NSW GOVERNMENT

Health

South Eastern Sydney Local Health District

Aged Care Services Plan 2015-2018

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Foreword

Fuelled largely by a growing aged population and increasing costs in health care, the Aged Care sector in Australia has undergone a series of reforms over recent years. While containing costs is critical, an integrated, coordinated system should continue to be the main driver of change in aged care. Integration recognises the value and need for close connection and collaboration between health, social and other relevant sectors (public and private) to support better outcomes for aged care patients. The need to better invest in primary and secondary prevention and wellness activities, to reduce the need for acute health care among the elderly, is also extremely important.

Providing efficient, comprehensive care for older persons is one of the most important issues currently facing the South Eastern Sydney Local Health District. The development of various service improvements, innovations and models of care to better support older people has occurred incrementally across the District over recent years. Highlighted in this plan are further service and program developments that have one or more of the following **goals**:

- Extend the period in which older people are well and independent.
- Reduce the number and length of periods of ill health in older people.
- Build the capacity of communities to address health issues.
- Increase the time before an older person becomes frail and increasingly dependent on care.
- Increase services and programs that keep older people out of hospital
- Continue to shift the balance of care to community and home settings.
- Increase services that are integrated across the continuum and forms of care.
- Create better linkages between different parts of the aged care and other sectors.
- Ensure cost effective care for older persons.
- Ensure the wishes of each aged care patient is understood and respected.
- Optimise the exchange of patient information between providers and settings of care.

Aged care services across the South Eastern Sydney Local Health District will continue to recurrently evaluate their services to determine the quality of care being provided to older people and identify opportunities for improvement in line with new and emerging best practice models and approaches to care delivery. A continuous system improvement approach to ensure that best practice is shared among our facilities, services and beyond will also be maintained.

Associate Professor Peter Gonski,
Director Aged Care and Rehabilitation Stream
South Eastern Sydney Local Health District

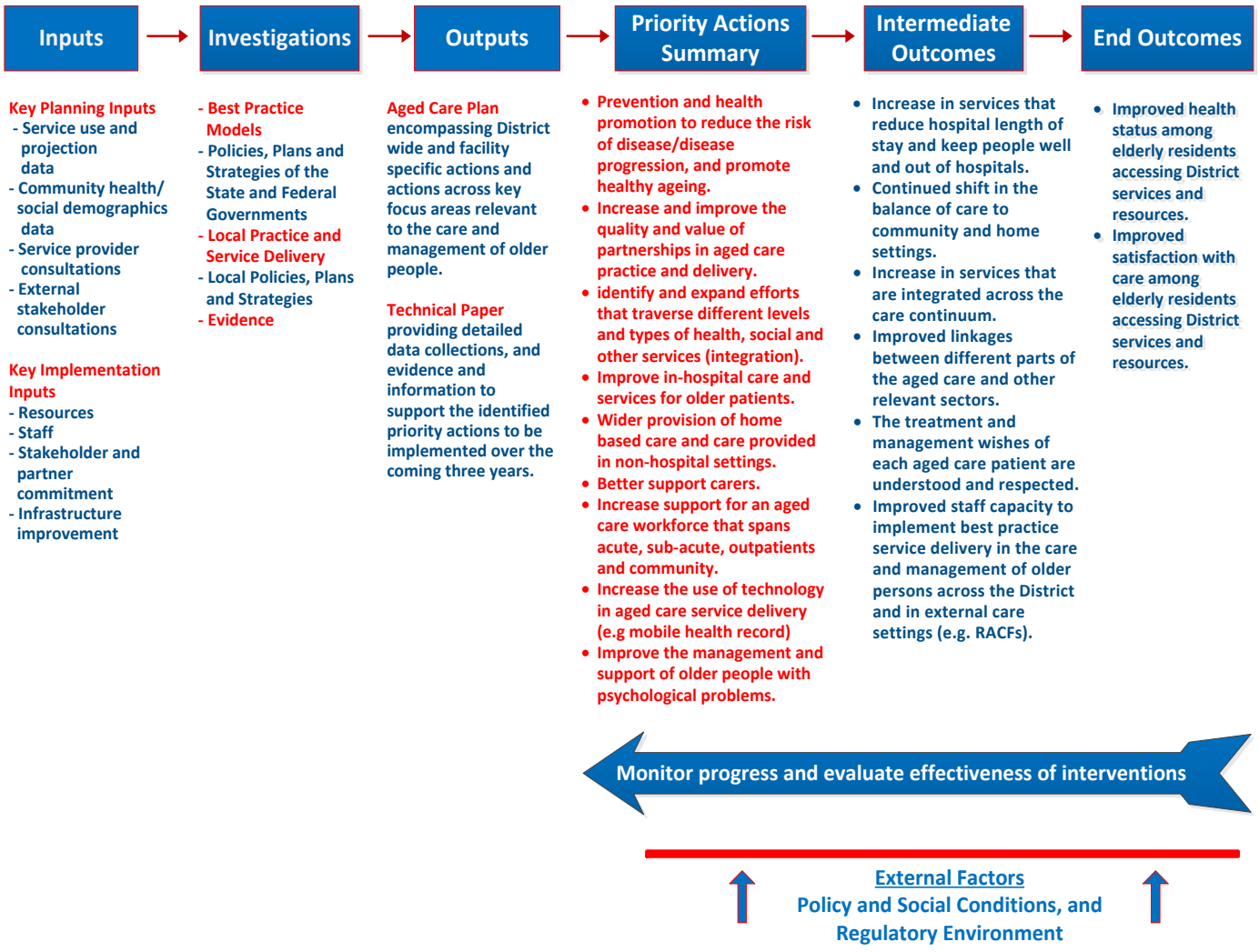
Executive Summary

The Aged Care Services Plan 2015 -2018 is one of an important suite of South Eastern Sydney Local Health District Clinical Stream plans. The plan has been developed for a range of audiences including the NSW Ministry of Health and other government sectors; health services; care providers and the wider community. It is consistent with NSW Government's vision of delivering high quality services responsive to consumer and community needs. A key focus of the plan is on supporting community members to access the right services, at the right time, in the most appropriate setting and also reduce the burden and impact of chronic disease on the health system. Our aged care services will work with other service providers across the District and beyond to support a better understanding of the unique requirements of older people.

The Plan has been informed by aged care strategies, plans and policies at local, state and national levels. The following diagram explains the key steps and resources utilised in the development of the plan. It also provides a summary of the priority actions and expected outcomes.

Aged Care Plan

Aim: Guide the development of solutions in aged care service provision that best address the current and future health needs of older people accessing District services and resources.



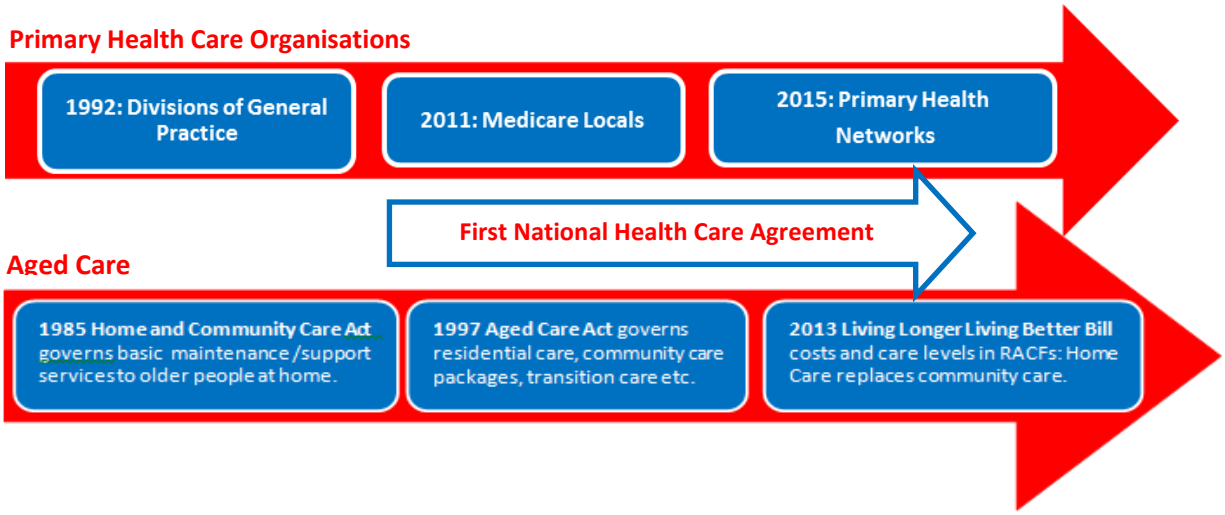
Introduction

The South Eastern Sydney Local Health District places significant importance on older community members having access to high quality and cost effective health services. Our District's population is ageing and living longer through advances in health care, medical technology and public health initiatives. As a consequence, there will be a steadily increasing demand for aged care services by a growing number of people. The associated increase in the required quantum of services is a key challenge for aged care service provision. The range of services provided will also need to respond to the changing health status of the aged. In recent years the trend in policy terms is for an increased emphasis on monitoring, timely intervention and 'healthy' ageing combined with 'ageing in place', i.e. keeping older people healthy at home for as long as possible. These concepts are supported throughout this plan and underpin many of the priority actions.

For many older people there is no or little need for specific ongoing health assistance until they are well advanced in age. As more people live to 'older old ages' (i.e. 80 years and older), the prevalence of chronic diseases increases markedly. It is generally understood that the greatest need for health care is in the last one to two years of a person's life.[1] Healthcare expenditure for people over 65 years is two to three times higher than for those under 65 years, and higher still for those aged 80 years or older. This latter age group also has a much higher level of reliance on informal and formal care services. At some point all 'older old' persons will require access to properly planned and resourced, quality aged care services that are flexible, equitable, that recognise diversity and promote choice and respect. It is this philosophy that underpins the current aged care services plan. Specifically, the plan fosters the development of solutions in aged care services that support older people and their carers to access appropriate, high quality health care that is provided in a safe, timely, equitable and coordinated manner. Importantly, this plan is informed by the current and future health needs of older people accessing District services; new and emerging effective technologies and approaches; and relevant key state and national aged care health plans and policies.

Context

Successive Australian Governments have introduced a variety of health and aged care reforms with further reforms signalled. Keeping abreast of the wide array of national level reforms is becoming increasingly difficult. The following diagrams illustrate a number of key national reforms over the past three decades.

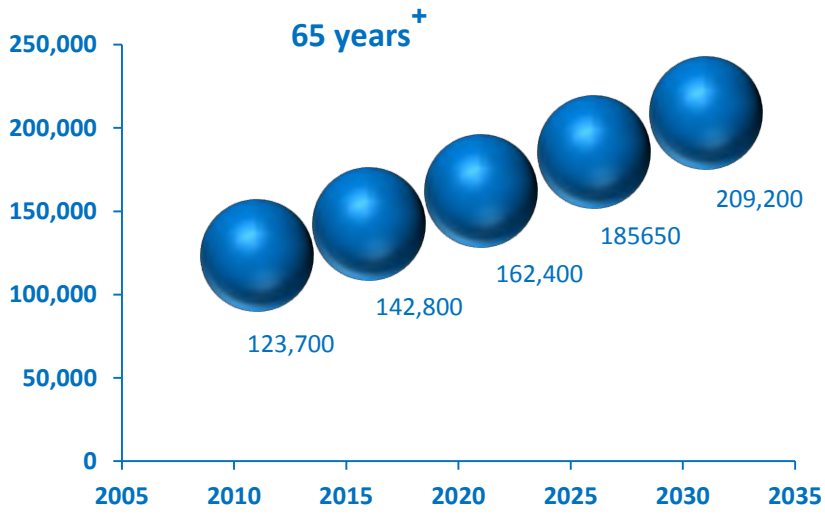


[1] Seshamani M, Gray A. Time to death and health expenditure: an improved model for the impact of demographic change on health care costs. Age Ageing. 2004 Nov;33(6):556-61

Ageing Population

The South Eastern Sydney Local Health District supports a culturally and linguistically diverse population of over 859,000 people. The estimated residential population is projected to increase by over 112,000 people by 2021 and reach one million by 2031. The fastest growing age groups will be the 70-84 age group and the 85 years and over age group. In our district, it is estimated that by 2016, our population aged over 65 will increase to 142,800, and by 2031 this will reach 209,200, with a 44% increase in the 'older old' (aged 85+) to 33,200 by 2031.[2] This demographic trend will drive a growing demand for services. Those aged 85 years or older tend to be the main users of both acute care and aged care services, and their numbers will grow substantially in coming years.

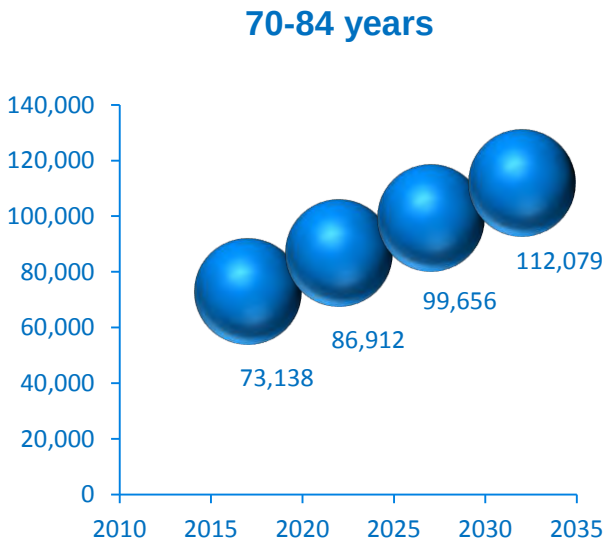
Projected Population South Eastern Sydney Local Health District, 65 years+, 2011-2031[3]

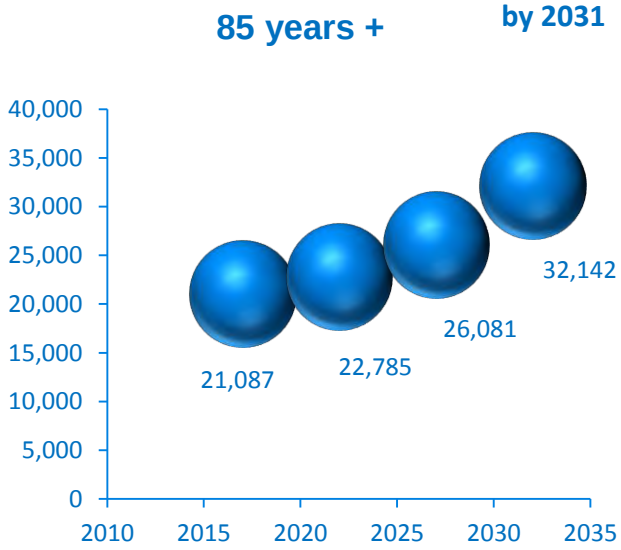


A 30% increase in people aged 65 years and older *(an additional 85,500 people aged 65 years and older by 2031)*

Projected Population South Eastern Sydney Local Health District, 2017-2032[3]

35% increase in 70-84 year olds and 44% increase in the 'older old' (85+) to 33,200 by 2031





[2] Population Projections by LHD, released by the Ministry of Health May 30, 2014.
[3] Source: Population Projections by LHD, released by the Ministry of Health May 30, 2014

Aged Health Demographics[4]

The Commonwealth Department of Health reports that around 80% of people aged 65 years or older have three or more long-term health conditions.[5] For this Health District, this means that by 2031, there may be over 167,000 people aged 65 years or older who have three or more long-term health conditions, including the more serious chronic diseases such as diabetes, heart failure, kidney disease and cancer.[6]

