged Care Services Clinical Redesign Project.*

Further development of demand management strategies consistent with NSW Health policy has occurred, including initiatives such as the Acute Care Triage and the Medical Acute Care Unit (MACU).

Overall development of this Plan has been overseen by a Steering Committee of Dr John Cullen, Clinical Director General, Geriatric and Rehabilitation Medicine (EZ), Dr David Conforti, Director Aged Care (WZ), Dr Friedbert Kohler, Director Rehabilitation (WZ), Ms Julie-Ann O’Keeffe, Senior Service Manager GGRM (EZ), Ms Debra Donnelly, Nurse Coordinator GGRM (EZ), and Ms Adele Lubiana, A/Service Development Manager Aged Care (WZ). Appendix 2 lists other contributors.

## 2. POLICY CONTEXT

The clinical complexity of aged care and rehabilitation services, combined with the cross-jurisdictional responsibility for funding, monitoring and provision of these services, results in a highly complex service environment which has multiple reporting layers.

Clarity and direction for this complex system is provided through a range of national, state-wide and local policies and strategies. The key policies and strategies which inform the delivery of AC&RS are discussed below. Various other initiatives such as Active Australia, have attempted to promote more healthy and active lifestyles to reduce the likelihood of chronic disease and other illnesses/injuries, particularly in older age groups. Success of these initiatives is difficult to quantify.

Following are policies and plans that establish a framework for AC&RS development and delivery.

### 2.1 National Policy Context

#### 2.1.1 *A New Strategy for Community Care – The Way Forward*

The Australian Government's program *A New Strategy for Community Care – The Way Forward* includes actions that will reshape and improve the community care system. The Australian Government has outlined its intention to develop an overarching framework within which all community care programs operate. The framework seeks to maintain flexibility while achieving consistency across community care programs, including the Home and Community Care (HACC) Program, in the following areas: Access; Eligibility; Assessment; Approach to determining consumer fees; Financial Reporting and Accountability; Information management; Co-ordinated Planning; and Standards and Quality Assurance. The three-phases of reform, research, development and implementation, will be complemented by actions to achieve consistency across community care programs.

#### 2.1.2 *National Framework for Action on Dementia 2006 – 2010*

The National Framework for Action on Dementia (NFAD) 2006 – 2010 (Australian Health Ministers Conference 2006) aims to improve the quality of life of people with dementia, and their carers and families. This vision will be achieved through work focussed around five priority areas. These are: care and support; access and equity; information and education; research; and workforce and training. Funding at both a national and state level is available to implement actions under each of these priority areas.

#### 2.1.3 *Standards for Rehabilitation Services in Public and Private Hospitals*

These standards, released in 2005, have been developed by the Australasian Faculty of Rehabilitation Medicine within the Royal Australasian College of Physicians (RACP). The document outlines standards in respect to leadership, staffing, facilities and equipment, policies and procedures, and quality management activities.

#### 2.1.4 *Commonwealth State and Territory Strategy on Healthy Ageing 2000*

This framework aims to foster identification of opportunities to maximise healthy ageing outcomes. Six principles underlie the strategy: support independence; encourage a good quality of life for Australians as they age; promote fairness and equity; recognise interdependence; recognise and respond to Australia's growing diversity; and encourage personal responsibility while providing support for those most in need. Areas for action are: community attitudes; health and well being; work and community participation; sustainable resourcing; inclusive communities; appropriate care and support; and research and information.

### 2.2 New South Wales Policy Context

#### 2.2.1 *NSW State Plan*

The NSW State Plan launched in November 2006 (NSW Premiers Department, 2006) outlines a clear direction for NSW and NSW Government services. Five areas of activity are identified: Rights, respect and responsibility; Delivering better services; Fairness and opportunity; Growing prosperity across NSW; and Environment for living. Within each area, a range of goals are identified.

In relation to Health, the Plan focuses on prevention, early intervention and community based care, linked with avoiding hospital admissions and delivering better services. Specific priorities focus on Aboriginal health, mental health and child abuse/neglect.

### **2.2.2 NSW State Health Plan: Towards 2010**

The NSW State Health Plan (NSW Department of Health, 2007) has been developed to be consistent with the NSW State Plan (described in Section 2.2.1), and to meet the needs identified through the 2006 Futures Planning exercise conducted by NSW Health.

The NSW State Health Plan identifies the vision for NSW Health as “Healthy People – Now and in the Future”. Four key goals underpin the achievement of this vision:

- To keep people healthy;
- To provide the health care that people need;
- To deliver high quality services; and
- To manage health services well

Seven strategic directions have been identified, as the basis for planning and service delivery across the NSW Health system. They are:

1. Make prevention everybody's business
2. Create better experiences for people using health services
3. Strengthen primary health and continuing care in the community
4. Build regional and other partnerships for health
5. Make smart choices about the costs and benefits of the health services
6. Build a sustainable health workforce
7. Be ready for new risks and opportunities

### **2.2.3 Two Ways Together: the NSW Aboriginal Affairs Plan 2003 -2012**

*Two Ways Together* (NSW Premier's Department 2005) aims to “positively improve the lives of Aboriginal people in 7 priority areas”. The first of these is health, along with education, economic development, justice, families and young people, culture and heritage, and housing and infrastructure. The philosophy of the Plan is based on the interrelationships between these priority areas and the flow on effects of positive outcomes.

Specific health issues addressed through *Two Ways Together* include: the health and wellbeing of Aboriginal mothers and children; otitis media and conductive hearing loss; injury, ill health and disease from substance misuse; and physical health. Environmental health is considered as it relates to the quality of living conditions.

### **2.2.4 Future Directions for Dementia Care and Support in NSW 2001 – 2006**

This Plan focuses on building structures to maintain the dignity and enhance the quality of life of people living with dementia in NSW (NSW Department of Ageing, Disability and Home Care, 2002). The principles guiding the Plan are: a focus on the individual, recognising carers as central, responding to diversity, facilitating early intervention, adopting a public health approach, developing partnerships, and influencing the policy and funding environments. To achieve this objective, actions around 7 focus areas have been proposed. These focus areas are: policy and planning; supportive and inclusive communities; diagnosis, assessment and management; education and training; community support services; acute care; accommodation options; and protection of rights and interests.

A third dementia plan for NSW has been developed in line with the NFAD ( Section 2.1.2).

### **2.2.5 NSW Framework for the Integrated Support and Management of Older People in the NSW Health Care System (The Framework)**

The “*Framework*” was developed by NSW Health to assist Area Health Services to “re-engineer the system to better manage the needs of older people” (NSW Department of Health 2004a). It provides guidance on the key components in providing integrated care.

*The Framework* has identified five pressure points on the existing system, being the management of older people in emergency departments, discharge planning and post-acute care, management of cognitively impaired older people, increasing demand for community based assessments and services, and coordination of care.

Area Health Services report annually on progress towards achieving the targets of *the Framework*. The latest SSWAHS response to *the Framework*, developed in December 2006, identifies actions required to improve the care and support of older people in the health system, at each of the 'pressure points'. These are linked to the recommendations and actions in this Plan and in the Clinical Redesign Program (see Section 2.3.4).

### **2.2.6 Management Policy to Reduce Fall Injury Among Older People 2003-2007 (Falls Prevention Policy)**

The Falls Prevention Policy aims to "actively reduce the burden of fall injury across the community" (NSW Department of Health, 2003a, p4). It has three core components: generating a low risk population; preventing injury in people from high-risk groups; and improving the effectiveness of health and other systems, including data collection.

NSW Health has funded SSWAHS to develop a Falls Prevention Plan (refer Section 2.3.5) to address these issues, building on significant work which has been undertaken locally. An Area Falls Prevention Coordinator has been appointed.

### **2.2.7 NSW Chronic Care Program**

The NSW Chronic Care Program is currently in its second three year phase. It aims to improve the quality of care and the quality/quantity of life for people with chronic and complex conditions and their families/carers and to reduce crisis situations and unplanned/avoidable admissions to hospitals. SSWAHS has received funding under this Stage 2 program to work more closely with General Practitioners (GPs) in managing chronic disease and to appoint medical, nursing and allied health staff in areas such as heart failure, palliative care, diabetes and respiratory medicine.

Specific standards have been developed to assist clinicians working with Aboriginal people. These standards relate to coordination of prevention and management of chronic disease, targeted health promotion, initiatives across the life course and disease continuum, effective systems for diagnosis, and enhancing the Aboriginal health workforce.

### **2.2.8 NSW Chronic Care Program: Rehabilitation for Chronic Disease**

This program recommends an integrated approach to the provision of rehabilitation services for people with a chronic disease. The key issues addressed in the document include: access to rehabilitation for chronic diseases Area-wide; staffing; referral pathways to rehabilitation; rehabilitation service delivery; rehabilitation service content; discharge from rehabilitation; and monitoring and data collection. Recommendations are made on the basis of physical as well as emotional and psycho-social functioning. Particular attention is given to providing rehabilitation in a range of settings, based on the assessed needs of the recipient. Supporting documentation has been provided to assist Area Health Services to implement this component of the program (NSW Department of Health 2006a).

### **2.2.9 NSW Carers Action Plan 2007 - 2012**

The *NSW Carers Action Plan* (NSW Department of Health, 2007a) outlines a whole of government policy commitment to recognising and supporting carers over the next 5 years. It includes strategies to increase the respect and recognition of carers, reach out to family members who may not see themselves as carers, improve services to carers and the people they care for, encourage agencies to view carers as partners in care, and support carers to combine work and caring. SSWAHS is required to develop an Area Carers Action Plan in response to the NSW Plan, which will also be linked to the SSWAHS Disability Action Plan.

### **2.2.10 NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005 – 2015**

This Plan (NSW Department of Health, 2006b) guides development of SMHSOP to 2015. It focuses on providing services for older people who have a diagnosable mental health disorder or problem, or severe behavioural and psychological symptoms of dementia (BPSD). The Plan is focussed on services managed by Mental Health, but recognises the strong links between mental health and aged care services in meeting the needs of these people. It outlines a service delivery model comprising community teams, acute inpatient and non-acute inpatient services, community residential services, and a specific model for the management of people with severely and persistently challenging behaviours.

## **2.3 SSWAHS Policy Context**

SSWAHS has recently developed, or is in the process of developing, a range of policies and plans which will inform the delivery of health services across the Area, including the AC&RS.

### **2.3.1 SSWAHS Strategic Plan Towards 2010**

The SSWAHS Strategic Plan Towards 2010 is the first corporate plan for Sydney South West Area Health Service. It is the premier planning document for SSWAHS, setting the overall direction for the development and delivery of all services and systems. The Plan is consistent with the NSW State Plan and the NSW State Health Plan: Towards 2010.

Consistent with the vision outlined by NSW Health, the SSWAHS Vision for our communities is “vibrant communities who enjoy and value good health and who work with us to improve health for everyone”. For our organisation and staff, the SSWAHS vision is “an energetic and progressive team delivering innovative health care and inspiring pride and confidence through a determined pursuit of excellence”.

The values underpinning the work of SSWAHS are justice, integrity, respect, flexibility, reflectiveness and conviction. Numerous corporate objectives support the Vision.

### **2.3.2 SSWAHS Draft Area Healthcare Services Plan 2006 – 2016**

The draft Healthcare Services Plan 2006 – 2016 has been developed through extensive consultation since the establishment of SSWAHS in January 2005. It outlines an approach for management of increased demand in SSWAHS to 2016, based on the establishment of clinical networks.

The draft Plan includes extensive discussion on the current inpatient, outpatient and community based services provided by AC&RS, including a summary of current and emerging issues, key clinical relationships and a proposed model of care. Models of Care Principles are outlined as a strategic vision for AC&RS by 2016, as follows:

- the provision of acute geriatric units of sufficient size to minimise outliers under geriatric management at all acute hospitals;
- enhancement to models of care that provide:
  - the opportunity to reduce the need for acute hospitalisation;
  - rapid assessment with a move to definitive treatment and/or transfer to alternative settings for those attending Emergency Departments (EDs);
  - for those admitted to wards – multidisciplinary care, reduction of the length of stay and move to definitive sub-acute units for active rehabilitation – complemented by the provision of transitional care and community based services to enable rapid return to a residential setting;
- Provision of a seamless continuum of care across residential, community and hospital settings, in conjunction with primary care partners;
- Enhancement to domiciliary and community based services enabling the provision of more accessible care and support;
- Expansion of the service provided to people with a traumatic brain injury and the development of an associated service to provide care for people with a non-traumatic brain injury;
- Investigate the development of a burns step down unit in conjunction with the current State-wide Burns service at Concord Hospital, in the style of a transitional living unit, to support people in the post acute (rehabilitation) phase of a burns injury; and
- Improved management of inpatients with dementia through the provision of dedicated units and support staff.

### **2.3.3 Liverpool Hospital Clinical Services Plan**

A Clinical Services Plan for Liverpool Hospital (LH) developed in 2006 identified the scope of services required to meet the growing population of South West Sydney, particularly associated with the South West Growth Centre land release. Approximately \$390 million has been allocated for Phase 1, Liverpool Hospital Stage 2 redevelopment.

Liverpool Hospital Stage 2 includes the following AC&R services: integration of disparate aged care services into a central location; 50 acute aged care and rehabilitation beds (including 8 rehabilitation beds); 6 additional beds for people with a traumatic brain injury and a four bed non-traumatic brain

injury unit; a separate dining and socialisation area for patients to encourage rehabilitation; gymnasium and space for walking within the wards; a day hospital in conjunction with ambulatory care services; additional outpatient clinic space; and office space, including space for an Aged Care and Rehabilitation Academic Unit. The LH redevelopment commenced in 2007 and will be completed by 2011/12.

#### **2.3.4 SSWAHS Older Persons and Aged Care Services Clinical Redesign Program**

The SSWAHS Older Persons and Aged Care Services Clinical Redesign Program funded by NSW Health is part of the state-wide clinical reform projects, known as Clinical Redesign.

The project commenced in late 2006. It aimed to provide: improved understanding of the older persons (65 years +) journey in the health care system – community and hospital settings; improved patient flow and reduced access block for targeted older patients requiring aged care services across the care continuum; and identification, development and implementation of a range of aged care best practice service models across SSWAHS.

The project highlighted many issues and potential solutions to achieve these aims (SSWAHS, 2007). Through a planning process, 18 solutions were identified as integral to improving the care and support of aged care clients, which will be implemented between 2007 and 2010. These solutions are grouped under five priority areas of: Governance, Service Models and Performance; Quality and Safety; Continuity of Care; Demand Management; and Accessible Care.

Whilst this AC&RS Plan has close relationships with the whole Clinical Redesign project, it aims to articulate the Service Delivery Model for Aged Care in SSWAHS, which will facilitate the implementation of other Clinical Redesign initiatives.

#### **2.3.5 SSWAHS Draft Falls Prevention Plan**

The SSWAHS Draft Falls Prevention Plan aims to investigate, develop and implement strategies that reduce the prevalence of individual and environmental factors associated with risk of falls among older people.

The Plan will facilitate an increased proportion of people 65 years and older at risk of falling attending multidisciplinary community-based falls prevention programs; an increased proportion of people 65 years and older in acute care services receiving screening, assessment and management of falls risk factors; and an increased proportion of people 65 years and older participating in appropriate physical activity.

#### **2.3.6 Draft SSWAHS Disability Action Plan**

SSWAHS is developing a Disability Action Plan (DAP) to guide the delivery of services for people with disabilities across SSWAHS. The DAP will be implemented by all SSWAHS facilities and clinical services, to ensure that the health needs of people with disabilities and their carers are appropriately met.

The SSWAHS DAP will ensure implementation of a range of NSW Government Policies on Disability including the *NSW Government Disability Policy Framework; Stronger Together: A new direction for disability services in NSW 2006 – 2016; Better Together: A new direction to make NSW Government services work better for people with a disability and their families 2007 – 2011*, as well as NSW Health Policy Directives. A NSW Health discussion paper entitled *Development of a Service Framework to Improve Health Care of People with Intellectual Disabilities (January 2007)* identifies potential appropriate models of care.

As a result of these policy directions, SSWAHS will have an increased focus on the provision and/or coordination of therapy services; equipment and aids programs; specialist health services; carer support programs; and assessment for the accommodation needs of younger people with a disability.

#### **2.3.7 Draft SSWAHS Carers Action Plan**

SSWAHS is developing a Carers Action Plan (CAP) to guide direction in improving support for carers in SSWAHS. It will be implemented by all SSWAHS facilities and clinical services, to ensure that the needs of carers are appropriately met. Key directions include improved recognition and

respect for carers, involving them in individual care planning, involvement in service development, improved support, and supporting SSWAHS working carers.

### **2.3.8 The Resource Transition Program**

In the eastern part of SSWAHS, an extensive clinical service and asset planning process was completed in the mid 1990's, culminating in the development of the Resource Transition Plan (RTP). The RTP, a \$491 million asset strategic plan, guided the major redevelopment of services throughout the eastern part of the Area. It created changes in the provision of aged care and rehabilitation services, including a new AC&RS Precinct at Concord Repatriation General Hospital (CRGH), and improved community aged care facilities.

### **2.3.9 South Western Sydney Health Network - The Way Forward 2004 - 2008**

In the south west, a Clinical Strategy Group was established in November 2003 to oversee the development of an Area Wide Clinical Services Plan, known as *The Way Forward*.

The Minister for Health in 2004 endorsed a range of recommendations from *The Way Forward* with regard to Aged Care and Rehabilitation in the Western Zone of SSWAHS. A full list of recommendations, including a progress report, is provided in Appendix 3.

### 3. THE POPULATION OF SSWAHS

In 2001, the SSWAHS population was 1.28 million. This population is projected to rise to 1.52 million by 2016. As Table 3.1 indicates, the majority of the SSWAHS population reside in the south west with the most rapid growth expected in the LGAs of Liverpool, Camden and Campbelltown, due to the large scale urban release known as the South West Growth Centre.

Approximately 1.07% of SSWAHS residents identify as Aboriginal people or Torres Strait Islanders. There are considerable variations across SSWAHS in the proportion of Aboriginal residents (highest in the former South Sydney and Campbelltown LGAs). The Aboriginal population is relatively young, with more than 30% of the population under 14 years. There are approximately 1,800 Aboriginal people over 50 years ie 13% of the indigenous population.

SSWAHS is expected to remain the most ethnically diverse health area in NSW and continue to be home to approximately half the humanitarian arrivals in NSW each year (DIMIA, 2005). The highest proportion of people who speak a language other than English at home live in Fairfield and Canterbury LGAs. With its large CALD population, it is anticipated that the number of older residents of SSWAHS from non-English speaking countries will increase, with the size of cultural groups changing over time, mirroring migration patterns. This group will face barriers associated with poor English language and other cultural difficulties.

Projections developed by Booth & Tickle suggest that by 2027 the life expectancy of non-indigenous males could increase from 77 to 82.9 and for non-indigenous women from 82.4 to 85.1. They further predict that around 50% of 'baby boomer' women will live to at least 90 years of age (Australian Bureau of Statistics 2001, Booth & Tickle, 2003, p4).

**Table 3.1 Population characteristics by LGA – 2001 Census and projections to 2016**

LGA	Population 2001 (Census)	Aboriginal identified (2001 Census)		% Language other than English spoken at home (2001 Census)	Projected Population		
		No.	% 2001 pop		2006	2011	2016
Sydney (part)	32,698	61	0.19%	27	37,808	41,301	45,555
South Sydney (part)	25,813	1,134	4.39%	21.8	29,455	33,855	38,593
Leichhardt	50,450	631	1.25%	15.6	51,700	52,320	52,700
Marrickville	76,770	983	1.28%	38.6	76,230	75,880	78,700
Ashfield	40,540	205	0.51%	43.5	42,130	42,730	42,720
Burwood	30,590	113	0.37%	52.7	32,180	34,160	35,960
Strathfield	29,450	93	0.32%	53.7	33,940	37,680	41,160
Canada Bay	62,350	228	0.37%	30.3	67,000	73,890	78,610
Canterbury	137,520	664	0.48%	62.2	139,730	142,100	144,080
<b>Eastern Zone</b>	<b>486,181</b>	<b>4,112</b>	<b>0.85%</b>	<b>39.1</b>	<b>510,173</b>	<b>533,916</b>	<b>558,078</b>
Bankstown	172,030	1,303	0.76%	46.2	174,990	177,850	180,060
Fairfield	189,020	1,118	0.59%	66	191,920	193,350	191,460
Liverpool	159,070	2,038	1.28%	43.7	175,670	197,440	225,590
Campbelltown	150,160	3,602	2.40%	19.4	154,310	164,050	179,280
Camden	45,450	525	1.16%	8.5	54,630	69,020	83,030
Wollondilly	38,460	577	1.50%	5.1	42,210	45,510	47,840
Wingecarribee	42,760	497	1.16%	4.2	46,070	48,970	51,740
<b>Western Zone</b>	<b>796,950</b>	<b>9,660</b>	<b>1.21%</b>	<b>38.9</b>	<b>839,800</b>	<b>896,190</b>	<b>959,000</b>
<b>SSWSAHS</b>	<b>1,283,132</b>	<b>13,772</b>	<b>1.07%</b>	<b>39</b>	<b>1,349,973</b>	<b>1,430,106</b>	<b>1,517,078</b>
<b>NSW</b>	<b>6,578,980</b>	<b>134,888</b>	<b>2.05%</b>	<b>19</b>	<b>6,872,530</b>	<b>7,164,950</b>	<b>7,434,050</b>

Source: DIPNR Population Projections, NSW Regional Profile 2004, ABS.

Note: Sydney (Part) and South Sydney (part) now make up City of Sydney (part)

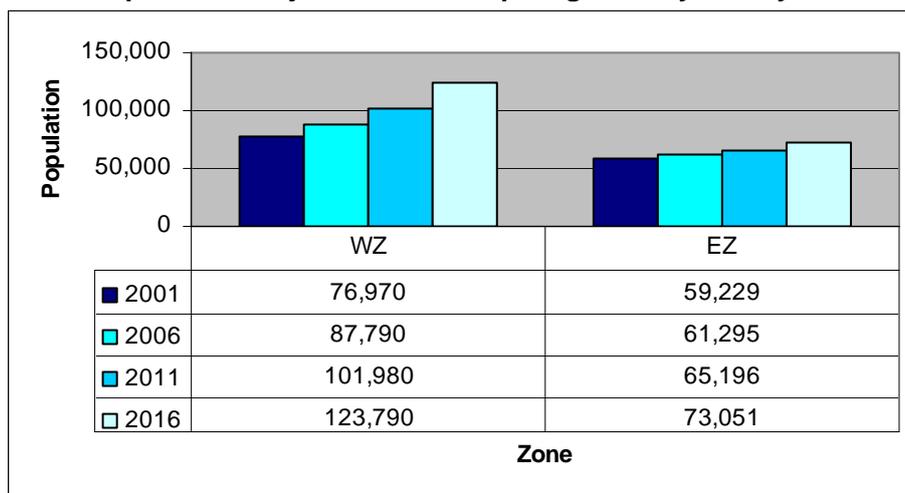
The Index of Relative Advantage/Disadvantage within the Socio-economic Index for Areas (SEIFA) data produced by the Australian Bureau of Statistics (ABS) in 2001, indicates that Bankstown,

Campbelltown, Canterbury, Fairfield and Liverpool LGAs are amongst the most disadvantaged LGAs in NSW. This level of disadvantage is likely to result in poorer health within the population.

### 3.1 People aged 65+ years

At 2001, the SSWAHS population aged over 65 years was 136,199 (11%) projected to increase to 196,841 or 13% of the total population in 2016. By 2026, this group is projected to represent 16% of the total population. The majority (57%) of people aged 65+ years live in the south west, however there will be a significant increase in the older population across the Area, with a 61% increase between 2001 and 2016 in the south west and a 23% increase in the east of the Area (Figure 3.1 below).

**Figure 3.1 Population Projections for People aged 65+ years by Zone 2001 – 2016**

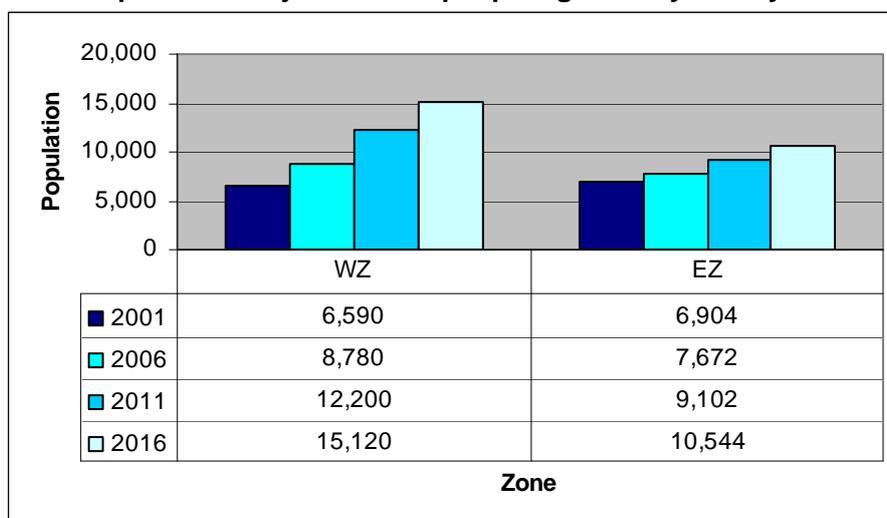


Source: DIPNR Population Projections (2004)

### 3.2 People aged 85+ years

In 2001, the SSWAHS population aged over 85 years was 12,685 (1%) projecting to more than double to 25,664 (2%) of the total population by 2016 (see Figure 2.2 below). Importantly, on today's figures, around 80% of this over-85 year age group is disabled in self-care abilities, with 70% having a gait disorder, 10% having Parkinson's disease, 70% having cognitive impairment and 30% with actual dementia (Waite, et. al. 1997). Despite these patients' disabilities, the majority of older people live at home.

**Figure 3.2 Population Projections for people aged 85+ years by Zone 2001 – 2016**



Source: DIPNR Population Projections 2004

### 3.3 Distribution in SSWAHS

Tables 3.2 - 3.4 provide a breakdown of population by age, according to zone and for the whole SSWAHS. It is evident from this data that the biggest increases in population will occur in the 85+ year age group, and that the overall impact of population growth and ageing will be most significant in the south west. However, there will be significant real growth in population numbers across the Area, with an additional 13,822 people aged over 65 years in the east and an additional 46,822 in the south west, projected by 2016. This substantial growth will generate demand for additional services as well as service redesign.

**Table 3.2 Eastern Zone Population Projections by Age Structure**

Age Group	2001	2006	2011	2016	No. increase 2001-16	% increase 01-16
0-64	426,953	448,878	468,720	485,027	58,074	13.60%
65-69	16,868	17,202	18,562	22,373	5,505	32.64%
70-74	15,338	14,653	15,428	16,978	1,640	10.70%
75-79	12,162	12,676	12,372	13,363	1,201	9.87%
80-84	7,957	9,091	9,732	9,794	1,836	23.08%
85+	6,904	7,672	9,102	10,544	3,639	52.71%
<b>Total</b>	<b>486,182</b>	<b>510,173</b>	<b>533,915</b>	<b>558,077</b>	<b>71,896</b>	<b>14.79%</b>
<b>Total 65+</b>	<b>59,229</b>	<b>61,295</b>	<b>65,196</b>	<b>73,051</b>	<b>13,822</b>	<b>23.34%</b>

Source: DIPNR Population Projections (2004)

**Table 3.3 Western Zone Population Projections by Age Structure**

Age Group	2001	2006	2011	2016	No. increase 2001-16	% increase 01-16
0-64	719,980	752,010	794,210	835,210	115,230	16.00%
65-69	23,510	26,950	32,220	42,050	18,540	78.86%
70-74	21,070	21,230	24,660	29,700	8,630	40.96%
75-79	16,500	18,020	18,530	21,790	5,290	32.06%
80-84	9,300	12,810	14,370	15,130	5,830	62.69%
85+	6,590	8,780	12,200	15,120	8,530	129.44%
<b>Total</b>	<b>796,950</b>	<b>839,800</b>	<b>896,190</b>	<b>959,000</b>	<b>162,050</b>	<b>20.33%</b>
<b>Total 65+</b>	<b>76,970</b>	<b>87,790</b>	<b>101,980</b>	<b>123,790</b>	<b>46,820</b>	<b>60.83%</b>

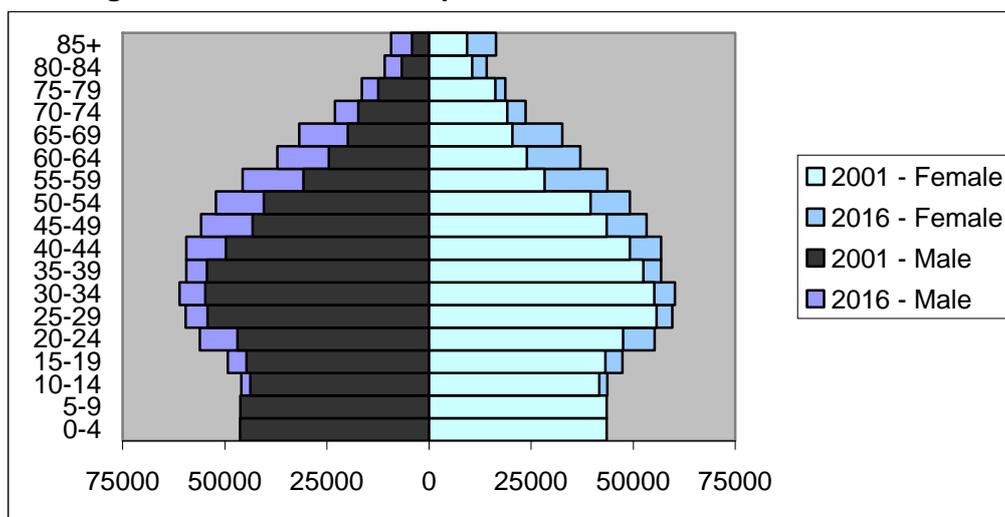
Source: DIPNR Population Projections (2004)

**Table 3.4 SSWAHS Population Projection by Age Structure**

Age Group	2001	2006	2011	2016	No. increase 2001-16	% increase 01-16
0-64	1,146,933	1,200,888	1,262,930	1,320,237	173,304	15.11%
65-69	40,378	44,152	50,782	64,423	24,045	59.55%
70-74	36,408	35,883	40,088	46,678	10,270	28.21%
75-79	28,662	30,696	30,902	35,153	6,491	22.65%
80-84	17,257	21,901	24,102	24,924	7,666	44.42%
85+	13,494	16,452	21,302	25,664	12,169	90.18%
<b>Total</b>	<b>1,283,132</b>	<b>1,349,973</b>	<b>1,430,105</b>	<b>1,517,077</b>	<b>233,946</b>	<b>18.23%</b>
<b>Total 65+</b>	<b>136,199</b>	<b>149,085</b>	<b>167,176</b>	<b>196,841</b>	<b>60,642</b>	<b>44.52%</b>

Source: DIPNR Population Projections (2004)

Figure 3.3 following shows the way the structure (age and gender) of the population will change between 2001 and 2016. Most noticeable is the ageing of the population and the longevity of women as compared to men.

**Figure 3.3 SSWAHS Population Structure 2001 - 2016**

Source: DIPNR Population Projections (2004)

NSW Health recently released projections identifying that over 70% of total demand in growth for services will be related to the needs of people over 75 years of age (NSW Department of Health, 2005d). It has also projected that 45% of growth will be for non-acute, rehabilitation and geriatric care. In SSWAHS, people over 80 years accounted for an increase of 2,000 separations or 19,000 bed days over the past 5 years. This represented 58 additional beds. Health Roundtable data indicates people over 80 years comprise 3% of the population but make up 11% of hospital admissions, 22% of ED admissions, 19% of acute bed days and 22% of complex bed days (NSW Department of Health 2005e).