An estimated 10,600 (1.3% of population) are affected by dementia in our District. In the 85+ age group, 30% (1 in 3) are affected. Among those in residential aged care, the prevalence of dementia is even higher. Over the next 20 years, the numbers of our residents with dementia is expected to nearly double to reach 19,200 by 2031.	Increasing age is an important risk factor for cardiovascular disease (heart, stroke and blood vessel diseases). Cardiovascular disease is the leading cause of death in South East Sydney. Smoking, physical inactivity, poor diet, high blood pressure, high blood cholesterol and obesity are other important risk factors.	Over 20,500 of our 60 years+ residents have Type 2 Diabetes. The prevalence of doctor-diagnosed diabetes or `high blood glucose' among adults of all ages increased by 64% between 2002 and 2011. Sixty of our residents are hospitalised every day with diabetes (as principal diagnosis or important co-morbidity)
Adult Australians 60 years or older are at an increased risk of chronic kidney disease, with around 42% of people 75 years+ having a clinical indicator of the disease. Over 84,000 of our residents have chronic kidney disease with most being 60 years of age or older. Diabetes is now the most common cause of chronic kidney disease (accounting for around 34% of the disease).	According to Cancer Institute NSW projections, the number of new (notifiable) cancers across the District will rise from 4,590 in 2011 to over 5,420 in 2021. This represents an 18% increase. Cancer is largely a disease of ageing. Its development increases as people age. Australian women have a 1 in 3 lifetime risk of developing cancer while men have a 1 in 2 risk.	Around 45% of Australians experience a mental illness in their lifetime. Around 10-15% of older Australians experience anxiety and depression. Mental illness in older people frequently accompanies physical health problems. Older Australians receive fewer specialist psychiatric consultations than any other population group.
16% of people aged 65 years or older have osteoporosis.[7] Among the elderly, osteoporosis is a major cause of pain, disability, deformity, mobility impairment and loss of independence which result from the fracture of bones and related complications. For people with osteoporosis, even a minor bump or fall can cause a serious fracture.	A high number of falls occur in our community with 24 residents hospitalised each day as a result. The large majority of those hospitalised are aged 65 years or older. Over the last decade, hospitalisations for falls injury among residents aged 65 years + have increased by around one third.	Adverse medication reactions account for around 3% of all hospital admissions, around 50% of which are preventable.* Around half of hospital medication errors occur on admission, transfer and discharge of the patient, of which 30 % have the potential to cause serious harm**

* Runciman,W *et al* (2003), Adverse drug events and medication errors in Australia. Int Journal for Quality in Health Care 15: i49-i59.
** Duguid, Margaret (2012). The importance of medication reconciliation for patients and practitioners. Aust Prescr 2012;35:15-9.

[4] Sources:
- AIHW: Dixon T and Webbie K 2006. The National System for Monitoring Diabetes in Australia. AIHW CVD 32.
- The National Diabetes Services Scheme (NDSS) http://www.ndss.com.au
- Cancer incidence and mortality: projections 2011 to 2021 Cancer Institute NSW, Sydney: May 2011.
- South Eastern Sydney LHD, Falls Injury Prevention Plan 2013-2018.
- Kidney Health Australia. http://www.kidney.org.au. Accessed August 2014
- Royal Australian and NZ College of Psychiatrists. Older Australians Deserve a Better Deal in Mental Health (Aug 2010)

[5] Department of Health (2012), Chronic Disease: Prevalence www.health.gov.au/internet/main/publishing.nsf/Content/chronic
[6] AIHW. Chronic Disease http://www.aihw.gov.au/chronic-diseases/
[7] Department of Health (2012), Chronic Disease: Osteoporosis www.health.gov.au/internet/main/publishing.nsf/Content/pq-arthritis-osteopor

Brighter Future

Research indicates that to adequately address non-communicable disease into the future, the following actions are needed:

- Strengthened collaboration between health care providers and consumers.
- Improved use, by the health care system, of prevention and early detection services.
- Population health is improved and sustained by strengthening collaborations between communities and health-care providers, which will, in turn, improve health equity by building communities that promote health rather than disease, have more accessible and direct care, and focus the health-care system on improving population health.[8b]

In 2011, the UN General Assembly adopted a declaration that committed member states, including Australia, to the prevention and control of Non-Communicable Diseases (NCD). Countries agreed to adopt nine global targets, including an overarching target of reducing premature mortality from the four main NCDs (cardiovascular diseases, chronic respiratory diseases, cancers, diabetes) by 25% by 2025. Countries also agreed on targets for selected risk factors: tobacco, harmful alcohol use, salt intake, obesity, raised BP, raised blood glucose and diabetes and physical inactivity. A modelling study estimated that if risk factor targets were achieved, the probability of dying from the four main NCDs between the ages of 30 and 70 years would decrease by 22% in men and 19% in women by 2025.[8]

Aged Care Services

Services and supportive care for older people are provided by a number of government programs (Commonwealth, State, local) as well as services and programs from the community and voluntary sectors (particularly families and carers), primary care, the private for-profit and the not-for-profit sectors. Because older people commonly access 'mainstream' services it can be difficult to identify the true scope, level and types of services accessed by this group. Across the District aged care services consist of a range of different models, approaches and programs provided in varied care settings. Inpatient acute services are provided within the District's acute hospitals (primarily St George, Prince of Wales and Sutherland Hospitals). Inpatient sub-acute services are provided by both acute hospitals and sub-acute facilities (War Memorial and Calvary). Aged care is also provided out of community health and a range of other community based District services and programs. Home based services are still limited in terms of those who could potentially benefit, but are increasing across the District.

South Eastern Sydney Local Health District has one publically funded residential aged care facility (The Garrawarra Centre). Importantly, the District also provides aged care assessment services which offer an assessment of care needs and levels, to allow access to permanent residential care, respite and/or Commonwealth funded placements and packages.

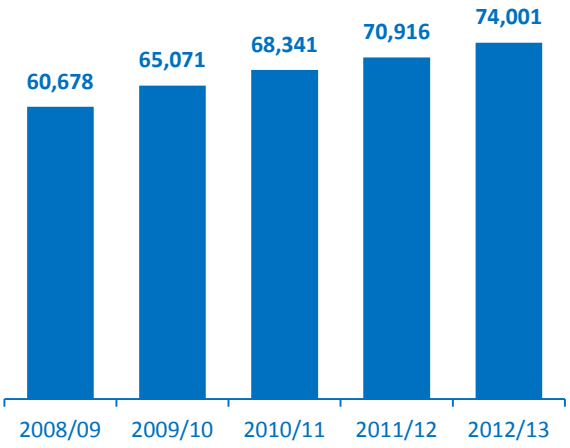
Aged care services across the District have been established in different ways to meet the specific challenges and needs in each community. Aged care service providers include a range of medical practitioners, nurses, allied health, social and welfare professionals and volunteers.

[8] Vasilis Kontis et al. Contribution of six risk factors to achieving the 25×25 non-communicable disease mortality reduction target: a modelling study. Lancet. 2014 Aug 2;384(9941):427-37.
[8b] Bauer UE, et al.. Prevention of chronic disease in the 21st century: elimination of the leading preventable causes of premature death and disability in the USA.Lancet. 2014 Jul 5;384(9937):45-52.

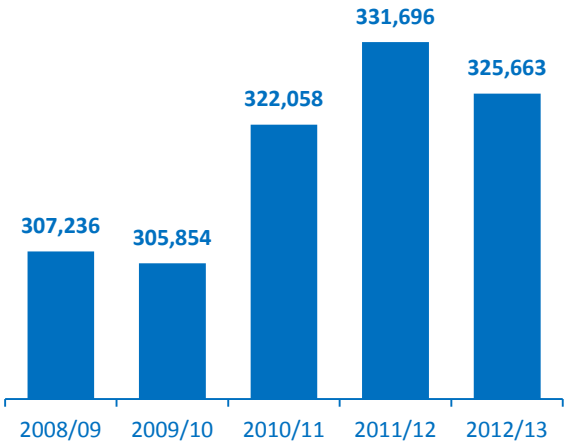
Admitted Care Utilisation

In 2012-13, fifty percent (50%) of patients cared for across all District hospitals were aged 65 years or older and an increasing number are frail and/or have a diagnosis of dementia. Over 10% were in the 75 to 79 years age group and another 10% were in the 80-84 years age group. In the same year, over 55% of hospital bed days were utilised by people 65 years or older, with 12% of these bed days taken up by people in the 80-84 years age group. Between 2008/09 and 2012/13, hospital separations for people aged 65 years or older increased by 13,323 (18%). Importantly, there was a reduction of over 6,000 bed days between 2011/12 and 2012/13. The average length of hospital stay for people aged 65 years or older has reduced by almost a day since 2008/9. Contributors to reduced bed days and length of hospital stay are the implementation of new models of care, improved discharge planning processes and improved access to community based services, including case management and home based services. Medical separations and bed days far outnumber procedural and surgical separations and bed days in those 65 years and older.
*Refer to **Technical Paper 1** for detailed data and information on data sources and restrictions.*

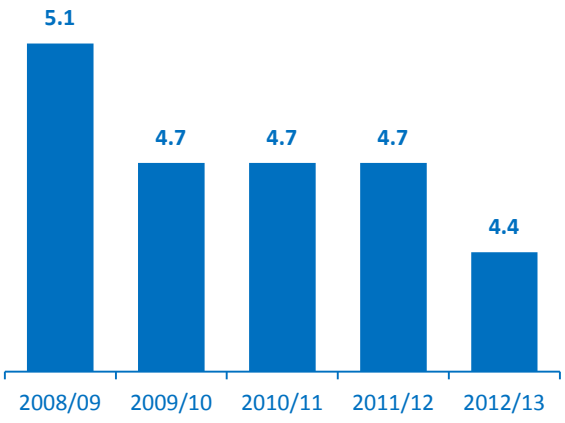
Hospital Separations, 65 years+ 2008/09-2012/13



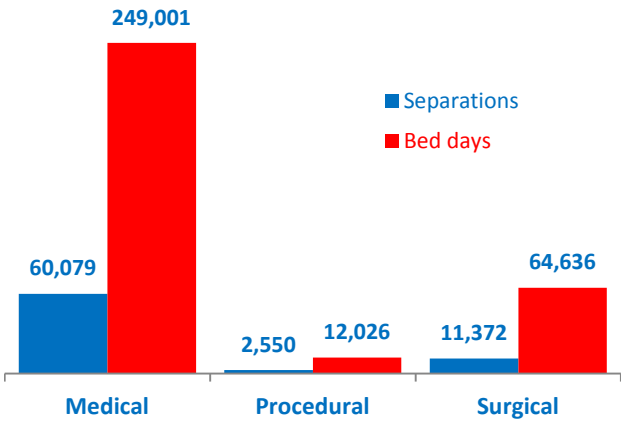
Hospital Bed Days, 65 years+ 2008/09-2012/13,



Average Length of Stay, 65 years+ 2008/09-2012/13



Medical, Surgical, Procedural Separations and Bed days, 65 years+ 2012/13



Admitted Care Projections

The future level and types of care that will be provided in hospitals must always be considered within the context of the overarching health system and its future evolution. Base projections provide insight into hospital service demand if ways of working and service delivery models remain the same in coming years and indicate a steady increase in inpatient service demand in those aged 70 years and older. Increases between 2011 and 2032 include an additional 36,500[+] acute separations (requiring over 115,000 extra hospital bed days) and an increase in active sub-acute episodes by 6,489 (requiring over 62,400 extra patient days).

Acute and sub-acute inpatient separations and bed day projections 2008 to 2032, persons 70 years[+], SESLHD Hospitals (POWH, TSH, St George, Syd/Syd Eye, RHW)

	2008	2009	2010	2011	2017	2022	2027	2032
Acute Separations	43,499	44,457	46,245	48,979	57,604	66,639	75,556	85,245
Acute Bed days	208,762	195,641	186,383	198,348	233,536	258,289	283,526	313,443

Source: aIM 2012. Excludes ED only presentations and collaborative care

Sub-acute inpatient active episodes and patient day projections 2008 to 2032, persons 70 years[+] SESLHD

	2008	2009	2010	2011	2017	2022	2027	2032
Active episodes	6,701	7,108	8,710	9,405	10,115	11,723	13,566	15,894
Patient days	77,895	80,116	82,296	85,952	103,625	115,266	129,182	147,705

Source: SiAM 2012. Excludes collaborative care patients and ED only presentations

Total acute and sub-acute inpatient projections 2008 to 2032, persons 70 years[+], SESLHD

	2008	2009	2010	2011	2017	2022	2027	2032
Separations/ Active episodes	50,200	51,565	54,955	58,384	67,719	78,362	89,122	101,139
Days	286,657	275,757	268,679	284,300	337,161	373,555	412,708	461,148

Source: aIM 2012. Excludes ED only presentations and collaborative care

Non-Admitted Care Utilisation

Non-admitted patient care is provided in outpatient services across the District. Other non-admitted patient services (other than emergency department services) and various outreach services, such as community nursing are also provided.

Community care is increasingly the preferred mode of care for older people to avoid the need for, or expand the time before requiring, residential aged care.

Refer to Technical paper 1 for the range, type and location of District outpatient services and the number of older people that were provided services in 2013/14.

Admitted vs Non-Admitted

Non-admitted service provision is increasing across the District. In 2013/2014, the number of non-admitted occasions of service for those aged 65 years and older was over 473,000, from over 250 different outpatient services across seven District facilities. This is almost twice that of inpatient bed days and almost 6.5 times the number of inpatient separations.

District Priority Actions

The projected (base case) increased need for inpatient care for older people in coming years, supports enhancements and growth in non-admitted care settings. District priorities in aged care are informed by the most effective strategies to reduce the need for high cost hospital care:

Population Health: reduce the risk of disease/disease progression, and promote healthy ageing via prevention/health promotion programs that target **principal** causes of morbidity/ premature mortality among older people (e.g. obesity, inactivity, hypertension, mental health issues). [9,10]

Partnerships: Establish an ongoing commitment among community partners (e.g. Uniting Care, Hammond Care, Kincare, Primary Health Care, others) to support the formal sharing of information and identification of opportunities for collaboration, including shared resources and patient care via regular meetings and other forums, and robust communication mechanisms. Improve clients, carer and service provider understanding of the existing range of aged care services (public, private and not-for-profit) by regularly contributing correct, timely information to the 'My Aged Care' website, and widely promoting its use.

Care in Hospital Settings: Older people often require access to specialist hospital assessment and treatment to regain or maintain independence in the community. Enhancing in-hospital services will improve the potential for older patients to be well and independent on discharge e.g. expanding effective models of care for older patients, improving care of the confused older person in hospital, improving orthogeriatrics, improving surgery/aged care relationships, reducing in-hospital falls and others.

Care in Non-Hospital Settings: wider provision of home based care and care provided in non-hospital settings for older persons (including anticipatory care i.e. early issue identification and proactive intervention) to reduce the need for acute care services and the associated risks.[11]

Care Coordination and Integration: identify and expand efforts that traverse different levels and types of health, social and other services. Better support older people on discharge from hospital who are at risk of rehospitalisation, including building the capacity of patients and carers to better understand and self-manage chronic health problems.[10,12]

Carers: while many older people are recipients of care, much of the care is provided by other older people (as spouses, relatives, or friends). Expanding services to assess/support improvements in the health of older carers will reduce the number of older people precluded from providing care because of ill health.[13]

Workforce: Increase professional development opportunities for the aged care workforce as a specialty that spans acute, sub-acute, outpatients and community, including integration and sharing of rotational professional development resources between acute, sub-acute, community and residential locations.

Technology: investigate the potential of devices and other technologies that will aid the development of an older person interoperable ambulatory medical record (an electronically stored file of a patient's outpatient medical records) to improve accuracy and create time efficiencies in non-admitted settings (e.g. negate the need for double entry of the health care record).[14]

Psychological Wellbeing:

- Work with internal and external services and organisations to develop and implement a regional integrated dementia plan, which includes agreed service coordination arrangements and enhancements to improve the early detection of dementia and the timely provision of support programs that allow affected people to live in the community for as long as possible.
- Identify opportunities and partnerships to support long term improvements in the community management of increasing numbers of younger onset dementia patients in the region.
- Implement recommendations from the Delirium Quality Self-Assessment and Delirium Care Pathways across the District.
- Identify and embed effective access/referral mechanisms to multidisciplinary mental health care for older patients across the District.

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[9] Joyce G et al. The lifetime burden of chronic disease among the elderly. Health Affairs, 2005, 24 Suppl 2:W5R18–29.
[10] Gandjour A. Aging diseases – do they prevent preventive health care from saving costs? *Health Economics*, 2009, 18(3):355–362.
[11] Wanless D. *Securing good care for older people: taking a long-term view*, London, King's Fund, 2006.
[12] Rechel B et al. (eds). Investing in hospitals of the future. Copenhagen, WHO Regional Office for Europe, 2009.
[13] Arber S, Ginn J. The meaning of informal care: gender and the contribution of older people. *Ageing and Society*, 1990, 12:429–454.
[14] Coyte PC, Goodwin N, Laporte A. How can the settings used to provide care to older people be balanced? Copenhagen, WHO Regional Office for Europe, 2008.

Recommended Models of Care and Services for Older Persons

The Garling Report into acute care services in New South Wales noted that treating older patients with complex health needs should be pursued out of the hospital setting wherever possible. Where patients need admission, they should be admitted to the most appropriate service directly and discharged home with appropriate support as soon as possible.[15] The current range of evidence based approaches, to support the recommendations of the Garling Review, are provided below.

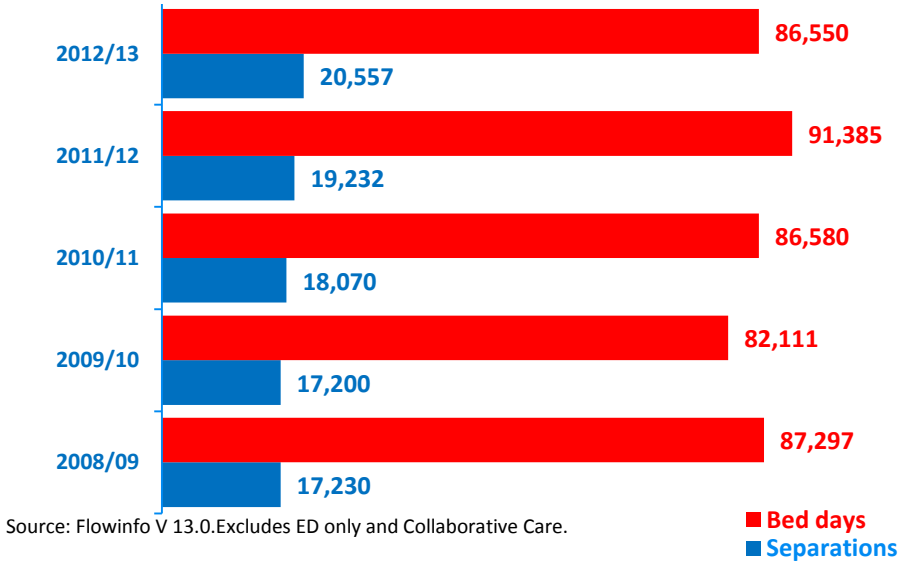
Hospital Care in Non-Hospital Settings	**Hospital-in-the-Home Services** - provision of acute care in the patient's home in line with best-practice clinical guidelines with the aim of minimising the disruption to a patient's life; reduce adverse events associated with inpatient hospital treatment and reduce avoidable admissions to hospital. **In-reach Services to Residential Aged Care Facilities (RACF)** - services (e.g. CNC, community nurse, geriatrician, psychogeriatrician etc.). RACF staff training and other support to enable effective early detection and on-site management of illness to prevent health deterioration and potential hospital admission; and/or supporting RACF staff in new clinical, preventative, health-promotion roles/responsibilities.
Emergency Acute, Sub-acute	**Specialised Emergency Staff** - (e.g. Aged Care Services In Emergency Teams - assessment of the need for clinical, support and care services for older persons; liaison and referral to appropriate services; advice to ED medical staff about the safety of discharge to home and social/functional care needs etc.). **Specialist Medical Staff Working in ED** e.g. specialised aged care registrars and/or geriatricians **ED Assessment/Bypass** – dedicated area and early aged care specialist staff assessment. **Rapid Assessment and Response Services** - (e.g. for example, Medical Assessment Units offer rapid early multidisciplinary assessment, management, care planning etc.). **Geriatric Acute/Sub-Acute Wards** - intense focus from: geriatricians; aged care nursing and AH staff **Psychogeriatric Care** - assessment, management/care of people 65 years or older with psychological illness. **Secure Behavioural Units** - manage patients with behaviour problems in the acute setting. **Geriatric Evaluation and Management** - sub-acute care of chronic or complex conditions. **Dementia/Delirium Management** (e.g. Care of the Confused Hospitalised Older Person offers t**raining**, education, support to enhance care and minimise harm to the confused older person). **Geriatric Rehabilitation** - a process of restoring people to achieve optimum functional independence **Orthogeriatric Service – to** ensure older fracture patients have a geriatric medicine review and benefit from shared care arrangements. **Inpatient Geriatric Consultation and Shared Care** for older patients not in designated geriatric inpatient wards/units. **Home and Community Outreach Services** to better support older people on discharge from hospital and in RACFs who are at risk of rehospitalisation.
Outpatient and Non-admitted	**Outpatient Services** (e.g. dementia respite day care; aged respite care; dementia day centres, dementia monitoring; community rehabilitation; aged care psychiatry services etc.). **Outpatient Clinics** (e.g. falls and mobility, cognitive disorders, geriatric medicine, pain etc.). **Community Health** (e.g. aged care assessment teams, transitional care (community-based), ComPacks, continence nursing, medication review and monitoring etc.). **Home and Community Outreach Services** to better support older people at risk of hospitalisation.
Cross System	**Discharge planning** - Effective discharge planning processes to ensure each patient receives appropriate follow-up services they need in a timely manner to reduce inappropriate readmission. **Advance Care Planning** - a person's preferences for future health and personal care are available to guide clinical decision making when unable to make or communicate decisions. **Primary Care/Social Sector Integration** - improved linkages, coordination and sharing care with GPs and social services to reduce acute exacerbations and avoidable hospital admissions (including GP services in RACFs) e.g. shared care plans, pathways, agreed linked processes. **Chronic Care Programs / Coordinated Care Services** (e.g. Connecting Care Program - regular monitoring of comorbidities; referral; self-management support; medicines compliance monitoring) **Dementia Behaviour Management Advisory Services** – supports clinicians, staff, carers/families, residential and primary care providers etc. with assessment, advice, short and medium term support.

[15] Garling P. Final report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals. Sydney: NSW Government, 27 Nov 2008.

Prince of Wales Hospital and Health Services

The Prince of Wales Hospital is a tertiary referral teaching hospital of the University of NSW with over 400 beds, an average occupancy rate of over 90% and almost 3,000 staff. Prince of Wales Hospital accepts patients from other parts of Sydney, NSW and beyond. The Prince of Wales Hospital and associated health services provide a wide range of aged care specific services (see table page 14). Consultant-led geriatric medicine speciality input is available for orthopaedics and other specialities and services across the health service. Geriatric Medicine also offers a consultative geriatric service to Sydney Hospital. A Geriatric grand round is conducted weekly which affords a comprehensive review of all patients under the care of a hospital geriatrician. Good working relationships exist between Geriatric medicine, psychogeriatricians and neuropsychologists. Specialist medical traineeships in Geriatric medicine are provided with rotation through acute geriatrics, medical assessment unit, rehabilitation medicine, post-acute services (hospital-at-home), community geriatrics, orthogeriatrics, surgical liaison service and other aged care specific services. As well, there are also strong links with several research institutions such as Neuroscience Research Australia (NeuRa).

Total Separations and Bed Days, 65 years +, 2008/09-2012/13



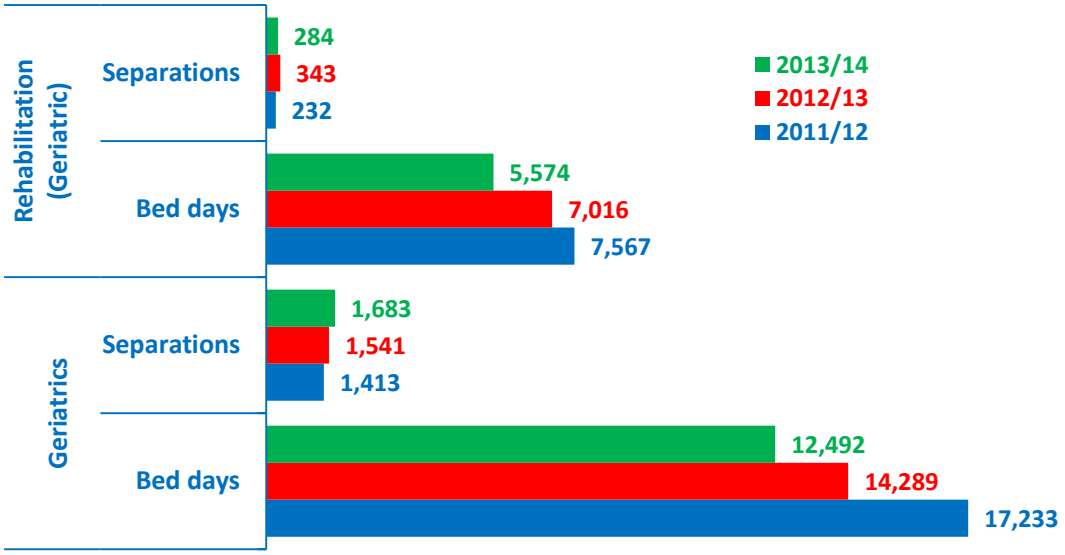
Source: Flowinfo V 13.0.Excludes ED only and Collaborative Care.

The numbers of inpatient bed days utilised by patients 65 years or older in Prince of Wales Hospital have fallen slightly (by over 700 or 0.8%) between 2008 and 2013. Over the same period, the average length of stay fell from 4.8 in 2010 to 4.2 in 2013. These results reflect recent changes in the coding/classification of HITH/PACS services and advantageous changes in care approaches and settings that have been found to contribute to a reduction in the need for inpatient bed days by older patients and currently implemented at Prince of Wales Hospital and Health Services (see table next page). Efforts in bed day reductions will need to continue to deal with the 37% increase in overnight separations and 35% increase in overnight bed days in persons 70 years+ projected between 2011 and 2032 (reflects the growing aged population in the region). Over 14,000 non-admitted occasions of service were provided to patients 65 years+ from Prince of Wales Health Services in 2013/14.This is in line with the steady upward trend in utilisation of this care type.

Between 2011 and 2014 there were over 45,100 inpatient bed days in Prince of Wales Hospital acute geriatric services and over 20,700 sub-acute geriatric inpatient bed days. Almost 96.5% of geriatric subacute bed days (19,939) and 93.5% (817) separations were for the rehabilitation DRG. Collectively across geriatric services there were 65,878 bed days and 5,639 separations in the three years between 2011 and 2014. Acute inpatient geriatric bed days decreased by almost 28% (4,741) between 2011 and 2014, while separations increased by 19% (270). Similarly, between 2011 and 2014, sub-acute inpatient geriatric rehabilitation bed days in Prince of Wales

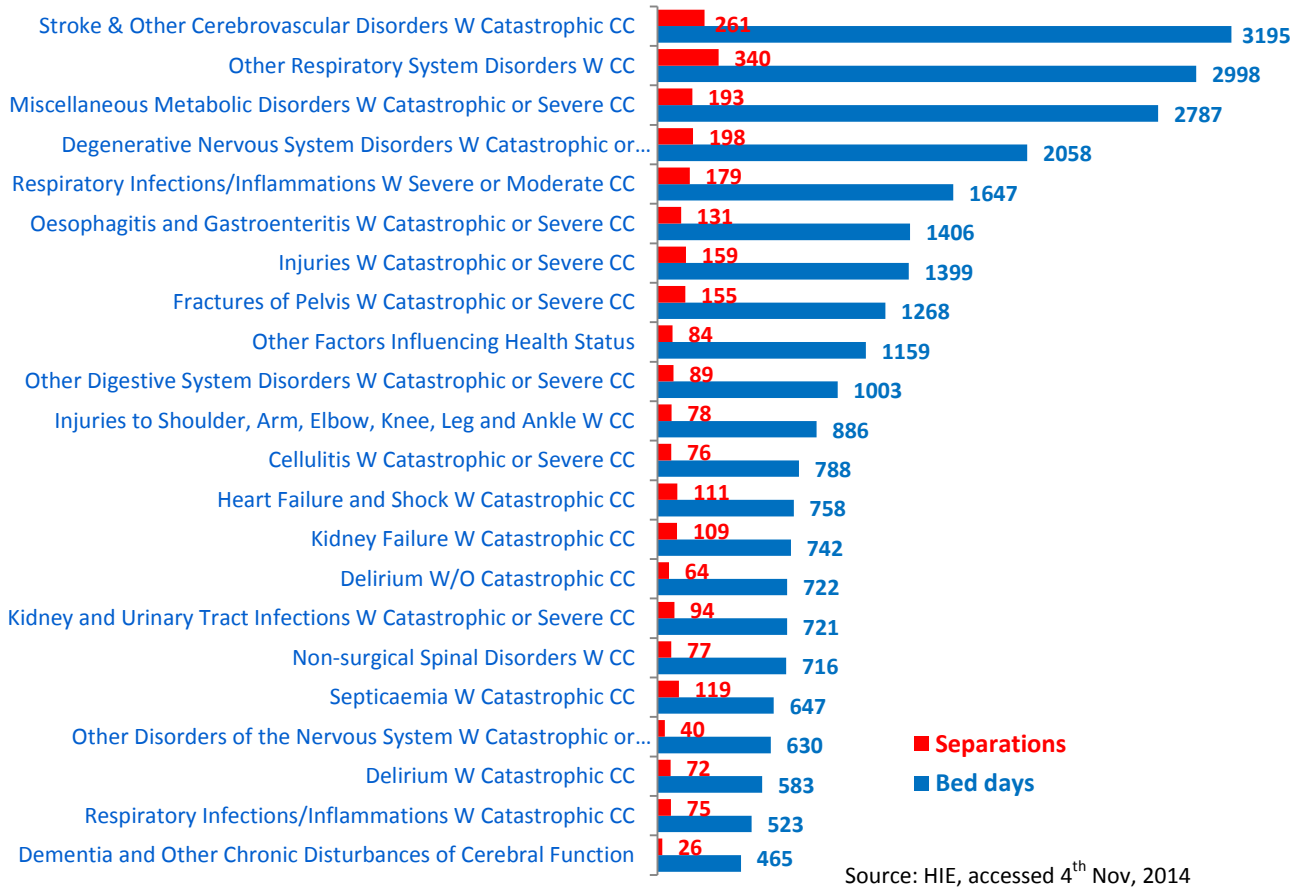
Hospital decreased by 26% (1,993), while separations increased by 22% (52) over the same period. The reduced average length of stay of patients in the acute and sub-acute aged care rehabilitation wards has allowed an increase in the number of aged care patients that can be provided hospital based services. These results reflect beneficial changes in care approaches and settings (e.g. increase in the number of patients receiving Hospital in the Home care) that have been found to contribute to a reduction in the need for inpatient bed days by older patients and currently implemented at the Prince of Wales Hospital.