The 2003 Australian Bureau of Statistics Survey of Disability, Ageing and Carers (SDAC) reported that 20% of people in Australia (3,958,300) had a disability. Disability was defined as any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities. Examples range from hearing loss, which requires the use of a hearing aid, to difficulty dressing due to arthritis, to advanced dementia requiring constant help and supervision. Approximately 6.3% of the people surveyed considered themselves to have a profound or severe core-activity limitation.

Of those with a reported disability, 86% were limited in the core activities of self-care, mobility or communication, or restricted in schooling or employment. Most people with a disability (76%) were limited in one or more of these core activities.

The pattern of prevalence of profound or severe core-activity limitation gradually increased from 3% for those aged 0-4 years, to 10% for 65-69 years, followed by a sharp increase to 74% for those aged over 90 years. This contrasted with the overall disability rate, which increased steadily from 4% children aged 0-4 years, to 41% adults aged 65-69 years, to 92% people aged over 90 years.

With respect to the use of aids and equipment, the SDAC reported that 1 in 10 people in Australia used equipment or an aid to help them cope with their condition or manage with their everyday life. Extrapolated for SSWAHS, this would mean that over 14,000 people require the use of an aid or equipment to assist them with functional tasks.

## 4. TARGET GROUPS – INCIDENCE AND PREVALANCE

This Plan has been developed for people who fall into a specific grouping due to their clinical and/or functional status. The following defines the target groups, including information about best practice in the provision of care and support for target group members. For ease of reference, clients have been divided into either aged care or rehabilitation. Although much of the focus appears to be on the aged care client, in reality, the boundary between the two primary target groups is arbitrary.

### 4.1 The Aged Care Client

The term 'aged care client' refers to people (including families/carers) who "will most benefit from access to multidisciplinary aged care assessment and management" (NSW Health 2004a). The definition of the aged care client is therefore not based just on an age cut off of over 65 years, or on particular Australian National Diagnosis Related Groups (AN-DRGs), but based on need. Further, people who will most benefit from receiving specialised aged care services are generally those who present with high levels of need due to problems with their physical, mental or functional ability, or with the provision of their care, accommodation and support (adapted from NSW Health 2004a). An estimated 25% of hospitalised people over 65 years fulfil this definition (Flintoft et.al., 1998).

The aged care client requires multi-disciplinary support across the continuum of care, ranging from acute, post acute, rehabilitation, maintenance and palliative care. This support is required in hospitals, the community and residential settings, depending on the unique needs of the client/carer at an individual point in time.

Clients to be offered acute inpatient aged care services are those older people (and where appropriate their family/carers), who present with acute medical problems with high level needs requiring hospital care, and have one or more of the following problems which means they are best cared for within a specific aged care service, rather than by general or other sub-specialty units (NSW Health 2004a):

#### **Physical disability**

- Falls and their complications
- Immobility and its complications
- Incontinence
- Chronic pain
- Malnutrition
- Inability to perform activities of daily living (bathing, dressing, grooming, eating, toileting)
- Sensory deficits

#### **Mental disability**

- Behaviour disturbance
- Cognitive impairment
- Other psychiatric illness
- Lifelong psychiatric illness in old age
- Developmental disability in old age

#### **Multiple Medical Problems/Polypharmacy**

#### **Care, accommodation and support**

- Bereavement and loss
- Loss of carer / carer collapse
- Alcohol and other drugs
- Social isolation (as distinct from living alone)
- Living in residential care
- Guardianship and other aged care legal issues
- Elder abuse
- Multiple referrals to services especially hospital readmissions

Similar criteria assess the suitability of older people to receive other designated aged care services. Acute Aged Care Services may assist some younger adults with disability and high level acute needs.

Within the broad definition of the aged care client, particular attention must be given to people with dementia and people at risk of falls/who have fallen/or have a history of falls.

#### 4.1.1 People with Dementia

Dementia has a profound affect on clients/patients and their carers' quality of life. Early and accurate diagnosis and assessment is critical to the successful care and management of people with dementia and the development of care plans to support their carers. A correct medical diagnosis to clarify the dementia syndrome is essential as some dementias are reversible, people often have co-morbid psychiatric conditions, medical illnesses may be masked by their dementia, and medical treatment may be affected by subtle physiological and pathological disturbances.

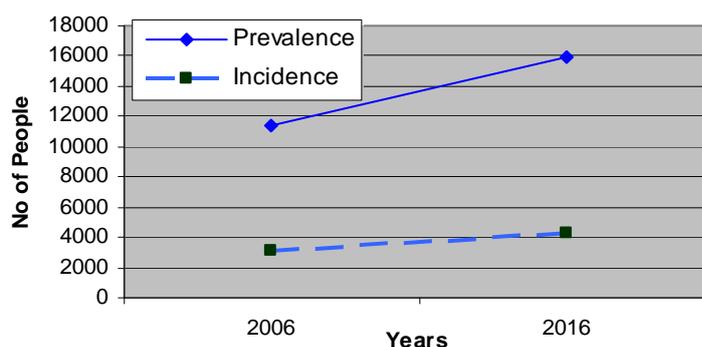
People with dementia are extensive users of the health system and this will clearly increase. Within a year of an outpatient assessment, Callahan, Hendrie & Tierney (1995) reported that patients with moderate to severe cognitive impairment were more likely than those with no impairment to be hospitalised, to visit the emergency department or to die. People with dementia are more prone to develop delirium when they have an acute medical or surgical condition. The rates of morbidity, mortality and length of hospital stays are much greater in this population compared to those without dementia, with length of stay 4 times longer. (Nichol, Lonergan & Mould, 2000). This longer length of stay may be able to be reduced via rapid recognition and management of delirium, involvement of carers in management plans and the development of more supportive hospital environments, both in terms of the physical environment and the availability of consultative services and educated clinical staff.

Age is the strongest risk factor for the development of Alzheimer's Disease, the most common form of dementia. There is currently no cure for the disease, although drugs are now available which have been shown to slow its progression.

The prevalence of dementia is increasing in line with the ageing of the population. Access Economics (2005) has estimated that the prevalence of dementia in NSW will increase from 62,680 in 2001 to 110,310 in 2020. In Sydney South West, Access Economics estimate that the prevalence of dementia in 2006 is 11,419 people, increasing to 15,872 people by 2016. This is an increase of 4,453 people or 39%. The incidence of dementia overall is also projected to increase over the next 10 years across SSW, with the estimated annual incidence in 2006 at 3,169, rising to 4,245 by 2016 (Access Economics 2005).

Figure 4.1 shows the projected incidence and prevalence of dementia in SSW to 2016. The increased survival rates are likely as a result of early and correct diagnosis and symptomatic medical therapies, along with the treatment of co-morbid illnesses. This new regime of treatment results in a cohort of people with unique care needs across a longer life span.

**Figure 4.1 Projected Incidence and Prevalence of Dementia 2001 - 2016 (Access Economics 2005)**



It is recognised that people from CALD communities with dementia are likely to revert to their language of birth as their dementia progresses. They will face greater problems in communication, resulting in further clinical management problems.

There is little information on prevalence of dementia in Aboriginal and Torres Strait Islander people in Australia. However they may experience the physical and cognitive impacts of ageing at an earlier age. A NHMRC funded study into dementia and cognitive problems in urban indigenous communities is being undertaken. This study, which includes the SSWAHS communities, will seek to identify appropriate care models for Aboriginal people with dementia and cognitive problems.

#### 4.1.2 People with Delirium

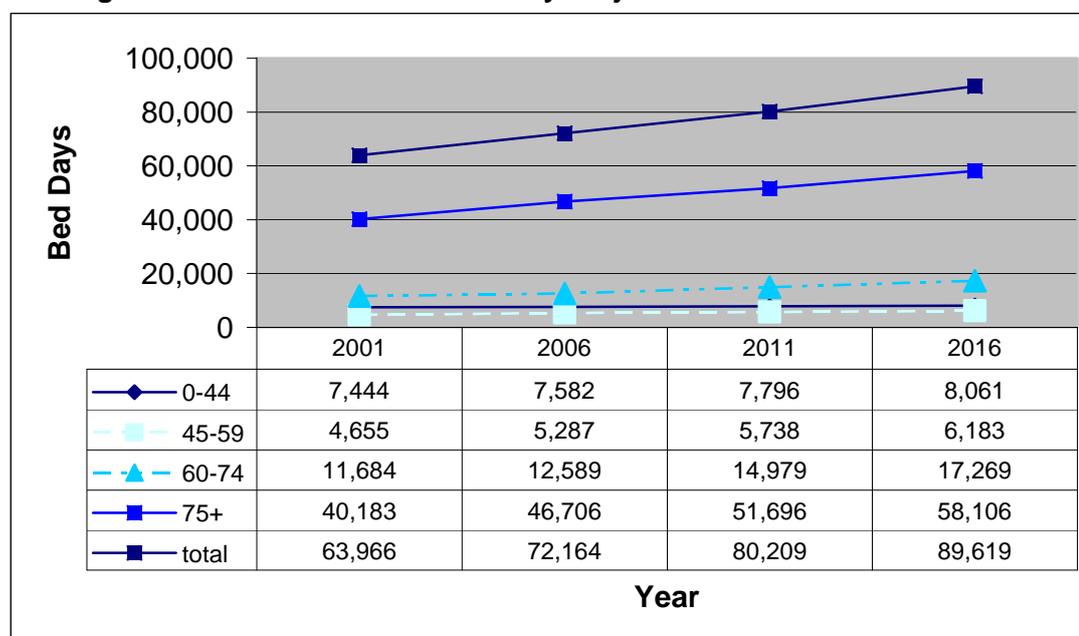
Delirium is an acute, reversible organic brain disorder characterised by reduced ability to maintain attention to external stimuli and disorganised thinking as manifested by rambling, irrelevant or incoherent speech. The Australian Society of Geriatric Medicine (2005) reports the prevalence rates of delirium on admission are 10% - 24% and that delirium develops in up to 56% of older people in hospital (climbing to 61% post operatively). All these patients require rapid assessment followed by the development of management plans that involve minimising the risk of adverse events during the acute phase and supporting carers in maintaining their caring role post discharge

#### 4.1.3 People with Fall Related Injuries or at risk of Fall Related Injuries

Older people (over 75 years) are known to have a higher incidence of fall related injury than the remainder of the population. Fall related injuries have a significant impact on the quality of life of older people and are a significant cost to the NSW Health system in terms of inpatient and residential aged care beds, medical and allied health staff, and pharmaceuticals (NSW Health, 2005b).

NSW Health is projecting a considerable increase in the SSWAHS bed day demand for people aged 75+ years, with an additional 17,923 bed days required between 2001 and 2016, an increase of 44%. Falls related bed days are also projected to increase in the 60 -74 year age group, with an additional 8,028 bed days required by 2016, an increase of a little more than two thirds (NSW Department of Health, 2005b). See Figure 4.2 following.

**Figure 4.2 Falls Related Bed Day Projections 2001 - 2016**



Source: NSW Fall Injury Risk Indicators for SSWAHS 2001 – 2021 (2005)

In 2001, 208 beds were required in SSWAHS to manage fall related injuries. This is projected to increase by 38% to 288 beds in 2016 (assuming an occupancy rate of 85%). This equates to an additional 80 beds.

Closely linked with the issue of falls is the need to provide orthogeriatric support involving geriatricians and orthopaedic surgeons across acute, sub-acute and community settings. Rehabilitation specialists are also essential to the delivery of holistic care for patients with fall related injuries.

#### **4.2 The Rehabilitation Client**

The Australasian Faculty of Rehabilitation Medicine (AFRM) of the Royal Australian College of Physicians (2005:2) defines rehabilitation medicine as “that part of the science of medicine involved with the prevention and reduction of functional loss, activity limitation and participation restriction arising from impairments; and the management of that disability in physical, psychosocial and vocational dimensions”. A person may require rehabilitation for many reasons, such as the results of injury or trauma, chronic disease or another acute episode. The AFRM (2005) describes a client of rehabilitation medicine as those people with a loss of function or ability due to injury or disease who can reach the highest possible level of independence (physically, psychologically, socially and economically) through a combined and co-ordinated use of medical, nursing and allied health professional skills.

Rehabilitation services are provided to people of all ages, however this Plan will focus on the needs of adults (16+ years) requiring rehabilitation services. As with the aged care client, the rehabilitation client can be categorised into various sub-groups. Those that are the major areas of workload, or of planned service development, are described below. However, it should be noted that there are many other patients requiring rehabilitation services who are not described in the following sections.

In addition to language and cultural barriers experienced by people from CALD communities, people who have a refugee or refugee-like background may have experienced torture or trauma, or have different perceptions and expectations of rehabilitation. This will impact on assessment and treatment, and compliance with treatment.

##### **4.2.1 People who have had a Stroke**

According to Pollack & Disler (2002) stroke is the leading cause of chronic disability in adults in Australia. Almost all patients require rehabilitation services after an acute episode of care for stroke (Pollack & Disler, 2002). For at least a year after the stroke occurs, people will, to varying degrees, require assistance with activities of daily living, with mobility and with managing a speech impairment. Up to a quarter may also have an associated dementia or cognitive impairment, or a disabling anxiety or depression (SWSAHS, 1999).

An analysis of hospitalisations due to stroke and transient ischemic attack (TIA) in SSWAHS over recent years has shown a slight increase in the number of hospitalisations from 2,341 in 1999/2000 to 2,352 in 2005/06 (FlowInfo 2005/06), with 74% of residents hospitalised for stroke or TIA in 2005/06 were aged over 65 years.

If, as expected, the incidence of stroke increases with the ageing of the population, this will result in a greater demand for rehabilitation services and an increased burden of disability in NSW (NSW Department of Health 2004c). Rehabilitation of these patients should commence in the acute setting, with continued multi-disciplinary rehabilitation provided in either a sub-acute, community or home based setting depending on individual circumstances.

Geriatricians are also active in the provision of stroke rehabilitation services.

##### **4.2.2 People with a Chronic Disease**

People with a chronic disease are projected to account for up to 80% of the health care burden by 2020, with these people likely to have several co-morbidities (NSW Health 2005c). Chronic diseases include respiratory problems, cardiovascular disease, diabetes and cancer.

It is recognised that people with a chronic disease would benefit from integrated, multidisciplinary rehabilitation services; however at present only a small proportion of people with a chronic disease receive the level and range of rehabilitation services which are likely to provide for the longest term benefits to manage their disease. The provision of rehabilitation services for people with chronic disease may result in greater health and psychosocial outcomes for the individual, reduced hospitalisations and length of stay, and reduced morbidity and mortality (NSW Health 2005c).

Given the increasing likelihood of developing multiple chronic conditions with age, services must be responsive to the needs of people with more than one condition.

#### **4.2.3 People with Non-Traumatic Brain Injuries**

Non traumatic brain injuries include stroke, brain tumours, hypoxia, infections or poisonings. The vast majority of these patients are treated by general or neurological (stroke) rehabilitation services. A smaller number of these patients have more severe cognitive and behavioural problems, which makes their clinical picture more like the patient with a traumatic brain injury. To treat these patients requires a higher level of staffing and supervision, in line with the requirements of clients with a traumatic brain injury, regardless of setting.

#### **4.2.4 People with a Traumatic Brain Injury**

People with a traumatic brain injury are usually in the 16-40 year age group (ie. working age) and are predominantly male. Most wish to be rehabilitated to return to work, however their recovery often takes place over a long period, with 20% of patients each year requiring a stay longer than 6 months. The needs of people with a traumatic brain injury are unique, in terms of their length of stay and behaviours. In particular, the younger male with a brain injury may be aggressive and have other challenging behaviours which mean that they are unable to be catered for in a general ward.

#### **4.2.5 People with a Spinal Cord Injury**

Patients with a spinal cord injury (SCI) can be classified as either having a traumatic or non-traumatic spinal cord injury. SCI injuries cause significant hardship and disability to victims and their families, resulting in life-long care and loss of productivity.

Nationally, SCI data is only collected for those registered in Spinal Cord Injury Units ie it does not include the actual number of people sustaining a spinal cord injury who may be treated in local hospitals. Of the 374 adult cases of SCI registered in Australia in 2005-06, 284 (76%) were caused by a traumatic SCI. Traumatic SCIs are caused through incidents such as motor vehicle accidents, falls and water or sports related injuries. The highest number of traumatic SCI's occurred in the 15-24 year age group. Most cases (72%) of traumatic SCI occurred in males (Cripps 2007).

The remaining 90 cases (24%) of spinal cord injury in Australia were as a result of disease, not trauma. Non-traumatic injuries are most commonly associated with conditions such as transverse myelitis, spinal infarction, multiple sclerosis or malignancy. The average age for people with non-traumatic injuries was 59 years, compared with 41 years for traumatic injury.

NSW data indicates that of those treated in a spinal cord injury unit in NSW, approximately 61% of acute SCIs were subsequently discharged to a local rehabilitation service (NSW State Spinal Cord Injury Service Minimum Data Set 2005, 2006).

Falls are a leading cause of spinal cord injury, representing 33% of reported traumatic SCI in Australia. Although high falls are most common, proportionally low falls are twice as common in the 65+ year age group. Research from the USA based Spinal Cord Injury Information Network (<http://www.spinalcord.uab.edu/show.asp?durki=21446>) indicates that the percentage of patients aged 60+ years in the SCI population has increased from 4.7% prior to 1980 to 11.5% since 2000. Mortality during a hospital stay and post discharge were also significantly higher for this age group.

#### **4.2.6 People with Severe Burns**

The NSW Health Severe Burn Service Plan (2003b) describes burn injuries as occurring largely as a result of an unpredictable, potentially catastrophic event, which may produce individual or multiple victims. People are considered to have a severe burn injury if they meet a defined set of criteria relating to the thickness, location and method of receiving the burn injury. Severe burn injuries, as treated by a specialist unit, result in "physical and psychological sequelae requiring long term and intensive treatment and follow-up" (NSW Health 2003b, p6).

The majority of people treated for severe burns are adults (NSW Health 2003). In 2004/05 at Concord Repatriation General Hospital (CRGH), there were 204 admissions to the Burns Unit, 49 of which (24%) were through the Emergency Department (ED); and 197 separations, 39 of which (20%) were same day. The average length of stay (ALOS) in the Burns Unit in 2004/05 was 44.84 days.

The survival rate for patients with severe burns has improved over time, with the introduction of new treatment modalities and technological advances, including early surgical intervention, and advances in intensive care, nutrition and the development of skin substitutes (NSW Department of Health, 2003b).

Given the specialised and complex nature of the management of burns, from both a physical and psychological perspective, unique acute and rehabilitation units are required.

#### **4.2.7 People with an Intellectual or Developmental Disability**

Children with an intellectual or developmental disability receive a range of 'early intervention' and therapy health services, generally through the Department of Ageing, Disability and Home Care (DADHC) or SSWAHS Community Health. However, adults with an intellectual or developmental disability do not have ready access in SSWAHS to specialised therapy and rehabilitation services. These residents have unique needs as they have multiple and coexisting medical problems, combined with the need for assistance in managing their disability, activity and participation limitations.

Current estimates suggest that there are approximately 30,000 people living with a cognitive disability in some form in SSWAHS, including approximately 10,000 people with a lifelong intellectual disability. This group is increasingly well, and has a greater longevity than in previous decades. However, this greater longevity creates demands for health and support services to assist people to live independently. One of the critical points in the continuum of care for these patients is in the transfer from paediatric to adult services. As the population in the target group increases, it is likely that a separate team with a focus on the unique needs of this target group will be required. Further, as people with an intellectual or developmental disability age, they also acquire age associated conditions (such as dementia) and experience other comorbidities. Expertise is required to respond to the needs of this emerging group of clients, along with the needs of their carers (who are often parents and also ageing).

Planning for disability services in SSWAHS is being undertaken through the SSWAHS Disability Action Plan which will include actions related to the draft *Service Framework to Improve Health Care of People with Intellectual Disabilities*.

### **4.3 Carers**

The ABS defines a carer as "a person of any age who provides any informal assistance, in terms of help or supervision, to persons with disabilities or long-term conditions, or persons who are elderly (i.e. aged 60 years or over)". The assistance has to be ongoing, or likely to be ongoing, for at least six months. Assistance to a person in a different household relates to 'everyday types of activities', without specific information on the activities. Where the care recipient lives in the same household, the assistance is for one or more activities such as personal care, housework, transport and maintenance. Approximately 13% of the Australian population identifies as having a caring role, with 20% of carers identifying themselves as primary carers (Australian Bureau of Statistics, 2004).

Carers play a fundamental role in the health and support system for older people, people with a disability and people with a chronic illness. Early discharge and long term independence is often related to the availability and capability of a carer and as such carers must be considered as an integral part of health care services for older people.

Carers from CALD backgrounds are more likely to be second or third generation family members, due to their skills in English. They will not necessarily identify themselves as carers perceiving their role as "a duty" and as a result, they will struggle with the concept until it is explained.

Consultation with Aboriginal people indicate that they are less likely to identify as carers. Many Aboriginal carers will have poor health and disabilities themselves. They may also care for more than one family member with a health problem or disability, in addition to responsibilities for children.

The SSWAHS Carers Action Plan will further address the needs of carers in the Area.

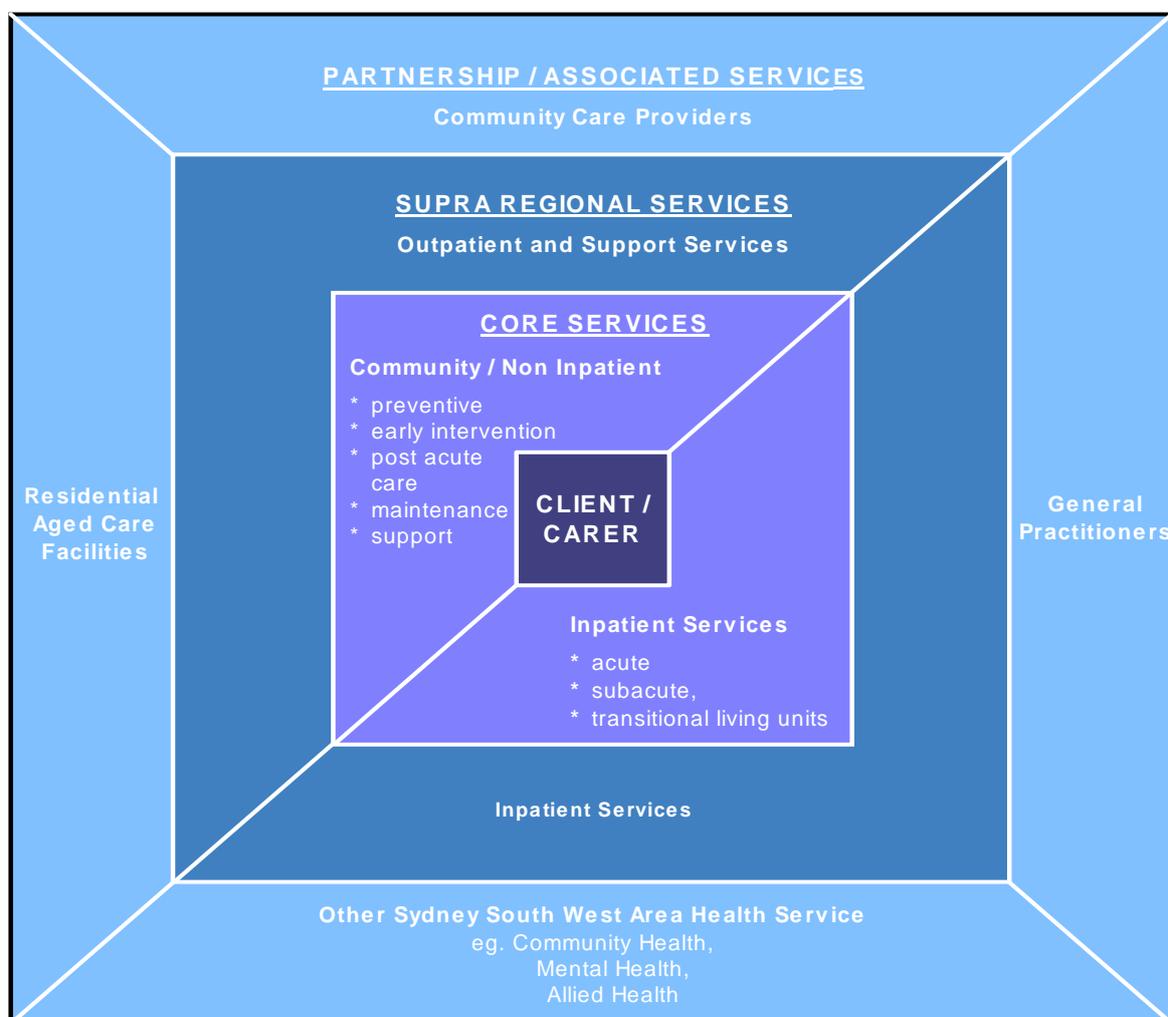
## 5. SERVICE DELIVERY MODEL

SSWAHS residents have access to a range of acute and sub-acute AC&RS inpatient services, supported by various outpatient and community services provided by SSWAHS and other external organisations. A summary of all AC&R services is included in Appendix 4.

Across SSWAHS, services differ in relation to the model of care utilised, staffing structures and profiles, and availability and equity of access to services. These differences stem from historical factors such as SSWAHS formerly operating as two separate area health services, variation in clinical stream structure, availability of external funding to develop particular service types, ability to attract and retain staff, and structure of the local service system external to SSWAHS.

To guide the development and delivery of AC&RS into the future and to ensure equity of service access across the Area, it is necessary to define and implement a consistent service model across SSWAHS. The service model recognises that current and future AC&RS clients are distributed across SSWAHS in large numbers. This means that there is a need for a distribution of services across the Area to ensure equity of access for all residents of SSWAHS.

**Figure 5.1 SSWAHS Aged Care and Rehabilitation Service Delivery Model**



January 2008

The AC&R Service Delivery Model incorporates three key aspects:

- **Core services** – services which are provided by AC&RS to targeted clients and which need to be available consistently and equitably across the whole Area;

- **Supra-regional services** – specialised services catering for a small number of people with specific health needs. Such specialised services are to be concentrated on one site to facilitate access to specialist expertise and equipment;
- **Partnership/Associated services** – services providing extensive assistance to AC&RS clients and/or are operated cooperatively between AC&RS and other clinical services. This includes services provided by the non-government sector, such as community and residential care.

A service delivery system comprising core, supra-regional and partnership/associated services working collaboratively, will ensure that a high quality, safe and comprehensive system of care is provided to all AC&RS clients, at different stages within the lifecycle and disease progression. These services operate along a care continuum from community/residential care, the interface between community and acute services, post-acute services and community/residential care (refer Figure 5.2). Services are categorised as:

- **Community/Non-Inpatient Services** – with a focus on prevention of illness, deterioration and hospital admission; early intervention; post acute care; maintenance or support; and
- **Inpatient Services** – provided in the inpatient setting – be it acute or sub-acute.

As clients access AC&RS through multiple entry points along the continuum of care, this is an illustrative delineation only. AC&RS are delivered seamlessly to clients, and at a local level, service management is well integrated. Thus, a client may move between aged care and rehabilitation services and other partnership/associated services, throughout their course of treatment.

Implementation of the Service Delivery Model will be dependent on a range of factors. However, priority should be given to ensuring that the core services are available as outlined in this Plan. Supra-regional and partnership/associated services are also integral to the whole model of care. If this model is implemented, clients will have timely access to appropriate services and there will be an associated reduction in unnecessary reliance on the acute setting, through implementation of preventative care models, early intervention systems and post discharge support.

### 5.1 Core Services

Core services are essential, evidence based services which should be provided across the Area to service local catchments. It is proposed that these services be consolidated in facilities which have adequate and appropriate back-up support, and in which the critical mass necessary to provide a quality service can be obtained. The Core Service Delivery Model is discussed in detail in Section 6.

Extensive literature outlines the benefits of core evidence based services, including reduced mortality, improved function and cognition, reduction in adverse events, improved quality of life, and gains in efficiency such as a reduction in hospitalisation, length of stay and health care costs.

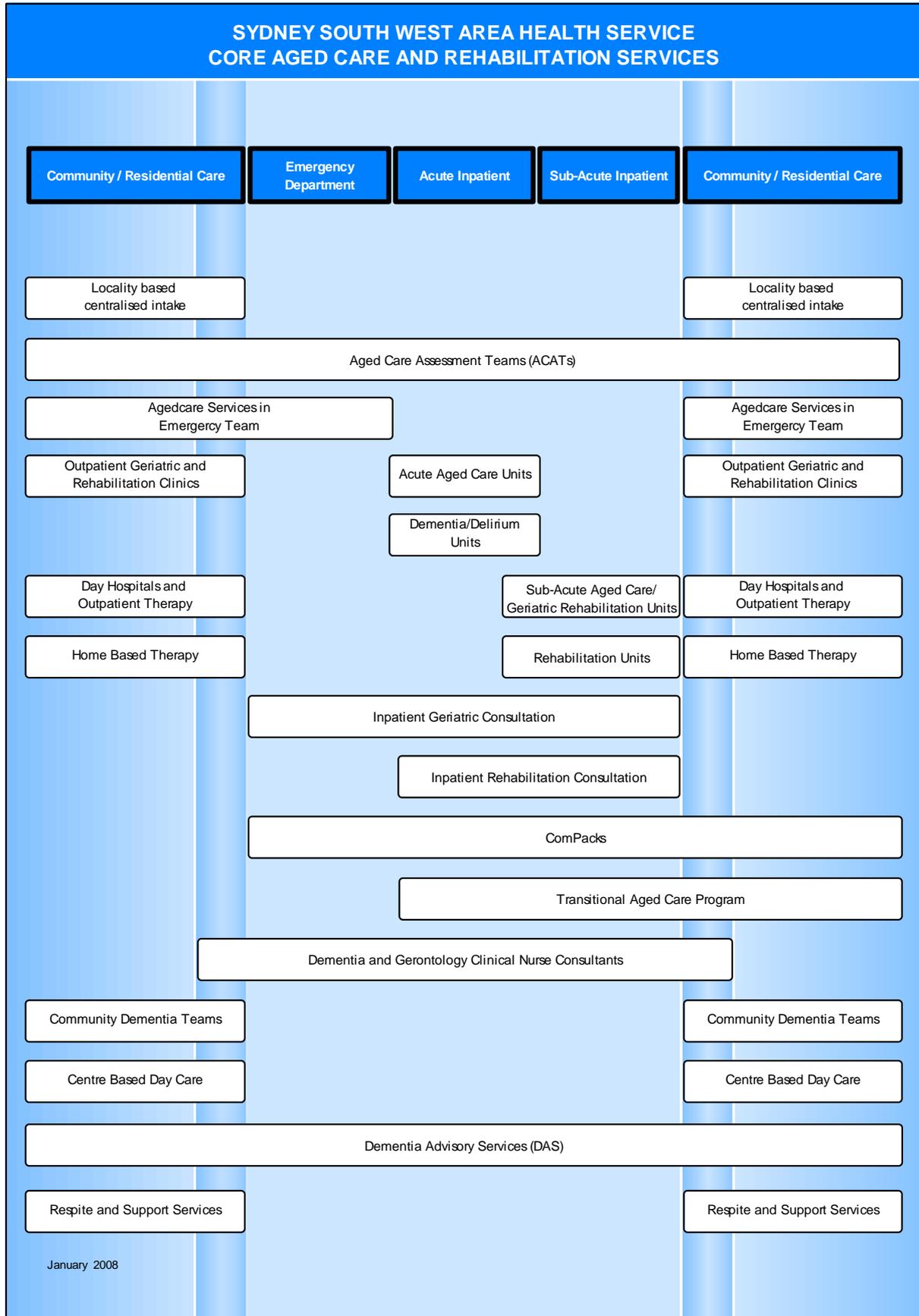
A range of professionals (including medical, nursing and allied health staff) provide these services in community, residential and acute settings. They are designed to be complementary with strong linkages between the various service settings, to ensure continuity of care, regardless of the service provider. Table 5.1 lists core services according to service category.