Aged Care (Acute Geriatrics and Sub-acute Rehabilitation) Inpatient Service Utilisation, 2011-2014



Source: HIE, accessed 4th Nov, 2014

Most Common Principal Diagnoses (DRG by bed days) in Acute Geriatric Services, POWH, 2011-2014



Source: HIE, accessed 4th Nov, 2014

Currently Implemented Aged Care Models and Services (Prince of Wales Health Services)

Hospital Care in Non-Hospital Settings	**Residential Aged Care:** To reduce the need for transport of RACF residents to the Prince of Wales Emergency Department the Geriatric Residential Aged Care Facilities (GRAFS) program facilitates care delivery within local residential aged care facilities. The program aims to build capacity of staff to identify and manage problems within the RACF for appropriate conditions; improves the use of available resources for residents in RACFs to meet health needs outside the acute hospital environment e.g. HITH. Offers streamlined geriatric assessment in consultation with GPs, ensures planned follow up for patients discharged to RACFs, advice and monitoring of residents with behavioural management issues and acute management plans. **Hospital In The Home:** The Post-Acute Care Service comprises a suite of services aimed at expediting outward hospital flow and hospital avoidance. The service comprises of an acute admitted model, Hospital in the Home (HITH), acute and sub-acute care at home and in residential aged care facilities, as a substitute for hospitalisation and post-acute care rehabilitation services. The service also assesses patients in the ED. All services are intrinsically linked. A multidisciplinary team cares for patients who can be referred from a variety of inpatient wards, medical specialists, ED and GPs.
Emergency Acute, Sub-acute	**Aged Care Services Emergency Team (ASET)** is a seven day (0700-1930) multidisciplinary team which offers assessment of the care needs of patients over 75 presenting to the ED. It works collaboratively with the Geriatric Medical assessment Unit Geriatrician and ED staff to ensure the most appropriate model of care is provided and close links with Community Health are established to provide ongoing follow-up care. **Acute Geriatric Service (including the Geriatric Medical Assessment Unit):** Parkes 6 ward has four acute geriatric teams including a Medical assessment Unit team. The aged care teams include nursing and a wide range of allied health staff. Eight of the beds are designated a rapid geriatric assessment unit with a 48-hour length of stay, after which patients can be discharged or admitted to the Acute Aged Care Service. **Acute Aged Care Extension:** is a six bedded unit located on Parkes 5, which is designed to support behaviourally challenging aged care patients who are physiologically stable but require behavioural management in a secure facility. **Orthogeriatric Liaison Service:** offers a shared care model for all older fracture patients requiring orthopaedic services. The service ensures that the pre-peri and post-operative needs of an older person are addressed. Patients are assessed with respect to their rehabilitation potential and whether they would benefit from a discharge with Post-Acute Care Service or require a further period of inpatient rehabilitation. It also ensures older fracture patients are assessed for secondary fracture prevention. **Geriatric Surgical Liaison:** This service provides daily input into acute surgical specialities. It supports surgeons in the medical management of complex older surgical patients including management of the confused hospitalised older person. **Acute Aged Care Rehabilitation:** is a 17 bed unit located on Parkes 5 ward which supports restoration and optimal functional independence in those aged 65 years or older. **Aged Care Psychiatry Unit (Euroa ward):** Euroa ward is a 6 bed Acute Inpatient Aged Care Psychiatry Service at the Prince of Wales Hospital Euroa Centre, which provides a multidisciplinary team specialising in the assessment, management and care of people aged 65 years or more who have an acute psychological disorder or mental illness. **Acute Rehabilitation Therapy (ART):** The ART model of care enhances the treatment of patients in the acute setting by providing simultaneous rehabilitation services, driven by enhanced collaboration between acute medical/surgical and rehabilitation multidisciplinary teams. ART services have led improved patient outcomes with the earlier onset of therapy services (i.e. decrease average length of stay across the acute and rehabilitation settings; reduced number requiring a sub-acute inpatient stay and reduced discharge delays as a result of early assessment and discharge planning). **ReVive Aged Care Volunteer Service:** is provided in ED and on aged care wards.
Outpatient and Non-admitted	**Aged Care Outpatient Clinics:** (Falls, Balance and Bone Health; Cognitive Disorders; Caplan General Geriatric Medicine; Sim General Geriatric; Falls, Balance and Bone Health; Nutrition and Dietetics Aged Care Rehab etc.) **Aged Care Outpatient Services:** **Euroa Centre Aged Care Psychiatry Service** offers specialised assessment and management of older people in outpatient and community settings. It provides domiciliary assessment and management of people living at home, in a hostel or nursing home - includes a Community Nursing Outreach Psychiatry service for the Elderly. The service support to Health Care Workers, Residential Care Facilities and NGOs and offers behavioural assessment intervention and services for older people with challenging behaviours. **The Annabel House Dementia Respite Care Day Centre** (Randwick/Botany) **Aged Care Assessment Team:** provides a comprehensive assessment of care needs to determine eligibility for permanent residential care, respite and /or Commonwealth funded programs such as Home Care packages or Transitional Aged Care. ACAT staff also provide referral to services for complex issues such as dementia care, suspected elder abuse, guardianship etc.

	Aged Care Related Community Health Services: (Community Health Nursing; Assessment and Therapy Team; Transition Aged Care - Randwick and Botany residents only; AIM For Fitness - exercise program for the aged; WAVES gentle water exercise classes for frail and well elderly people).
Cross System	**Connecting Care Program:** is a linked health management program for people with program specific chronic diseases who are at high or very high risk of unplanned hospital or Emergency Department presentation. The Program works with primary care and other services to identify rapidly assess and link patients to appropriate care early to reduce chronic illness severity. It also provides a consultation service to Aboriginal communities. **Discharge Planning:** Comprehensive discharge planning to provide a safe and smooth transition from hospital to home, including detailed GP letter is available from most of Prince of Wales hospital aged and other relevant health services.

Priority Actions (Prince of Wales Hospital and Health Services)

Hospital Care in Non-Hospital Settings

To continue to meet the growing demand for aged health care across the catchment area, identify available and pursue *(e.g. via persuasive business cases, grants, submissions etc.)* the resources required to progressively expand the capacity of the Prince of Wales Hospital and Health Services i.e.:

- The Geriatric Flying Squad (e.g. to include more geriatrician-led residential aged care facility and home based support, and support advanced care planning in community settings).
- Hospital in the Home and other hospital avoidance and diversion services and strategies.
- Aged Care Community Health Services.

Emergency, Acute, Sub-Acute

- Identify and implement additional approaches and pathways to improve the management and flow of rehabilitation patients with high acuity levels who cannot be managed in rehabilitation specific facilities, and who often have longer length of stays.
- Expand the concept of shared care with surgical specialties beyond that of orthopaedics.
- Ensure systems and processes are in place to support staff across the hospital in delivering care for the confused older person.

Outpatient

- Identify and action opportunities to share the care of clients and improve care coordination through the establishment of formal ongoing arrangements with aged care not-for-profits (e.g. Benevolent Society and Uniting Care) and St Vincent's Health, Sydney.

Cross System

- Strengthen relationships with War Memorial, Calvary and St George Hospitals to optimise opportunities and improve older patient care integration across the District.
- Work with local community partners to identify and implement opportunities to expand care coordination to support the increasing number of high risk community health clients with multiple health and social issues requiring multi-agency involvement to reduce the need for acute care services.

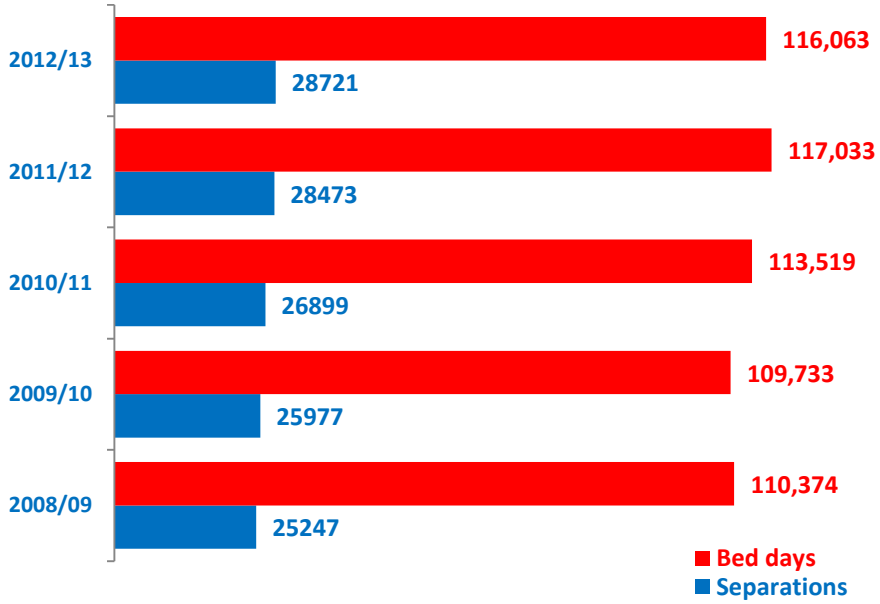
Other

- Implement ongoing research into the effectiveness of physical therapy in terms of improved outcomes and reduced length of stay.
- Undertake a gap analysis of current Allied Health services for aged clients across care settings.
- Implement and evaluate the effectiveness of cross site integrated models of care in partnership with private rehabilitation units (e.g. via translational research)
- Continue to support, facilitate and promote the undertaking of high quality research into issues relating to older people.
- Explore opportunities to work more effectively with local GPs in providing high quality care for the older population
- Work toward implementation of the State level strategic framework for integrated care for older people with complex health needs.

St George Hospital and Health Services

St George Hospital is a 500+ bed tertiary referral teaching hospital of the UNSW with an average occupancy rate of over 90%. St George Hospital accepts patients from other parts of Sydney, NSW and beyond. Approximately 35% of the St George area's residents are from a non-English speaking background. The Hospital is also the nearest provider of specialist medical services for around 200,000 residents of the Sutherland Shire. The hospital and associated health services provide a comprehensive range of aged care services, including an inpatient aged care precinct; a purpose built Older Persons Sub-Acute Unit offering multidisciplinary assessment and care for older people with a mental health problem (an integrated service that works closely with the Community Older Adults Service and relevant stakeholders); and a Rehabilitation Unit which provides a multidisciplinary service to patients who require general rehabilitation, many of whom are older. Specific aged care rehabilitation is referred to Calvary Hospital or other sites. Rose Cottage Day Rehabilitation Unit provides multidisciplinary rehabilitation after acute hospital admission; and the St George Community Health Team offers a comprehensive range of services for the aged.

All Separations and Bed Days, 65 years and older 2008/09-2012/13

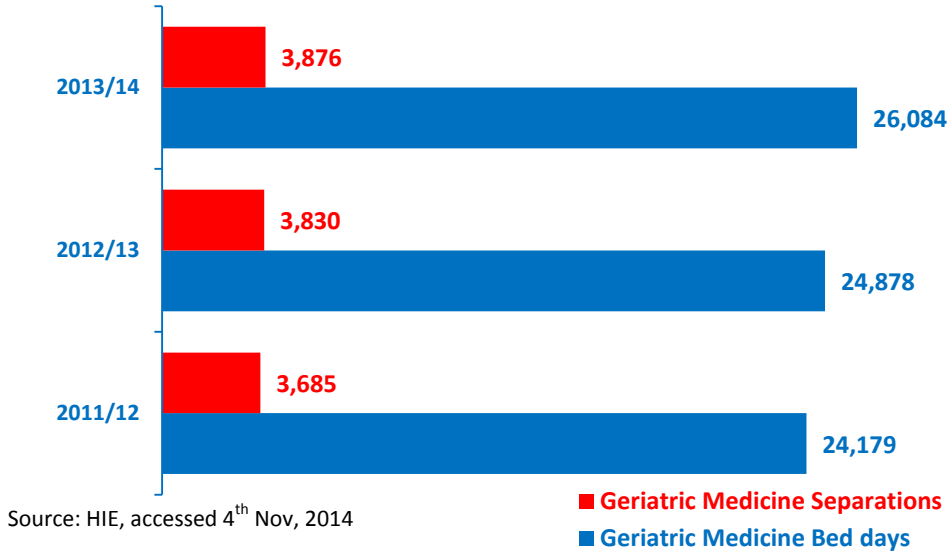


Source: Flowinfo V 13.0.Excludes ED only and Collaborative Care.

The numbers of inpatient bed days utilised by patients 65 years or older in St George Hospital have increased by just over 5,680 (or 5%) between 2008 and 2013, while separations during this time have increased by over 13% (almost 3,500). Over the same period, the average length of stay fell from 4.4 in 2008 to 4.0 in 2013. These results (i.e. almost three times the increased proportion of separations to bed days) reflect advantageous changes in care approaches and settings that have been found to contribute to a reduction in the need for inpatient bed days by older patients and currently implemented at St George Hospital and Health Services (see table next page). Efforts in bed day reductions will need to continue to deal with the 44% increase in overnight separations and 33% increase in overnight bed days in persons 70 years+ that are projected between 2011 and 2032 (reflects the growing aged population in the region).

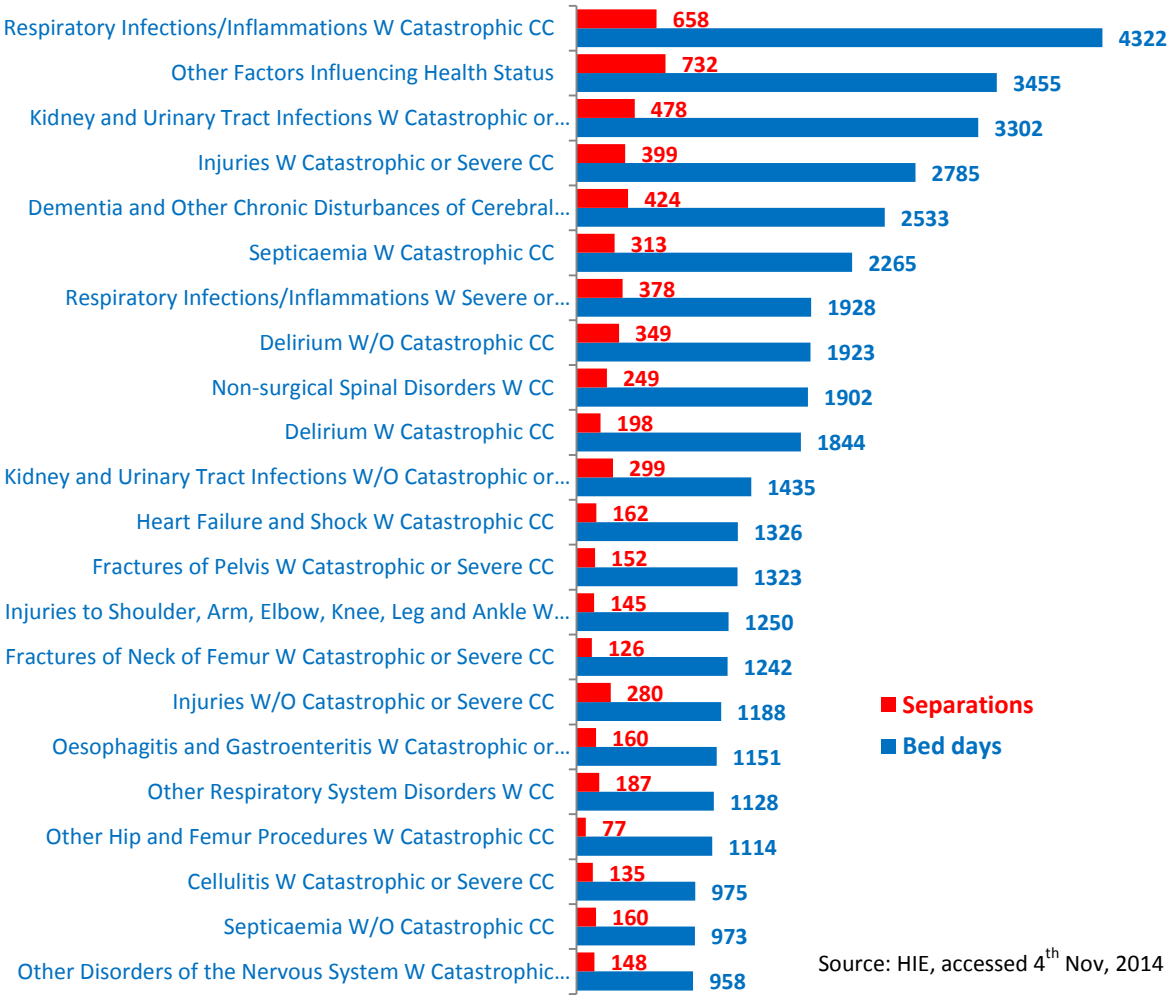
Over 103,500 non-admitted occasions of service were provided to patients 65 years+ from St George Hospital and Health Services in 2013/14.This is in line with the steady upward trend in utilisation of this care type. Between 2011 and 2014 there were over 77,600 geriatric medicine inpatient bed days in St George Hospital and over 11,700 separations. Geriatric medicine inpatient bed days increased by almost 8% (1,905) between 2011 and 2014, while separations increased by 5% (191). The average length of stay remained relatively constant over this period.

Geriatric Medicine Inpatient Service Utilisation (Separations and Bed Days) St George Hospital, 2011-2014



Source: HIE, accessed 4th Nov, 2014

Most Common Principal Diagnoses (DRG by bed days) in Acute Geriatric Services, St George Hospital, 2011-2014



Source: HIE, accessed 4th Nov, 2014

Currently Implemented Aged Care Models and Services (St George Hospital & Health Services)

Non-Hospital Settings	**Residential Aged Care** The Geriatric Flying Squad to Residential Aged Care facilities (RACF) provides early medical and nursing intervention for RACF patients flagged as potentially requiring transfer to the Emergency Department. The service provides training and education to RACF staff on improving the early detection and management of acutely unwell patients. The service also provides phone consultations to optimise patient care. The service reduces the number who would have presented to the ED and potentially admitted, to avoid hospital and be more comfortably treated within their facility.
Emergency Acute, Sub-acute	**Aged Care Services Emergency team (ASET**) is a consultancy service to staff and clients of the St George Emergency department. ASET provides clinical assessment and interventions for aged clients with a range of geriatric problems and unstable chronic and complex conditions. **Medical Assessment Unit** is a service to improve the efficiency in the admission process for unplanned patients by providing assessment, care and treatment for a designated period of usually 48 hours, prior to transfer to a medical ward or home where appropriate. **Aged Care Precinct (7 South and 7 West)** includes two 30 bed units caring for the acutely ill older person. The innovative model of care within the precinct's 60 beds includes a rapid assessment unit, acute and sub-acute beds, and delirium and high dependency rooms. **Psychogeriatric Service** is a specialist psychogeriatric assessment and management service. **6 West Rehabilitation Unit** is a 22 bed unit offering multidisciplinary care under the direction of rehabilitation specialists. Individualised rehabilitation programs, nursing and allied health assessments, treatment and facilitates a coordinated discharge planning of complex patients. The Acute Rehabilitation Therapy Team reaches into the acute wards at St George Hospital to provide rehabilitation expertise (medical and allied health care) in the acute wards. **Acute Rehabilitation Therapy (ART):** The ART model of care enhances the treatment of patients in the acute setting by providing simultaneous rehabilitation services, driven by enhanced collaboration between acute medical/surgical and rehabilitation multidisciplinary teams. ART services have led improved patient outcomes with the earlier onset of therapy services (i.e. decrease average length of stay across the acute and rehabilitation settings; reduced number requiring a sub-acute inpatient stay and reduced discharge delays as a result of early assessment and discharge planning). **The Older Persons Mental Health Service** provides assessment and treatment for people 65 years+ with mental health problems. Treatment is provided in both hospital and the community. The team also offers consultation and support to other aged care services. **Rose Cottage Day Rehabilitation Unit** offers rehabilitation services for patients recovering from surgery, illness or who have a disability.
Outpatient and Non-admitted	**Aged Care Outpatient Clinics** (Geriatrician outpatient clinics; specialist allied health clinics; Medical Assessment Clinic; Memory Disorders Clinic) **Aged Care Outpatient Services** (Rehabilitation Outpatient Service; Older Persons Mental Health Service) **Aged Care Related Community Health Services –** including community health nursing, continence advisory service, ASET, Quick Response Program, ComPacks, single point of access for referral. **Aged Care Assessment Team** provides a comprehensive assessment of care needs to determine eligibility for permanent residential care, respite and /or Commonwealth funded programs such as Home Care packages or Transitional Aged Care. ACAT staff also provide referral to services for complex issues such as dementia care, suspected elder abuse, guardianship etc.
Cross System	**Osteoporotic fracture program (people over 50 years)** offers assessment and secondary preventative management and treatment for osteoporosis in partnership with South East Sydney Medicare Local. **Connecting Care Program** is a linked health management program for people with program specific chronic diseases who are at very high risk or high risk of unplanned hospital or Emergency Department presentation. The Program works with primary care and other services to identify rapidly assess and link patients to appropriate care early to reduce chronic illness severity. **Discharge Planning:** comprehensive discharge planning to provide a safe and smooth transition from hospital to home, including detailed GP letter is available from most of St George hospital aged and other relevant health services.

Priority Actions (St George Hospital and Health Services)

Hospital Care in Non-Hospital Settings

To continue to meet the growing demand for aged health care across the catchment area, identify available and pursue *(e.g. via persuasive business cases, grants, submissions etc.)* the resources required to progressively expand the capacity of the St George Hospital and Health Services i.e.:

- Expand community based clinical services to address issues of chronic disease, frailty and ageing, including enhancing existing outreach services such as the St George Geriatric Flying squad by establishing it as a 7 day per week nurse practitioner model to support Residential Aged Care Facilities.
- Increase integrated models of care and resources to support the provision of multidisciplinary care from the acute setting to the community e.g. the St George Area Geriatric Assessment in Nursing Home Program.

Emergency Acute, Sub-acute

- Expand hospital and emergency department avoidance strategies e.g. rapid assessment of residents of aged care facilities and in the community; rapid transfer to aged care wards without going through emergency department; increasing referrals back to general practice and community level services.
- Expand the Aged Care Services Emergency Team to increase clinician availability across extended hours.
- Investigate the opportunity to broker Guardianship services to expedite patient discharge.

Outpatient

- Identify required and attain resources *(e.g. via persuasive business cases, grants, submissions etc.)* to extend the hours of the Quick Response Program.
- Increase community services, with more services delivered at home.

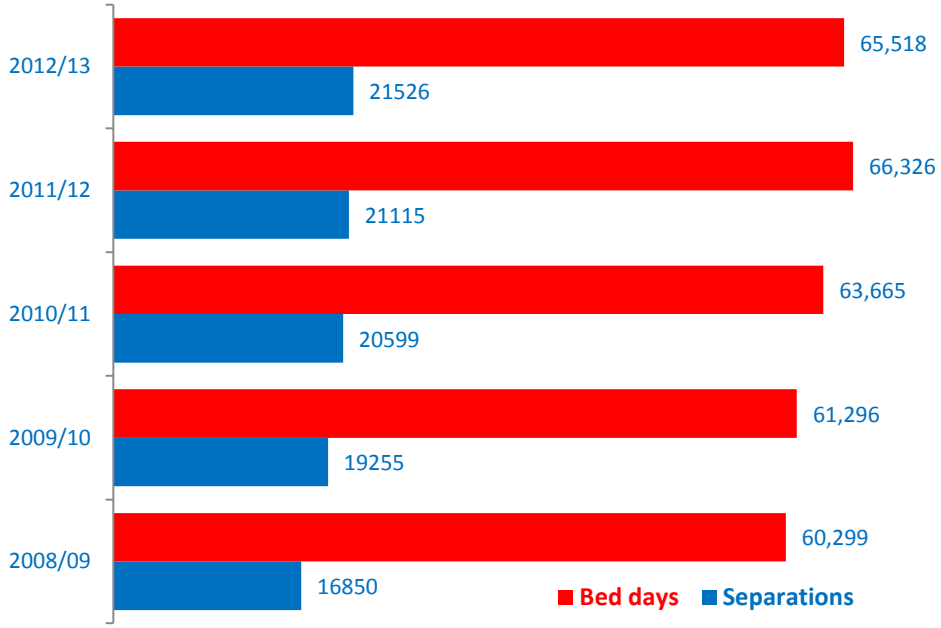
Cross System

- Strengthen relationships with War Memorial, Calvary and Prince of Wales Hospitals to optimise opportunities and improve integration of older patient care across the District.
- Work with community partners to investigate the potential for volunteer run dementia and falls home monitoring service.

The Sutherland Hospital and Health Services

The Sutherland Hospital is a 270+ bed teaching hospital of the University of NSW. The hospital and its health services provide a comprehensive range of aged care services for the local community. Southcare (Division of Aged and Extended Care) is a Division of the Sutherland Hospital and Community Health Service offering a range of services predominantly for frail older people and those with disabilities living in our community. To support and allow advancement in the integration of hospital and community services, a range of services are co-located in the Southcare building situated on the grounds of the Sutherland Hospital, including Aged Care Assessment Team, Geriatricians (Aged Care Specialists); Generalist Community Nurses; Allied Health; Centre Based Socialisation / Respite; Support Services and Support & Education Groups.

All Separations and Bed Days, 65 years and older 2008/09-2012/13

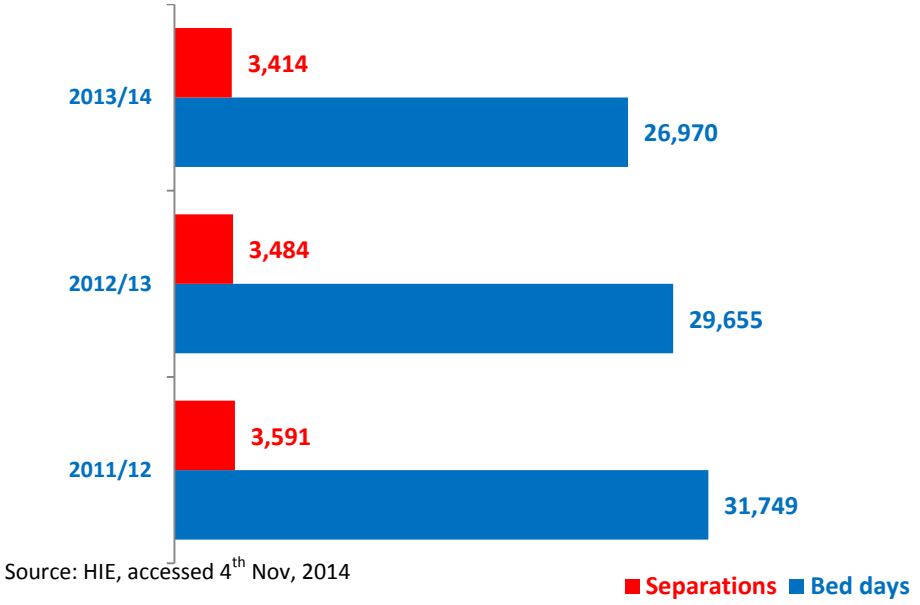


Source: HIE, accessed 4th Nov, 2014

The numbers of inpatient bed days utilised by patients 65 years or older in Sutherland Hospital have increased by just over 5,200 (or 8%) between 2008 and 2013, while separations during this time have increased by over 27% (over 4,670). Over the same period, the average length of stay fell from 6.1 in 2008 to 5.0 in 2013. These results (i.e. over three times the increased proportion of separations to bed days) reflect advantageous changes in care approaches and settings that have been found to contribute to a reduction in the need for inpatient bed days by older patients and currently implemented at Sutherland Hospital and Health Services (see table next page). Efforts in bed day reductions will need to continue to deal with the 65% increase in overnight separations and 8% increase in overnight bed days in persons 70 years+ that is projected between 2011 and 2032 (reflects the growing aged population in the region).

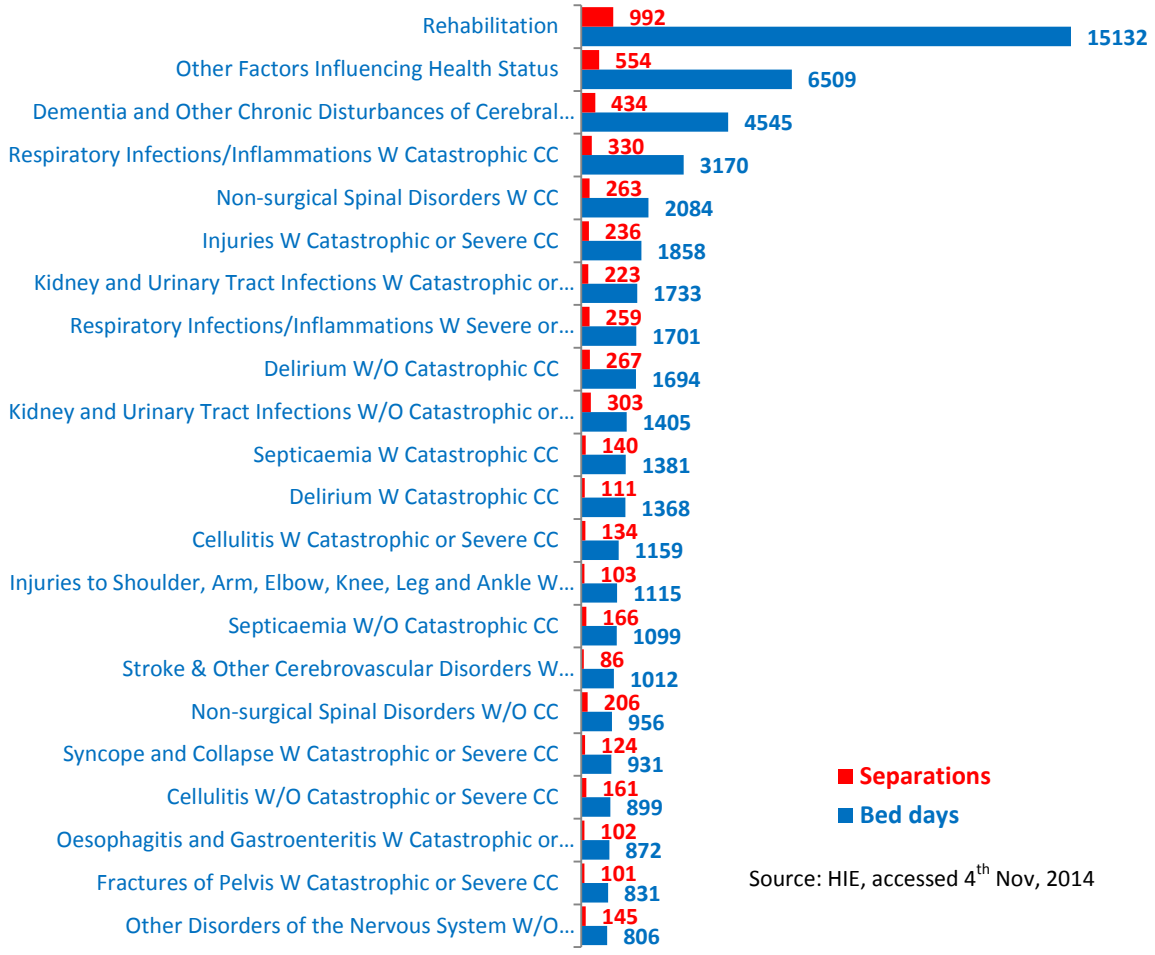
Over 86,380 non-admitted occasions of service were provided to patients 65 years+ from Sutherland Hospital and Health Services (including Southcare) in 2013/14.This is in line with the steady upward trend in utilisation of this care type .