**Table 5.1 Core SSWAHS AC&RS by Service Category**

Service Category	Service Type
Community / Non-Inpatient (preventative, early intervention, post acute care, maintenance and support)	<ul style="list-style-type: none"> <li>• Centralised intake</li> <li>• Aged Care Assessment Teams (ACAT)</li> <li>• Agedcare Services in Emergency Teams (ASET)</li> <li>• Outpatient Clinics – Geriatric and Rehabilitation</li> <li>• Day Hospitals and Outpatient Therapy</li> <li>• Home Based Therapy</li> <li>• ComPacks</li> <li>• Transitional Aged Care Program</li> <li>• Community Dementia Teams</li> <li>• Centre Based Day Care</li> <li>• Dementia Advisory Services</li> <li>• Respite and Support Services</li> </ul>
Inpatient Services	<ul style="list-style-type: none"> <li>• Acute, Sub-Acute Aged Care &amp; Rehabilitation Units (including dementia/delirium units)</li> <li>• Inpatient Geriatric/Dementia Consultation</li> <li>• Inpatient Rehabilitation Consultation</li> <li>• Dementia and Gerontology Clinical Nurse Consultants</li> </ul>

Core services operate within a continuum of care represented in the figure following.

Figure 5.2 AC&RS Continuum of Care – Core Services



## **5.2 Supra-regional Services**

SSWAHS operates a state-wide Brain Injury Rehabilitation Service and has developed specialist capacity in other areas, such as Acute Burns. Expansion of specialist rehabilitation associated with these and other services will complement the AC&RS structure in SSWAHS in the future. The provision of additional specialist services will enhance the current services available for patients and clients. It will also assist in attracting and retaining staff and educating students. Supra-regional services are discussed in greater detail in Section 7.

## **5.3 Partnership/Associated Services**

AC&RS has close relationships with other internal and external service providers in the delivery of services. Many of these partners are essential in the delivery of core and supplementary services for AC&RS clients. They include other Medical and Surgical sub-specialities, the Specialist Mental Health Service for Older People (SMHSOP), Allied Health and Community Health Services. Service partners and associated services are discussed in greater detail in Section 8.

## **5.4 Understanding and Interpreting the AC&RS Delivery Model**

New models of care are continually being developed for AC&RS. The evidence base for these services is variable, though some services may have the potential to alter current health service utilisation rates. Evaluation of emerging models is required, to determine if more effective models of care than those identified as core services can be implemented across the Area. As required, the Service Delivery Model will be adjusted to take into account new evidence and best practice.

Due to the complex funding and legislative environment in which AC&RS function, there is a lack of consistency in the way services operate. Some services are targeted at particular age groups. For example, Agedcare Services in Emergency Teams and Aged Care Assessment Teams primarily target people aged over 70 years. Different service criteria make it difficult to compare services across program boundaries.

There are a number of significant issues relating to Aged Care and Rehabilitation data at National, State and Area level. These include:

- Different data management and information technology systems;
- Different data definitions;
- Different standards of reporting requirements eg. client registrations; and
- Different service structures and models of care, resulting in data which cannot reliably be compared across locations.

Data presented in this Plan is variable and not always reliable. A solution to address these issues is included within the *Older Persons and Aged Care Services Clinical Redesign* project.

## 6. CORE SERVICES

Core services are those which must be available locally for local populations across SSWAHS. These services are essential for the delivery of safe and timely aged care and rehabilitation services. Core services have been categorised as either community/non-inpatient or inpatient.

### 6.1 Community and Non-Inpatient Services

A range of community and non-inpatient services are required for AC&RS clients, including community and hospital based prevention, early intervention, support and maintenance services. The following core community and non-inpatient services are required to provide for the growing demand from AC&RS clients.

- Section 6.1.1 - Centralised Community Intake
- Section 6.1.2 - Aged Care Assessment Teams
- Section 6.1.3 - Agedcare Services in Emergency Teams
- Section 6.1.4 - Outpatient Clinics – Geriatric and Rehabilitation
- Section 6.1.5 - Day Hospitals and Outpatient Therapy
- Section 6.1.6 - Home Based Therapy
- Section 6.1.7 - ComPacks
- Section 6.1.8 - Transitional Aged Care Program
- Section 6.1.9 - Community Dementia Teams
- Section 6.1.10 - Centre Based Day Care
- Section 6.1.11 - Dementia Advisory Services
- Section 6.1.12 - Respite and Support Services

#### 6.1.1 Centralised Community Intake

In the eastern part of the Area, AC&RS operated three Intakes, servicing the local areas of Canterbury, Camperdown and Concord. Each Intake has dedicated intake clinicians and accepts referrals for Aged Care Assessment Teams, Home Based Therapy, Community Options (Camperdown & Concord), Respite Services, and Day Hospital services and local Geriatric speciality clinics.

Research indicates that Central Intake provides an:

- Informed, single point of contact for information, and a referral point for local health community services;
- Improved consistency in access to information, and referral to local community services for consumers;
- Increased clarity regarding community services;
- Increased clarity for GPs around the level and type of SSWAHS services;
- Reduction in the number of incorrect referrals to community services;
- Improvement in the quality of referral information; and
- Improved consumer satisfaction

The *Older Persons and Aged Care Services Clinical Redesign Project* will concentrate on the development of a single access point, consistent eligibility criteria and a concise referral guide. Implementing the centralised intake model across the Area and monitoring its effectiveness should occur.

#### **Recommendation – Centralised Community Intake**

***Expand the centralised community intake model across the Area through the Older Persons and Aged Care Services Clinical Redesign Project***

#### 6.1.2 Aged Care Assessment Teams (ACAT)

Although traditionally funded to undertake assessment of people to facilitate entry into residential or residential level care, in practice, the role of ACATs in NSW has expanded to be significantly more comprehensive. There is contention at a state and national level about whether ACATs should have a narrow or broad function in assessment and service delivery.

In SSWAHS, multi-disciplinary ACAT services are provided in community and hospital settings. If accessed in a timely manner, they can assist in early identification and resolution of a range of problems for clients, thus reducing their need for admission to hospital.

ACATs provide multidisciplinary assessment of the aged care client; short term care coordination as appropriate; recommend an appropriate level of support; and provide a consultative service to hospital, specialist and primary care practitioners. ACATs may also provide assistance with programs such as chronic disease self-management, carer support, advocacy, dementia support, community and professional education. The range of services delivered by ACATs varies across SSWAHS depending on locality based service management structures and opportunities which have arisen over time. The level of staffing varies depending on catchment populations, historic factors and operating issues.

People referred for an ACAT assessment are usually over the age of 70 years (or 50 years if they are from an Aboriginal or Torres Strait Islander background). These people are considered to be the 'target group'.

#### 2005/06 Activity Data

The data in Table 6.1 provides an indication of the number of referrals accepted and assessments completed in 2005/06. The rate per 1,000 people in the target group can be used as a guide to the need for service within the population and/or the availability of service locally. Some teams do not collect all data on inpatient assessments. This data therefore should not be used to compare efficiencies.

**Table 6.1 ACAT Activity – Referrals and Completed Assessments 2005/06**

ACAT	2003 Estimated Target Population	Referrals Accepted	Completed Assess- ments	Target Group Assess- ments	% of Assess- ments done for Target Group	Completed Assess- ment Rate per 1,000 target population per year
Bankstown	18,514	2,160	1,802	1,615	89.6%	97.3
Liverpool/ Fairfield	21,728	3,699	3,110	2,708	87.1%	143.1
Camden	11,970	1,717	1,408	1,168	83.0%	117.6
Wingecarribee	4,936	640	627	575	91.7%	127.0
Concord	17,875	1,940	1,810	1,674	92.5%	101.4
Canterbury	12,865	1,046	874	774	88.6%	67.9
Camperdown	12,970	1,688	1,502	1,217	81.0%	115.8
<b>Total</b>	<b>100,858</b>	<b>12,890</b>	<b>11,133</b>	<b>9,731</b>	<b>87.4%</b>	<b>110.3</b>

Source: Aged Care Assessment Program Quarterly MDS Report 2005-06

#### Current and Emerging Issues

- **The role of ACATs** - resolution of the definition of an ACAT between the Australian Government and NSW Health is required to facilitate future planning;
- **Service access** – waiting lists exist to access ACAT services across the Area. The length of waiting lists differ and are variable over time, subject to local circumstances;
- **Policy and Procedures** – there is variation in practice across the Area;
- **Avoidable hospital admissions** – timely access to ACAT assessment in the community may reduce avoidable hospital admissions by identifying and arranging care for clients at an early stage, rather than after an acute episode;
- **ACAT delegation** – reductions in the number of staff able to function as ACAT delegates (authorise eligibility for residential or residential level care) has occurred in some areas, resulting in longer waiting lists and waiting times for assessment;
- **Inpatient assessment** – different models of inpatient ACAT assessment operate across SSWAHS hospitals. Inpatient assessment processes require review to ensure compliance with ACAT Guidelines. This may result in a transfer of workload from inpatient staff to ACAT staff, and may subsequently produce longer waiting lists and waiting times for community assessments;
- **Introduction of new Australian Government programs and requirements** - since 2003/04 these include: ACATs mandated role in asset testing procedures necessary for entry into residential aged care facilities; increased numbers of non-target group, complex assessments

due to the responsibility for the completion of the Boarding House Screening Tool for clients wishing to enter Boarding Houses; ACATs identified as one of the HACC Comprehensive Assessment agencies under Regional HACC protocols; ACATs identified as the investigative and assessment agency for HACC agencies in cases of suspected abuse of older people; changes to ACAT assessment requirements, including data entry, and the introduction of the Transitional Aged Care Program. These additional roles have increased ACAT workloads, and contribute to the long waiting lists;

- **Access to motor vehicles** - the majority of ACAT assessments are undertaken in the community setting. Access to motor vehicles is essential to facilitate timely assessment of clients and reduce waiting lists;
- **Interpreters** - in some language groups and at particular times, there is unmet demand for interpreter services. Work continues to be required between staff and interpreter services particularly regarding diagnoses and professional separation;
- **Review of the Aged Care Assessment Program in NSW (BSR Solutions)** – there has been a major review of ACAT policy. It is anticipated that the review will recommend major structural reform; and
- **NSW Auditor-General's Report** – Strategies are being developed to implement recommendations in the Auditor-General's report on ACATs in NSW (Auditor-General 2006).

#### Projected Activity

The need for the traditional ACAT service (assessment of eligibility for residential level care) is projected to almost double in the future, in line with the eligible population. Assuming the average rate of assessment across SSWAHS is maintained (110 per 1,000 people in the target group), it is projected that 12,803 people would require assessment in 2011, an increase of 1,670 from 2005/06 (based on the number of completed assessments).

Taking into consideration existing waiting lists, the need to undertake assessments for people outside of the target group and the increase in the 85+ year old population, a benchmark of 120:1,000 people over 70 years may be a more appropriate target (see Table 6.2). To meet this projected need, additional staffing for all ACATs, and enhanced information and communication systems, will be required to develop efficiencies in the service model.

**Table 6.2 Estimated Number of People Requiring Assessment 2006 - 2016**

ACAT	Current rate 110:1,000 target population		Required rate 120:1,000 target population	
	2011	2016	2011	2016
Bankstown	2,026	2,113	2,210	2,305
Liverpool/Fairfield	3,172	3,715	3,460	4,052
Camden	1,774	2,291	1,936	2,500
Wingecarribee	701	872	764	952
Concord	2,079	2,257	2,268	2,462
Canterbury	1,560	1,672	1,702	1,824
Camperdown	1,490	1,645	1,626	1,795
<b>SSW</b>	<b>12,803</b>	<b>14,566</b>	<b>13,967</b>	<b>15,890</b>

Source: Aged Care Assessment Program Quarterly MDS Report 2005-06 and DIPNR Population Projections (2004)

Note: Target Population based on Number of People 70+ only (not weighted for Aboriginality). Target population does not include the number of assessments undertaken for other people eg. younger people with a disability or dementia.

#### Future Model of Care

The activity projections outlined above indicate a need to increase the number of ACAT staff performing traditional roles by 2016 in line with population growth, if existing service levels are to be maintained. Greater resources will be required if the desired higher rate of assessment is offered, or if a more comprehensive model is agreed between funding bodies.

The preferred model is to develop a more responsive service comprising a rapid response team to respond to the needs of inpatients, patients post discharge from hospital or ED, patients referred urgently by GPs, and residents of aged care facilities.

Multi-disciplinary staffing should include staff from a range of disciplines such as nursing, physiotherapy, social work, occupational therapy, speech pathology, welfare and dietetics. Appropriate linkages should also be created and maintained with SMHSOP trained staff in

psychology and neuropsychology. In addition, psychogeriatric nurses could also be attached to ACAT or provided as a separate but closely linked service (refer Section 8.2).

It is estimated that each ACAT staff member manages an approximate case load of 140 people per annum. This is based on a multi-disciplinary assessment service which involves staff having an active role in the support and management of clients who are not recorded in their case load. It should be noted that the availability of support services in each locality will need to be taken into consideration in the use of these projections, with potential adjustments required based on local circumstances.

#### **Recommendation – Aged Care Assessment Teams**

***As funding permits, expand the accessibility of ACAT services in hospitals and community settings, including the development of an Area-wide rapid response capacity***

#### **6.1.3 Agedcare Services in Emergency Teams (ASET)**

Given the number of older people accessing SSWAHS Emergency Departments (ED), specific services have been developed to enhance the responsiveness of EDs to the needs of older people. This is consistent with the *Framework for the Integrated Support and Management of Older People in the NSW Health System*. At present the Agedcare Services in Emergency Teams (ASET) is the only ED based aged care service model in SSWAHS. As identified in 'the Framework', the community/residential care to ED interface is a critical pressure point in the continuum of health care for the older person and in relieving pressure on the acute hospital system. Closely associated with this is the need for preventive community services and sound communication mechanisms.

ASET's provide a rapid and comprehensive multifaceted geriatric assessment of targeted elderly patients who have presented to the ED. This improves the understanding of the elderly person's presentation to ED, and facilitates appropriate discharge home (by the organisation of services and liaison with primary health providers) or fast tracking of appropriate admissions. Referrals to ASET come from other ED staff, using an agreed screening protocol, leading to a collaborative approach to the delivery of specialized care.

ASET's are based in EDs at RPAH, CRGH, Canterbury, Liverpool, Fairfield, Bankstown-Lidcombe, and Campbelltown Hospitals during core office hours. An extended hours/weekend service recently commenced at Bankstown-Lidcombe Hospital.

#### 2005/06 Service Activity

Because ASET is predominantly targeted at people aged 70+ years (the main users of the service), the following data is presented for this age cohort. However, to highlight the changes which will occur with the ageing of the population, a separate analysis of the 85+ year cohort is also included.

In 2005/06, there were 277,884 ED presentations comprising 102,511 (in the east) and 175,373 (in the south west) presentations. The distribution of presentations across the Area is consistent with the differing demographic profiles. Table 6.3 indicates that ED presentations for people aged 70+ years equate to approximately 45% of the total population in that cohort. More notably, approximately 70% of people aged 85+ years presented to an ED in 2005/6.

**Table 6.3 Emergency Department Presentations by Zone and Age (70+ years) 2005/06**

	<b>70-84 Est. Pop. 2006</b>	<b>70-84 ED Presen- tations</b>	<b>% of total 70- 84 pop.</b>	<b>85+ Est. Pop. 2004</b>	<b>85+ ED Presen- tations</b>	<b>% of total 85+ pop.</b>	<b>70+ Est. Pop. 2006</b>	<b>70+ ED Presen- tations</b>	<b>% of total 70+ pop.</b>
<b>East</b>	36,421	15,742	43%	7,672	5,332	69%	44,093	21,074	48%
<b>South West</b>	52,060	20,269	39%	8,780	6,153	70%	60,840	26,422	43%
<b>SSWAHS</b>	<b>88,481</b>	<b>36,011</b>	<b>41%</b>	<b>16,452</b>	<b>11,485</b>	<b>70%</b>	<b>104,933</b>	<b>47,496</b>	<b>45%</b>

Source: HIE 2007

Table 6.4 quantifies the number of referrals made to ASET at each participating hospital in 2005/6. If incomplete RPAH data is excluded from analysis, it indicates that across the Area approximately 13% of people aged 70-84 years and 21% of people aged 85+ years presenting to ED are referred to ASET. At present, not all referrals are able to be actioned due to the team circumstances at the time, however it does provide an indication of demand.

A review of 2005/6 ED presentations by over 70 year olds showed that they are consistent across weekdays and weekends. Approximately 60% of patients present between 8am - 5pm, 23% present between 5pm - 10pm, and the remainder overnight.

Of total ED presentations by over 70 year olds, 44% occurred during the core ASET hours of 8am - 5pm weekdays. A further 17% occur between 5 - 10pm weekdays, and 15% occur during weekend business hours.

**Table 6.4 ASET Activity 2005/06**

Facility	People Aged 70-84			People Aged 85+		
	ED Presentations	ASET Referrals	% Referred to ASET	ED Presentations	ASET Referrals	% Referred to ASET
Bankstown	5,618	487	9%	1,907	325	17%
Liverpool	5,865	691	12%	1,555	331	21%
Fairfield	3,264	277	8%	885	123	14%
Campbelltown	3,058	493	16%	1,083	233	22%
RPAH	6,123	N/A	N/A	1,691	N/A	N/A
Canterbury	3,618	504	14%	1,293	319	25%
CRGH	6,002	1,128	19%	2,343	586	25%
SSWAHS	33,548	N/A	N/A	10,757	N/A	N/A
SSWAHS excl.	27,425	3,580	13%	9,066	1,917	21%

Source: 2005/06 ASET Activity Reports; HIE

Note: Full year data is not available for RPAH

#### Current and Emerging Issues

- **Population ageing** – as the population continues to age rapidly and if current access trends continue, there will be an increase in demand from older people, particularly frail older people, on EDs;
- **Prevalence of dementia** – the prevalence of dementia is expected to double by 2016. Particular expertise will be required to assist clients with dementia;
- **Service accessibility** – ASET is not available at Bowral and Camden Hospitals. At present, the service is generally only available during core business hours;
- **Emergency Department Roles/Ambulance flows** – ED based aged care services will need to be responsive to the facility's role in emergency care, including ambulance flows. Changes may be required over time in response to changing facility roles;
- **Local service model** – there is considerable variability in ASET staffing across the Area. Some ASETs are single discipline, whilst others are multidisciplinary;
- **Evolving models of care in ED** – new ED based models of care are being trialled across NSW. Results on service effectiveness are not yet available; and
- **Staffing** – it is not possible to backfill ASET positions in many cases, resulting in reductions in service activity.

#### Projected Future Activity

If the Emergency Department/Urgent Care Centre configuration remains the same, it could be expected that the pattern of presentations for those aged 70-84 years and 85+ years will occur as reflected in Table 6.5. This calculation is based on 2005/6 activity and population estimates which indicate that across SSW 41% of people aged 70-84 years and 70% of those aged 85+ years present to ED annually.

**Table 6.5 Projected Emergency Department Activity 2011 – 2016 by Age**

Facility	Actual 2005/06		2011		2016	
	70-84	85+	70-84	85+	70-84	85+
Bankstown	5,618	1,907	6,048	2,569	6,154	2,940
Liverpool	5,865	1,555	3,993	1,372	4,941	1,820
Fairfield	3,264	885	5,879	1,960	6,376	2,499
Campbelltown	3,058	1,083	4,125	1,239	5,285	1,519
Camden	524	134	1,447	539	1,939	728
Bowral	2,102	618	2,107	861	2,620	1,078
RPAH	6,123	1,691	4,655	1,541	6,433	3,381
Canterbury	3,618	1,293	4,711	1,883	4,949	2,191
CRGH	6,002	2,343	6,027	2,856	6,433	3,381
<b>SSWAHS</b>	<b>36,174</b>	<b>11,509</b>	<b>38,992</b>	<b>14,820</b>	<b>45,130</b>	<b>19,537</b>

Source: DIPNR 2004 Population Projections; 2005/06 ED Activity HIE (2007)

Note: This is a simplistic analysis based on LGA of residence. The data assumes all Wollondilly residents will flow to Campbelltown; all City of Sydney, Leichhardt & Marrickville residents will flow to RPAH and all Burwood, Strathfield, Ashfield & Canada Bay residents will flow to CRGH. There is no modelling of actual flows for the purpose of this exercise.

The projections show an overall increase of 8,956 presentations for people aged 70-84 years between 2006 and 2016, an increase of 25%, whilst for the 85+ year population it is projected that there will be an additional 8,028 presentations, or an increase of 70%. The data presented in Table 6.5 does not take into account ED flows. For example, Liverpool Hospital will receive a proportion of the Fairfield flows, as a result of its tertiary status.

It should be noted that changes to the health status of these patients and the success of early intervention initiatives (eg. with residential aged care and GPs) may see changes in the rate of presentations to EDs. There is considerable debate regarding how the health of the 'older' population might change, with some schools of thought indicating that they may be more well, whilst others believe there will be more older people with chronic illness and disabilities who will require care, such as the number of people with dementia. Given the projected longevity of the population, it is likely that both of these schools of thought are correct, as people will be healthier for longer and live with longer periods of disability. The status quo projections following may adjust a small amount either way. It is not possible as yet to quantify the impact of early intervention initiatives, but as they are introduced, key performance indicator data should be collected to monitor this trend.

Given the projections above and current ASET activity, it is possible to project the minimum level of activity an ASET service would be required in the future. Table 6.6 outlines projected activity based on the current average proportion of assessments (13% for those 70-84 years and 21% for 85+ years) and a clinically validated preferred proportion of assessments per facility (18% for those 70-84 years and 25% for 85+ years).

The projections indicate that by 2011, there will be at least 8,199 referrals to ASET compared with the current 5,497 referrals (a 50% increase). If the service is enhanced as per the clinically validated projections, the number of people referred to ASET will increase to 10,476 referrals (a 95% increase).

**Table 6.6 Projected ASET Activity: Status Quo and Clinically Validated Scenarios**

Facility	2011				2016			
	Status Quo		Validated		Status Quo		Validated	
	70-84	85+	70-84	85+	70-84	85+	70-84	85+
Bankstown	786	539	1,089	642	800	617	1,108	735
Liverpool	519	288	719	343	642	382	889	455
Fairfield	764	412	1,058	490	829	525	1,148	625
Campbelltown	536	260	742	310	687	319	951	380
Camden	188	113	261	135	252	153	349	182
Bowral	274	181	379	215	341	226	472	270
RPAH	605	324	838	385	836	710	1,158	845
Canterbury	612	395	848	471	643	460	891	548
CRGH	783	619	1,084	737	660	380	913	452
<b>SSWAHS</b>	<b>5,068</b>	<b>3,131</b>	<b>7,018</b>	<b>3,728</b>	<b>5,690</b>	<b>3,773</b>	<b>7,878</b>	<b>4,491</b>

Source: DIPNR 2004 Population Projections; 2005/6 ED Activity HIE (2007)

Note: This is a simplistic analysis based on LGA of residence. The data assumes that all Wollondilly residents will flow to Campbelltown; all City of Sydney, Leichhardt & Marrickville residents will flow to RPAH and all Burwood, Strathfield, Ashfield & Canada Bay residents will flow to CRGH. There is no modelling of actual flows for the purpose of this exercise.

To cater for this increase in demand, staffing numbers will need to be increased commensurate with the incremental growth in activity. ED bed numbers will also need to be enhanced to cater for growth in the older population in each facility.

#### Future Model of Care

An Aged Care Service such as ASET should be provided in all hospital EDs. Such a service should incorporate multi-disciplinary staffing, to enhance the ability of the service to respond rapidly to the needs of the older patients, and to establish strong links with community based services. However, it is recognized that not all facilities will have a sufficient number of older people presenting to ED to provide a full, comprehensive multidisciplinary team. As such, the size and configuration of the team should be determined locally, based on demand. At some sites, ED based aged care services should operate extended hours (5pm - 10pm) and weekend days to capture additional patients. The demand for this service will need to be determined locally, subject to activity.

New models to improve the care of older people presenting to EDs are continually being developed and piloted. Sydney West Area Health Service (SWAHS) Emergency Departments are piloting the Older Persons Evaluation Review & Assessment (OPERA) Unit model, comprising a dedicated unit for older people designed to facilitate better processes of care and improved patient outcomes. In addition, NSW Health is developing the sub-acute fast track elderly (SAFTE) model of hospital avoidance for patient ages 75 years and older. At this stage it is not possible to determine the effectiveness of these models.

The Aged Care and Older Persons Clinical Redesign Project will review these models and recommend strategies to improve the care of older people within EDs. Solutions may include strategies such as Acute Care Triage and Medical Acute Care Units (MACUs).

#### **Recommendation – Agedcare Services in Emergency Teams**

- A. *Expand existing ASET services to cover extended hours according to demand***
- B. *Review existing and develop new models for the care of older people presenting to Emergency Departments.***

#### **6.1.4 Outpatient Clinics – Geriatric and Rehabilitation**

Outpatient clinics may be medical, multidisciplinary, nursing, or allied health. The range of clinics available varies according to site, and includes general and specialist clinics. Referrals to outpatient clinics come from a variety of sources including General Practitioners, ASET, ACAT and inpatient units. Access to these clinics may prevent avoidable hospital admissions, enable a reduced length of stay through the provision of acute and post-acute care, and provide ongoing support and maintenance. Some clinic types include wound, cognitive disorders, amputee and continence. In some facilities, Ambulatory Care services complement the outpatient clinic role.

Outpatient clinic services are provided at Royal Prince Alfred (RPAH), Concord Repatriation General (CRGH), Canterbury, Bankstown/Lidcombe, Braeside, Liverpool and Camden Hospitals, often with shared infrastructure between aged care and rehabilitation.

#### 2005/06 Activity

Given differences in structure, function and funding sources for the various outpatient clinics across the Area, and differences in data collection and analysis systems, it is not possible to portray accurately outpatient clinic activity.

#### Current and Emerging Issues

- **Population ageing** – as the population continues to age rapidly, there will be an increase in demand from older people, particularly frail older people;
- **Prevalence of dementia** – the prevalence of dementia is expected to double by 2016. Particular expertise will be required to assist clients with dementia;
- **Geriatric medical workforce** – some parts of the Area, particularly in the south west, have been experiencing difficulties in recruiting geriatric medical staff. As such, there is limited, if any capacity to provide outpatient clinics from some facilities;
- **Service access** – there are long waiting lists to access certain clinic types and/or particular locations;

- **Service equity** – different generalist and specialist clinic services are available across the Area, subject to historical service development;
- **Interpreters** – in some language groups and at particular times, there is unmet demand for interpreter services;
- **Transport** – many AC&RS clients identify difficulties in accessing hospital based services. Appropriate parking, including disabled parking and safe drop-off spots are required for clients using private transport. Organised transport to and from geriatric clinics facilitates access and improves safety;
- **Physical capacity** – AC&RS clients are usually accompanied by carers and/or family members and often have mobility aids to assist them in the activities of daily living. Clinic space must include sufficient room to accommodate these needs; and
- **Data collection and management** – there is a need for standardised data collection and management across outpatient services, to assist in service performance management and monitoring. Such a system must recognise the variability in funding sources and reporting requirements. Improving these systems will allow clinical staff to have a greater focus on the delivery of clinical services.

#### Projected Future Activity

If equity of service provision across the Area is to be achieved, and services are able to meet the needs the target group, additional medical, nursing and allied health staff, as well as administrative support will be required.

#### Future Model of Care

Outpatient clinics will continue to be a core service within AC&RS, with a focus on early identification and treatment of illness or functional decline, to prevent avoidable hospitalisation and/or premature admission to residential aged care, as well as post-acute care, support and maintenance. Patients may be referred to these clinics by their General Practitioner, ASET/ED based services, ACAT, or inpatient unit.

These clinics will complement other services within the service model. They will be client focussed, offering 'whole of patient' care, where appropriate in a multidisciplinary model.

The range and scope of clinics at each facility should be based on local demand and the local service system, including access to medical or other expertise. An aged care/geriatrics clinic should be available at all sites with an aged care medical presence. Highly specialised services should be available across the Area, particularly memory, falls and balance and continence clinics. Some of these clinics will need to be linked with other services, such as the Specialist Mental Health Service for Older People. A rehabilitation clinic should be available at all sites with a rehabilitation medical presence, and highly specialised services should be available at central locations. These are considered in Section 8.

#### **Recommendation – Outpatient Clinics**

***Outpatient geriatric clinics are established at Camden and Bowral Hospitals by 2010 and all outpatient clinics are expanded across the Area in line with population growth and ageing***

#### **6.1.5 Day Hospitals and Outpatient Therapy**

Day hospital and/or outpatient therapy services are provided at RPAH, CRGH, Liverpool, Braeside and Camden Hospitals. Service recipients may be under the management of either a Geriatrician or Rehabilitation Specialist, or both.

Day Hospital services provide a mix of medical, nursing and allied health interventions to assist older people to improve functional outcomes, reduce the need for hospitalization and achieve earlier discharge from hospital. The service is usually associated with the provision of a range of therapies over the course of up to 4 hours, which provides opportunities for socialization and a shared meal. Transport to and from the day hospital is also provided.

Beyond these basic services, there is a specialised diabetes and pulmonary rehabilitation service (Canterbury Hospital), a specialised amputee rehabilitation service (Liverpool and RPAH/Balmain), a HACC funded Community Rehabilitation and Physical Disability Team (Camden Hospital), and Extended Care Services (via Bankstown-Lidcombe and Bowral Hospitals).

2005/06 Activity

Data on home based therapy services is collected as part of a larger data set and as such, is not able to be clearly identified.

Current Emerging Issues

- **Hospital alternatives** – the development and expansion of day hospital and outpatient therapy services will reduce the demand on inpatient rehabilitation and sub-acute beds;
- **Chronic disease** - with the introduction of the Rehabilitation for Chronic Disease Program in NSW, work is required across clinical streams to develop a model which can support the demand for outpatient rehabilitation services for people with a range of chronic conditions eg. diabetes, cardiovascular disease, and respiratory disease. Frail older people are a particular target group for these cooperative services;
- **Ambulatory care** – day hospitals can link closely with ambulatory care or community acute post acute care models. Further investigation is required to determine how these links can be best made and/or strengthened;
- **Workforce** – there is a limited global pool of allied health staff to meet the demand for day hospital and outpatient therapy services;
- **Parking** – particularly at Liverpool Hospital and CRGH is difficult to access. Clients of AC&RS services generally have mobility restrictions that make this a significant issue. Patients regularly complain about parking difficulties and report this as a disincentive for continuing their required outpatient treatment;
- **Transportation** – clients requiring outpatient therapy and day hospital services often experience difficulties in accessing services, due to their limited mobility and lack of access to public and private transport. Organised transport can assist in making these services more accessible; and
- **Data management** – there is a need to improve data management to assist in performance reporting and service management.