Aged Care Specific Inpatient Service Utilisation (Separations and Bed Days), Sutherland Hospital 2011-2014



Source: HIE, accessed 4th Nov, 2014

Most Common Admitted Aged Care Principal Diagnoses (DRG by bed days), Sutherland Hospital, 2011-2014



Source: HIE, accessed 4th Nov, 2014

Currently Implemented Aged Care Models and Services (Sutherland)

Non-Hospital Settings	**Residential Aged Care: Southcare Geriatric Flying Squad incl. Nurse Practitioner** - provides early medical and nursing intervention for patients flagged as potentially requiring transfer to the Emergency Department. Provide training and education to RACF staff on improving management of acutely unwell patients. The service also provides phone consultations to optimise patient care. The GFS intervention means that people, who would have presented to the ED and admitted, avoid hospital and are more comfortably treated within their facility. A Geriatrician or Nurse Practitioner/Transitional Nurse Practitioner/Clinical Nurse Consultant review of RACF clients located in the Sutherland Shire who has had an acute deterioration and a hospital transfer is being considered. Additional services include: outbreak management, education and support in detecting and managing clinical deterioration and care pathways. **Hospital in the Home Services: The Southcare Outreach Service** is a multidisciplinary rapid response community team for Sutherland residents over 65 years of age, providing short term acute and sub-acute interventions for up to six weeks, by Nursing and allied health staff to facilitate enhanced patient care and safe clinical outcomes**. Southcare In-Home Allied Health Services** are also available**.**
Emergency Acute, Sub-acute	**Aged Care Services Emergency Team (ASET)** provides a multidisciplinary consult service for patients 70 years and older who present to the Emergency Department. ASET work collaboratively with ED staff to achieve optimal management of older patients. ASET assess and identify complex issues, advocate for patients/carers', refer and facilitate access to other relevant services if medically cleared from the ED. **Aged Care Assessment Unit (ACAU)** is a 9 bed unit located in Barkala ward and provides comprehensive, multidisciplinary person-centred care by a geriatrician-led aged care team. The team offers diagnostic assessment, nursing and allied health screens, treatment and discharge planning for up to 48 hours, prior to discharge or transfer to another ward. **Barkala Acute Medical Aged Care** is a 23 bed acute aged care ward where patients 65 years+ with acute medical conditions are admitted under the care of a geriatrician. Barkala works with the other aged care areas by supporting the ongoing care of patients transferred from the ACAU who need to remain in hospital beyond 48 hours, and treating patients in the acute phase of their illness who may also need transfer to the rehabilitation or behavioural monitoring units. **Killara Acute / Extension Aged Care** is a 28 Bed Unit that comprises of a 6 bed secure unit (Killara Extension) designed to manage patients with dementia and challenging behaviours. The remaining 21 beds are dedicated to management of acute medical aged care patients. Included in these beds is a 4 bed "falls" room has been dedicated to the care and observation of high falls risk patients. **Killara Rehabilitation** is a 34 bed Unit providing specialised and general rehabilitation. **Orthogeriatric Service** provides geriatric medicine review to older fracture patients. **Intensive Therapy Programs:** The ITP model of care enhances therapy services within the sub-acute inpatient rehabilitation setting to accelerate patient functional recovery. Successful ITP services decrease rehabilitation length of stay by achieving rehabilitation goals earlier through: • Improved access to multidisciplinary rehabilitation services • Increased throughput in the sub-acute inpatient rehabilitation setting through decreasing patient length of stay • Improved patient Functional Independence Measure (FIM) outcomes *(FIM is one of the current measures of relative complexity for sub-acute rehabilitation services).*
Outpatient and Non-admitted	**Aged Care Outpatient Clinics** (Geriatrician outpatient clinics; specialist Psychogeriatric clinic) Aged Care Assessment Team - determines eligibility for some Commonwealth subsidised aged care services, including Residential Aged Care, Community Aged Care Packages and Flexible Care, (i.e. Extended Aged Care at Home (EACH) and Transitional Care). **Sutherland Heart and Lung Team** is a community based multidisciplinary team that provides home monitoring, specialised education and gym based exercise programs to people with chronic heart failure, chronic cardiac disease and pulmonary hypertension who live in the Sutherland Shire. **Sutherland Transitional Aged Care Service** provides short-term intervention (up to 12 weeks) for older persons who have the capacity to benefit from a package of services that includes at least low intensity therapy/social work and/or nursing support/personal care. The service aims to optimise older person's functional capacity and assist in making long-term care arrangements. **Southcare Generalist Community Nurses** provide nursing care to Sutherland residents (e.g. Home assessments; medication/injections; palliative care (with Calvary community team; etc.). **Southcare Nurse Continence Service** is available to all Sutherland residents via clinics and home visits. **Southcare Allied Health** is a comprehensive range of allied health services (outpatient and in-home). **The Retreat** is a day care centre for frail or disabled aged people (12 per day) requiring more assistance than can be provided by volunteer run caring centres. Potential clients are assessed by the Coordinator at home to determine if the centre can meet their needs. Staff includes a Registered Nurse Coordinator, Assistant in Nursing (AIN), Diversional Therapist and a Bus Driver/General Assistant. **Sutherland Case Management Services (Community Options)** offers comprehensive case management for complex HACC eligible clients.

Outpatient and Non-admitted (cont)	**The Cottage** is a day care centre for people with a diagnosed dementing illness. Maximum 15 clients per day. Potential clients are assessed by the Coordinator at home to determine suitability. Staff includes a Registered Nurse Coordinator, AIN, Diversional Therapist and a Bus Driver/General Assistant. **Aged Care Assessment Team** provides a comprehensive assessment of care needs to determine eligibility for permanent residential care, respite and /or Commonwealth funded programs such as Home Care packages or Transitional Aged Care. ACAT staff provide referral to services for complex issues such as dementia care, suspected elder abuse, guardianship etc. ACAT will also provide advice regarding appropriate Southcare and/or Home and Community Care (HACC) and other services. **Dementia Home Monitoring Program** provides registered nurse assessment and care plan development; community support worker/coordinator provides dementia care information and practical in home support including meal and medication supervision, assistance with personal care, shopping, transport to appointments e.g. GPs, hairdressers and supervised social outings. The program operates in conjunction with other community support services e.g. Home Care, Neighbour Aid, Meals on Wheels, Dementia Day Care, etc.
Cross System	**Connecting Care Program:** is a linked health management program for people with program specific chronic diseases who are at very high risk or high risk of unplanned hospital or Emergency Department presentation. The Program works with primary care and other services to identify rapidly assess and link patients to appropriate care early to reduce chronic illness severity. **Discharge Planning:** comprehensive discharge planning to provide a safe and smooth transition from hospital to home, including detailed GP letter is available from most of Sutherland hospital and Health Services aged and other relevant services.

Priority Actions

Hospital Care in Non-Hospital Settings

- Identify opportunities to further develop rehabilitation, aged care and transitional aged care through an expansion of Southcare services to enable increased availability of community and home support (e.g. expand the Geriatric Flying Squad home based and RACF services) to further reduce the need for Sutherland Hospital inpatient services.
- Improve Orthogeriatric services e.g. Effective use of existing data sources to identify relevant patients.
- Improve levels of aged care/surgical shard care arrangements.
- Identify available and pursue *(e.g. via persuasive business cases, grants, submissions etc.)* the resources required to improve the physical infrastructure and IT capability of Southcare, to allow expansion of services.
- Continue to work with local RACFs to increase referrals/requests for Southcare services to further reduce the need for Sutherland Hospital inpatient services.
- Improve access and integration of electronic records to avoid duplication of notes and improve access to medical records.

Emergency Acute, Sub-acute

- Investigate opportunities for the expansion of the Aged Care Services Emergency Team to a 7 day service with extended hours.
- Expand other specific aged care and rehabilitation services by improving aged care inpatient services at Sutherland Hospital by expanding the medical aged care assessment unit; increasing the use of telemetry in the unit; expanding in-hospital acute aged care beds and providing a seven day rehabilitation service.
- Investigate the opportunity to broker Guardianship services to expedite timely patient discharge.

Outpatient

- Increase community services, with increased service delivery in the home to avoid hospitalisation.
- Establish an Ambulatory Care clinic to reduce the need for inpatient care.
- Retender for ComPacks services as required.
- Increase flying squad beyond the aged care facilities to the community.

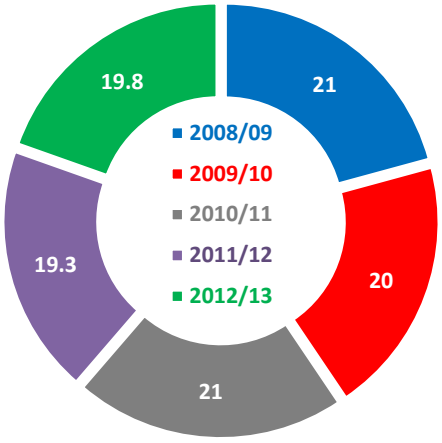
Cross System

- Initiate volunteer services in the community, for example a volunteer led dementia Day Care and home monitoring service.

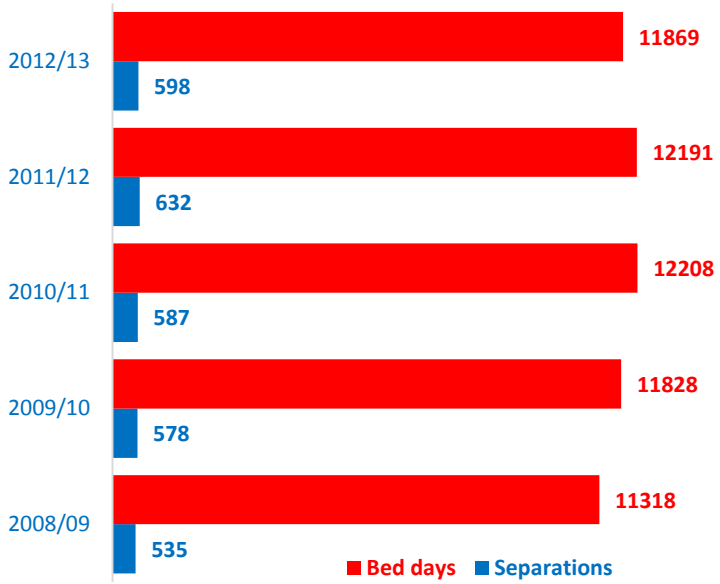
The War Memorial Hospital

The War Memorial Hospital Waverley is an Affiliated Health Organisation, subsidised by NSW Health and is owned and operated by Uniting Care Ageing. The primary role and specialty of the hospital is sub-acute rehabilitation and assessment services for people aged over 60 years. The facility provides a 35 bed specialist inpatient rehabilitation unit, a large number of multidisciplinary outpatient services, dementia, frail and culturally and linguistically diverse aged day care services, alongside a range of targeted specialist community services outlined in the table below. There are strong clinical links with Prince of Wales Hospital, Sydney Hospital and St Vincent's Hospital Sydney with staff specialists attending from both sites to provide medical directorship and consultation. The hospital forms part of the medical rotations for Medical Officers undergoing their training at SVH and has a specialist Registrar in attendance as part of the Advanced Specialist Trainee Programme. The Hospital houses the Prince of Wales Hospital Home Dialysis Service. Elizabeth Hunter Lodge operates as a separate entity but remains part of War Memorial Hospital. It offers cost efficient accommodation service for regional and rural patients or carers of metropolitan health care services. Many guests attend treatment and perform informal carer roles using Hunter Lodge as a base which is reflective of the social justice arm of War Memorial and Uniting Care, and indicative of the value placed on broad integration with the District and NSW Ministry of Health populations.

Average Length of Stay, 2008/09-2012/13



All Separations and Bed Days, 2008/09-2012/13



Source: Flowinfo V 13.0.

The numbers of inpatient bed days and separations at War Memorial Hospital remained relatively constant between 2008 and 2013, as did the average length of stay, reflecting the nature of sub-acute care. Projections of inpatient activity in persons 70 years or older for War Memorial Hospital indicate a 57% increase in active episodes of care between 2011 and 2032 (from 593 to 1,400) and a 48% increase in bed days for the same period (from 11,824 to 22,867). This is in line with the increase in aged population in this geographic area. In 2013/14, War Memorial Hospital provided over 44,600 non-admitted patient occasions of service.