Projected Future Activity

Demand for day hospital and outpatient therapy services will continue to increase in line with ageing of the population and increasing numbers of people with chronic disease. By increasing activity, patients will be able to be effectively and efficiently transferred from the inpatient setting to receive ongoing care and support through outpatient services.

Future Model of Care

Day Hospital services should be provided to clients who require multiple therapeutic interventions and are able to access centralised services. The benefits of this model to the patient include socialisation and the convenience of access.

Day Hospitals should be provided in association with hospital and community/home based rehabilitation facilities, or in facilities with access to the range of services, infrastructure and equipment required, such as multidisciplinary staffing, food services and gymnasiums. Patient transport must be provided to facilitate access to all day hospital and outpatient therapy services. Links with outpatient clinics, ACATs, ASET and Emergency Departments are vital to the success of the Day Hospital model of care.

Day Hospital and outpatient therapy services should be staffed by comprehensive multi-disciplinary teams including, but not limited to, physiotherapists, occupational therapists, speech pathologists, psychologists (neurological & clinical), dieticians, social workers and diversional therapists, alongside medical and nursing staff. These staff should work in conjunction with other staff from hospital and community settings, particularly with regard to chronic disease management and rehabilitation, ambulatory care and falls management. Access to diagnostic services is essential for day hospitals.

**Recommendation – Day Hospitals and Out patient Therapy Services**

***Day hospital and outpatient therapy services across SSWAHS are expanded at appropriate sites, in line with population growth and ageing***

**6.1.6 Home Based Therapy Services**

Home based therapy (HBT) services complement day hospital and outpatient therapy services. They are particularly provided to people who are able to be treated in the community and who have an adequate support network but are unable to access centre based services. There are limited HBT

services provided in SSWAHS, including a Physical Disabilities Team for younger people with a disability at Macarthur, and a Stroke Outreach Service at Canterbury. Many services have been developed through periodic HACC funding. The HBT services are in addition to those provided through the Transitional Aged Care Program (see Section 6.1.8) and service a wider range of clients. The level and nature of service in each location is dependent on a range of historical factors, including the funding amount and source. This service model is not comprehensively available.

Home based therapy can prevent deterioration and institutionalisation or improve function of the patients, depending on their individual need, and potentially prevent readmission to hospitals. This service works closely with day hospital and outpatient therapy services to ensure the changing needs of clients are met within the most appropriate service model.

#### 2005/06 Activity

Data on HBT services is collected as part of a larger data set and as such, is not able to be clearly identified.

#### Current and Emerging Issues

- **Population ageing** – The population aged 85+ years will increase by almost 100% by 2016. As the population continues to age rapidly, there will be an increase in the prevalence of disability and an associated demand for home based therapy services;
- **Increasing rates of chronic disease** – most of the older age group will experience at least one chronic condition (NSW Chronic Care Program: Phase 2). The prevalence of diabetes is resulting in increased partial foot amputations, showing a need for improved preventative and rehabilitative services;
- **Increasing prevalence of falls** – an increase in the prevalence of falls is anticipated, at least in the short term, as effective intervention strategies are developed and implemented. People experiencing falls require access to a range of appropriate therapy services;
- **Service access** – access to home based services is not equitably available across the Area. This is in part due to external program funding (eg. HACC) being available to develop the service model in some areas only;
- **Access to motor vehicles** – the provision of home based therapy services is only possible if staff have appropriate access to motor vehicles; and
- **Interpreters** – in some language groups and at particular times, there is unmet demand for interpreter services. Home based services receive a lower priority from interpreter services than emergency or hospital services;

#### Projected Future Activity

Demand for therapy services is expected to continue, in line with the ageing of the population, increases in chronic disease and disability.

#### Future Model of Care

Home based therapy services should be provided to clients unable to access outpatient or day therapy services, due to limited mobility and access. Benefits are that rehabilitation services can be offered in an environment (the community setting) which provides the best context for the provision of therapies, and enables training of family and carers in the continued provision of therapeutic interventions. These services should utilise a multi-disciplinary model and be available to suit the needs of clients, for example carers who are working. To be most effective, HBT services should be available on hospital discharge.

By 2016, HBT services should be provided to residents across SSWAHS, through expansion of the existing small services and the development of new teams located at Fairfield (Braeside) and Bankstown-Lidcombe. The services should link closely with day hospital and outpatient therapy services. The HACC program is a possible source of external funding.

#### **Recommendation – Home Based Therapy**

***Home based therapy services are reviewed across the Area, in association with the proposed review of HACC services, to develop a consistent model of care and to inform future services planning and funding applications***

#### **6.1.7 ComPacks**

ComPacks reduce avoidable delays in hospital discharge by ensuring that short term, low level support (such as personal care and domestic assistance), is available to clients immediately on

discharge from an acute care setting. To access ComPacks, clients must need at least two support services.

ComPacks are coordinated by NSW Health and provided through the local Community Options (COPS) provider. Only designated acute hospitals can refer a client for ComPacks. As a result of recent expansion, ComPacks are now available to patients discharged from RPAH, Balmain, Canterbury, CRGH, Bankstown-Lidcombe, Liverpool, Fairfield, Campbelltown and Camden Hospitals. Bankstown, Liverpool and Fairfield ComPacks are funded by the Australian Government to 30 June 2008, and the CRGH program was temporarily funded through Sustainable Access Plan 3 (SAP3). The NSW Health Department will ensure program continuation in the future.

CRGH and RPAH/Balmain ComPacks are provided by AC&RS as the local COPS provider. All other ComPacks are provided by external organisations, which are closely linked with discharge planning teams. ComPacks are predominantly used by AC&RS clients, however they are available for the general hospital population.

A maximum of 6 weeks service is available on this program. As not all clients require the full 6 weeks, ComPacks has capacity to service additional clients (refer Table 6.7).

#### 2005/06 Activity

In 2005/06, ComPacks were only available from some SSWAHS hospitals. Table 6.7 depicts the availability and utilisation of ComPacks. The estimated bed equivalents have been calculated as 1.5 ComPacks per week equals 1 bed equivalent.

**Table 6.7 2005/06 ComPacks Activity**

Facility	ComPacks per week funded	Number of clients serviced by ComPacks	Clients Per Week	Estimated Approximate Bed Equivalents
Bankstown/ Liverpool/ Fairfield	10	905	17.4	6 beds
RPAH/Balmain	4	302	5.8	2 beds

Source: ComPacks Program Forum 2006, NSW Health

With the expansion of ComPacks through the 2006/07 Sustainable Access Plan (SAP3) funding, 17.5 additional ComPacks per week (910 clients annually) were created, with the program expanded to patients discharged from Canterbury, Concord (temporary only), Camden, Campbelltown and Bowral Hospitals. This will enable approximately an additional 1,616 clients to receive the service in SSWAHS, equating to a saving of about 11 beds.

#### Current and Emerging Issues

- **Recurrent funding** – Bankstown, Liverpool, Fairfield and Concord ComPacks receive time limited funding. Loss of funding would delay discharge at participating hospitals;

#### Projected Future Activity

As the utilisation of acute facilities increases, particularly by AC&RS clients and patients with chronic illnesses, demand on ComPacks will increase. An increase in activity will be dependent on funding for additional packages becoming available. Unmet demand for ComPacks increase length of stay.

#### Future Model of Care

Ideally one generic home based care service would be available to meet the short term post-acute care needs of all patients (technical nursing, personal care, domestic support, and functional improvement). At present, inequities exist in the availability of services, and eligibility criteria limit access. However, having one generic home based care services would require substantial systemic change at a national and state level.

Until such consolidation of aged care program occurs, ComPacks should be available to ensure timely, supported discharge for patients who are medically stable, but still require some short term assistance with activities of daily living.

#### **Recommendation – Compacks**

***As funding permits, expand ComPacks services across the Area consistent with population growth and demand***

### 6.1.8 Transitional Aged Care Program

The Transitional Aged Care Program (TACP) is a joint Australian Government-NSW Government funded initiative, which provides time limited post-acute support and rehabilitation to clients who would otherwise be placed in residential care. Access to the TACP requires an ACAT assessment, which identifies that the person would be eligible for residential aged care, has the capacity to optimise their functional capacity and/or requires time to determine their appropriate long-term care requirements. Services provided to TACP clients include: assistance with personal care; domestic duties; the provision of aids, equipment, home modifications and maintenance; and a full range of rehabilitation therapies. To access the program, recipients must be medically stable.

The TACP operates differently across SSWAHS in recognition of the existing available services and structures. In the eastern part of the Area, AC&RS work with Uniting Care to offer 36 community based packages, complemented by a 14 bed transitional aged care unit at Balmain Hospital. In the south west, the AC&RS offer 36 community based TACP packages, with 56 packages to be available from 2007/8.

#### Service Activity

The TACP commenced in SSWAHS in mid 2006, with full year activity data unavailable. NSW Health data from program commencement to mid February 2007 (Table 6.8) indicates that the programs in SSWAHS did not provide a service to anyone aged under 49 years, with 48% of clients aged 70-84 years, 41% aged 85+ years, and 11% aged 50-69 years. The majority of clients utilised TACP from 1 - 3 months.

**Table 6.8 TACP Discharge Destination 01 July 2006 – mid February 2007**

Discharge Reason	WZ	%WZ	EZ	%EZ
To Hospital	10	31%	29	28%
To RACF – high care	0	0%	5	5%
To RACF – low care	2	6%	1	1%
Other	6	19%	7	7%
Return to the community without support	7	22%	22	21%
Return to the community with HACC	0	0%	27	26%
Return to the community with CACP	7	22%	10	10%
Return to the community with EACH	0	0%	0	0%
Client move to other TACP service	0	0%	0	0%
Death	0	0%	2	2%
<b>Total</b>	<b>32</b>	<b>100%</b>	<b>103</b>	<b>100%</b>

Source: NSW Department of Health Inter-Government Funding Strategies Branch (2007)

The program in the east part of SSWAHS commenced earlier than the south west program, resulting in a greater number of discharges. As the program becomes more established and full year figures are available, it is expected that any such discrepancy will not be significant.

#### Current and Emerging Issues

Due to the different models of care employed across SSWAHS, it should be noted that the following issues do not necessarily affect the whole Area:

- **Referral patterns** – there is variability in referral patterns to TACP across hospital facilities, with some facilities not maximizing the benefits TACP offers;
- **Interpreters** - in some language groups and at particular times, there is unmet demand for interpreter services; and
- **Workforce** – difficulties have been experienced in attracting a suitably qualified workforce to available positions. Some disciplines are more difficult to recruit than others.

#### Projected Activity

Presuming full utilization, with each client receiving 12 weeks of service, the following activity is anticipated. Not all clients will require the full 12 weeks of service and as such, these projections are likely to under-anticipate the number of clients who will access the service.

**Table 6.9 Projected TACP Activity**

Facility	Activity at Full Utilisation – based on a 12 week length of stay
Balmain	61 clients per annum
EZ	156 clients per annum
WZ	243 clients per annum

### Future Model of Care

Research is necessary to determine whether or not a “facility based” service is required in the south west, complementing a smaller number of community packages than the 56 which is currently planned. The Australian Government funded Pathways Home Research Project will inform this decision by mid 2008.

#### **Recommendation – Transitional Aged Care Program**

***Monitor Transitional Aged Care Program activity to determine the most appropriate client mix and service structures for ongoing program management***

### **6.1.9 Community Dementia Teams**

Community Dementia Teams (CDT) are a service not yet established in SSWAHS, although the service is successfully operating in South Eastern Illawarra and Hunter New England Area Health Services. The teams generally comprise registered nurses and clinical psychologists.

These teams can provide specialist support in community and residential settings, including the community/acute interface, to support people with dementia and their carers. The focus of CDTs is in providing assistance to manage the behavioural and psychological symptoms of dementia. There is strong evidence that early intervention/appropriate assessment and planning, around the time of diagnosis or onset of severe behavioural disturbance, can prevent escalation of behaviour problems, reduce carer stress, and reduce inappropriate admissions to either hospital or a residential aged care facility (Brodaty, Draper & Low, 2003). At present, SSWAHS has a limited capacity to respond to this area of need, beyond the initial assessment phase.

The service model does not involve long term case management, but rather assessment, initial case coordination, development of behaviour management and modification strategies, referral for long term services, and carer education and support. The service should be developed jointly between Aged Care and Mental Health, with staff ideally located within each ACAT and linking closely with the Specialist Mental Health Service for Older People (SMHSOP), including the BASIS teams. Funding for a Community Dementia Clinical Nurse Consultant (CNC) for SSWAHS was announced in early 2007. This position may focus on development of Community Dementia Teams.

The HACC program is a possible source of funding for the development of Community Dementia Teams. To date, DADHC has not funded such a service in SSWAHS, despite SSWAHS identifying this as a priority for new funding.

#### **Recommendation – Community Dementia Teams**

***Pilot two Community Dementia Teams in SSWAHS (at Concord and Liverpool) staffed by Registered Nurses and Clinical Psychologists, linked with ACAT and the Specialist Mental Health Service for Older People.***

### **6.1.10 Centre Based Day Care**

Centre Based Day Care (CBDC) provides socialisation and monitoring opportunities for frail older people and respite for carers.

SSWAHS operates 20 dementia specific, frail aged, multicultural, ethno-specific and Aboriginal CBDC services, funded by SSWAHS, the HACC Program, and the National Respite for Carers Program (NRCP), or a combination of programs. Each service uses a slightly different model to meet local needs and funding requirements. There are different opening hours, days of operation, activities and staffing. All provide transport to and from the service, greatly facilitating access. CBDC programs operate from a variety of venues such as stand alone buildings on hospital sites, Community Health Centres, and Council premises. Some services share facilities to create economies of scale.

### 2005/06 Activity

CBDC data is collected and reported differently across the Area due to the variability in funding sources. As such, it is not possible to compare this data.

Current and Emerging Issues

- **Increasing prevalence of dementia** - the prevalence of dementia is expected to double by 2016. Particular expertise is required to assist clients with dementia;
- **Model of Care** – models of CBDC differ due to local circumstances. Operational policies also differ. There is a need for consistency and equity across SSWAHS;
- **Increasing frailty of clients** – services note that clients are becoming increasingly complex and frail, requiring greater assistance to attend and participate in activities;
- **Continuum of care/service integration** – it is essential for recipients of CBDC services to be appropriately linked with other acute and community aged care services;
- **Service access** – waiting lists exist to access some services. Growth allocations for CBDC have been forthcoming through the HACC program in recent years, although there is often a time delay to access this funding and develop additional services;
- **Service flexibility**– CBDC is often provided in purpose designed facilities. To maximise use and improve service to the community, out of hours and weekend services are required;
- **Workforce** – equitable staffing profiles should be established across all services and staff should receive appropriate training, especially in the early identification and management of client deterioration;
- **Cultural diversity** – attention needs to be given to the needs of people from culturally diverse communities. This could occur through the employment of bilingual staff for people with dementia from CALD communities, or Aboriginal staff for older Aboriginal people, and use of clustering or ethno-specific days;
- **Corporate governance** – arrangements are being made to streamline CBDC governance to create consistent Area wide structures;
- **Funding** – some CBDC services are funded by SSWAHS and others through HACC and/or National Respite for Carers Programs. Funding amounts and expectations vary between centres; and
- **Staffing** – staffing levels and numbers vary across centres, as do the type of staff employed to provide the service.

Projected Activity

Future CBDC activity will be determined subject to availability of external funding, and a review of CBDC operations in SSWAHS. Demand for this service will increase, although new services may be provided by non-government organisations in the future rather than by SSWAHS, as a result of infrastructure constraints and increasing service costs.

Future Model of Care

As recurrent funding for new CBDC services is now provided through the HACC Program, it is not proposed to establish new centres using SSWAHS resources.

To enhance the service provided to the community and maximise the use of available infrastructure, existing services could be expanded to provide after hours and weekend support, using funding from external programs. Opportunities to develop new dementia specific services may also be considered, which take into account language and cultural needs of local residents. Opportunities to utilise CBDC centres for the provision of outreach assessment and therapy services, and carer support services, should also be considered.

**Recommendation – Centre Based Day Care**

***Undertake a comprehensive review of Centre Based Day Care in SSWAHS, including governance, operations, funding, staffing, policies, procedures, client mix, opportunities for expansion and clinical service delivery***

**6.1.11 Dementia Advisory Services**

Dementia Advisory Services (DAS) are a recently developed service model, established to provide strategic support for people with dementia and their carers in acute, community and residential settings (subject to the funding source). The roles of DAS include: the coordination of services available for people with dementia and their carers; providing individual, group and community health promotion, education and support; undertaking service development initiatives with a range of providers; and assisting with dementia planning and service development. Recent DAS projects include education associated with Carers Week and Dementia Awareness Week, and coordination of carer support groups.

DAS are funded by the Department of Ageing, Disability and Home Care (DADHC), through the Ageing Program or the HACC Program. The Bankstown/Liverpool/Fairfield DAS and Macarthur DAS are funded through the HACC program, and as such are only able to support clients and carers in a community setting. Wingecarribee has a part time DAS position, auspiced by Alzheimers Australia NSW. The Funding Agreement for each individual DAS outlines service roles and responsibilities.

#### Current Activity

It is not possible to compare DAS activity due to different funding sources and roles.

#### Current and Emerging Issues

- **Population ageing** – there will be an almost 100% increase in the 85+ year old population to over 25,000 people in SSWAHS by 2016. Age is the greatest risk factor for Alzheimer's Disease;
- **Increasing incidence and prevalence of dementia** – the prevalence of dementia is expected to double by 2016, with incidence increasing consistently as the population ages. This will place additional demands on DAS services;
- **Younger onset dementia** – there is a need to develop specialist capacity to enable effective assistance of younger people with dementia and their families;
- **Education** – as the number of people working in the area of dementia grows, so does the demand for education services for care staff. There is limited dementia expertise in existing community services. Attention is also required for culturally appropriate education models for carers.

#### Projected Future Activity

Future activity in DAS will be dependent on external funding becoming available. Applications have been made in recent HACC funding rounds, however to date additional DAS funding has not been made available.

#### Future Model of Care

The future model of care provided by the DAS will be dependent on additional funding becoming available. At present, the Funding Agreement between DADHC and SSWAHS provides clear guidelines on the activities which can be undertaken.

#### **Recommendation – Dementia Advisory Services**

***Seek additional HACC funding through DADHC to extend the capacity of the existing DAS services, and their capacity to service culturally diverse communities***

#### **6.1.12 Respite and Support Services**

AC&RS offers a range of respite and support services, generally with external funding, including:

- Transcultural Respite – An Australian Government funded service providing out of home respite for small groups of people from non-English speaking backgrounds. The program facilitates access to broader group activities, such as centre based day care and community based activities. Funding is provided on a three yearly funding cycle, with the current cycle ending June 2008;
- Reslink – An Australian Government funded flexible respite program for carers of people with dementia and challenging behaviours. Funding is provided on a three yearly funding cycle, with the current cycle ending June 2008;
- Out of Hours and Weekend CBDC – An Australian Government funded program providing out of hours and weekend CBDC for people with dementia. Funding is provided on a three yearly funding cycle, with the current cycle ending June 2008;
- Macarthur Home Support Dementia Monitoring Program – a HACC funded monitoring service for people with dementia who live alone or who spend extended periods at home alone.
- Community Aged Care Packages (CACPs) – AC&RS in Liverpool/Fairfield operate CACPs, providing brokered home based assistance to people eligible for low level residential aged care. This service is funded by the Australian Government.
- Dementia Support Service – an Australian Government funded service providing in-home respite for people with severe dementia. Funding is provided on a three yearly funding cycle, with the current cycle ending June 2008;
- Transcultural Aged Care Service (TACS) – an Australian Government funded service supporting multicultural clusters in residential care. Funding is provided on a three yearly funding cycle, with the current cycle ending June 2007;

- Community Options – a Home and Community Care (HACC) funded service operating at Concord and Camperdown only, providing case management and packaged care for frail aged and people with disabilities. This is a capped service with ongoing funding;
- Community Visitors Scheme (CVS) – an Australian Government funded program, recruiting and supporting multicultural volunteers for residents of residential aged care in the Sydney Metropolitan area. Funding is provided on a three yearly funding cycle.

These services provide essential support to older people and their carers in SSWAHS. However, some programs may be equally well provided by non-government agencies. It is important to review the role of SSWAHS in the provision of respite and support services, within the context of the service delivery system.

### **Recommendation – Respite and Support Services**

***Review the role of SSWAHS in the provision of externally funded respite and support services.***

## **6.2 Inpatient Services**

A range of inpatient services at an acute and sub-acute level is required for AC&RS clients. These services include specialised wards, as well as a range of consultative services. Section 8.3 describes options for the improvement of the capacity of specialties other than aged care and rehabilitation to respond to the needs of the target group, particularly in recognition of the high number of 'older' patients throughout the hospital system.

A growing proportion of people entering AC&R inpatient services will be from culturally diverse communities. These clients will require access to interpreter services, or Aboriginal Hospital Liaison Officers, to ensure that their needs are identified and appropriately met. Access to culturally appropriate services should reduce client fear and anxiety about the future.

The following core inpatient services are required to meet the demand from AC&RS clients:

- Section 6.2.1 - Inpatient Beds – Acute and Sub Acute Aged Care and Rehabilitation
- Section 6.2.2 - Aged Care Inpatient Consultation
- Section 6.2.3 - Rehabilitation Inpatient Consultation
- Section 6.2.4 - Dementia and Gerontology Clinical Nurse Consultants

### **6.2.1 Inpatient Beds – Acute and Sub Acute Aged Care and Rehabilitation**

SSWAHS provides inpatient beds for AC&RS clients including acute aged care, sub-acute aged care, rehabilitation and aged care psychiatry. Some beds are in dedicated units, whilst others are located in mixed wards. Table 6.10 depicts availability of inpatient beds in SSWAHS in 2007.

**Table 6.10 AC&RS Beds in SSWAHS**

Facility	Ward Name	Ward Type	Beds as at Dec 2007
RPA	Ward 8 West 1	Acute aged care	30
Balmain <sup>1</sup>	John Beasley	Rehabilitation	26
	Lever	Mixed Acute/Sub-Acute Aged Care	26
	Wakefield	Mixed Acute/Sub-Acute Aged Care	26
Concord	Ward 10	Sub-Acute Aged Care	24 – 28
	Ward 11	Acute Aged Care	24
	Ward 14	Rehabilitation	15
	Ward 15	Acute Aged Care	24
Canterbury	Ward 17	Delirium	12
	Banksia	Mixed Acute/Su-Acute Aged Care	30
	Boronia	Mixed Acute/Su-Acute Aged Care	30
Bankstown	Cassia	General Medicine (shared Aged Care)	12
	Ward 2A	Rehabilitation	20
	Ward 2B	Stroke/ Rehabilitation	20
	Ward 2C	Acute Aged Care	20
Liverpool <sup>2</sup>	Ward 2D	Psychogeriatrics	20
	Aged Care Unit	Acute Aged Care	20
	BIRU	Acute and Transitional Living	20
	BIRU	Community Living Unit	4

Facility	Ward Name	Ward Type	Beds as at Dec 2007
Fairfield	Ward 1b	Sub-Acute Aged Care and	20
Braeside	Ward A	Rehabilitation	36
	Ward C	Aged Care Psychiatry	16
Camden	AC&RSU	Sub-Acute Aged Care / Rehabilitation	20
	MTU	Sub-Acute Aged Care / Rehabilitation	20

Note:

1. The Balmain Hospital Inpatient Bed Profile excludes the 14 bed Residential Aged Transitional Care Program based at Balmain
2. The supra-Area Brain Injury Rehabilitation Unit (BIRU) at Liverpool (which includes acute, transitional and community beds) noted above, is discussed in detailed in Section 7.1

The role of general medicine and stroke units in each hospital has an impact on the utilisation of these inpatient units. Older people requiring hospitalization for a single medical illness may be admitted under geriatric medicine or subspecialty medical services. The number of these patients admitted under geriatric medicine varies greatly across SSWAHS and is reflective of local demands, the presence of General Medicine services, the presence of subspecialty services, and the capacity of the geriatric service to care for these people. There are no general medicine services at Bankstown-Lidcombe, RPAH and CRGH. In mid 2006, the General Medicine service at Liverpool Hospital ceased operation. The impact of this is difficult to quantify at this stage. The future of general medicine in SSWAHS is being debated, with the impact on aged care services (in particular) needing to be considered subject to a determination on the role of general medicine.

The stroke unit at Bankstown-Lidcombe Hospital is managed by Aged Care, with stroke services at other hospitals managed primarily by Neurology. In the eastern part of the Area, most particularly at CRGH, a model of shared care between neurology and AC&RS has been developed to ensure patients have access to multi-disciplinary assessment and treatment, coordinated through the acute and sub-acute phases of inpatient care and post discharge. Such a model has been developed to a lesser extent in the south west.

Acute aged care units provide care for acutely unwell older people using a model of Comprehensive Multidisciplinary Geriatric Assessment and Geriatric Evaluation and Management. These principles aim to identify and treat the multidimensional problems of the aged care client and to plan and provide coordinated medical, psychosocial and rehabilitative care tailored to the patient's specific needs, from the acute setting to the community. The essential components of this holistic model include a Geriatrician-led adequately staffed multidisciplinary team, including Nursing and Allied Health personnel.

#### *Delirium Units*

An acute aged care delirium unit is provided at CRGH (Ward 17), colocated with the broader CRGH Aged Care Service. Patients are older and require management of severe behavioural disturbance, in conjunction with their acute medical care. As appropriate, older patients with primary psychiatric illness who also require acute medical care are also admitted. A higher ratio of staff is required to manage concomitant behavioural problems and acute illnesses. This ward is managed by Aged Care with significant Aged Care Psychiatry input, and is the only unit in SSWAHS. Planning for Liverpool Stage 2 redevelopment has recommended a delirium unit within the aged care precinct.

#### *Falls Units*

A model of inpatient falls prevention has been developed in the neurosurgical ward at Liverpool Hospital. The unit comprises four beds managed by the neurosurgical team, which are allocated for patients who are at a high risk of falling. The small bed number enables improved monitoring of these at risk patients.

Subacute aged care/geriatric rehabilitation inpatient units provide post acute and restorative care for geriatric patients. These patients are frailer, have multiple co-morbidities and are therefore less medically stable than those who receive rehabilitation in a general unit. There is one dedicated unit at CRGH, mixed acute/sub acute and general medicine units at Canterbury, and mixed acute/sub-acute units at Balmain Hospital. Similar units have been established at Fairfield (Ward 1b - shared sub-acute geriatrics and rehabilitation) and Camden Hospitals.

Balmain Hospital has historically provided inpatient rehabilitation services in the east. An additional 15 beds have also been established at CRGH, funding through the Sustainable Access Plan 2005 (SAP2), to enable improved access to rehabilitation.

Braeside Hospital, a Schedule 3 Hospital managed by Hope Healthcare, provides the largest rehabilitation service in the south west, focussing on specialist rehabilitation services for younger, complex rehabilitation patients, primarily from the Liverpool and Fairfield LGAs. A new 20 bed rehabilitation and subacute unit (noted above) recently opened at Fairfield Hospital using SAP2 funding. At Bankstown-Lidcombe Hospital, acute rehabilitation beds, including the specialised orthopaedic/amputee unit, are co-located with the stroke unit. All beds are managed by geriatricians. The Camden Hospital inpatient rehabilitation unit provides services primarily to residents of Campbelltown, Camden, Wollondilly, and Wingecarribee. Bowral & District Hospital offers a low level rehabilitation service using existing acute and sub-acute beds.

Rehabilitation medical staff have admitting rights to four beds at Liverpool Hospital.

In the south west, general rehabilitation beds fulfil the role of the Subacute Aged Care Inpatient Units (Geriatric Rehabilitation Units) provided in the east of the Area.

#### 2004/05 Activity

The majority of admissions for people aged over 65 years occur through the ED. AC&RS activity (2004/05) is reflected in Table 6.11 following. Where shared wards or services exist, the table shows activity for general medicine and aged care psychiatry. Due to historical data collection methods, data for Bankstown-Lidcombe, Liverpool, Camden, Braeside, RPA, Balmain and CRG Hospitals reflect statistical separations (ie. include type changes in respect to acute, sub-acute and rehabilitation separations). Canterbury Hospital data reflects financial separations, or the total hospital stay.

**Table 6.11 Inpatient Activity for Aged Care and Rehabilitation 2004/05**

Hospital	Ward	Separations			% Same Day	O'night ALOS	O'Night Beddays	O'night Beds @ 85%
		O'N	D'O	All				
Bankstown-Lidcombe	Acute Geriatric (2C)	529	0	529	0.00	11.45	6,059	20
	Aged Care Psychiatry (2D)	390	1	391	0.26	16.84	6,568	21
	Rehabilitation (2A&2B)	694	3	697	0.43	24.59	17,067	55
	Other	707	97	804	12.06	11.65	8,234	27
Liverpool	Acute Geriatric	638	1	639	0.16	12.14	7,748	25
	Other	149	6	155	3.87	16.52	2,461	8
Camden	Inpatient Rehabilitation	253	3	256	1.17	28.42	7,191	23
Braeside	Inpatient Rehabilitation	457	1,511	1,968	76.78	23.63	10,800	35
	ACP	139	5	144	3.47	35.04	4,870	16
RPAH	Acute Geriatric	1,224	119	1,343	8.86	8.57	10,491	34
Balmain	All inpatient (acute geriatric/ subacute geriatric & rehabilitation)	1,481	68	1,549	4.39	14.70	21,773	70
TCH	General Medicine	2,854	194	3048	6.36	5.31	15,155	49
	Acute & Subacute Geriatrics	685	8	693	1.15	12.84	8,795	28
CRGH	Acute Geriatric	1,725	19	1,744	0.01	12.70	21,910	71
	Subacute Geriatric	427	116	543	0.21	18.50	7,901	25
	Inpatient Rehabilitation	60	0	60	0.00	27.33	1,640	5

Source: CERNER 2005

Camden and Braeside Hospitals provide rehabilitation services, with 20 and 36 beds respectively operational in 2004/05. The data demonstrates a need for approximately 23 and 35 beds

respectively for the year, calculated at 85% occupancy. The high average length of stay (ALOS) at Camden is likely to reflect the transfer of long stay patients from Campbelltown Hospital.

Liverpool Hospital has a 20 bed acute geriatric ward. In 2004/05, 33 beds at 85% occupancy were utilised by these patients. At any stage, between 15 and 30 patients have active rehabilitation issues. A number of these patients would benefit from being colocated, with an emphasis on a rehabilitation milieu, whilst at the same time having their acute medical needs met at Liverpool Hospital.

Bankstown-Lidcombe Hospital does not have a general medicine unit, with geriatricians providing the general medicine service. This shared service, along with shared aged care/aged care psychiatry wards, make analysis of activity data for geriatric medicine difficult. The data indicates a large number of outliers are being treated by geriatricians, with 27 beds outside of the aged care/aged care psychiatry wards utilised. Bankstown-Lidcombe Hospital also runs a 40 bed rehabilitation unit (including 8 designated stroke beds). Activity in 2004/05 utilised 55 beds.

RPAH operated a maximum of 28 acute aged care beds in 2004/05, including winter beds. In 2004/05, 34 beds were occupied by acute geriatric and general medicine patients. It is not possible to disaggregate general medicine from acute geriatric patients in this total bed analysis.

Balmain Hospital operates as a stand alone 78 bed geriatric and rehabilitation facility. Patients are transferred from RPAH to Balmain, predominantly for sub-acute and rehabilitative care. Activity at Balmain Hospital in 2004/05 indicates that 70 beds were required. However, with the changes to acute beds at RPAH, these additional beds are likely to be fully utilised in 2005/06.

The CRGH service has a complex service role, incorporating acute and sub-acute aged care, and rehabilitation. The geriatricians also provide general medicine. Until 2005/06 there were no designated rehabilitation beds and as such rehabilitation activity is fairly low. In 2004/05, there were 88 aged care and general medicine beds at CRGH, however activity suggested the need for 96 beds, plus another 5 beds for rehabilitation (totally 101 beds). The development of the 15 bed rehabilitation unit in 2005/06, meets the additional bed requirements at present.

Canterbury Hospital operates a general medicine service and an acute and sub-acute aged care service. Beds are located in shared wards. Current activity in geriatrics suggests that 28 beds, or essentially a designated ward, were required in 2004/05.

Average length of stay (ALOS) for patients varies across the hospitals, and is difficult to break down due to the combination of patients within the data presented. However, it is evident that rehabilitation patients generally stay for between 20 and 30 days, and aged care patients stay between 8 and 16 days, depending on their level of acuity. Whilst changes to models of care and other improvements may enable a less variable length of stay to be achieved, clinicians indicate that length of stay is unlikely to be greatly reduced, given the ageing population and increasing frailty of most patients.

#### Current and Emerging Issues

- **Population ageing** – the increasing number of older people will result in increasing demand for AC&RS beds;
- **Prevalence of dementia** – people with dementia are known to have a four times longer length of stay in hospital than older people without dementia. A high proportion of aged care inpatients also experience delirium. Improvements to ward environments and staffing may assist in reducing this length of stay;
- **Younger people with a disability** – AC&RS inpatients include younger people with a disability. Some will have ongoing guardianship issues, delaying appropriate discharge;
- **Emerging models of care** – the delivery of community based services for the treatment of chronic illness, and alternative settings for the delivery of therapy services, may reduce inpatient demand;
- **People with complex discharge needs** – many AC&RS patients require the coordination of an array of community services before they can go home, including home modifications and support services;
- **Patients requiring residential aged care placement** – a number of patients in each facility will be awaiting placement in a residential care facility, but for various reasons have not yet been discharged;

- **Patients with severe aggression** – a number of patients in hospital display severe behavioural disturbance and aggression. They require specialised care and support, to improve safety for the patient themselves, other patients and staff. This group of patients are at significant risk of creating adverse events and are resource intensive with a high rate of one to one nursing; and
- **Data and performance management** – Data on inpatient activity is variable, due to a range of factors including the inability to sort patients by particular AN-DRGs, the presence of shared wards and shared specialties, and current data collection issues.

#### Projected Future Activity

Projected future activity and need for additional inpatient beds calculated is based on estimated activity in 2004/05 and a clinically validated benchmark of likely future activity. This benchmark suggests that in the future 0.05% of people aged over 65 years will require an acute aged care bed and have a 12 day ALOS, and 0.03% of people aged over 65 years will require a sub-acute aged care or rehabilitation bed, with a 20 day ALOS. This includes consideration of increased beddays associated with falls and the projected number of patients with dementia/delirium (refer Sections 4.1.1, 4.1.2 and 4.1.3).

Table 6.12 following indicates that by 2016 there will be over 16,000 separations annually, utilising almost 250,000 beddays. If there are no changes to the models of care for AC&RS clients by 2016, over 300 additional beds would be required.

**Table 6.12 Projected Acute & Sub-Acute Aged Care & Rehabilitation Activity**

South West Services	2006		2011 (estimated)			2016 (estimated)		
	Pop	Beds	Pop	Seps	Beddays	Pop	Seps	Beddays
<b>Aged Care*</b>	87,790	204	101,980	5,099	61,188	123,790	6,190	74,274
<b>Rehabilitation</b>				3,393	67,863		4,119	82,376
<b>Total AC&amp;RS</b>				8,492	129,051		10,308	156,650
Eastern Services	2006		2011 (estimated)			2016 (estimated)		
	Pop	Beds	Pop	Seps	Beddays	Pop	Seps	Beddays
<b>Acute AC</b>	61,295	230	65,196	3,283	39,402	73,051	3,679	44,149
<b>Sub Acute</b>				1,494	29,888		1,674	33,489
<b>Rehabilitation</b>				613	12,253		686	13,729
<b>Total AC&amp;RS</b>				5,391	81,543		6,040	91,368

Source: Cerner 2004/05 and DIPNR Population Projections 2004

#### Assumptions and Notes:

1. The EZ runs a specific sub-acute geriatric service. Equivalent patients in the WZ are treated in rehabilitation beds.
2. Where general medicine is provided by geriatricians, it has not been possible to separate the activity. Adjustments of projected bed numbers downwards are required to reflect this activity (captured in planning for EZ through the RTP, and WZ through the Medicine and Ambulatory Care Plan). General Medicine activity has not been projected for any hospital with a unique general medicine service.
3. Aged Care activity in the WZ includes aged care psychiatry beds which are planned for in the Mental Health Clinical Services Plan. Projected bed numbers will need to be adjusted downwards to reflect this activity.
4. Rehabilitation in the WZ includes the stroke unit at Bankstown - also addressed in medicine plan under neurology and therefore projected bed numbers may need to be adjusted downwards to reflect this activity.
5. Not all rehabilitation clients are aged 65+, though the focus of the service is on older people.

It is recognized that it will not be possible to provide the infrastructure required, based on the projections referred to in Table 6.12, although some beds may be provided through a reconfigured bed base. However, it is evident that a significant increase in inpatient beds will be required to meet additional demand over the next 10 years. To counter this demand for AC&RS inpatient beds, a range of supplementary support services, and improved management of all older people within the hospital environment, must be provided. These were discussed throughout Sections 6.1 and 8.

Through planning for the Liverpool Hospital Stage 2 redevelopment, it has been agreed to develop an additional AC&RS capacity of 30 beds (taking the total bed numbers to 50, in two 25 bed units). Eight of these beds have been dedicated to rehabilitation. The AC&RS units will be complemented by an additional 20 bed aged care psychiatry unit within the proposed AC&RS precinct. It is envisaged at this stage that these beds will be operational by 2016.

## Future Model of Care

### *Aged Care*

Aged Care clients managed with the Geriatric Evaluation and Management Inpatient Care Model have fewer acute care hospital admissions, spend less total time in acute care hospitals and have a lower mortality rate as a result (Stuck et.al, 1993; Rubenstein , LZ, 1987; Winograd & Stearns, 1990; Inouye et. al, 1993; Landefeld et.al, 1995; Asplund et. al, 2000; Cohen et. al, 2002). In addition, greater improvements in functional status have been demonstrated, with fewer initial discharges to residential aged care facilities (RACFs) and less time spent in RACFs. Studies evaluating the cost-effectiveness of this model of inpatient services demonstrate either cost neutrality, or long-term cost-benefit, compared with inpatient hospital care in generic wards.

By 2016, acute Aged Care inpatient beds should be provided at RPA, Balmain, CRG, Canterbury, Liverpool, Fairfield, Bankstown-Lidcombe, Campbelltown and Bowral Hospitals. Further investigation should occur to determine the appropriateness of developing a separate sub-acute aged care inpatient unit at Camden Hospital. If established, this sub-acute unit should be clinically networked with acute aged care services provided at Campbelltown Hospital. Such a networking arrangement would allow for the appropriate management of patients who become unwell/unstable in subacute care. To be effective, all units need to be staffed with multi-disciplinary teams. Within identified acute aged care inpatient units (CRG, RPA, Liverpool and Campbelltown Hospitals), it is preferable to designate a separate ward area to manage complex delirium in the inpatient setting.

### *Rehabilitation*

A range of rehabilitation beds is required to continue to provide for the wide range of rehabilitation clients requiring inpatient treatment. Whilst there is the option of having some beds located in stand-alone facilities (subject to the availability of timely, networked support), there should also be beds located within the acute hospital system for higher acuity patients. An acute rehabilitation unit should be established at Liverpool Hospital, colocated with aged care. The rehabilitation unit would be primarily for patients undergoing renal dialysis, plasmapheresis or ongoing chemotherapy and radiotherapy, simultaneously to having underlying rehabilitation needs, as well as more acute neurological patients who need combined management. A small rehabilitation unit should be established at Bowral Hospital to complement the acute aged care role, with networked support from Macarthur.

After hours medical cover and access to medical consultative services is an issue in the standalone rehabilitation facilities at Balmain, Braeside and Camden. A review of the level of after-hours coverage available should be undertaken and services need to be enhanced for after-hours medical coverage.

The development of Transitional Living Units (TLUs) could be considered for those clients who either require a level of service between residential care and acute rehabilitation, or between intensive rehabilitation and community living. A detailed proposal examining the scope and likely impact is required in order to assess viability.

Other models that may be of benefit are associated with the provision of supported accommodation for people with a disability and high medical needs (in conjunction with the Departments of Ageing, Disability & Home Care, and Health & Ageing). Such a model may result in significant bed day savings through a reduced LOS and the provision of more appropriate and supportive long term accommodation for patients.

#### **Recommendation – Inpatient Beds – Acute and Sub-Acute Aged Care and Rehabilitation**

- A. As funding permits, expand the bed capacity of AC&RS services through the creation of additional units and/or the collocation of outlier patients to improve inpatient management;**
- B. Review issues associated with after hours medical coverage at sub-acute/stand alone facilities, to determine appropriate service and staffing models;**
- C. Investigate the feasibility of developing specialist inpatient bed capacity such as transitional living units and specialist units for younger people with a disability**

### 6.2.2 Aged Care Inpatient Consultation

Geriatricians provide consultative services for many older inpatients admitted by other services. Inpatient consultations are available in most SSWAHS acute hospitals; however the level of coverage is dependent on the staffing situation at the time and other available resources. Consultations are provided to patients managed by all relevant medical and surgical sub-specialties, particularly with regard to the management of geriatric syndromes, assessment of rehabilitation potential with a view to accepting transfer of care, assessment for residential level care, and the facilitation of discharge planning and transition to community care.

#### *Orthogeriatrics*

Orthogeriatric care is a key area of inpatient consultation, however the level of service provided is dependent on the settings and systems at each facility. In hospitals in the east of the Area, Memorandums of Understanding have been agreed between geriatricians and orthopaedic surgeons to facilitate the timely provision of consultative services to patients with defined characteristics. This service is best developed at CRGH where there is a significant commitment of Geriatrician and Registrar time to its function, a model consistent with the *Australian Society of Geriatric Medicine's Position Paper on Orthogeriatric Care*. Bankstown-Lidcombe Hospital has also developed an orthogeriatric service.

#### 2005/06 Activity

Data on aged care inpatient consultation for 2005/06 is not available consistently across the Area and as such, has not been reported.

#### Current and Emerging Issues

- **Population ageing** – as the population continues to age rapidly, there will be an increase in demand from older people, particularly frail older people, on EDs;
- **Prevalence of dementia** – the prevalence of dementia is expected to double by 2016. Particular expertise will be required to assist clients with dementia;
- **Geriatric medical workforce** – some parts of the Area, particularly in the south west, have been experiencing difficulties in recruiting geriatric medical staff. As such, there is limited, if any capacity to provide outpatient clinics from some facilities;
- **Specialty skills** – aged care clients in non-aged care wards do not have the benefit of specialised aged care nursing and allied health skills. These need to be developed to improve the appropriateness of care provided to older patients and to reduce unnecessarily long lengths of stay;
- **Interpreters** – in some language groups and at particular times, there is unmet demand for interpreter services. Without timely access to interpreter services, hospital lengths of stay can increase; and
- **Data collection and management** – there is a need for standardised data collection and management across aged care outpatient services, to assist in service performance management and monitoring. Such a system must recognise the variability in funding sources and reporting requirements.

#### Projected Future Activity

Inpatient consultation activity will increase in line with the growth and ageing of the population. The number of Geriatrician positions should also increase consistent with this change in demographics.

#### Future Model of Care

As the population ages, there will be an increasing demand on acute hospital services from aged care clients. Not all this demand will be able to be met directly by acute aged care units. Where appropriate, patients will be admitted under the relevant sub-specialty for their primary diagnosis, with consultative support from geriatric medical staff.

#### **Recommendation – Aged Care Inpatient Consultation**

*Develop the capacity of aged care inpatient consultation services, consistent with population growth and ageing, whilst strengthening the capacity of non-AC&RS wards to respond to the needs of older people, people with a disability and their carers*

### 6.2.3 Rehabilitation Inpatient Consultation Service

An inpatient multidisciplinary rehabilitation consultative service is provided at all acute hospitals, though to varying degrees, depending on availability of staff and resources. This service provides

the opportunity for patients to be assessed appropriately at an early stage in their inpatient stay and to commence an integrated multidisciplinary rehabilitation program, concurrent with ongoing acute medical management. Such early intervention from Rehabilitation Specialists and the rehabilitation team, assists in preventing or minimising secondary disability as a result of hospitalisation. It may also reduce hospital lengths of stay, through early and appropriate intervention and the prevention of de-conditioning. Current evidence suggests that early rehabilitation in particular, results in improved functional outcomes. Further, the availability of this service streamlines the transfer of patients from acute care to sub-acute/rehabilitation services, at the conclusion of their acute episode.

#### 2005/06 Activity

Data on rehabilitation inpatient consultation for 2005/06 is not available consistently across the Area and as such, has not been reported.

#### Current and Emerging Issues

**Emerging models of care** – the delivery of community based services for the treatment of chronic illness, and alternative settings for the delivery of therapy services, may reduce inpatient demand.

#### Projected Future Activity

Inpatient consultation activity will increase in line with the growth and ageing of the population. The number of Rehabilitation Specialist and therapist positions should also increase consistent with this change in demographics.

#### Future Model of Care

Rehabilitation Consultancy Services should continue to be provided to all hospitals. Patients will be prioritised and referred for inpatient or community based rehabilitation services, based on their needs and potential for positive rehabilitation outcomes.

### **Recommendation – Rehabilitation Inpatient Consultation Service**

***Expand the capacity of inpatient rehabilitation consultation services consistent with population growth and ageing***

#### **6.2.4 Dementia and Gerontology Clinical Nurse Consultants**

Dementia and Gerontology Clinical Nurse Consultants (CNCs) provide expert advice, support and education to staff and patients regarding issues relating to the aged care client, such as dementia, delirium and falls. In SSWAHS hospitals, there are various Dementia and/or Gerontology CNC positions.

NSW Health has funded two fixed term Dementia CNC positions (one for each end of the Area) until July 2008. One Dementia CNC position is based at Bankstown Hospital with responsibility for the south west. The second CNC is based at Canterbury Hospital and provides assistance to RPAH and Balmain Hospitals as required. The role of the Dementia CNC is to work with other clinicians to better manage people with delirium/dementia in the acute setting and to reduce complications associated with hospital stays through education and modeling care. Through the third State Dementia Plan, NSW Health is seeking to obtain recurrent funding for these positions. Funding has not yet been confirmed.

Gerontology CNCs are based at Concord Repatriation General and Bowral Hospitals.

#### 2005/06 Activity

CNC activity is captured within larger data sets and as such cannot be clearly identified.

#### Current and Emerging Issues

- **Population ageing** – The population aged 85+ years will increase by almost 100% by 2016. As the population continues to age rapidly, there will be an increase in demand from older people, particularly frail older people;
- **Prevalence of dementia** – the prevalence of dementia is expected to double by 2016. Particular expertise will be required to assist clients with dementia;
- **Delirium** – older patients are at particular risk of developing delirium as a result of an inpatient episode. Patients with delirium have a longer length of stay and a greater risk of falls than other patients. As the number of older patients increases, expert resources will be needed to identify and manage delirium in the inpatient setting;

- **Patients with severe aggression** – there are a number of patients in hospital who display severe behavioural disturbance and aggression. They require specialised care and support, to improve safety for the patient themselves, other patients and staff. This group of patients are at significant risk of creating adverse events and are resource intensive with a high rate of one to one nursing;
- **Workforce** – SSWAHS has experienced difficulty in recruiting to CNC positions in the recent past. Workforce development is required to enhance the capacity of nursing staff to undertake specialist roles;
- **Hospital avoidance** – some CNC positions are actively involved in hospital avoidance initiatives with residential aged care facilities. There are opportunities to expand this capacity with current and future CNC positions;

#### Projected Future Activity

Demand for Dementia and/or Gerontology CNC services will increase with the ageing of the population and the increased capacity of aged care services.

#### Future Model of Care

There is an evidence base of interventions to prevent delirium/manage dementia for patients in hospital. The role of the Dementia or Gerontology CNC is to implement initiatives to improve outcomes for frail patients with complex medical/social issues, and patients with delirium and/or dementia. The benefits of this service include improved quality of care for the patient, reduced length of stay, improved support and education of other clinical staff, better support to carers/families, and less disruption to other patients.

#### **Recommendation – Gerontology and Dementia CNC's**

***Expand the availability of Dementia and/or Gerontology CNC positions ensuring a presence in each facility to support inpatient management of people with dementia and/or delirium***

## 7. SUPRA-REGIONAL SERVICES

Supra-regional services based in SSWAHS support a larger catchment than SSWAHS. These services include:

- Section 7.1 - Liverpool Brain Injury Rehabilitation Unit (Traumatic and Non-Traumatic)
- Section 7.2 - Burns Rehabilitation
- Section 7.3 - Non-Traumatic Spinal Cord Injury Rehabilitation

People who access these supra-regional services are more likely to be younger and from culturally diverse communities. These individuals and their families will have varying understanding to deal with and manage health issues in the longer term.

### 7.1 Liverpool Brain Injury Rehabilitation Unit (Traumatic and Non-Traumatic)

The Liverpool Brain Injury Rehabilitation Unit (BIRU) is part of a state-wide network of three traumatic brain injury units providing services to adults (16-65 years) with a traumatic brain injury. This service complements the existing Rehabilitation Service which treats patients with a traumatic brain injury older than 65 years, and a proportion of those aged 50 to 65 years.

The Liverpool BIRU provides acute inpatient beds, a transitional living unit, and community living unit. These inpatient units provide support for the south west, the majority of South Eastern Illawarra Area Health Service (SEIAHS), and the majority of southern NSW from Goulburn to Albury. Referrals from other parts of NSW will be accepted on a case by case basis, in consultation with other BIRU's. Referrals to the inpatient unit are primarily from the acute metropolitan trauma hospitals, with Liverpool accounting for 40%, Canberra Hospital 20% and St George Hospital 15%. Residents of the eastern part of the Area access these services through the Royal Rehabilitation Centre at Ryde, which is more geographically convenient. As such, traumatic brain injury services for residents in the east are not included in this Plan.

Associated outpatient clinics and community support services such as community outreach are also provided, in association with vocational rehabilitation and driving assessment for traumatic brain injury (TBI) based at Liverpool, and driving assessments/retraining, based at Bankstown. In total, these services provided approximately 6,000 individual occasions of service in 2005/06, and more than 100 group programs provided to over 500 participants.

#### 7.1.1 Inpatient Activity 2005/06

Current activity in the BIRU shown in Table 7.1 indicates 164 separations from the BIRU in 2005/06, with an average length of stay ranging from 148.55 days in the inpatient unit to 8.53 days in the community living unit. 2005/06 was characterised by a large number of patients with severe disabilities in the inpatient unit who required particularly long lengths of stay. There was 6.5% growth between 2004/05 and 2005/06 in inpatient BIRU services.

**Table 7.1 BIRU Inpatient Activity 2005/06**

Service	Beds	2005/06			
		Seps	Bed Days	LOS	Occ. %
Inpatient	16	38	5,645	148.55	96.66
Transitional Living Unit	4	18	1,230	68.33	86.13
Community Living Unit	4	108	921	8.53	64.86
<b>TOTAL</b>	<b>24</b>	<b>164</b>	<b>7,796</b>	<b>47.53</b>	<b>88.99</b>

Source: SSWAHS Performance Indicator Reports 2005/06

#### 7.1.2 Current and Emerging Issues

- **Non-traumatic brain injury services** – general rehabilitation units provide the majority of services to people with a non-traumatic brain injury, along with some limited support from the Liverpool BIRU for people who meet particular criteria. There is a need for more specialised support for this group;
- **Driver assessment** – there are currently long waiting lists to access services; and

- **Vocational/occupational rehabilitation** – there are currently long waiting lists to access services. Expansion is required to support the needs of people with a non-traumatic brain injury.

### 7.1.3 Future Model of Care

Patients with a non-traumatic brain injury are treated both within existing general rehabilitation services and the BIRU. These patients have similar behavioural, cognitive, functional and physical features as patients with a traumatic brain injury, although recovery processes differ.

Ten beds are required to establish a comprehensive brain injury (traumatic and non-traumatic) service at Liverpool Hospital. Additional bed capacity should be focussed on the “transitional living unit” model rather than the acute inpatient model. These patients will have higher nursing care needs than general rehabilitation patients. Planning for this service is being undertaken as part of the Liverpool Hospital Stage 2 redevelopment.

Developing a unique non-traumatic brain injury service will require access to sufficient psychology and other therapy services and a higher nurse to patient ratio to allow adequate treatment. It is therefore appropriate to co-locate the service with the existing Brain Injury Rehabilitation service. To support inpatient services for clients with traumatic and non-traumatic brain injuries, there is a need for expanded outpatient and community support service capacity, particularly driver assessment and occupational/vocational rehabilitation programs.

#### **Recommendation – Brain Injury Services**

***Consistent with state-wide planning for brain injury, develop an additional 10 beds to expand the existing Liverpool Brain Injury Rehabilitation Unit and to facilitate provision of services for targeted people with a non-traumatic brain injury, supported by outpatient and community support services as part of the Liverpool Hospital Stage 2 redevelopment***

## 7.2 Burns Rehabilitation

The adult Acute Burns Unit at CRGH is a state-wide service provided in a network with Royal North Shore Hospital and the Children’s Hospital at Westmead. There are eight beds located in the Acute Burns Unit at CRGH. Inpatient rehabilitation for these patients is provided either at Royal Rehabilitation Centre Sydney at Ryde or through dedicated beds within the general rehabilitation ward at CRGH.

SSWAHS does not provide a formal burns rehabilitation service at present. Annually, a small number of patients require a high level of multidisciplinary rehabilitation, due to the complexity of their injuries. These patients are transferred to Royal Rehabilitation Centre Sydney at the conclusion of their acute episode.

### 7.2.1 Current and Emerging Issues

- **Continuum of care** - People who have had a severe burn injury require a continuum of services to enable them to return to independent living. At present acute and limited rehabilitation services in SSWAHS are available at CRGH only.

### 7.2.2 Future Model of Care

There is a need to establish an Area-wide (or supra-Area) four bed burns step down unit and non inpatient treatment service at CRGH, to support and enable timely discharge from the acute unit when the patient is medically stable, but continues to require nursing and therapeutic support. The step-down unit, or transitional living unit, would cater for those clients who require a level of service between acute or intensive rehabilitation and community living, and who are unable to be supported by alternative means due to a lack of services in their local area or an inability to travel to receive ongoing specialist services. Patients who are medically or psychologically unstable would not meet entry criteria.

Such an independent "dedicated" unit would need to be located within the CRGH campus allowing for ease of access to outpatient services, medical review, therapy and wound management. A Registered Nurse would be required to provide supervision, coordination of patient activities and

assistance with medication within the Unit during the day. A review of the impact on other services would be required after a period of time. Ideally the unit would offer a home-like atmosphere with private bedrooms and a shared bathroom, kitchen and living area, thus enabling the patient to return to activities of daily living at the earliest possible time within the continuum of care. The length of stay in such a unit would be anticipated as ranging between two weeks and two months, depending on the circumstances of the patient.

The benefits will be reduced length of stay in the acute Burns Unit, reduced dependency and institutionalisation effects resulting from long periods of hospitalisation, increased empowerment to enable a person to take control of their activities of daily living, and to start to socialise and reconnect with their families in a more homely environment.

Where practical, patients should then be transferred to receive outpatient services from their local hospital if possible.

#### **Recommendation – Burns Rehabilitation**

***Contingent on the outcomes of the state-wide planning for Burns Services, establish a four bed Burns Step Down Unit at CRGH in the style of a transitional living unit, supported by non-inpatient services***

### **7.3 Non-Traumatic Spinal Cord Injury Rehabilitation**

Acute spinal cord injury (SCI) services are based at Prince of Wales and Royal North Shore Hospitals. These services also offer specialist SCI rehabilitation, predominantly for people with traumatic SCIs. SSWAHS manages patients with a non-traumatic SCI in general rehabilitation wards.

#### **7.3.1 Current and Emerging Issues**

- **Increasing prevalence** – particularly associated with population ageing;
- **Expertise required** – there is particular expertise required to meet the needs of people with non-traumatic SCI's, including the need for close relationships with neurology, urology and plastics services;
- **Interaction with traumatic spinal cord injury services** – existing outreach therapy services associated with traumatic SCI services are unable to meet the demand;

#### **7.3.2 Future Model of Care**

Patients with a non-traumatic SCI and those requiring post-acute spinal injury rehabilitation should be managed in a single unit for SSWAHS. An inpatient unit should be established to provide this service, ideally located on a site with access to neurology, urology and plastics services. The establishment of a dedicated unit would require a higher level of nursing and allied health expertise to provide the required care for this group of patients. Additional outpatient clinics and non-inpatient therapy services are also required to support this service. Specialised spinal cord injury outpatient therapy services would facilitate the maintenance of gains made through the inpatient episode and further improvement of functioning and independence in the community.

#### **Recommendation – Non-Traumatic Spinal Cord Injury Rehabilitation**

***Subject to the outcomes of state-wide planning for Spinal Cord Injury Services, investigate the development of a 14 bed non-traumatic spinal cord injury / post-acute injury rehabilitation unit within SSWAHS, supported by outpatient and non-inpatient therapy services***

## 8. PARTNERSHIP AND ASSOCIATED SERVICES

AC&RS do not operate in isolation and, to ensure the highest possible level of care is provided to patients and clients, work closely with a range of other services and service providers. The complex funding, monitoring and service delivery environment associated with aged care and rehabilitation, adds to the reliance of AC&RS on the development and maintenance of cooperative partnerships with other organizations.

Some of these service providers are internal to SSWAHS, whilst others are external. In some cases, as a result of local service development initiatives, SSWAHS is also a provider of some service types generally operated by the non-government sector. Key service partners include:

- Section 8.1 - Health Promotion
- Section 8.2 - Mental Health
- Section 8.3 - Other Sub-specialty Medicine and Surgery
- Section 8.4 - Allied Health
- Section 8.5 - Community Health
- Section 8.6 - Palliative Care
- Section 8.7 - Biomedical Engineering
- Section 8.8 - Program of Appliances for Disabled People
- Section 8.9 - Carer Support Services
- Section 8.10 - Ventilator Dependent Quadriplegic Program
- Section 8.11 - General Practitioners
- Section 8.12 - Residential Aged Care
- Section 8.13 - Community Care Providers
- Section 8.14 - Aboriginal Health Services
- Section 8.15 - Multicultural Health Services and Interpreter Services

### 8.1 Health Promotion

Health promotion activities have benefits in improving the health and wellbeing of AC&RS clients and the wider community. In conjunction with the Health Promotion Unit, a targeted response to health promotion and injury prevention programs, such as falls prevention, is required. Appropriate spaces should be provided in hospitals and community health centres to support such initiatives. These programs should involve acute and community based services, residential care and non-government organizations in their implementation.

Whilst AC&RS manages the Area Falls Prevention and Management Program, specific initiatives are also being managed by the Health Promotion Unit. For example, the Central Sydney Tai Chi study has established that a simple, once a week program of Tai Chi over 16 weeks can reduce the falls in community living older people (people aged over 60 years) by 36%. Health Promotion, through the Active over 50 Program and through SHARE, is establishing community-based Tai Chi classes, making Tai Chi more accessible to older people.

AC&RS has a major prevention role in health and wellbeing, appropriate support and care, and research and information. It also works with other parts of the health system and external agencies to extend options and choices for older people. Examples of this focus include the work of TACS with the residential care sector, increasing support for people with dementia, and providing older people and their carers with information and practical advice about care options.

#### **Recommendation – Health Promotion**

***AC&RS participate in the implementation of the SSWAHS Falls Prevention and Management Program and other relevant Health Promotion initiatives***

### 8.2 Mental Health

Clinical care for older people which focuses upon disturbances of their mental health, cognition, or behaviour is provided by both AC&RS and Area Mental Health Services (AMHS) in SSWAHS.

Services have been developed and funded in different ways across the Area, with teams having internally mixed funding sources and differing reporting requirements.

Specialist Mental Health Services for Older People (SMHSOP) funded by AMHS is a clinical substream.

There are designated acute SMHSOP beds located at Rozelle Hospital, with no equivalent beds provided in the south west. The new 30 bed acute inpatient unit on the CRGH site, within the mental health facility relocating from Rozelle to Concord, will open in early 2008. Planning has also commenced for a new 20 bed acute unit within the Liverpool Hospital Stage 2 redevelopment, with the unit to be colocated with the proposed new Aged Care and Rehabilitation Precinct. These inpatient services provide short term management of both older people with acute psychiatric illness and people with high support needs as a result of the behavioural and psychological symptoms of dementia (BPSD). Both Bankstown-Lidcombe and Braeside Hospitals have 'sub-acute' aged care psychiatry/SMHSOP beds. The beds at Braeside Hospital are managed by Hope Healthcare within the AMHS stream. Bankstown-Lidcombe Hospital beds are managed by Aged Care.

There is a need to develop acute SMHSOP beds in the south west, supported by a number of sub-acute beds across the Area. The lack of specialist gazetted beds for the older patient creates access issues (for these patients and others). It also has significant safety implications due to admissions from ED to acute geriatric or adult mental health beds, sub-acute beds with limited clinical support services and interruptions to continuity of care.

Longer stay 'special care units', within residential aged care facilities, have also been established through AMHS and NGO partnerships, with Catholic Care operating Holy Spirit Croydon in the Inner West, and a project with Hammond Care at Hammondville in development. These services provide the capacity to assess and treat older people with severe BPSD outside of the inpatient setting, prior to transition to a more 'mainstream' dementia residential care unit.

There are small community SMHSOP services (either within ACAT or closely linked with ACAT) at Concord, Canterbury, RPAH, Bankstown, Braeside and Camden Hospitals. A position has also been funded at Bowral. These services provide assessment and community management of older people with mental health disorders or dementia, with severe BPSD living independently or in residential aged care, and their carers. These services also assist other staff in the management of shared clients. A restructure of these services will occur in 2008.

Community based SMHSOP require enhancements to provide more timely and intensive interventions in the community in order to reduce ED presentations and hospital admissions. Implementation should be well coordinated with the proposed Community Dementia Teams (see Section 6.1.9) and other Aged Care services.

The development of integrated specialist Behavioural Assessment and Intervention Services (BASIS) by AMHS will build on the ACAT and SMHSOP community teams. BASIS will provide a structured, integrated and intensive role in assessment and case management of older people with severe and complex behavioural and psychological symptoms and/or unclear aetiology. In its fully developed form, the BASIS model would offer integrated, comprehensive, multidisciplinary assessment, intervention and referral.

Generalist adult mental health services provide assessment, treatment and rehabilitation services to older people with mental disorders. This will include clients with existing (prior to age 65 years), continuing or episodic mental illness, provided there are not significant age related issues impairing function; urgent intervention if SMHSOP is unable to provide this or if out of regular business hours; and/or patients requiring admission under the Mental Health Act or more intensive patient care. This may include a shared care role with SMHSOP clinicians.

Further planning in relation to SMHSOP is being undertaken through the Mental Health Clinical Services Planning process and the development of a specific plan for SMHSOP.