Currently Implemented Aged Care Models and Services (War Memorial)

Non-Hospital Settings	**Multidisciplinary Community Service:** The Geriatric Flying Squad is a community based comprehensive assessment and short term case management program for patients 65 years and over with a sub-acute functional decline and multiple and chronic conditions, including dementia, with a goal to prevent unnecessary admission to hospitals. Multi-disciplinary team (geriatrician, nurses, OT, PT, SW, dietitian and clinical psychology with treatment plan generation). Referrals come from GPs, community and the ACAT/ACART teams. Patients are triaged on the telephone by the CNC.
Sub-acute	**Inpatient Rehabilitation Unit** is a 35 bed unit providing specialist rehabilitation from a multidisciplinary team including geriatricians, nurses, allied health and a range of support staff **Geriatric Medical Assessment Service** offers specialist medical assessment and recommendations **Clinical Psychology Services** provide comprehensive psychological assessment and therapy services to geriatric rehabilitation patients on an inpatient and outpatient basis. **Intensive Therapy Programs:** The ITP model of care enhances therapy services within the sub-acute inpatient rehabilitation setting to accelerate patient functional recovery. Successful ITP services decrease rehabilitation length of stay by achieving rehabilitation goals earlier through: • Improved access to multidisciplinary rehabilitation services • Increased throughput in the sub-acute inpatient rehabilitation setting through decreasing patient length of stay • Improved patient Functional Independence Measure (FIM) outcomes *(FIM is one of the current measures of relative complexity for sub-acute rehabilitation services).*
Outpatient	**Outpatient Clinics:** Continence Clinic; Bone and Joint Clinic; Falls Assessment & Injury Prevention Clinic; Multidisciplinary Cognitive Assessment And Treatment; Parkinson's Disease Multidisciplinary Assessment Clinic and services. **Younger Onset Dementia Service** provides age appropriate activities, service and support to individuals between the ages of 45-65 years with a primary diagnosis of dementia who are independent in mobility, able to self-care and live in their own home. **Aged Care Assessment Team** provides a comprehensive assessment of care needs to determine eligibility for permanent residential care, respite and /or Commonwealth funded programs such as Home Care packages or Transitional Aged Care. ACAT staff also provide referral to services for complex issues such as dementia care, suspected elder abuse, guardianship etc. **Day Care Centre** offers structured individual and small group activities (dementia or frail aged) **Other Community Health:** Transitional Aged Care; Access and Referral **Outpatient Services:** Clinical Psychology; Podiatry Services; Physiotherapy; Occupational Therapy; Social Work; Speech Pathology; Parkinson's Disease Information Program; Stress Management Program; Carer's Group; Speech Pathology communication therapy group programs; Aquatic Physiotherapy / Hydrotherapy; Community Independence Group; Move and Stay Well exercise program; Health Promotion Groups and Programs (including Lite & Ezy Exercise program, Stepping Out Falls Prevention Program, Walkwell group program of supervised walks); Transitional Aged Care Packages; Men's Shed.
Cross System	**Discharge Planning:** comprehensive discharge planning to provide a safe and smooth transition from hospital to home, including detailed GP letter is available from War Memorial Hospital. **Geriatric Flying Squad Domiciliary Response team:** provides specialised holistic and comprehensive rehabilitation services to community dwelling and low-level RACF patients 'at-risk' of not coping living independently in the community. These services have facilitated an improved quality of life for many people through improved functional ability, increased confidence and safety to remain living independently in their homes by avoiding hospitalisation (thereby reducing client stress and anxiety) and avoiding premature aged care placement.

Priority Actions

Hospital Care in Non-Hospital Settings

- Consolidation of the community based Geriatric Flying Squad model to further extend and build on current relationships with the residential aged care and primary care sectors.

Sub-acute

- Progress work towards the establishment of a Day Rehabilitation Unit for the northern sector. War Memorial Hospital has potential space for service allocation, further consideration to business modelling and human resource requirements are needed.
- Undertake a review of our internal model of care to ensure a dynamic, contemporary evidence based model that meets the needs of an increasingly complex aged care demographic.
- Recruitment and establishment of a specialist aged care rehabilitation volunteer service that supports targeted clinical services and health literacy. This unique volunteer service would seek to encompass a wide demographic (from school age, to all generations and variety of skills) to foster the concept of participatory healthy ageing and the exposure of younger populations to an increasingly isolated 'old old' cohort who may find themselves with decreasing informal care options.
- Advocate for and participate in the development of further specialist aged and sub-acute services at the War Memorial Hospital Waverley site as part of future campus expansion plans with Uniting Care Ageing.

Cross System

- Continue collaboration and integration with our District colleagues especially Prince of Wales, Sydney/Sydney Eye and St Vincent's Hospitals to ensure optimal patient flow and service provision, matching 'care need with care location'.
- Consolidate and build on the direct relationship and partnerships between sub-acute and primary healthcare to enable the patient to remain at home or facilitate a direct admission to sub-acute if required, in order to avoid costly acute admission and emergency presentations.
- Utilise the benefits of War Memorial Hospital as an Affiliated Health Organisation to enable integration across the acute, sub-acute and primary care sectors.

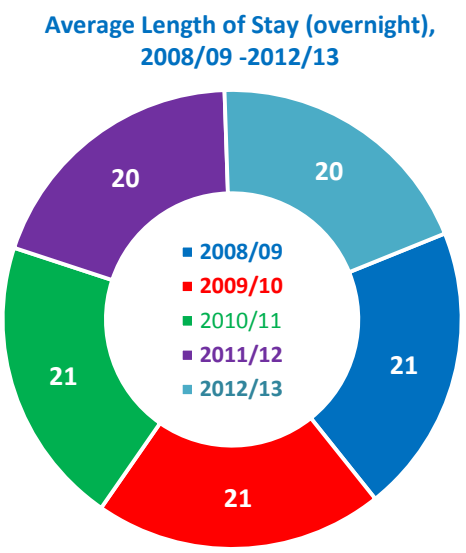
Other

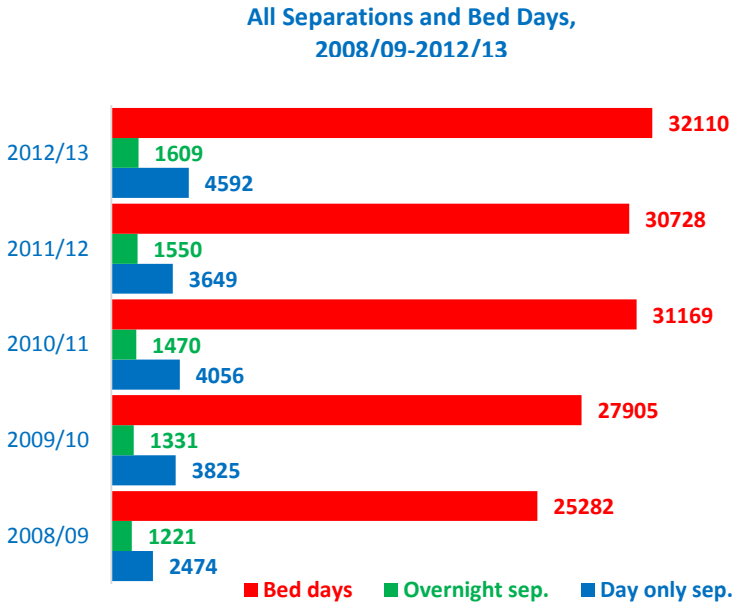
- Finalise the next War Memorial Hospital Clinical Services Development Plan 2015-2018
- Maintain high recognition of dementia as increasing morbidity and high healthcare impact. War Memorial Hospital is acutely aware of the need to develop dementia services accordingly to population need, utilising the existing expert clinical workforce and evidence based models.
- Further build our role as a health promoter for current and potential health consumers.
- Formalise War Memorial Hospital as a specialist aged care rehabilitation education provider for health and aged care colleagues, spanning all disciplines and profiling specialty for workforce retention and professional development.

Calvary Health Care Kogarah

Calvary Health Care Kogarah is an affiliated healthcare organisation which is owned and operated by Little Company of Mary Health Care providing a 95 bed subacute hospital specialising in multidisciplinary palliative care, aged care and medical and surgical rehabilitation. The facility also provides outpatient, community, ambulatory and home care services. Palliative care is provided as an inpatient service with 39 beds and accommodates patients with non-curable illnesses who may be admitted for pain and symptom management, respite care or terminal care. Palliative care is also provided as a specialised ambulatory and community-based service where staff visit clients in the home as well as see the new clients in a Multidisciplinary Clinic. The community-based service is delivered by the community palliative care team which provides a consultative and support service within the client's home environment 24 hours a day, seven day a week across St George and Sutherland areas.

Calvary Health Care Kogarah provides a range of unique services that are not currently available from other District facilities including Driver Rehabilitation; Bereavement; Holistic Healing Centre and a Motor Neurone Disease Specialist Multidisciplinary Team clinic. Mary Potter House (part of Calvary Community Health) is a day respite centre for residents living within the St George area that have a diagnosis of a moderate to advanced dementia. This facility aims to enhance the quality of life of people with dementia and their carers by providing community support, education and respite in order to prevent premature admission to residential aged care facilities. The day care centre strives to share the burden of care with families and introduce therapeutic activities to stimulate client activity. The centre commenced overnight respite in June 2013 for respite at weekends and during the week.





Source: Flowinfo V 13.0.

The numbers of inpatient bed days and separations at Calvary Hospital increased steadily between 2008 and 2013, while the average length of stay remained relatively constant, reflecting the nature of sub-acute care for the older person. Projections of inpatient activity in persons 70 years or older indicate a 42% increase in active episodes of care between 2011 and 2032 (from 4,821 to 8,254) and a 25% increase in bed days for the same period (from 28,151 to 37,396). This is in line with the increase in aged population in this geographic area. In 2013/14, Calvary Hospital provided over 52,000 non-admitted patient occasions of service.

Currently Implemented Aged Care Models and Services (Calvary)

Non-Hospital Settings	**Community Palliative Care Services:** are offered in the home and in residential aged care facilities in the St George and Sutherland areas. **In home rehabilitation and aged care assessment:** to the frail, elderly with dementia and other adults with disabilities living at home in the St George Local Government Area (this includes Kogarah, Hurstville and Rockdale).
Admitted Sub-acute Setting	**Palliative Care Inpatient Service:** operates within a multidisciplinary team model and includes specialist medical staff, vocational trainee medical staff, nursing staff, allied health staff (physiotherapists, occupational therapists and social workers), pastoral care, the bereavement service and a volunteer service. The service provides palliative care training from medical staff with specific affiliation with the University of NSW. The service also provides opportunities for tertiary providers for nursing and social work undergraduate placements. Calvary participates in the Palliative Care Clinical Studies Collaborative. **Bereavement Service and Pastoral Care:** provides services following a patient's death, where families and significant others are able to access Bereavement Services for follow-up grief support and counselling. **Inpatient Rehabilitation Unit:** is a 56 bed unit providing general and aged care rehabilitation. Assists patients who have experienced loss of function due to prolonged hospital admissions, disability, illness, inactivity or injury to return home safely with optimal independence. Calvary Health Care Kogarah offers a fully equipped gymnasium and modern hydrotherapy pool for use by inpatients and outpatients. **Day Rehabilitation Unit:** assists general, aged care and Parkinson's patients who have experienced loss of function to return to optimal independence. Day Rehabilitation utilising the gymnasium and hydrotherapy pool is a 12 x 3 hour session program over 4-6 weeks. **Overnight Dementia Respite:** is a service which reduces the burden on carers of people with dementia. **Intensive Therapy Programs:** The Intensive Therapy Programs model of care enhances therapy services within the sub-acute inpatient rehabilitation setting to accelerate patient functional recovery. Successful ITP services decrease rehabilitation length of stay by achieving rehabilitation goals earlier through improved access to multidisciplinary rehabilitation services; increased throughput in the sub-acute inpatient rehabilitation setting through decreasing patient length of stay and improved patient Functional Independence Measure (FIM) outcomes *(FIM is one of the current measures of relative complexity for sub-acute rehabilitation services).*
Outpatient and Non-admitted	**Community Palliative Care Team:** operates within a multidisciplinary team model and includes specialist medical staff, vocational trainee medical staff, nursing staff, allied health staff (physiotherapists, occupational therapists and social workers), pastoral care, the bereavement service and a volunteer service. Provides a multidisciplinary outreach service that includes RACFs and also provides a palliative care ambulatory multidisciplinary team assessment program (undertaken in the day hospital) **Community Rehabilitation:** provides in home and ambulatory rehabilitation and aged care assessment & interventions to the frail and elderly with/without dementia as well as other adults with disabilities living at home in the St George Local Government Area (this includes Kogarah, Hurstville and Rockdale). Rehabilitation services include Driver Rehabilitation Service; Continence Advisory Service; **Residential Care Placement Service:** maintains lists of current RACF vacancies across both local areas **Aged Care Assessment Team** provides a comprehensive assessment of care needs to determine eligibility for permanent residential care, respite and /or Commonwealth funded programs such as Home Care packages or Transitional Aged Care. ACAT staff also provide referral to services for complex issues such as dementia care, suspected elder abuse, guardianship etc. **Ambulatory and Community Aged Care:** HACC nursing, continence, podiatry, dietitian, OT ; Transitional Aged Care Service ; Aged Care assessment Team (STG area only) ; Physiotherapy ; Neuropsychology; Speech Therapy, Holistic healing (all ages); Aged Care Specialists, including Psychogeriatrician services. **Mary Potter House:** is a 6 day respite centre for residents living within the St George area that have a diagnosis of a moderate to advanced dementia. Overnight respite is also available mid-week and at weekends (maximum 2 clients per overnight stay). **Outpatient Clinics:** Rehabilitation; Palliative care (at St George Hospital and Sutherland Hospital); Aged care; Chronic pain management; Motor neurone disease; Podiatry; Psychogeriatrics).
Cross System	**Discharge Planning:** comprehensive discharge planning to provide a safe and smooth transition from hospital to home, including detailed GP letter is available from Calvary Hospital.

Priority Actions

Sub-acute and Outpatient

- Identify new models of care and patient groups for inpatient services including:
    - Post oncology rehabilitation for non-terminal disease processes
    - Terminal management of patients with chronic disease
    - Aboriginal Specific programs in Mary Potter House and Rehabilitation
- Develop a pathway and memorandum of understanding for patients having active treatment for a terminal illness who are unable to manage their own care at home, to have access to inpatient services in the palliative care unit.
- Increase numbers of inpatients having respite and palliative rehabilitation.
- Develop and deliver a "Living Well/Wellbeing" Unit in an inpatient area – consider the concept of a mixed service unit.
- Identify local Residential Aged Care Facility clients who require specialist palliative care interventions (pain and symptom management) in an inpatient setting and provide long term follow up for these patients after discharge.
- Identify opportunities to expand ambulatory care facilities to allow an increase in the number of in-reach patients, so that outreach services can target housebound patients. This will reduce waiting lists for home based community services. There are currently long waiting lists (2-3 months) for some community services. Ensure a community bus is available to transport patients to the expanded service.
- Identify potential funding opportunities for the re-establishment of a weekly multidisciplinary (doctor, neuropsychologist, and nurse) Cognition Clinic to service 4-6 patients per clinic.
- Establish one central referral intake centre for all services.
- Identify and pursue opportunities to access ComPacks services for clients.
- Develop a business case for a larger ambulatory care centre to provide more day hospital and outpatient services, with expanded community transport resources, to reduce increasing wait lists for day rehabilitation
- Develop and implement relationships with other Sydney Local Health District's providing services to patients with Motor Neurone Disease and expand this to include other neurodegenerative disorders. Work with ACI Palliative Care Network to identify opportunities to lobby for funding and a more streamlined State-wide Service for this group of patients.
- Identify and pursue opportunities to provide on-site Radiology services to decrease the need for patients to travel to St George Hospital or private facilities for these services.

Cross System

- Strengthen relationships with War Memorial, Prince of Wales, Sutherland and St George Hospitals to optimise opportunities and improve older patient care integration across the District and increase the integration of aged and palliative care services including working with the Geriatric Flying Squads in residential aged care facilities.
- Develop an improved communication plan for General Practitioners and Practices.
- Develop marketing tools and strategies to ensure all current and potential stakeholders are aware of the full range of services at Calvary Health Care Kogarah
- Develop improved communication with Primary Health Networks to develop clear pathways for GPs to services at Calvary Health Care Kogarah.

The Garrawarra Centre

The Garrawarra Centre is a 120 bed public dementia specific residential aged care facility for those aged 65 years or older. High level care is provided for people with a primary diagnosis of dementia who exhibit challenging behaviours and require a safe and secure environment. Garrawarra's aim is to provide security, while maintaining privacy, dignity and some freedom for the residents. Residents are on either a permanent or respite basis. The multidisciplinary care team specialise in the safety, management and care of people in the end stages of this disease and work closely with the residents' families and friends to ensure the highest possible quality of life. There are comprehensive physiotherapy, exercise physiology and diversional therapy programs including group and individual activities suited to residents with dementia.