### **Recommendation – Mental Health**

***Establish collaborative processes to improve the coordination and integration of Aged Care and Specialist Mental Health Services for Older People, particularly in the management of people with behavioural and psychological symptoms of dementia***

### **8.3 Other Subspecialty Medicine and Surgery**

Given the projected increase in the number of older patients over the next 5 - 10 years, there will be a need to ensure that all inpatient services, not just designated aged care services, are able to better respond to the needs of this group of patients. This is consistent with the *Framework for the Integrated Support and Management of Older People in the NSW Health Care System*.

To do this requires improvements to the way in which general medical and surgical wards respond to the needs of, in particular, the aged care client. Different solutions may be required in different facilities, depending on the availability of other sub-specialty services.

Strategies to achieve this include developing and/or formalising admission protocols, developing shared care models, improving access to aged care expertise and support, and improving early identification and prevention of aged care specific complications. These issues have been considered through the Older Persons and Aged Care Clinical Redesign Project and various potential solutions have been documented (refer to *SSWAHS Older People and Aged Care Health Service Project Solution Design Report, February 2007*).

Further, models of Ambulatory Care and Community Acute/Post Acute Care (CAPACs) provide opportunities for other subspecialties to take an active role in the care of the aged care client. This is formalised to varying degrees depending on the facility. The availability of these services facilitates early medical intervention in a non-inpatient setting (hospital outpatient or community) and enables discharge of patients with ongoing medical and nursing support services. People with a chronic disease are significant users of these services. The availability of Ambulatory Care/CAPACs reduces the need for hospital admissions for chronic diseases.

### **Recommendation – Other Subspecialty Medicine and Surgery**

***Implement a range of initiatives to improve the responsiveness of SSWAHS to the needs of older people, people with a disability and their carers***

### **8.4 Allied Health**

Allied Health Services, provided as part of a multi-disciplinary team, are integral to the provision of high quality aged care and rehabilitation services. Allied health staff include physiotherapists, occupational therapists, speech pathologists, podiatrists, social workers, psychologists/neuropsychologists and dietitians/nutritionists. The administrative models of management vary across SSWAHS. In the east of the Area, community based allied health staff working in aged care and rehabilitation are part of GGRM, whilst inpatient staff are managed through the hospital allied health departments in close association with GGRM. In the south west, two different models of allied health management are operating. This is the subject of discussion between the relevant clinical groupings.

There is a workforce shortage across all Allied Health disciplines, leading to difficulties in meeting the demand for a range of services. Across SSWAHS, particularly in lower socioeconomic localities, there are also few private allied health providers to support public services.

Allied Health Services provide a variety of hospital and community based programs to support and complement AC&RS and other health services. The key programs run by Allied Health which service AC&R clients are summarized below.

#### **8.4.1 Equipment Lending Pools**

SSWAHS Allied Health manage the Equipment Lending Pools (ELPs). ELPs lend equipment to patients for a defined period to support their discharge from hospital. They need to be expanded to

meet the growing demand for equipment, as well as the increasing costs of purchasing equipment, particularly as technical specialisation continues. Expansion must include sufficient resources for the maintenance and monitoring of equipment.

#### **8.4.2 Hydrotherapy**

Hydrotherapy is a key component of the rehabilitation plan for many patients. Access to hydrotherapy is especially important in relation to the increase in arthritic and musculoskeletal conditions particularly associated with the older population. Hydrotherapy pools are located at RPAH and Canterbury Hospital only. Given the infrastructure and maintenance cost of providing hydrotherapy services on site and the ability to access services elsewhere, it is most appropriate that resources are available to access hydrotherapy off-site. Significant work by Allied Health and Rehabilitation services will be required to develop and implement effective systems to enable this to occur.

#### **8.4.3 Orthotics Clinics**

Orthotics involves the fitting of appliances which are generally special braces/aids designed to support, control, protect or improve the function of the body affected by injury or disease. Education and support is also provided to patients and their families on the use, management and maintenance of the orthosis. The majority of clients access orthotics services for post operative care, rehabilitation or sports medicine. Paediatric and Aged Care patients are the most common.

Orthotics services are managed by Allied Health in the east of the Area (based at RPAH), with a private service only available in the south west, creating inequity across the Area.

Demand for orthotics services across the Area is likely to increase in line with population growth, the ageing of the population and the increasing prevalence of disability. Further investigation is required to determine the likely future activity and most appropriate locations and models for the delivery of services.

#### **8.4.4 Seating Clinics**

Specialised seating is required by a number of patients with a disability, including people with complex disabilities and those who are wheelchair dependent.

A seating clinic is provided at Liverpool Hospital through the Occupational Therapy Department. This is the only seating clinic available in the Area.

Further investigation is required to determine the likely future demand for this service type and to determine the most appropriate locations for the delivery of services.

#### **8.4.5 Prosthetics**

Prosthetics is a multidisciplinary service for amputees, which involves the fitting of custom made prostheses which are designed to both look and function as near as is practicable, to the original limb. Clients are referred to prosthetic services by Rehabilitation Specialists, usually through the inpatient setting or outpatient amputee clinics. A prosthetic service provides assessment for the fitting of a prosthesis, makes and fits the prosthesis, and undertakes all requisite maintenance. The service provides advice, education and support to patients and their families, on the rehabilitation process and living with a prosthesis.

At present prosthetics services across NSW are delivered by a combination of public physiotherapists and private prosthetists, making interim prostheses; with private prosthetists making all definitive prostheses under the auspices of the Artificial Limb Service of NSW (ALS). The model of care being proposed and developed will involve joint funding between the ALS and NSW Health/Area Health Services, with the ALS covering the cost of components and AHSs covering staffing and associated costs.

As demand for these services continues to grow as a result of increasing rates of peripheral vascular disease, diabetes and some other chronic diseases, there will be a need to develop additional amputee and prosthetic services.

The needs to link closely with Rehabilitation Specialists and other specialist amputee services, particularly Amputee CNC's located at RPAH/Balmain and Concord.

#### **8.4.6 Orthoptics**

Orthoptics services include vision assessment (visual acuity, visual field and visual neglect), assessment of eye movements (nystagmus, diplopia etc) and intervention for diplopia, as well as the implementation of strategies to address visual field loss and visual neglect.

Outpatient Orthoptics services are located at Bankstown-Lidcombe, Liverpool and Concord Hospitals. AC&RS clients are seen on referral by medical or allied health staff and may be seen either by the Orthoptist, or the Orthoptist in partnership with an Ophthalmologist from the Eye Department at each hospital. Most patients attending Eye Departments are assessed by the Orthoptists, undergoing extensive testing for the diagnosis of eye diseases and pre/post ocular surgery assessments.

Inpatient services are available by referral at Bankstown-Lidcombe, Liverpool and Concord Hospitals. At Bankstown-Lidcombe Hospital there is a dedicated Rehabilitation Orthoptist who receives blanket referrals for patients in the Stroke Unit, and other units as required.

Orthoptics in SSWAHS is a small team of highly trained clinicians whose services are at capacity. The existing staff numbers are inadequate to support the demands associated with the projected ageing population.

#### **Recommendation – Allied Health**

***Further develop and implement collaborative systems for responding to the allied health needs of AC&RS clients and expand the availability of specialized allied health services across the Area***

#### **8.5 Community Health**

Community Health Nurses (CHNs) are an integral provider of services to support older people and people with disabilities. They provide significant long term and post acute support to people in the target group, with an active role in chronic disease management including self-management. These services assist clients to live independently for as long as possible, and provide essential support to carers. Some CHN teams have active linkages into residential aged care facilities to provide early intervention and management of disease or illness. This reduces avoidable hospital admissions. There are inconsistencies in the quantum of HACC community nurses across SSWAHS.

Other services offered by Community Health in some parts of the Area, such as Community Nutrition and Allied Health services, also provide essential assistance to older people, people with a disability and their carers.

To ensure a smooth continuum of care for clients, health service structures need to ensure that collaboration and communication between Community Health and AC&RS is constantly improving.

It is appropriate to colocate some community AC&RS with other services, providing care and support to a similar group eg. palliative care, community nursing and allied health. Opportunities to colocate AC&RS and Community Health services should be considered. Community health centres should be accessible for AC&RS target groups, and consider transport, signage and design.

#### **Recommendation – Community Health**

***Improve the accessibility of AC&RS by delivering targeted services in Community Health Centres where possible***

#### **8.6 Palliative Care**

Palliative Care services in SSWAHS are part of either Cancer Services or Community Health. In the south west, there have been strong partnerships developed between aged care and palliative care services. Liverpool and Braeside Hospitals have had a shared Fellow in Palliative Care and Aged

Care, and have developed programs for care in aged care facilities. The Pathways Home Research Project in the south west is working collaboratively with a range of stakeholders, including Palliative Care, on issues associated with end of life decision making and Advanced Care directives.

**Recommendation – Palliative Care**

***Develop improved systems for end of life care in inpatient and community/residential settings, including through Advanced Care Directives initiatives***

### **8.7 Biomedical Engineering**

To support an innovative approach to the care of patients with a disability, access to a biomedical/rehabilitation engineer is required. Biomedical engineers develop and maintain technology designed to help people with a disability or injury to achieve quality of life and regain normal physical functions. This can be provided in hospital or a community-based setting. The advice and designs provided, cover many different fields including independent mobility, prosthetics and orthotics, specialised seating, alternative and augmentative communications or assistive technology. Demand is difficult to quantify as the service has not been available. As the population ages, and the number of people living in SSWAHS with a disability increases, there will be an increased requirement for this type of service.

Although SSWAHS has a well developed Biomedical Engineering service, at present this service does not have the staff capacity to service patients for rehabilitation purposes. With expansion of staff and the provision of some specialised equipment/resources, this service could be developed to undertake this role. Further investigation would be required to determine the most appropriate service delivery models and locations, as well as linkages to Allied Health.

**Recommendation – Biomedical Engineering**

***As funding permits, expand the existing biomedical engineering service to develop a specialist rehabilitation role***

### **8.8 Program of Appliances for Disabled People**

The Program of Appliances for Disabled People (PADP) provide aids and equipment to assist people in the community to live independently. NSW Department of Health funds each Area Health Service for PADP. At present, governance for PADP differs across the Area. NSW Health has undertaken an extensive review of PADP recommending a State wide structure.

At present, PADP services are located throughout SSWAHS, as lodgement and collection centres. Clients may also receive direct delivery of goods and equipment from suppliers to minimise storage requirements, improve maintenance of equipment, and assist clients who have limited mobility to receive goods and equipment. All services report that they are unable to meet current demand for aids and equipment, including an inability to provide preventive aids (such as special footwear which may prevent more serious conditions developing) due to competing service demands.

**Recommendation – PADP**

***Participate in implementing the recommendations of the NSW Health PADP Review***

### **8.9 Carer Support Services**

SSWAHS operates a variety of carer support services through AC&RS, Allied Health, Community Health and Mental Health. A proposal has been developed to create an Area-wide Carer Support Service, managed by Allied Health. However, this proposal will not incorporate each of the small carer support services operating.

AC&RS offers a range of carer support services such as the Working Carers Project in the eastern part of the Area, and Dementia Carers Support Groups through the Macarthur Dementia Advisory Service. Through the support of the Pathways Home Project, an internet site has been developed. This will assist carers to access service information.

Given the heavy reliance of AC&RS clients on carers, carer support is an essential component of the service mix available to support the target group. Regardless of governance arrangements, strong relationships are required between clinical services and the carer support services. These services are building cooperative links to strengthen their capacity to reach all carers across the Area and are implementing a range of initiatives. Opportunities to enhance carer support services are considered within the *NSW Carers Action Plan* (NSW Department of Health, 2007) and will be further explored in the SSWAHS Carers Action Plan to be developed by 2008.

**Recommendation – Carer Support Services**

***Improve and expand carer support services, consistent with the NSW Carers Action Plan***

### **8.10 Ventilator Dependant Quadriplegia Program including Children’s Home Ventilation Program**

The NSW Ventilator Dependant Quadriplegic (VDQ) and Children’s Home Ventilation Program (CHVP) Program was established with a principle aim to assist Area Health Services with the costs associated with the discharge of these clients from the acute inpatient facility. The program also allows clients to live with or close to family and friends, and to avoid inappropriate, long-term hospitalisation. Costs include establishing the client in the home, equipment and ongoing community-based clinical care.

The program’s target group includes 24-hour mechanical ventilation dependant quadriplegics who have a brain stem or spinal cord injury, are either non-compensable or who have been inadequately compensated and are medically stable, and willing to be discharged to the community.

In early 2007, the state-wide program supported 17 clients in NSW, including two clients in SSWAHS. By late 2007, an increasing number of children entered the Program in SSWAHS. If a non-traumatic spinal cord injury unit is developed in SSWAHS (see Section 8.3) then there may be growth in demand for this service.

The VDQ and CHVP Program is managed by AC&RS but given the growing number of children referred to SSWAHS, it may be more suitable for management by another clinical stream.

**Recommendation – Ventilator Dependent Quadriplegia and Children’s Home Ventilation Program**

***Review management arrangements of this Program within SSWAHS***

### **8.11 General Practitioners**

General Practitioners (GPs) are an essential element in the care of older people in the community and in residential care. The majority of GPs are members of a local Division of General Practice. Divisions of General Practice in SSWAHS include Central Sydney, Bankstown, Fairfield, Liverpool, Macarthur and Southern Highlands Divisions. Mergers of divisions commenced in 2007.

In 2005, there were 1,210 GPs who were a member of a Division. The total number of GPs in SSWAHS is however greater. The following table summarises the numbers of GPs (members and non-members) in each Divisional area in 2005. Non-members numbers are an approximation as they are difficult to accurately estimate due to the constant movement of the GP workforce. It should also be noted that a small percentage of members may not actively practice in the area.

Area populations have been provided to give an idea of the population the GPs service, however an accurate GP:population ratio cannot be determined from GP numbers alone. These GPs work a range of hours, from 10 to 60+ hours per week. Therefore the full-time equivalent (FTE) workforce is actually less than the numbers shown. Table 8.1 shows a FTE GP:population ratio estimate.

SSWAHS has ethnically diverse populations. Many GPs working in these areas speak one or more languages other than English. Approximate numbers of bi-lingual GPs are shown below. The most common languages spoken are Chinese, Arabic, Vietnamese, Spanish and Hindi.

**Table 8.1 GPs in SSWAHS 2005**

Division	Members <sup>1</sup>	Non-members <sup>1</sup>	Total	Population estimates 2004 ABS	FTE GP: population ratio 2003 <sup>5</sup>	Approx. No. of GPs who speak a language other than English <sup>2,3,4</sup>
Bankstown	175	21	196	175,428	1:1,107	102
Canterbury	154	49	203	135,048	1:1,185	102
Central Sydney	350	210	560	366,347	1:1,119	350
Fairfield	190	28	218	187,683	1:1,187	143
Liverpool	115	41	156	167,880	1:1,602	66
Macarthur	176	34	210	200,263	1:1,584	83
Southern	50	2	52	45,000 <sup>6</sup>	1:1,525 <sup>1</sup>	5
<b>Total</b>	<b>1,210</b>	<b>385</b>	<b>1,595</b>	<b>1,277,649</b>	<b>N/A</b>	<b>851</b>

1. The seven Divisions of General Practice in SSWAHS (September 2005)

2. Database (GPs in Western Zone 2004) GP Unit, SSWAHS

3. Eastern Zone GP database SSWAHS intranet

4. Medical Directory of Australia 2005

5. Annual Survey of Divisions – Primary Health Care Research & Information Service [www.phcris.org.au/resources/divisions](http://www.phcris.org.au/resources/divisions)

6. Wingecarribee Shire Council

SSWAHS works with the Divisions of General Practice on various collaborative projects to improve the care of the aged care client.

The new Medicare Plus scheme offers opportunities for the health service to improve the chronic care of older people. The development of care plans, combined with education, will assist in the chronic disease management of the aged care client. Issues to cover include hypertension, diabetes, immunisation, Chronic Airways Limitation (CAL), Congestive Cardiac Failure (CCF), nutrition, living alone, health literacy, culture, exercise, smoking and alcohol. In the frail elderly, this should be expanded to include falls, osteoporosis, functional decline, multiple medications, postural hypotension, vision, hearing, arthritis, dementia and depression. Other programs targeting management of the aged care client in residential aged care facilities, communication, pharmaceutical interventions and after hours care need to be implemented.

Improving the way in which SSWAHS and GPs work together to meet the needs of AC&RS clients may be achieved through initiatives such as the establishment of a locality based GP liaison service supporting initiatives in aged care and chronic and complex care, or creation of GP liaison positions within each ACAT. Enhanced rapid response clinical capacity into community and residential care, triggered in response to GP referrals, is also required.

Table 8.2 shows activity recorded by Medicare in relation to enhanced primary care and support by GPs in residential aged care facilities in 2004/05 and 2005/06. It is evident that GPs have invested greater time in many Enhanced Primary Care (EPC) and Residential Aged Care Facility (RACF) initiatives over the recording period. However, only some Divisions have experienced growth in the number of home based EPC assessments.

**Table 8.2 2005/06 GP Activity for Enhanced Primary Care and RACFs**

Division of General Practice	Enhanced Primary Care		Enhanced Primary		Attendance by GP at	
	2004/05	2005/06	2004/05	2005/06	2004/05	2005/06
<b>Central Sydney</b>	2,563	2,637	1,165	1,128	351	475
<b>Canterbury</b>	914	1,007	334	337	N/A	N/A
<b>Bankstown</b>	1,680	1,718	565	507	130	184
<b>Fairfield</b>	1,642	1,903	264	262	162	177
<b>Liverpool</b>	554	643	200	280	N/A	362
<b>Macarthur</b>	1,038	1,162	128	140	157	N/A
<b>Southern</b>	231	485	140	178	69	158

Source: Medicare Australia Divisions of General Practice Reports 2004/05 & 2005/06

\* Activity is by care recipient, not the number of visits made

Note: the above data only relates to the volume of services that have been processed by Medicare Australia. The figures do not include services provided by hospital doctors to public patients in public hospitals, or MBS services that qualify for a benefit under the Department of Veteran's Affairs National Treatment Account

Without significant investment, the impact of improved relationships and systems between SSWAHS and GPs will not be sufficient to address the demands from population growth.

#### **Recommendation – General Practitioners**

***Expand the range of services and supports offered in partnership with General Practice, to improve early intervention and reduce avoidable hospital admissions***

### **8.12 Residential Aged Care**

The Australian Government funds residential care services including high care, low care and both levels of dementia specific care throughout SSWAHS. To meet the expressed needs of older people to remain living at home rather than in residential aged care facilities (RACFs), new services such as Community Aged Care Packages (CACPs) and Extended Aged Care and Home (EACH) packages are also available to provide low level and high level care respectively, to older people in their own homes. SSWAHS AC&RS in the south west operates 80 CACPs for Liverpool/Fairfield.

Most patients that become residents of local aged care facilities have been assessed by the local ACAT. Many of these placements occur following acute hospital admissions. Residents of aged care facilities often have unstable health needs and require frequent attendance to EDs, often resulting in admission to hospital.

SSWAHS has a large number of cultural or language specific aged care facilities. Residents in these facilities come from a wide catchment, beyond the SSWAHS boundaries, but are treated in local health facilities when their health becomes unstable.

At present, the Area is relatively over-supplied with high care places and undersupplied with low care places and packages (see Appendix 5). However as stated above, many of the facilities are cultural or language specific and their wide catchments distort these bed numbers. Also of significance is a low number of designated dementia beds, at both a high and low care level to meet the unique needs of people with dementia and their carers (9% for high care and 6% for low care). Lack of suitable residential care facilities can impact on the ability of hospitals to discharge patients, even if the patients are medically stable. Availability of suitable residential aged care places will continue to be of high importance.

Access to residential respite services is also vital, to avoid inappropriate hospitalisation and high levels of carer stress. Linkages with aged care facilities should be strengthened to increase the capacity of facility staff to manage illness and disease.

The development of improved medical and nursing care in residential aged care facilities should reduce demand on hospital services, particularly the ED. Potential options include:

- Increasing the skill level of residential aged care staff to provide services such as sub-cutaneous fluids, palliative care and behaviour management, as well as reducing the incidence of falls and pressure ulcers, are likely to be effective.
- The proposal to develop MAPUs across SSWAHS.
- Establishment of GP panels and support in development of advanced care directives should reduce the need for residents to require hospitalisation. Preliminary results from the pilot site have shown a decrease in minor presentations (Caplan et.al. 2005, unpublished).
- The Geriatric Rapid Acute Care Evaluation (GRACE) model employed by Hornsby Ku-Ring-Gai Hospital is another possible service option where residents of aged care facilities obtain access to rapid treatment and appropriate care, either in the hospital or home environment. Hospital staff work in collaboration with GPs and RACFs to avoid hospital admissions, and reduce access block and length of stay for older patients. GRACE appears to have a positive effect, enhancing the care journey of RACF residents, and helping to improve communication and trust between the hospital, general practitioners and RACFs ([www.archinet.au/e-library/build/moc/grace](http://www.archinet.au/e-library/build/moc/grace)).
- Building capacity of residential aged care staff to accept more complex patients, including tracheostomy patients.

New service models associated with psychogeriatric care are also being developed between SSWAHS and Holy Spirit Croydon in the Inner West, and Hammond Care at Hammondville.

Various models have been proposed to undertake this work and are described further in the SSWAHS Sustainable Access Plan 2005. The Older Persons and Aged Care Services Clinical Redesign Project also addresses this issue. Without significant investment, the impact of improved relationships and systems between SSWAHS and RACFs will not be sufficient to address the demands from population growth.

#### **8.12.1 State Government Residential Aged Care Facilities**

SSWAHS operates two state government residential aged care facilities (SGRACF) on behalf of NSW Health. A review of all NSW SGRACFs has been undertaken, primarily to determine how the facilities will meet new legislative requirements by the end of 2008. Results of the review are not yet available; however preliminary findings indicate that SSWAHS will be required to undertake planning to determine the future of these services.

##### Queen Victoria Memorial Hospital

Queen Victoria Memorial Hospital (QVMH) is a state-government operated residential aged care facility. It holds 100 bed licences, 70 in high care and 30 in low care, although only 84 beds are currently operational. A number of options for the future of QVMH were raised through the review process, some of which may support SSWAHS with the management of complex patients. Planning for QVMH is not within the scope of this Plan.

##### Carrington Centennial Nursing Home

Carrington Centennial Nursing Home (CCNH) is a Third Schedule facility operated by Carrington Centennial Care Ltd. Carrington Centennial Care is licensed to provide 94 high care beds on behalf of NSW Health. These high care beds complement 144 low care beds and community services also delivered from the site. Again, there have been a number of options for the future of CCNH raised through the review process, some of which may support SSWAHS with the management of complex patients. Planning for CCNH is not within the scope of this Plan.

#### **Recommendation – Residential Care/Residential Level Care**

***Expand the range of services and supports offered in partnership with Residential Aged Care Facilities, to improve early intervention and reduce avoidable hospital admissions***

#### **8.13 Community Care Providers**

Along with community care services provided by SSWAHS, an extensive range of community care services are provided by other government agencies and the non-government sector. Examples include respite services, centre based day care, community options, transport and food services.

The Commonwealth Carer Respite Centre (CCRC) and Commonwealth Carelink program are auspiced by the non-government sector across SSWAHS. These programs coordinate respite care on a planned and emergency basis and provide information and referral advice with regard to services for frail older people, people with a disability and their carers.

Consistent with the high demand for services delivered by SSWAHS, there are long waiting lists to access many community care services. Lack of availability of community care services (particularly home modifications services) can delay patient discharge. A lack of community based case management services can also result in unnecessary readmissions to hospital and/or residential care placement, in situations where a client is unable to manage their multiple care needs.

Strong linkages exist between SSWAHS and many community based services, however these must be strengthened to ensure a quality continuum of care for the target group.

#### **Recommendation – Community Care Providers**

***Expand the range of services and supports offered in partnership with community care providers, to improve early intervention and reduce avoidable hospital admissions***

#### **8.14 Aboriginal Health Services**

In consultation with Aboriginal Health Services, including local Aboriginal Medical Services, the needs of Aboriginal people and Torres Strait Islanders have been identified. Nationally, access to residential care by Aboriginal people is poorer than for non-indigenous people with the overall permanent residential aged care usage rates for non-Indigenous permanent aged care residents 7.3 per 1,000 compared to 1.8 per 1,000 for Indigenous residents (2005, AIHW). Despite its large Aboriginal population, there are no Aboriginal specific residential aged care facilities in SSWAHS. In 2003, this gap was identified by the SSWAHS Janangalee Elders (Minto), the Aboriginal Medical Service Redfern, and SSWAHS Aboriginal Health staff, and again in 2007 during DADHC and SSWAHS consultations with Aboriginal consumers and service providers. The lack of culturally appropriate respite, and facilities for younger Aboriginal people with disabilities, was also raised as a significant issue.

Also of concern for older Aboriginal people is the lack of clustered housing for older Aboriginal people and associated social isolation, their lack of knowledge about health and other government services, AC&RS cultural sensitivity, and specific access issues associated with culture and history.

#### **Recommendation – Aboriginal People**

***Implement actions in the SSWAHS Aboriginal Health Plan which focus on Aboriginal people who are older or who have disabilities, and their carers***

#### **8.15 Interpreter Services and Multicultural Services**

SSWAHS has well developed interpreter services and multicultural services. Interpreter services are key support services for clinical care and are located in major hospitals. In addition to a phone services, interpreters work in inpatient, outpatient and community settings.

It is not always easy to access interpreters, particularly in newer or less commonly occurring languages. Other significant issues include the under-utilisation of interpreters, the need for staff to use culturally appropriate assessment tools, and the variable skill level of staff in working with culturally diverse communities. Attention needs to be given to information about newly emerging CALD communities and internal service data about access by existing CALD communities.

Multicultural health services work in partnership with AC&RS services through a number of initiatives. These include cross cultural training, community development and education programs. The SSWAHS Ethnic Aged Health Advisory supports the development of knowledge and skills in staff and the broader community, and with residential and community care services.

Access for CALD communities to AC&RS services requires a strong focus, particularly as new communities emerge. Culturally competent staff and services are key requirements.

#### **Recommendation – Interpreter Services and Multicultural Services**

***Continue to develop systems and staff skills to ensure a culturally competent and appropriate service***

## 9. INFRASTRUCTURE AND SUPPORT REQUIREMENTS

Ideally, AC&RS will be provided in a sub-area geographical setting, based around hospital facilities. Inpatient and outpatient services should be colocated where possible to improve administration and service management, with community based services provided in identified locations as appropriate.

### 9.1 Physical Infrastructure

AC&RS has particular physical infrastructure requirements associated with the unique characteristics of clients and their carers and the delivery of a multidisciplinary service model. Requirements include sufficient space to enable movement with mobility aids, for carers to support clients, and for the storage of the range of requisite equipment. More general requirements also exist for office space and the storage of clinical records.

The actual space requirements for each service depend on the service delivery setting, target group and model of care. As such, it is not possible to describe the requirements at each service / facility. Some general concepts are described below.

Aged care services within hospital settings require access to the full range of medical and surgical services such as imaging and pathology.

Specific to aged care inpatient services is the need for assessment spaces and rehabilitation areas within the ward to improve functional independence. This may include spaces for walking and for more formal rehabilitation, such as gymnasiums. The colocation of aged care and rehabilitation units within each facility will enable the shared use of these spaces.

Given the projected increase in the prevalence of dementia (and delirium), inpatient aged care services should be designed to be “dementia/delirium friendly” and include appropriate security for staff, visitors and patients.

Other clinical infrastructure which may be considered includes mechanisms to monitor the movement of patients, particularly those at risk of falls.

The Australian Faculty of Rehabilitation Medicine (2005) defines the standards for the design of rehabilitation facilities in Public Hospitals. Expectations outlined in the standards relate to:

- disability access in all areas, including full wheelchair access and assistance with general mobility;
- a designated dining room being available;
- a designated day room for the use of patients and families when the patient is not receiving therapy services;
- a meeting room of sufficient size for case conferences;
- a physiotherapy treatment area with adequate open space for gait training, general exercises, gymnastics and recreational activities (gymnasium);
- an occupational therapy treatment area which has sufficient space for group activities
- rooms for individual therapy and consultations;
- access to a room for the application and removal of plasters, bandages etc;
- a heated, fully accessible hydrotherapy pool;
- access to a therapy workshop.

Essential for provision of rehabilitation services is a range of specialist rehabilitation equipment including:

- physical therapy equipment;
- gait training facilities;
- equipment for aerobic fitness training;
- equipment for training activities of daily living;
- equipment for recreation

This equipment should be provided on-site or off-site with appropriate access arrangements.

These requirements also reflect the needs of geriatric sub-acute units and to some extent, acute aged care units.

The Pathways Home Program operates in the south west of the Area and includes funds for capital development to assist in the transition of older people from hospital to home. Planning is underway to determine the most suitable option for the use of this funding. Priorities are focused on the development of improved outpatient clinic/day hospital/ambulatory care areas at Bankstown-Lidcombe Hospital. However, implementation of any capital solution is dependent on a thorough options analysis. Planning has also commenced for an AC&RS precinct as part of the Liverpool Hospital Stage 2 redevelopment.

#### **Recommendation – Physical Infrastructure**

***Develop/redevelop physical infrastructure in AC&RS services consistent with guidelines, and take into account the unique needs and circumstances of clients eg. people with dementia/delirium***

### **9.2 Information Technology and Telehealth**

The patient management information system endorsed by SSWAHS is CERNER Millennium. It was introduced through a phased approach in the EZ commencing in 1999, with AC&RS services in the EZ implementing CERNER in 2005. Roll-out of this system is underway across the south west to ensure a single, efficient system to aid patient management and meet mandatory data reporting requirements. A major upgrade of IT hardware will be required in the south west for this to occur.

Services have traditionally used paper based medical records to document client care. The move towards electronic medical records using CERNER needs to occur to maximise continuity of care across service settings, enhancing safety and quality of care.

Due to the complex funding arrangements within Aged Care and Rehabilitation, there are multiple mandatory data collection and reporting requirements. In order to meet these requirements, the AC&RS service requires constant collaboration with the Information Services Department of SSWAHS. This relationship needs to be responsive to changes in reporting requirements, changes to service delivery patterns and work practices. A commitment of funding to maintain appropriate hardware is also required.

If Telehealth initiatives are trialled in response to the need to develop new models of care, infrastructure will be required at identified sites to ensure the appropriate level of support is available. Exact requirements would depend on the nature and scope of Telehealth initiatives developed. They may include case conferencing with GPs and residential aged care facilities, family conferences (particularly if family live outside of the area) and case conferencing between sites.

#### **Recommendation – Information Technology and Telehealth**

***Upgrade IT systems across SSWAHS, to facilitate service integration and improved performance monitoring, and enable the expansion of Telehealth initiatives to facilitate communication across sites and reduce avoidable hospital admissions***

### **9.3 Data Management**

Aged care services in particular receive funding of a recurrent, non-recurrent and capital nature from multiple sources over varying periods. This complex funding and service delivery arrangement results in the need to comply with the collection and collation of a internally and externally enforced data sets. Dedicated data managers are required to support the effective management of data within aged care services and to support research initiatives. Standardised data collection methods across the Area should be developed to facilitate the comparison of service models and activity.

#### **Recommendations – Data Management**

***Develop improved data and performance management systems, including analysis, across AC&RS through the establishment of standardised processes and infrastructure***

#### 9.4 Access to Motor Vehicles, Patient Transport and Affordable/Accessible Parking

Inpatient and community based AC&RS rely heavily on access to a fleet of vehicles to enable home visits for discharge planning and assessment, and to provide treatment in the community. As domiciliary models of service (such as TACP) grow to relieve pressure on the hospital system, it will be necessary concurrently to grow the motor vehicle fleet.

Clients of AC&RS are those most likely to have mobility limitations and difficulty accessing public transport. Many also rely on carers, who may themselves be ageing and have mobility limitations. A critical aspect in the ability to provide care and support for these patients includes access to outpatient treatment through clinics, day hospitals and community health centres. Access to respite through day care centres is also an essential component in the management and support of aged care clients. To provide these services, adequate patient transport should be made available.

#### **Recommendation – Patient Transport Services and Affordable, Accessible Parking**

***Increase access for AC&RS to appropriate transport services, including patient transport, accessible parking and fleet vehicles, to enable the delivery of centre and community based services***

#### 9.5 Governance

At present AC&RS operate with two distinct governance models. Each model operates differently, through different management and staffing structures. In the eastern part of the Area, there is a Clinical Director responsible for all aged care and rehabilitation clinical services. In the south west, both aged care and rehabilitation services are managed by sub-specialty Directors, within the Complex Care and General Practice Clinical Stream.

SSWAHS has reviewed the Clinical Stream structure, influencing the governance of AC&RS. In the short term, an Implementation Management Committee has been established through the Older Persons and Aged Care Services Clinical Redesign Project, to provide an Area wide governance structure which can ensure corporate accountability requirements for AC&RS programs are met. This is essentially an expanded membership for the SSWAHS Aged Care Committee established in 2006, to facilitate cooperation and collaboration across SSWAHS.

It is anticipated that AC&RS will be grouped into three clusters: a Southern Cluster (Wingecarribee and Macarthur areas), Central Cluster (Liverpool, Fairfield and Bankstown areas) and Northern Cluster (Canterbury, Concord and Camperdown areas). Clustering will be progressively implemented.

The new AC&RS structure will require the development of a comprehensive infrastructure to support clinical governance and management. AC&RS will identify this structure in consultation with the Area Executive. The core functions of the AC&RS clinical stream will include clinical services planning/networking, quality and safety/clinical governance, succession and workforce planning, and integration of like departments across SSWAHS.

#### **Recommendation – Governance**

***Implement the recommendations from the SSWAHS Review of Clinical Streams 2007***

#### 9.6 Workforce

For SSWAHS, our workforce is an investment. An investment in the care of our community, an investment in the future sustainability of the care we need to provide to our community; and an investment in the individual and their career with us. The theme of the SSWAHS Workforce Strategic Plan is “Investment in our Workforce”. The SSWAHS Workforce goal is to be the Area Health Service in which people want to work. In achieving this goal, there are four key tasks:

- Secure, retain, develop, manage and support our workforce
- Be a good place to work;
- Offer opportunities to build a career with us; and
- Ensure our workforce numbers and skills, and their tasks, location and mix, are sufficient to meet our service needs.

AC&RS workforce issues are significant, posing a barrier to effective management and service delivery. A draft paper highlighting the range and scope of issues in aged care was prepared as part of the *Older Persons and Aged Care Services Clinical Redesign Project* (see Appendix 6). It is imperative that this paper is distributed appropriately to raise awareness of workforce issues.

Preliminary work has also been undertaken in estimating additional staff and resources required, based on the estimated growth in the aged population and factors which contribute to frailty and disability. The implications for SSWAHS hospitals and AC&RS services are significant and need to be factored into current and future discussions and planning. A separate paper which considers these implications in detail, and which can be used by the Area Executive, Stream Directors, and General Managers of health facilities in considering strategic direction, is required.

### **9.6.1 Clinical Staff**

There are currently workforce shortages for many clinical disciplines and in particular for staff with an interest and/or expertise in working with AC&RS clients.

Attempts have been made to set AC&RS staffing benchmarks. Due to the limited pool of available staff, it has not been possible to meet these benchmarks consistently in SSWAHS.

The Greater Metropolitan Transition Taskforce (GMITT) recommended the establishment of four inpatient geriatrician positions (providing support to acute and sub-acute units, clinics and consultative services) per 25,000 people aged over 65. This number does not include the Geriatricians providing a community based service, General Medicine component, or fulfilling a primarily academic role.

To implement the service delivery model consistently, enhancements to the geriatric medical staff will be required. In particular, the development of a specialist aged care capacity at Campbelltown and Bowral Hospitals is essential. Additional staff specialists and registrars across the Area will be required to respond to anticipated population growth. Further detailed planning of staffing numbers will need to occur as the services develop.

To ensure quality, safety and the capacity to develop skills across AC&RS, where a geriatric medical service is being provided on site, ideally a minimum of two FTE Geriatricians should be employed. At present, AC&RS have a number of advanced trainees due to complete their training requirements by 2010. These trainees are a potential source of long term medical workforce, if positions can be secured.

The Australasian Faculty of Rehabilitation Medicine (2005) has established staffing standards for inpatient rehabilitation teams. These standards could be used as a guide to staffing rehabilitation services.

### **9.6.2 Management and Administrative Support**

Adequate levels of both managerial and administrative support are required to ensure the optimal delivery of AC&RS services. This is particularly because:

- Support capabilities in management and administration enable clinical staff to focus on clinical activities;
- The range of funding sources (most notably for aged care) is extensive. Associated with these are numerous performance measures and accountabilities which are complex and demanding in terms of human resources;
- The anticipated growth in the supply of services

As clinical services expand, it is essential to expand management and administrative support to enable effective delivery of clinical services.

### **9.6.3 Innovative Solutions**

In the eastern part of the Area and in Macarthur casual pools of skilled staff have been established to provide support to the aged care client in home based and community settings, such as centre based day care. The creation of a skilled pool of staff has enabled a more efficient and client oriented service to be provided. Opportunities to expand this pool across SSWAHS, to provide a

mobile, specialised workforce to support clients in inpatient, outpatient and home based services, should be considered. Benefits of this approach include the creation of a skilled workforce who are familiar with local operating environments and procedures, and improve cost effectiveness.

Other innovative workforce solutions have been proposed through the Older Persons and Aged Care Services Clinical Redesign project.

#### **Recommendation – Workforce**

**A. Strengthen the capacity of the SSWAHS workforce to respond to the needs of AC&RS clients, in particular through the recruitment and retention of Advanced Trainees and other staff with specialist qualifications in aged care and/or rehabilitation**

**B. Work with the Director Workforce Planning and Development to incorporate the needs of AC&RS services into the broader workforce planning initiatives within SSWAHS**

**C. Develop a compendium document which focuses on workforce projections and infrastructure.**

### **9.7 Research and Education**

Opportunities for research and education are unique in SSWAHS, as the area includes urban, semi-urban and rural settings and the population is the most ethnically diverse in Australia.

Staff have strong teaching relationship with academic institutions, particularly the University of Sydney (EZ) and the University of NSW (WZ). The development of the University of Western Sydney (UWS) Medical School will expand opportunities for these relationships.

With the growth in the ageing population as described earlier, there will be a need for more staff with skills and expertise in geriatric medicine and the care of older, particularly frail older, people. The establishment of an Academic Aged Care and Rehabilitation Unit in conjunction with a clinical education unit will enable the progression of this service.

The Centre for Research and Education on Ageing (CERA) is a joint Centre of the University of Sydney's Department of Medicine and CRGH, based in the CRGH Aged Care and Rehabilitation Precinct. This location is unlikely to meet CERA's future accommodation needs.

The CSAHS Plan for General, Geriatric and Rehabilitation Medicine (CSAHS, 2003) described CERA's functions as including:

- epidemiological, clinical, biological and health service research on ageing;
- coordinating a structured education program for the University of Sydney Faculty of Medicine, and providing educational input into courses for health workers and community organisations
- supporting postgraduate research

CERA undertakes work in a range of disciplines, using funding from a variety of sources including CSAHS, University of Sydney, National Health & Medical Research Council (NHMRC) grants, project tenders from government departments, and the Ageing and Alzheimer's Foundation, a Foundation of the University of Sydney. Many of the CERA staff hold conjoint appointments within the eastern part of SSWAHS.

CERA is now the largest and most successful academic geriatric medical organisation in Australia. It has expanded dramatically in the last 5 years to include 4 professors and some 40 affiliated staff and researchers. It has achieved over \$6 million in competitive Australian Research Council (ARC) and NHMRC funds. In terms of space, the major issues relate to the development of the Concord Hospital Ageing Male Project (CHAMP) funded primarily by an approximately \$2 million NHMRC grant. CHAMP aims to study prospectively, some 3,000 older men in the Concord region, and will continue for at least 10 years. This substantial project is expected to establish CRGH's reputation internationally and increase the connections with local residents by their involvement in the project as subjects. In addition, the \$2.5 million ARC NHMRC Ageing Research Network, places CRGH at

the centre of ageing within Australia. This project involves leading national research in ageing and is centred within Concord Hospital. The CERA laboratory research in the Basic Sciences Laboratories and the ANZAC Institute also continues to be highly successful in terms of grants and publications, with a steady increase in post graduate students. As a result of this activity, CRGH has been successful in attracting specialist medical registrars and junior medical staff to Concord Hospital, with many continuing on to research Masters and PhD qualifications (with approximately 12 medical practitioners completing or enrolled in PhD and Masters programmes since 2001).

Such growth has enormous benefits for the hospital in terms of national and international reputation and attraction of high quality medical staff, as well as providing a milieu that supports and develops nursing and allied health professionals. Given the rate of growth of CERA and the ageing of the population, it is likely that the spatial requirements of the unit will at least double in the next 10 years.

Aged Care research in the south west has a focus on multidisciplinary, clinically based research into geriatric syndromes such as falls prevention and management, and cognitive assessments, in particular, multicultural cognitive assessment. These services have not as yet been integrated into a specific academic unit, although it is a recommendation of both *The Way Forward* and this Plan that such a unit is created. The recent appointment of a Research Manager to implement the \$1 million Australian Government funded Pathways Home Research Project, will facilitate early development of this unit, particularly in relation to formalizing links with other academic units within SSWAHS, with Universities and post-graduate students.

Rehabilitation services in SSWAHS have an active interest in research around a range of themes including multidisciplinary teams and their effect on patient care; patient outcomes particularly in relation to stroke, cancer and amputee rehabilitation; the availability of day hospital rehabilitation; comparisons of different models of rehabilitation care and factors effecting length of stay and functional outcomes. Services are also collaborating on international research, on the development and validation of International Classification of Functioning, Disability and Health core sets for stroke, brain injury and cancer.

In addition, the Brain Injury Rehabilitation Unit has a well developed research program with strong links to the University of Sydney's Rehabilitation Studies Unit. Brain Injury research in SSWAHS has been successful in attracting external funding, and post-graduate students involved in research into various physiological, psychological and social factors associated with brain injury.

To progress research and teaching in the south west, there is a need for additional support staff, including access to statistical support services.

Consistent with the recommendations from *The Way Forward*, there is a need to develop a full time academic presence for Aged Care in the south west, in collaboration with the Universities of NSW and Western Sydney. A similar presence should also be established for rehabilitation services. This is required in response to the ageing population and particularly, the need for training and support of the health workforce in responding to the needs of aged care and rehabilitation clients.

The role of the unit would include the development of multidisciplinary education and research programs and the establishment of a support unit to enhance education services within the Area, and to improve the quality of care of the aged care and rehabilitation client. These units would complement the role of the CERA.

It is proposed that the Aged Care and Rehabilitation Research Unit will be housed with AC&RS within the Liverpool Hospital Stage 2 redevelopment, whilst the Brain Injury Rehabilitation Research Unit will be colocated with the proposed new research facility at Liverpool Hospital.

#### **Recommendation – Research and Education**

***Strengthen the capacity of SSWAHS to undertake research and education in aged care and rehabilitation***

## **10. IMPLEMENTATION, MONITORING AND EVALUATION**

The AC&RS Clinical Services Plan outlines a service delivery model for community and acute AC&RS within SSWAHS, along with a range of service development initiatives which are outlined in detail in the *2006 Self Assessment response to the Framework for the Integrated Support and Management of Older People in the NSW Health System 2004 – 2006*; (SSWAHS, 2006) and the *Older People and Aged Care Health Services Project Solution Design Report* (SSWAHS, 2007), produced through the Clinical Redesign process.

The Plan documents the actions required to deliver this service model across SSWAHS by 2012, whilst delivering the structure to develop this service model to 2016, in response to anticipated demographic changes. It follows the structure of the aged care service delivery model, incorporating core services, enhanced services, supra-regional services and partnership/associated services. Actions are also included in relation to infrastructure and support requirements.

Plan implementation will be monitored through the SSWAHS Aged Care and Rehabilitation Executive, including the SSWAHS Older Persons and Aged Care Services Clinical Redesign Implementation Management Committee, and report six monthly to the Area Executive.

The Plan will be comprehensively reviewed in 2012, and its success evaluated, prior to further plans being developed.

## Sydney South West Area Health Service – Aged Care and Rehabilitation Clinical Services Plan 2007 - 2012

### ACTION PLAN

AC&RS CSP Section	Action	Performance Indicator	Responsibility	Time-frame	Resource Implications	Link to the Framework Standards	Link to Clinical Redesign	Link to SSWAHS Strategic Plan
6.1.1	1. Implement the centralised community intake solution from the Older Persons and Aged Care Services Clinical Redesign Project	Solution Implemented	Implementation Management Committee	December 2008	To be determined (TBD) through Clinical Redesign	1.3	Centralised Community Intake	2b.4 / 2c.5
6.1.2	2. Using annually allocated DoHA funding, increase the capacity of ACAT's across SSWAHS to undertake traditional roles	Increase in ACAT FTE Increase in ACAT MDS activity	Clinical Director AC&RS	Annually	DoHA funding	1.14	N/A	2c.5
6.1.2	3. Review the role of ACATs in SSWAHS and investigate opportunities to increase SSWAHS funding of ACAT positions to provide more rapid response and treatment capacity	ACAT review complete and business case for additional positions developed	Clinical Director AC&RS	Dec 2008	Business case may identify need for additional recurrent funding	1.14	Consistent ACAT Processes and Standards	2c.5
6.1.2	4. Implement the Consistent ACAT Processes and Standards solution from the Older Persons and Aged Care Services Clinical Redesign Project	Solution implemented	Implementation Management Committee	December 2009	TBD through Clinical Redesign	1.14	Consistent ACAT Processes and Standards	
6.1.3	5. Implement the Improved Care of Older People in Emergency Departments Clinical Redesign Solution	Review complete and recommendations disseminated	Implementation Management Committee	July 2008	TBD through Clinical Redesign	2.7	Improved Care of Older People in Emergency Departments	2c.5
6.1.3	6. Subject to the outcomes of the Improved Care of Older People in Emergency Departments Clinical Redesign Solution, develop a Business Case to trial the operation of extended hours/weekend ASET at Liverpool and Concord Hospitals for a 12 month period and evaluate	Business case developed. Trial implemented and outcomes evaluated	Clinical Director AC&RS; General Managers CRGH & Liverpool Hospital	June 2009	TBD through Business Case	2.7	Improved Care of Older People in Emergency Departments	2c.5

AC&RS CSP Section	Action	Performance Indicator	Responsibility	Time-frame	Resource Implications	Link to the Framework Standards	Link to Clinical Redesign	Link to SSWAHS Strategic Plan
6.1.4	7. Establish generalist geriatric clinics at Bowral Hospital and explore opportunities to establish generalist geriatric clinics at Camden Hospital	Options investigated Clinics established	Clinical Director AC&RS; General Manager Bowral and Camden Hospitals	Bowral – April 2008; Camden – September 2010	Bowral – funding source identified; Camden – recurrent funding may be required	1.7 / 1.8 / 1.10		2b.5
6.1.5	8. Investigate the feasibility of developing a Day Hospital at Bankstown-Lidcombe Hospital through the Pathways Home Capital Project planning process	Service Procurement Plan/Project Definition Plan (SPP/PDP) developed	Director Clinical Operations; Director Aged Care Bankstown	December 2007	Capital – funded through Pathways Home Capital Project Recurrent implications TBD through SPP/PDP	1.5		2b.5
6.1.5	9. Work with Hope Healthcare to investigate options for the expansion of day hospital services at Braeside Hospital	Options paper developed	Clinical Director AC&RS; Director Rehabilitation; Hope Health Care	December 2010	TBD	1.5		2b.5
6.1.5	10. Expand the availability of AC&RS outpatient therapy services at Canterbury Hospital	Annual occasions of service	Clinical Director AC&RS; General Manager Canterbury Hospital	December 2010	Funding required	1.10		2b.5
6.1.6	11. Undertake a review of home based therapy services across the Area and develop a consistent model of care	Review complete and model developed	Clinical Director AC&RS	July 2008	Within existing	1.10		2b.5
6.1.6	12. Subject to the outcomes of the Home Based Therapy review, investigate the option of establishing new and expanding services	Annual occasions of service	Clinical Director AC&RS	December 2011	Funding required	1.10		2b.5
6.1.7	13. Develop and implement an Area wide system to monitor ComPacks demand and utilisation across SSWAHS	System developed and implemented	Director Clinical Operations	July 2008	Within existing	1.14		3a.6

AC&RS CSP Section	Action	Performance Indicator	Responsibility	Time-frame	Resource Implications	Link to the Framework Standards	Link to Clinical Redesign	Link to SSWAHS Strategic Plan
6.1.7	14. Investigate opportunities to recurrently fund 7 packages per week through ComPacks at CRGH	Recurrent funding allocated	General Manager CRGH; Clinical Director AC&RS	July 2008	Funding required	1.14		3a.6
6.1.7	15. Investigate opportunities to expand the existing ComPacks capacity by 4 packages at Bankstown, 2 packages at Fairfield and 8 packages at Liverpool	Service expanded	General Managers Bankstown, Fairfield & Liverpool Hospitals; Clinical Director AC&RS	July 2009	Funding required	1.14		3a.6
6.1.8	16. Participate in the National Evaluation of TACP	SSWAHS activity, issues and concerns raised through National Evaluation process	Clinical Director AC&RS	December 2008	Within existing	1.13		3a.6
6.1.8	17. Through the Pathways Home Research project investigate the demand for facility based TACP places in the south west	Demand determined and recommendations made	Pathways Home Research Manager	December 2008	Within existing	1.13		3a.6
6.1.9	18. Develop a business case to pilot two community dementia teams in SSWAHS at Concord and Liverpool, and evaluate outcomes.	Business case developed. Pilot completed and evaluation undertaken	Clinical Director AC&RS	December 2009	TBD through business case. HACC is a possible source of funding	1.7/1.8		3a.2
6.1.10	19. Undertake a comprehensive review of Centre Based Day Care in SSWAHS including governance, operations, funding, staffing, policies, procedures, client mix, opportunities for expansion and clinical service delivery	Review completed and recommendations developed	Clinical Director AC&RS; General Manager Community Health; Director Aboriginal Health; SSWAHS HACC Coordinator	Dec 2008	Within existing	1.5/ 1.6		3a.2

AC&RS CSP Section	Action	Performance Indicator	Responsibility	Time-frame	Resource Implications	Link to the Framework Standards	Link to Clinical Redesign	Link to SSWAHS Strategic Plan
6.1.10	20. Submit an application for HACC Capital funding for the redevelopment of Broughton House, Camden. If application is unsuccessful, investigate alternative capital funding options	Application submitted. Investigation completed as required	Service Development Manager Aged Care, WZ	June 2008	HACC	1.11		
6.1.11	21. Request expansion of the existing Dementia Advisory Services (DAS) in SSWAHS through local HACC planning processes, including their capacity to service multicultural communities	Request submitted; recurrent HACC funding allocated	SSWAHS HACC Coordinator	July 2009	HACC	1.7		3a.2
6.1.12	22. Review the role of SSWAHS in the provision of externally funded respite and support services	Review complete and recommendations made	Clinical Director AC&RS	July 2008	Within existing			
6.2.1	23. Investigate opportunities to colocate outlier patients to improve inpatient management	Outlier patients are colocated	Implementation Committee	July 2008	Nil	1.4	Colocation of Outlier Patients	2b.5
6.2.1	24. Investigate the feasibility of establishing an acute aged care inpatient unit at Campbelltown Hospital	Feasibility assessment conducted	Health Services Planning; General Manager Campbelltown Hospital; Clinical Director AC&RS	July 2010	TBD	1.13		2b.5
6.2.1	25. Participate in planning for additional inpatient facilities through the Liverpool Stage 2 redevelopment	Additional bed capacity	Director Clinical Operations; Liverpool Hospital General Manager; Clinical Director AC&RS	December 2011	Within existing – capital costs TBD	1.7/1.8/1.13		2b.5
6.2.1	26. Improve ward environments to better cater for the needs of people with delirium/dementia	Reduced length of stay for people with dementia/delirium	Hospital General Managers; Dementia CNCs	December 2011	Within existing	1.7		

AC&RS CSP Section	Action	Performance Indicator	Responsibility	Time-frame	Resource Implications	Link to the Framework Standards	Link to Clinical Redesign	Link to SSWAHS Strategic Plan
6.2.1	27. Investigate opportunities to develop Transitional Living Unit models for clients transitioning between hospital and alternative accommodation arrangements	Feasibility assessment undertaken	Clinical Director AC&RS	December 2010	Within existing			3a.6
6.2.1	28. Investigate the feasibility of providing supported accommodation for people with a disability and high medical needs, in conjunction with DADHC	Feasibility assessment undertaken	Clinical Director AC&RS	December 2010	Within existing			3a.6
6.2.2	29. Investigate opportunities to develop the capacity of aged care inpatient consultation services, consistent with population growth and ageing	Feasibility assessment undertaken	Clinical Director AC&RS	Ongoing	Funding required			
6.2.2	30. Enhance the capacity of non AC&RS wards to respond to the needs of older patients with complex co-morbidities and/or ageing related problems	Patient/carer satisfaction with care provided; improved staff awareness of the needs of older patients	Clinical Director AC&RS; Implementation Management Committee	December 2010	TBD	1.4/ 1.7/1.9	Improved Care of Older People in the ED; Principles for Integrated Care; Medical Specialty Care Partnerships; Aged Care Resource Nurse; Colocation of Outlier Patients; Standardised Assessment Tool	6b.7
6.2.3	31. Investigate opportunities to develop the capacity of rehabilitation inpatient consultation services consistent with population growth and ageing	Feasibility assessment undertaken	Clinical Director AC&RS	Ongoing	Funding required			

AC&RS CSP Section	Action	Performance Indicator	Responsibility	Time-frame	Resource Implications	Link to the Framework Standards	Link to Clinical Redesign	Link to SSWAHS Strategic Plan
6.2.4	32. Investigate the feasibility of establishing a Dementia and/or Gerontology CNC across SSWAHS	Feasibility assessment undertaken	Clinical Director AC&RS; Hospital General Managers	July 2009	TBD	1.7	Aged Care Resource Nurse	
7.1	33. Undertake planning for the expansion of the Liverpool Brain Injury Rehabilitation Unit (BIRU) as part of the Liverpool Stage 2 Redevelopment, consistent with state-wide planning	Planning for Liverpool BIRU is consistent with state-wide planning	Director Clinical Operations; Director Brain Injury Rehabilitation Unit	Ongoing	Planning – within existing Capital & recurrent – TBD	1.10		7b.3
7.2	34. Participate in planning for the state-wide Burns Service	SSWAHS participates in planning for state-wide Burns Service. SSWAHS priorities recognised in state-wide planning	Director Burns Unit; General Manager CRGH	Ongoing	Within existing	1.10		5b.2
7.3	35. Participate in planning for the state-wide spinal cord injury service	SSWAHS participates in planning for state-wide spinal cord injury service. SSWAHS priorities recognised in state-wide planning	Clinical Director AC&RS	Ongoing	Within existing	1.10		5b.2
8.1	36. Participate in the implementation of the SSWAHS Falls Prevention and Management Program	Prevent further increases in hospitalisations for fall injuries among people 65 and over	Clinical Director AC&RS	Ongoing	TBD through Falls Prevention Plan	1.2 / 1.3		1c.3

AC&RS CSP Section	Action	Performance Indicator	Responsibility	Time-frame	Resource Implications	Link to the Framework Standards	Link to Clinical Redesign	Link to SSWAHS Strategic Plan
8.2	37. Participate in planning for specialist mental health services for older people (SMHSOP) to ensure integration between aged care and mental health	SMHSOP Plan completed and inclusive of Aged Care issues	Director SMHSOP Mental Health; Clinical Director AC&RS	December 2008	Within existing	1.8		
8.2	38. Develop systems to coordinate and, where possible integrate, Aged Care and SMHSOP services to provide a seamless service delivery system	Client and carer satisfaction with complaints regarding service system;	Director SMHSOP Mental Health; Clinical Director AC&RS	Ongoing	Within existing	1.8	Principles for Integrated Care;	3a.8
8.3	39. Implement relevant solutions from the Older People and Aged Care Health Service Clinical Redesign project, aimed at improving the treatment of older people and aged care clients in all medical and surgical services	Solutions implemented	Implementation Management Committee	December 2009	TBD	1.4	Principles for Integrated Care; Medical Specialty Care Partnerships	3a.8
8.3	40. Participate in planning to expand CAPAC and Ambulatory Care services across SSWAHS	AC&RS issues are incorporated into planning and service development initiatives	Director Clinical Operations; Clinical Director AC&RS	Ongoing	TBD	1.4 / 1.5		2b.5
8.4	41. Work with Allied Health to streamline the management and operation of Equipment Lending Pools across the Area	ELP management structures resolved	Director Allied Health; Clinical Director AC&RS	July 2008	Within existing	1.10		
8.4	42. Investigate opportunities to expand the capacity of Equipment Lending Pools	Additional equipment available	Director Allied Health; Clinical Director AC&RS	Ongoing	TBD			3a.6
8.4	43. Explore new initiatives to facilitate access for AC&RS patients to off-site hydrotherapy services	Improved access to hydrotherapy	Director Allied Health; Clinical Director AC&RS	Ongoing	TBD	1.10		2b.5
8.4	44. Investigate the feasibility of expanding orthotics services across SSWAHS	Feasibility assessment completed	Director Allied Health; Clinical Director AC&RS; Director Rehabilitation	December 2009	Within existing	1.10		2b.5

AC&RS CSP Section	Action	Performance Indicator	Responsibility	Time-frame	Resource Implications	Link to the Framework Standards	Link to Clinical Redesign	Link to SSWAHS Strategic Plan
8.4	45. Investigate opportunities to develop additional seating clinics in SSWAHS	Feasibility assessment completed	Director Allied Health; Clinical Director AC&RS	December 2009	Within existing	1.10		2b.5
8.4	46. Investigate opportunities to expand prosthetics services in SSWAHS	Feasibility assessment completed	Director Allied Health; Clinical Director AC&RS	December 2009	Within existing	1.10		2b.5
8.5	47. Consistent with the Community Health Strategic Plan, formalise arrangements between AC&RS and Community Health on the use of space within Community Health facilities	Service Level Agreements developed	General Manager Community Health; Clinical Director AC&RS	December 2009	Within existing			2b.5
8.5	48. Support expansion of HACC funded Community Nursing services across SSWAHS	Increased recurrent HACC funding for community nursing; increased outputs	SSWAHS HACC Coordinator	Ongoing	HACC	1.13		
8.6	49. Finalise the End of Life component of the Pathways Home Research Project	Project completed; results disseminated	Pathways Home Research Manager	July 2008	Within existing	1.12	Advanced Care Planning	3a.3
8.6	50. Implement the Advanced Care Planning solution identified through the Older Persons and Aged Care Health Services Clinical Redesign Project	Increased number of patients with documented Advanced Care Plans; reduced avoidable admissions	Implementation Management Committee	December 2010	Funding required	1.12	Advanced Care Planning	3a.3
8.7	51. Investigate opportunities to expand the existing Biomedical Engineering Service to provide a specialist rehabilitation role	Feasibility assessment undertaken	Manager Biomedical Engineering Services; Clinical Director AC&RS	June 2010	TBD	1.10		2b.5
8.8	52. Participate in implementing the recommendations of the NSW Health PADP Review	Recommendations actioned	Director Allied Health; Clinical Director AC&RS	June 2008	Within existing	1.10		

AC&RS CSP Section	Action	Performance Indicator	Responsibility	Time-frame	Resource Implications	Link to the Framework Standards	Link to Clinical Redesign	Link to SSWAHS Strategic Plan
8.9	53. Investigate opportunities to consolidate some of the existing carer support services within SSWAHS	Simplified governance structure for carer support services	Director Allied Health; Clinical Director AC&RS	June 2008	Within existing	1.5/1.6/1.12		1b.5
8.9	54 Participate in the development of the SSWAHS Carer Action Plan	AC&RS issues incorporated in SSWAHS Carer Action Plan	Director Allied Health; Clinical Director AC&RS	June 2008	Within existing	1.6/1.7/1.12		1b.5
8.10	55. Review management of the VDQ and CHVP Programs within SSWAHS	Review completed	Director Clinical Operations; Clinical Director AC&RS	June 2008	Within existing resources			
8.11	56. Implement the General Practice Education Support solution from the Older Persons and Aged Care Health Services Clinical Redesign Project	Solution implemented	Implementation Management Committee; Divisions of General Practice	December 2008	TBD	2.6 / 2.7 / 2.8 / 2.13	General Practice Education and Support	1c.1 / 3a.2
8.12	57. Implement the Care Partnerships with Residential Aged Care Facilities (RACFs) solution from the Older Persons and Aged Care Health Services Clinical Redesign Project	Solution implemented	Implementation Management Committee; RACFs; Divisions of General Practice; Clinical Director AC&RS	December 2008	TBD	2.6 / 2.7 / 2.8	Care Partnerships with RACFs	3a.3
8.12	58. Participate in the evaluation of psychogeriatric care partnerships between SSWAHS, Holy Spirit Croydon and Hammond Care	AC&RS issues incorporated into evaluation	Clinical Director AC&RS; Director SMHSOP Mental Health	December 2010	Within existing			
8.12	59. Work with RACF's to identify areas of undersupply in the RACF market and provide information to assist in identification of consumer demand	New RACF bed allocations are consistent with identified needs	Clinical Director AC&RS; RACFs	Ongoing	Within existing	1.14		3a.3

AC&RS CSP Section	Action	Performance Indicator	Responsibility	Time-frame	Resource Implications	Link to the Framework Standards	Link to Clinical Redesign	Link to SSWAHS Strategic Plan
8.12	60. Participate in planning associated with the outcomes from the review of state government owned residential aged care facilities	AC&RS services participate in planning processes	Clinical Director AC&RS	December 2010	Within existing	1.14		3a.3
8.11 / 8.12	61. Work with Divisions of General Practice and RACFs to improve the delivery of GP services in RACFs	Attendances by GPs at RACFs (Medicare)	Clinical Director AC&RS; Divisions of General Practice; RACFs	December 2009	Within existing	2.6 / 2.7 / 2.8 / 2.13		1c.1 / 1c.2 / 3a.3
8.13	62. Implement the Improved Carelink Utilisation solution from the Older Persons and Aged Care Health Services Clinical Redesign project	Increased utilisation of Carelink; increased satisfaction with Carelink service	Implementation Management Committee	Ongoing	Within existing		Improved CareLink Utilisation	
8.13	63. Continue to facilitate local dementia networks to encourage joint planning and cooperation between public, private and NGO providers of dementia care	Number of participants attending local dementia networks; Satisfaction with local dementia networks	Senior Service Manager; Service Development Manager Aged Care; SSWAHS DAS Coordinators	Ongoing	Within existing	2.6		4b.5
8.14	64. Work with SSWAHS Aboriginal Health Services, local Aboriginal Medical Services and other Aboriginal agencies to improve access and support	Number of new initiatives developed	Clinical Director AC&RS; Director Aboriginal Health	December 2010	TBD	1.6		1b.2/ 1b.5
8.15	65. Continue to provide training to interpreter service and AC&RS staff in clinical practice with diverse communities, and develop systems to support better practice	Number of staff trained; increased satisfaction with interpreter use	Clinical Director AC&RS; Director Multicultural Health; Multicultural Aged Care Advisor	December 2011	Within existing	1.6		1b.2
9.1	66. Participate in planning for the Pathways Home Capital Project	Completion of SPP/PDP	Health Services Planning; Clinical Director AC&RS	June 2010	DoHA funding	1.8 / 2.6 / 2.8		

AC&RS CSP Section	Action	Performance Indicator	Responsibility	Time-frame	Resource Implications	Link to the Framework Standards	Link to Clinical Redesign	Link to SSWAHS Strategic Plan
9.1	67. Design briefs for AC&RS developments/ redevelopments take into account the high levels of disability, carer support requirements and high prevalence of dementia/delirium in patients and clients	Comprehensive design briefs developed for AC&RS services	Clinical Director AC&RS; Director Capital Works	Ongoing	TBD	1.11		
9.2	68. Roll-out CERNER across AC&RS to ensure integration of clinical information systems across sites and standardised data collection capacity	All services have access to CERNER	Director ISD; Clinical Director AC&RS	December 2011	Funding required	1.11		5b.7
9.2	69. Develop the SSWAHS AC&RS internet and intranet site	AC&RS internet and intranet sites operational; annual number of hits	Pathways Home Research Manager; Senior Service Manager	December 2007	Within existing resources	2.6		5b.7
9.2	70. Scope the capacity of SSWAHS AC&RS services to utilise Telehealth initiatives	Scoping paper developed	Clinical Director AC&RS	December 2008	Within existing resources	1.1 /1.2		2c.4
9.3	71. Implement the Data and Performance Strategy solution from the Older Persons and Aged Care Clinical Redesign project	Solution implemented	Implementation Management Committee	December 2007 and ongoing	Within existing		Data and Performance Strategy	5b.7
9.3	72. Investigate the feasibility of employing a data manager(s) for AC&RS and/or establishing a Data Management Unit	Feasibility assessment undertaken	Clinical Director AC&RS	December 2008	TBD	2.15	Data and Performance Strategy	
9.4	73. Expand AC&RS access to fleet vehicles to facilitate the delivery of community based services, including designated AC&R services	Additional fleet vehicles available	Clinical Director AC&RS	Ongoing	Funding required – utilise external aged care funding eg. TACP			2c.2

AC&RS CSP Section	Action	Performance Indicator	Responsibility	Time-frame	Resource Implications	Link to the Framework Standards	Link to Clinical Redesign	Link to SSWAHS Strategic Plan
9.4	74. Investigate opportunities to expand the availability of transport services to facilitate client access to AC&RS, including through external funding	Options assessed; additional transport services available	Clinical Director AC&RS; Director Corporate Services	Ongoing	Funding required – utilise external funding eg. TACP			2c.2
9.5	75. Implement recommendations from the SSWAHS Review of Clinical Streams 2007	Recommendations implemented	Director Clinical Operations	July 2008	Within existing			
9.6	76. Finalise the draft Workforce Paper initiated through the Older Persons and Aged Care Services Clinical Redesign Project and distribute	Paper finalised and distributed	Implementation Management Committee	July 2007	Within existing	2.9 / 2.10		6b.1
9.6	77. Implement workforce related solutions within the Older Persons and Aged Care Services Clinical Redesign Project	Solutions implemented	Implementation Management Committee	December 2010	Funding required	2.9 / 2.10	Aged Care Coordinator; Aged Care Resource Nurse; Aged Care Specialist Nurse; Allied Health Seniors	6b.1
9.6	78. Develop a compendium document to this Plan for future planning which focuses on workforce projections and infrastructure	Compendium developed and circulated	Director Health Services Planning	June 2008	Within existing	2.9/2.10		6b.1 / 2c.6
9.7	79. Investigate opportunities to establish academic positions within AC&RS, located at Liverpool, Bankstown and CRGH	Feasibility assessment undertaken; additional academic positions established	Clinical Director AC&RS	December 2011	TBD			7a.3

## LIST OF ABBREVIATIONS

<i>ABS</i>	<i>Australian Bureau of Statistics</i>
<i>AC&amp;RS</i>	<i>Aged Care and Rehabilitation Service</i>
<i>ACAT</i>	<i>Aged Care Assessment Team</i>
<i>ACT</i>	<i>Australian Capital Territory</i>
<i>AFRM</i>	<i>Australasian Faculty of Rehabilitation Medicine</i>
<i>AHMAC</i>	<i>Area Health Medical Advisory Council</i>
<i>AHS</i>	<i>Area Health Service</i>
<i>ALOS</i>	<i>Average Length of Stay</i>
<i>ALS</i>	<i>Artificial Limb Service</i>
<i>AMO</i>	<i>Admitting Medical Officer</i>
<i>AN DRG</i>	<i>Australian National Diagnosis Related Group</i>
<i>ARC</i>	<i>Australian Research Council</i>
<i>ASET</i>	<i>Agedcare Services Emergency Team</i>
<i>ASGM</i>	<i>Australian Society for Geriatric Medicine</i>
<i>BASIS</i>	<i>Behavioural Assessment and Intervention Services</i>
<i>BIRU</i>	<i>Brain Injury Rehabilitation Unit</i>
<i>BPSD</i>	<i>Behavioural &amp; Psychological Symptoms of Dementia</i>
<i>CACP</i>	<i>Community Aged Care Package</i>
<i>CAL</i>	<i>Chronic Airways Limitation</i>
<i>CAPAC</i>	<i>Community Acute/Post Acute Care</i>
<i>CBDC</i>	<i>Centre Based Day Care</i>
<i>CCF</i>	<i>Congestive Cardiac Failure</i>
<i>CCNH</i>	<i>Carrington Centennial Nursing Home</i>
<i>CCRC</i>	<i>Commonwealth Carer Respite Centre</i>
<i>CERA</i>	<i>Centre for Education and Research on Ageing</i>
<i>CHVP</i>	<i>Children's Home Ventilation Program</i>
<i>CNC</i>	<i>Clinical Nurse Consultant</i>
<i>COPS</i>	<i>Community Options</i>
<i>CRGH</i>	<i>Concord Repatriation General Hospital (Concord Hospital)</i>
<i>CSAHS</i>	<i>Central Sydney Area Health Service</i>
<i>CVS</i>	<i>Community Visitors Scheme</i>
<i>DADHC</i>	<i>NSW Department of Ageing, Disability and Home Care</i>
<i>DAP</i>	<i>Disability Action Plan</i>
<i>DAS</i>	<i>Dementia Advisory Service</i>
<i>DoHA</i>	<i>Commonwealth Department of Health and Ageing</i>
<i>EACH</i>	<i>Extended Aged Care at Home</i>
<i>ED</i>	<i>Emergency Department</i>
<i>ELP</i>	<i>Equipment Lending Pool</i>
<i>EPC</i>	<i>Enhanced Primary Care</i>

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<i>EZ</i>	<i>Eastern Zone of SSWAHS (formerly Central Sydney Area Health Service)</i>
<i>GGRM</i>	<i>General, Geriatric and Rehabilitation Medicine</i>
<i>GPs</i>	<i>General Practitioners</i>
<i>HACC</i>	<i>Home and Community Care</i>
<i>HBT</i>	<i>Home Based Therapy</i>
<i>ICF</i>	<i>International Classification of Functioning, Disability and Health</i>
<i>IRO</i>	<i>Institute of Rheumatology and Orthopaedics</i>
<i>LGA</i>	<i>Local Government Area</i>
<i>LH</i>	<i>Liverpool Hospital</i>
<i>LOS</i>	<i>Length of Stay</i>
<i>MACU</i>	<i>Medical Acute Care Unit</i>
<i>MBS</i>	<i>Medical Benefit Scheme</i>
<i>MTU</i>	<i>Medical Transit Unit</i>
<i>NFAD</i>	<i>National Framework for Action on Dementia</i>
<i>NHMRC</i>	<i>National Health &amp; Medical Research Council</i>
<i>NRCP</i>	<i>National Respite for Carers Program</i>
<i>OPERA</i>	<i>Older Persons Evaluation Review and Assessment unit</i>
<i>PADP</i>	<i>Program of Appliances for Disabled People</i>
<i>RACP</i>	<i>Royal Australasian College of Physicians</i>
<i>RPAH</i>	<i>Royal Prince Alfred Hospital</i>
<i>RTP</i>	<i>Resource Transition Program</i>
<i>SAFTE</i>	<i>Sub-acute Fast Track Elderly</i>
<i>SAP2</i>	<i>Sustainable Access Plan 2005/06</i>
<i>SAP3</i>	<i>Sustainable Access Plan 2006/07</i>
<i>SCI</i>	<i>Spinal Cord Injury</i>
<i>SDAC</i>	<i>Survey of Disability, Ageing &amp; Carers</i>
<i>SEIAHS</i>	<i>South Eastern Illawarra Area Health Service</i>
<i>SEIFA</i>	<i>Socioeconomic Index for Areas</i>
<i>SGRACE</i>	<i>State Government Residential Aged Care Facility</i>
<i>SMHSOP</i>	<i>Specialist Mental Health Service for Older People</i>
<i>SSWAHS</i>	<i>Sydney South West Area Health Service</i>
<i>SWAHS</i>	<i>Sydney West Area Health Service</i>
<i>SWSAHS</i>	<i>South Western Sydney Area Health Service</i>
<i>TACP</i>	<i>Transitional Aged Care Program</i>
<i>TACS</i>	<i>Transcultural Aged Care Service</i>
<i>TBI</i>	<i>Traumatic Brain Injury</i>
<i>TBD</i>	<i>To Be Determined</i>
<i>TIA</i>	<i>Transient Ischemic Attack</i>
<i>UWS</i>	<i>University of Western Sydney</i>
<i>VDQ</i>	<i>Ventilator Dependent Quadriplegic</i>
<i>WZ</i>	<i>Western Zone of SSWAHS (formerly South Western Sydney Area Health Service)</i>

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**APPENDIX 1 PRINCIPLES, FRAMEWORK FOR THE INTEGRATED SUPPORT AND MANAGEMENT OF OLDER PEOPLE IN THE NSW HEALTH CARE SYSTEM 2004 – 2006**

- The majority of older people can live independently within the community with varying degrees of support
- Older people may need to be in contact with a range of organisations in order to maintain, improve or prevent deterioration in their health and quality of life
- Smooth transition between services should be possible, particularly across organisational boundaries
- An acute episode (health, social, emotional, economic) may trigger the need for:
  - Adjustment to existing support system
  - Acute health care (with or without associated post acute, mental health, rehabilitation and community services)
  - Change in accommodation arrangements
- The likelihood of return to previous lifestyle is optimised by:
  - Early response to acute episode, including identification of problems and assessment of need
  - Timely access to least disruptive intervention options
  - Timely service or intervention delivery with minimal disruption to current lifestyle
  - Appropriate brokerage of support services to optimise outcomes
- Older people need:
  - Access to safe and appropriate care and support
  - Access to information about their health care and service availability
  - Access to ongoing support through effective partnership of service providers
  - Coordinated continuity of care, including regular assessment
- Core values of care and service delivery should include:
  - Forming a partnership with older people and their families and carers to achieve the best outcome
  - Respect for older people and their values
  - Client and family/carer satisfaction
  - Respect for the privacy, dignity and cultural diversity of individuals
  - Respect for the views of older people and their family/carers
- No person or group should be discriminated against on the grounds of age
  - Age should not be used in eligibility criteria or policies to restrict access by older people and their families/carers to available and needed services
  - Older people should be able to access mainstream health promotion and disease prevention programs, as well as activities specially tailored to benefit the older person
- Australian and State government and non-government agencies need to work in partnership to support and enable older people to live as fulfilling lives as possible

**AGE FRIENDLY PRINCIPLES AND PRACTICES: MANAGING OLDER PEOPLE IN THE HEALTH SERVICE ENVIRONMENT** (Source: AHMAC 2004)

*Principle 1: Health treatment and care delivered to older people will be based on strong evidence and have a focus on maintaining, improving and preventing deterioration in their health and quality of life*

*Principle 2: Health services will recognize and address older people's complex needs*

*Principle 3: Health treatment and care are respectful and recognize individual differences and specific needs, such as cultural, religious and sexual differences*

*Principle 4: Health treatment and care are delivered in a coordinated and timely manner across care settings*

*Principle 5: Unnecessary admission to hospital and extended hospital stays of frail elderly people are avoided*

*Principle 6: The care of older people is a primary focus of all health services*

*Principle 7: Where safe and cost-effective to do so, older people receive health treatment and care in a setting that best meets their needs and preferences*

## **APPENDIX 2 CONTRIBUTORS TO THIS PLANNING PROCESS**

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Andrew Bernard, General Manager, Clinical Streams

Angela Blazely, A/Director Psychology, Western Zone

Dr Triet Bui, Geriatrician, Bankstown

Susan Burke, GGRM Community Service Manager (Canterbury), IWTACP Manager and SSWAHS VEQ Program Coordinator

Nina Catalano, Dementia Advisory Service, Bankstown/Liverpool/Fairfield

Dr Daniel Chan, Geriatrician, Bankstown

Trudy Coffey, Chief Social Worker

Mrs Pat Cotton, Community Representative, WZ Aged Care Advisory Committee (resigned)

Dr Helen Creasey, Geriatrician, Concord

Sue Crowley, ComPacks Coordinator, Health Service Performance Improvement Branch, NSW Health

Jean-Jacques Dath, Director Occupational Therapy, EZ

Professor Hugh Dickson, Director Ambulatory Care, Liverpool Hospital

Debra Donnelly, Nurse Coordinator, GGRM

A/Prof Brad Frankum, Director Complex & Primary Care, WZ

Wendy Geddes, Community Health

Mary Gibbs, NUM Rehabilitation Unit, Braeside

Kerry Gilson, Speech Therapist, Braeside

Dr Ross Hawthorne, Rehabilitation Specialist, Concord Hospital

Dr Adeline Hodgkinson, Director, Brain Injury Rehabilitation Unit

Michelle Horgan, A/Director Social Work, EZ

Gemma Irvine, Senior Occupational Therapist, Bankstown Hospital

Ann Kelly, A/General Manager, Balmain Hospital

Dianna Kenrick, Director Community & Allied Health, WZ

Professor David LeCouteur, CERA

Adele Lubiana, A/Service Development Manager, Aged Care, WZ

Dr Colin Macarthur, Geriatrician, Liverpool/Fairfield

Regina McDonald, Area CNC Older Persons Mental Health, Braeside

Dr Rod McKay, Psychogeriatrician, WZ

Janine Masso, ACAT Coordinator, Wingecarribee

Lorraine Merheb, Senior Social Worker, Liverpool Aged Care & Rehabilitation Team

Dr Katherine Moore, Director of Allied Health

Gai Moore, Multicultural Health

Catherine Murray, A/Senior Nurse Manager, Aged Care & Rehabilitation, Liverpool

Sharyn O'Grady, General Manager, Community Health

Julie-Ann O'Keeffe, Senior Service Manager, GGRM, Eastern Zone

Patrick O'Mealey, Area Director, Biomedical Engineering

Ms Lorraine Pike, Bankstown ACAT Team Leader

Kerry Plumer, A/Assistant General Manager, Community Health

Dr Jeff Rowland, Geriatrician, Liverpool (resigned)

Yvonne Santalucia, Area Ethnic Aged Care Advisor

Jacqueline Siren, Wingecarribee Health Service

Alison Sneddon, Area Coordinator, Specialist Mental Health Services for Older People

Dr John Snowdon, Psychogeriatrician, SSWAHS

Sharon Sutherland, CNC ASET/CNC Dementia & Delirium, Liverpool

Jola Swierczynski, Service Manager, Social Work, Fairfield

Denis Thomas, A/General Manager, Bowral Hospital

Frances Tinsley, ACAT Team Leader, Concord

Michelle Warwick, Community Aged Care & Rehabilitation Manager, MAC&RStur

Barbara Westwood, Consultant

Bronwyn Wilkinson, ComPacks Manager, Health Service Performance Improvement Branch, NSW Health

Michael Woodhouse, General Manager, Fairfield Hospital (resigned)

**Supported By**

Leah D'Souza, Senior Planner

David Lawrence, Senior Planner

Stephen Wong, Senior Planner

Gay Horburgh, Senior Planner

Lou-Anne Blunden, Director Health Services Planning

Julia McGinty, Decision Support Officer, WZ (resigned)

**APPENDIX 3 THE WAY FORWARD – PROGRESS**

<b>Aged Care</b>	<b>Progress from June 2004 - March 2007</b>
Aged care services be an Area-wide service with an Area Clinical Leader	Achieved – appointment of Area Director Aged Care within the Complex Care and General Practice Clinical Stream
An Academic Chair be appointed	Not achieved
Acute inpatient aged care services be provided at Bankstown, Liverpool and Campbelltown with appropriate links to ACAT services	<ul style="list-style-type: none"> <li>• Achieved at Bankstown and Liverpool</li> <li>• Not achieved at Campbelltown as attempts to recruit a geriatrician have not been successful (a rehabilitation specialist has subsequently been appointed)</li> </ul>
Fairfield Hospital and Camden Hospital provide non-acute aged care beds and the majority of transitional care beds. Geriatric medical cover at Fairfield will be provided in collaboration with Liverpool. Development of a number of transitional care beds at Liverpool will be considered to facilitate appropriate patients flow out of the acute beds located at Liverpool	<ul style="list-style-type: none"> <li>• Transitional care bed proposals will be considered as part of the Pathways Home capital project</li> </ul>
Aged care services be progressively enhanced in acute, sub-acute and transitional beds	<ul style="list-style-type: none"> <li>• Additional 20 bed ward established at Fairfield Hospital (sub-acute)</li> <li>• Medical Transit Unit established at Camden Hospital (sub-acute)</li> <li>• Community transitional aged care program established. Currently 36 packages approved.</li> <li>• ComPacks expanded to MAC&amp;RStur and Wingecarribee</li> </ul>
<b>Rehabilitation Services</b>	<b>Progress from June 2004 - March 2007</b>
Rehabilitation services form into an area-wide service based at Liverpool, Bankstown, Fairfield, Braeside and Camden Hospitals	Achieved
There be Area-wide cross accreditation of medical rehabilitation staff	There has been an increase in the number of medical rehabilitation staff employed across the Area. As such, this is no longer a service priority.
Rehabilitation beds and transitional care services be enhanced and operate collaboratively with Braeside Hospital rehabilitation service	<ul style="list-style-type: none"> <li>• Additional 20 bed ward established at Fairfield Hospital (sub-acute)</li> <li>• Medical Transit Unit established at Camden Hospital (sub-acute)</li> <li>• Community transitional aged care packages being accessed by patients of Braeside Hospital</li> </ul>
Further develop outpatient rehabilitation services across the Area	Not achieved.
<b>Brain Injury Services</b>	<b>Progress from June 2004 - March 2007</b>
Liverpool Brain Injury Unit provide additional beds to improve access for non-traumatic brain injury patients. A Procurement Feasibility Plan be conducted to identify the capital options to provide the additional beds	Included in the Liverpool Hospital Stage 2 redevelopment
Additional medical, nursing and allied health staff be provided to fulfil its role as a state-wide service	0.5 FTE Staff Specialist position advertised

**APPENDIX 4 DISTRIBUTION OF AGED CARE & REHABILITATION SERVICES IN ACUTE AND COMMUNITY SETTINGS, SSWAHS****A. Acute Settings**

Service Type	Availability in Hospitals / Localities									
	RPAH	CRGH	TCH	Balmain	Bankstown	Fairfield	Brae-side	Liverpool	Macarthur	Bowral
Designated Acute Geriatric Inpatient Beds	30	48 (+ 4 outliers)	Approx. 28 patients in 2 shared 30 bed wards	52 beds in mixed acute/sub-acute ward	28 (20 in 2C & 8 in 2D)	0	0	20	0	0
Designated Sub-acute Geriatric Inpatient Beds	0	24-28		As above	0	See rehab beds below	0	0	0	0
Inpatient Geriatric Consultation Service	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes via Rehab service	Local GP
Aged Care Psychiatry	0	12 Delirium - GGRM	0	0	12 - Aged Care	0	16 - Mental Health	0	0	0
Residential Transitional Aged Care Program (inpatient component)	0	0	0	14	0	0	0	0	Converted to community places subject to review	0
ASET	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes (C'town)	No
Designated Rehabilitation Beds	0	15		26	32 designated rehab, +8 colocated stroke beds to create a 40 bed ward, 4 (SAP)	20 (inc approx 7 sub acute geriatric)	36	0	20 designated rehabilitation at Camden 20 MTU at Camden	
Rehab Inpatient Consult. Service	Yes	Yes	Ad hoc	N/A	Yes	Yes	Yes	Yes	Yes	Yes
Brain Injury	0	0	0	0	0	0	0	20 (16 in BIU ward +4 beds in the transitional living unit)	0	0
Brain Injury Community Living Unit	0	0	0	0	0	0	0	4	0	0

**B. Outpatient and Community Based Services by Locality**

Service	Location						
	Camperdown	Concord	Canterbury	Bankstown	Liverpool/ Fairfield	Macarthur	Wingecarribee
<b>ACAT*</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>ELP/PADP</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Psycho-geriatric Consultation Community Older Persons Mental Health</b>	Yes	Yes	Yes	Day Hospital	Yes – referral to Braeside Aged Care Psychogeriatric Nurse to facilitate consultation	1 dpm	1 day per month MH funded via ACAT
<b>Continance Advice</b>	Balmain Hospital	Bladder Clinic		Yes –	Liverpool Clinic	CNC Camden Hospital (not AC&RS managed)	CNS in PHN Team not specific funding
<b>Day Hospital and Outpatient Therapy</b>	RPAH – Geriatrics clinic Podiatry  RPAH Day Hospital – rehabilitation clinic Amputee clinic Continance  GP Casualty @ Balmain Hospital	Physio OT Speech Social Worker Nurse Podiatry Geriatric Medicine Cognitive Disorders Parkinsons (w/ Neurology) Bladder clinic Amputee clinic Neuropsychology General rehabilitation Chronic pain management	Podiatry	Physio OT Speech Podiatry Social Work Medical assessment Neuropsychology	Liverpool HSB: Rehab therapy  Braeside: Rehabilitation Day Hospital & Outpatients	Physio OT Speech Social Work Medical assessment	No Day Hospital, limited physio outpatient service, very limited speech. 3 day Community OT Podiatry clinic 1 day per week at Community Health
<b>Home Based Therapy</b>	Through RPA	Through Concord	Stroke Outreach Team – mainly services Canterbury	No	No	Yes Through Camden	No
<b>Transitional Aged Care Program (TACP)</b>	31 places across EZ – 05/06 36 places across EZ – 06/07			36 places across the WZ (05/06) 56 places across the WZ (06/07) Subject to review re: demand for facility based places			

Service	Location						
	C'down	Concord	Canterbury	Bankstown	Liverpool/ Fairfield	Macarthur	Wingecarribee
<b>Generalist Day Care - days per week</b>	Sita Carter - 5 dpw	Kindilan - 4 dpw	Karinya Centre	Bankstown, Panania, Greenacre, Villawood	Carramar (5 dpw) & Lurnea (4 dpw)	Rose-meadow - 2 dpw; Picton - 5 dpw	
<b>Aboriginal Day Care</b>					Hoxton Park CHC (2 dpw)	Minto - 4 dpw	No
<b>Ethnic Day Care</b>		Kindilan 1 dpw - Greek		Multicultural Centre - Arabic, Vietnamese, Greek, Polish, Macedonian/ Croatian/Serbian, Italian & Chinese	Fairfield - 5 dpw - Vietnamese, Spanish, Arabic, Chinese, Italian, Macedonian/ Croatian/Serbian, Polish & Filipino  Liverpool 3 dpw- Italian, Macedonian/ Croatian/Serbian	Volunteer service adj. Camden Hospital; QVM & Carrington, Church @ Narellan	No
<b>Dementia Day Care</b>	Jane Evans Centre - 7 dpw	Kalparrin - 7 dpw;	Karinya Centre	Georges Hall (Bankstown Frail Aged Trust)	Fairfield (Aimees Place) - 5 dpw  Liverpool (Hammondville Homes)  Liverpool & Fairfield - Greek Welfare Centre operates Dementia Day Care for CALD	Rosemeadow - 2 dpw; Broughton House - 2 dpw; Picton Day Centre - 2 dpw. Expanding to provide outreach to Warragamba	
<b>Community Nursing</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Dementia Advisory Service</b>	Yes			Yes		Yes	Yes
<b>Brain Injury Community Team</b>	N/A	N/A	N/A	Includes all the south west of SSWAHS, St George and Sutherland area - home visits, centre based services and clinics			
<b>ComPacks from discharge hospital</b>	Yes	Yes (temporary)	Yes	Yes	Yes (excl. Braeside)	Yes	Yes

- also provided in hospital;
- ^ provided by an agency external to SSWAHS

## APPENDIX 5 DISTRIBUTION OF RESIDENTIAL CARE AND RESIDENTIAL TYPE CARE IN SSWAHS

	Availability of Residential Places (2006 Projected Population and 2005 actual places)							
	Camper-down	Con-Cord	Canterbury	Banks-town	Liver-pool/ Fairfield	Macarthur	Winge-carrabee	Total SSWAHS
<b>Projected Population 2006 70+</b>	<b>12,763</b>	<b>18,000</b>	<b>13,330</b>	<b>18,260</b>	<b>24,430</b>	<b>12,820</b>	<b>5,330</b>	<b>104,933</b>
<b>High Care Places Benchmark per population (40 per 1,000 over 70)</b>	510	720	533	730	977	512	213	<b>4,195</b>
<b>Total High Care Beds</b>	904(+)	1,761(+)	605(+)	911(+)	1,153(+)	594(+)	185(-)	<b>6,058(+)</b>
<b>General High Care Beds</b>	801	1,352	450	765	810	594	185	<b>4,854</b>
<b>Dementia High Care Beds</b>	103	301	0	146	72	32	0	<b>670</b>
<b>Ethno-specific High Care beds</b>	0	108	155	0	271	0	0	<b>534</b>
<b>Low Care Places Benchmark per population (48 per 1,000 over 70)</b>	613	864	640	876	1,173	615	256	<b>5,037</b>
<b>Total Low Care Beds</b>	753(+)	731(-)	246(-)	595 (-)	634 (-)	437 (-)	182 (-)	<b>3,503(-)</b>
<b>General Low Care Beds</b>	724	645	210	595	282	437	146	<b>2,932</b>
<b>Dementia Low Care Beds</b>	29	68	10	0	80	32	36	<b>255</b>
<b>Ethno-specific low care beds</b>	0	18	26	0	272 (16 dementia)	0	0	<b>316</b>
<b>CACPs per population (20 beds per 1,000 over 70)</b>	255	360	267	365	489	256	106	<b>2,098</b>
<b>Total CACPs</b>	381(-)			712(-)			<b>1,043(-)</b>	
<b>General CACPs</b>	185		327 (-)	180 (-)		80 (-)	<b>772</b>	
<b>Ethno-specific CACPs</b>	196		125		0		<b>271</b>	
	Includes Bankstown for some							
<b>EACH places available</b>	30			38 – Liverpool / Fairfield / Bankstown & Campbelltown			12	<b>80</b>

Source: DIPNR Population Projections (2005); SSWAHS Residential Information Service (2005) and DoHA 2004/05

Note: includes approved bed licenses (non operational) where known

(-) denotes undersupplied compared to National Benchmark, (+) denotes oversupplied compared to National Benchmark

**APPENDIX 6 BRIEFING PAPER: AGED CARE WORKFORCE ISSUES 9 (CLINICAL REDESIGN)**

Sydney South West Area Health Service Older People and Aged Care Health Services  
Clinical Redesign Project (DRAFT 3)

**Introduction**

The Diagnostic Phase of the Project identified workforce issues as an overarching concern throughout the delivery of health services to older people in Sydney South West. Due to the wide-ranging nature of workforce issues, it was not considered appropriate for these issues to be taken forward in the current Solution Design Working Groups. The Management Committee determined that the issues be included in the Solution Design report; and that they be forwarded to the SSWAHS Director of Workforce Planning and Area Human Resources Manager to inform the Area Workforce Strategic Plan and recruitment process review/policy decisions.

This paper summarises the Workforce issues found during the Diagnostic Phase and makes recommendations to progress resolution across SSWAHS.

**Workforce Issues**

The major issues identified were:

- I. Demand for aged care health services exceeds limited supply, especially for medical, nursing, Allied Health and support staff (ie. respite and community based aged care staff) limiting capacity to provide service to inpatients and community clients. This includes new community referrals and follow up of people in the community when they return home.
- II. Recruitment and retention of appropriately skilled staff in aged care is difficult, time consuming and a significant barrier to care
- III. Inconsistent workforce data to measure demand vs. supply
- IV. Non aged care staff generally do not have Aged Care specific knowledge, skills and or insights to provide holistic clinical treatment to older people admitted to non aged services. (Note: This issue is one of the issues being addressed by the Care Coordination and Delivery Working Group (ie. Solution 4: Improved access to Aged Care expertise and reference material).

**Potential solution areas identified by staff in consultations**

1. Recruitment processes (shorter term):
  - Timely approvals
  - Equity in recruitment across professions (e.g. community based positions, Allied Health etc)
  - Permission to recruit externally funded positions without delay
  - Flexibility in advertising (exceptions for vulnerable positions, explore private sector methods)
2. Aged Care as an appealing career option (longer term):
  - Attract and retain skilled and experienced candidates
  - Retain junior clinicians
3. More resources from general operating funds to meet expanding demand for Aged Care Services
4. Standardised approach to Aged Care across SSW:
  - Consistency in structures, roles and working conditions
  - Networking between services

5. Non Aged Care staff (excluding maternity/paediatrics) receive mandatory training in Aged Care. (Note: There are inherent difficulties in mandating education to staff. Any solutions need to be considered in the light of the work being done by the Working Group (see Issue IV above); and in collaboration with staff responsible for education / training within their clinical discipline and the Centre for Education and Workforce Development (CEWD).)

### **Existing SSWAHS workforce plans**

The Director of Workforce Planning advised that SSWAHS has developed a Workforce Strategic Plan (Draft) in which Aged Care is identified as a vulnerable workforce group. Also that the difficulties in providing incentives, especially financial, are acknowledged and alternative incentive options for vulnerable workforce groups will be explored.

Further, revision of Human Resources functions / infrastructure has resulted in the recent establishment of a SSWAHS central Recruitment Unit and the rolling out of an electronic recruitment system (EziSuite).

### **Recommendations:**

1. Aged Care Services Senior Personnel/Managers be engaged in workforce planning discussions (point 2 – Potential Solution Areas above).
2. Recruitment policy/practices across the recruitment process (ie. initiation of request to recruit through to commencement of individual) are revised in light of staff suggestions concerning improving recruitments by Aged Care Service Managers and HR Management (point 1- Potential Solutions above).
3. Senior Aged Care Services personnel (clinicians/managers) develop an evidence based business case for the Area Executive that identifies best practice, and the necessary level of resources to provide services consistent with the identified service level and standard (points 3 and 4 - Potential Solutions above).
4. Collaboration occur between CEWD and relevant multidisciplinary clinical staff responsible for education and training, to explore and develop appropriate education programs and delivery modes, for non aged care services personnel. (Point 5 – Potential Solutions above).

Prepared by the Older People and Aged Care Health Services Clinical Redesign Project Team  
17/01/2007