In response to initiatives identified in the Health Care Services Plan 2012-15, a permanent part-time geriatrician service has been established at the Garrawarra Centre to provided specialist on-site care for residents. Local GPs also provide a regular service to the Centre.

Average occupancy of the Garrawarra Centre is 98.3% with an average of 51 new residents accepted to the facility each year. The average length of stay is 834 days (2.3 years).

Residents are referred from hospitals (70% of referrals), Social Workers, Community Health ACAT Teams and other Aged Care Facilities. Priority is given to SESLHD residents. Average occupancy of the centre is 98.3% with an average of 51 new residents accepted to the facility each year. The average length of stay is 834 days (2.3 years) which includes those with very long stays.

The Garrawarra Centre has close ties with the University of Wollongong as a partner in dementia research, and as a student placement for nursing, exercise physiology and diversional therapy.

Priority Actions

- Develop and market a sound business case for the construction of a separate purpose designed residence for younger onset dementia patients with challenging behaviours, who cannot be safely co-located with frail, elderly residents; with appropriately qualified staff and diversional therapy activities in place.
- Develop the Garrawarra Centre as a teaching Nursing Home for the District.
- Continue to be an effective partner in dementia care research.

Key Areas of Focus

An Integrated Aged Care System

Ageing and chronic illness are drivers of care integration. Integrated care is defined as producing a *"coherent set of methods and models on the …… administrative, organisational, service delivery and/or clinical and service levels... [to] create connectivity, alignment and collaboration"*[16] between care providers, with the aim of improving patient outcomes. Not an end in itself, integrated care is a means of optimising system performance and improving patient outcomes.[10] Increasing the integration of aged care services has the potential to increase access to care; streamline existing care; promote more efficient use of existing resources; and improve the patient experience without increasing total service costs.[17] From a recent investigation of seven international studies, the Kings Fund identified a number of key implementation lessons to support clinical/service integration for older people:[18]

> "Integrated care depends on a tailor-made combination of structures, processes and techniques to address unique patient needs and system-institutional-community circumstances. To use a medical analogy, integrated care is more a precise surgical procedure than a broad-spectrum antibiotic. There are no 'one size fits all' or 'magic bullet' approaches to integrating health systems or services"[16]

- Professionals need to work together in multidisciplinary teams (with clearly defined roles) or provider networks – generalists and specialists, in health and social care.
- Important service-level design elements of care for older people with chronic and multiple conditions include holistic care assessments, care planning, a single point of entry, and care co-ordination and/or case management.
- Success is more likely where there is a specific focus on working with individuals and informal carers to support understanding and self-management.
- Personal contact with a named care coordinator and/or case manager is more effective than remote monitoring or telephone-based support.

The Kings fund found that a distinguishing feature across all the studies was the presence of a named care coordinator or case manager who had responsibility for supporting patients (and usually informal carers/family members). These staff coordinated not only aspects of medical care but also social care services such as home care and supportive housing and updated providers on changes in the individual patient's status and treatment. They were also in direct contact with clients to ensure that they attended appointments, understood and adhered to their medications, and had access to the appropriate services. Each coordinator/case worker had a defined caseload of patients, the size of which varied depending on the intensity and complexity of patients' needs and the admission/discharge criteria for the program.

> "Integration efforts can focus on entire communities or enrolled populations irrespective of health status; vulnerable client sub-groups (e.g. the frail elderly, persons with disabilities etc.); or patients with complex illnesses (e.g. chronic conditions; some cancers etc.). Vulnerable and complex patients benefit the most from integrated care"[16]

[16] Kodner, D. All Together Now: A Conceptual Exploration of Integrated Care Healthcare Quarterly, 13(Sp) Oct 2009: 6-15.
[17] Reed J, Cook G, Childs S, McCormack B. A literature review to explore integrated care for older people. International Journal of Integrated Care [Serial online] 2005 Jan 14;5.
[18] Nick Goodwin, Anna Dixon, Geoff Anderson, et al. (2014). Providing integrated care for older people with complex needs - Lessons from seven international case studies. Kings Fund.

Connecting Care Chronic Disease Management Program

The Connecting Care Program supports people with chronic disease *(Diabetes, Congestive Heart Failure, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease and Hypertension)* who are at high to very high risk of hospitalisation and who may benefit from care coordination and self-management support. It specifically focuses on enabling the primary health care sector to provide continuity of care by facilitating linkages with and referrals to community health and specialist medical services including rehabilitation programs, Aboriginal chronic disease programs, palliative care, aged care and disability services including falls prevention programs, and mental health and drug and alcohol services.

The prevalence of chronic disease is strongly correlated with age and is a significant factor in older people's utilisation of health services. The large majority of people in the Connecting Care Program are over 65 years of age and have multiple morbidities and complex health and care needs. The program has been very successful in reducing hospital admissions and length of hospital stays in program recipients. In 2013/14 over 2,440 patients aged 65 years and older were provided services from the Connecting Care Program including care navigation, care coordination, health coaching and referrals to specialist chronic care teams, ACAT other services.

Connecting Care Program (very high risk patient group)	**2012/2013**	**2013/2014**
Identified for Connecting Care Program	**1041**	**637**
Admissions 90 days before referral to program	751	492
Admissions 90 days after referral to program	290	145
Bed days 90 days before referral to program	3781	2364
Bed days 90 days after referral to program	1785	852
ALOS before admission	3.65	3.6
ALOS after admission	1.74	1.2

Priority Actions

- Identify opportunities to provide case management services to a greater number of older persons assessed to be at high risk of entering/re-entering the hospital system, to improve outcomes and reduce the severity of illness and avoidable hospitalisations.
- Work with partner organisations and groups to establish and routinely adopt health and social system service pathways for older persons discharged from South East Sydney Local Health District facilities.
- Establish agreed integrated models of acute and sub-acute management of complex dependent aged care patients in relevant District facilities.

Advance Care Planning

Advance care planning provides the opportunity for people to plan ahead for health care related decisions if they do not have capacity to make those decisions for themselves. This process has benefits for the individuals and families, clinicians and the broader health service system, including ensuring patient's wishes are known and respected, assisting clinicians to provide person-centred care and optimising the use of health resources. It has been shown that there is increased use of Emergency Departments and inpatient services in the last year of life by people whose deaths are clinically expected.[19] A 2011 Australian study identified that around 50% of people who die in hospitals do so from conditions where a palliative approach is warranted.[29] The widespread use of advance care and end of life planning are yet to be realised across health care providers in community and District services. Acknowledgement of the need for end of life and advance care planning among community members is also wanting. A recent Australian investigation found that "because most people do not speak up about the way they would like to die, they often experience a disconnected, confusing and distressing array of services, interventions and relationships with health professionals".[20] Several agencies have a focus on normalising advance care and end of life planning. A model for end of life care has been developed by the NSW Agency for Clinical Innovation, which supports clinicians to deliver care in the last year of life.[21] The NSW Clinical Excellence Commission has developed tools and guidelines for death audits in hospitals so that health professionals have better information to assess quality of end of life care and ensure appropriate services are delivered.[22] A training package is also available to provide special skills to assist Health Professionals in having end of life conversations. Similarly, the Royal Australian College of General Practitioners supports the incorporation of advance care planning into routine general practice and provides information, tools and support to this sector.[23] For community members, a public website has been established by the NSW Government to support end of life decisions.[24]

The AMBER Care Bundle

An approach for clinicians to follow when they are uncertain whether a patient may recover and are concerned that he or she may only have a few months left to live. It encourages clinicians, patients and families to continue with treatment, if they wish, in the hope of a recovery, while talking openly about preferences and wishes and putting plans in place. The Clinical Excellence Commission is piloting the project in nine facilities across NSW, including St George and Sutherland Hospitals, with a view to full implementation.

Advance Care Planning Initiative

Prince of Wales Hospital provides a nurse consultancy service to local residents (45years and over) wishing to consider their own advance care planning needs. The service is delivered via individual or group based interventions. The nurse also assists families of those individuals who require support with decision-making to develop a Plan of Care. The Plan of Care identifies the decision-maker, levels of treatment and feeding as well as request for or refusal of cardio pulmonary resuscitation. This plan then guides treatment aims in the event of deterioration. Support services available to the person (often in residential care) can also be detailed. The service also provides training and support to health professionals seeking to improve their advance care planning knowledge and scope of practice.

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[19] Johnson, Claire E. and Mitchell, Geoffrey K. (2011) Hospital and emergency department use in the last year of life: A baseline for future modifications to end-of-life care. *Medical Journal of Australia*, *195* 5: 267-267.

20 Swerissen, H and Duckett, S., 2014, Dying Well. Grattan Institute

[21] ACI. Framework for the Statewide Model for Palliative and End of Life Care Service Provision. May 2013. www.aci.health.nsw.gov.au/__data/assets/pdf_file/0019/184600/ACI-Framework-for-Statewide-Model-of-PEoLC-Service-Provision.pdf

[22] http://www.cec.health.nsw.gov.au/__documents/programs/qsa/qsa-reports/cec-care-for-the-dying-may-2013.pdf

[23] Advance Care Planning http://www.racgp.org.au/your-practice/business/tools/support/acp/

[24] Getting it in Black and White http://www.planningaheadtools.com.au/

Priority Actions

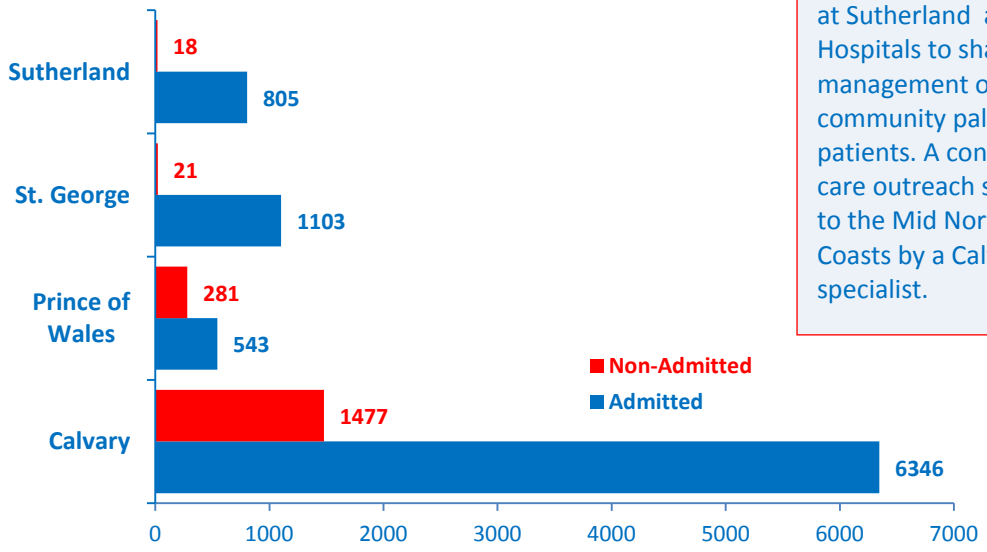
- Normalise advance care planning across the District by establishing support systems and approaches to ensure all aged care patients who could benefit from the process do so.
- Work across systems and services to systematise admission, clinical review and discharge procedures to ensure advance care plans are identified, used in clinical decision making, and transferred between care settings.
- Urge routine advance care planning in general practice and aged care outpatient clinics, and for residents of aged care settings.
- Widely promote and routinely adopt end of life/advance care planning tools that support staff to effectively undertake advance care planning with patients. Provide training to support staff to talk to patients sensitively about end of life/advance care planning.
- Ensure that information in advance care plans are incorporated in all electronic health records.
- Monitor progress in implementing Advance Care Planning across the District.

Palliative Care

The objective of palliative care is to improve the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, and spiritual and psychosocial support. The demand for palliative care services across the District is expected to increase over time due to the continued growth and ageing of the population, as well as improved referral rates to palliative care services. Collectively across Sutherland, St George, Prince of Wales and Calvary Hospitals there were almost 9,000 palliative care specific inpatient overnight bed days in 2012/13. There were also almost 1,800 non-admitted specific palliative care occasions of service during the same period.

Calvary Palliative Care Service
This service is a comprehensive Level 3 specialist service comprising 39 inpatient beds (includes a day hospital with one bed and two chairs), a multidisciplinary Community Palliative Care Team, a Bereavement Counselling Service, Pastoral Care Services, a large volunteer service, and the Palliative Care Academic Research and Palliative Care Clinical Trials Units. The Community Palliative Care Team have formally established shared care models with community nursing services at Sutherland and St George Hospitals to share the management of appropriate community palliative care patients. A consultative palliative care outreach service is provided to the Mid North and South Coasts by a Calvary palliative care specialist.

Palliative Care Bed Days, SESLHD Facilities, 65 years+, 2012/13



Source: SPaRC Report C3001: Palliative Care Inpatient Bed Days and Non-admitted Bed Day Equivalents. Accessed July, 2014

Palliative Care Utilisation

Of the 13,000 people in NSW who die of cancer each year, about two-thirds receive specialist palliative care. A similar number of people die of other conditions where death is predictable. Only about 10 % of these people receive specialist palliative care in their last year of life. *Source: NSW Ministry of Health. The NSW Government plan to increase access to palliative care 2012-2016.*

The National Palliative Care Strategy guides Australian and State/Territory governments in evidence based palliative care initiatives and services.[25] The Strategy has four key areas, including awareness and understanding of the importance of timely and appropriate access to palliative care services; effective palliative care that is available to all in need; collaborative, effective governance of palliative care strategies and resources; build and enhance capacity to provide quality palliative care.

The NSW Ministry of Health has recently developed a plan to increase access to palliative care across NSW.[26] This plan indicates that palliative care education will be included as part of general medical, nursing and allied health education and training. It also states that local health district's will be encouraged to participate in the national *Program of Experience in the Palliative Approach*[27] which provides opportunities for health professionals to enhance their knowledge and skills with input from experienced specialist staff. Health Districts will also be encouraged to support enrolment of palliative care services in the National Standards Assessment Program.

CareSearch is an online resource designed to provide reliable information and resources about palliative care. The website has been funded by the Australian Government and includes sections designed specifically for health professionals and patients, carers, family and friends. All material in the website has been checked for quality by Australian health professionals. www.caresearch.com.au

Priority Actions

- Support the further development and implement local integrated/coordinated/flexible models of palliative care service provision across the region.
- Adopt and adapt evidence based resources, templates, approaches and pathways that include user friendly referral triggers to specialist palliative care services in the South East Sydney region to increase access and appropriate use of these services.
- Support an increased understanding of available resources and the benefits of timely, appropriate access to palliative care services and end of life planning across District aged care services.
- Increase the involvement of people living with a life-limiting condition and their families/carers to inform improvements in District palliative care services.
- Identify funding opportunities to increase allied health support within the Calvary palliative care service (e.g. speech pathologist and dietitian) to fully meet the needs of palliative care patients.
- Support relevant aged care services staff to participate in the national *Program of Experience in the Palliative Approach* which provides opportunities for health professionals to enhance knowledge and skills via experienced specialist staff.
- Promote sharing of best practice between palliative care service providers across the District.
- Continue to support an ongoing quality improvement approach in palliative care services with a view to encouraging self-assessments using the national standards assessment program and meeting agreed national palliative care service standards.
- Provide home based support for carers to support people to die at home.

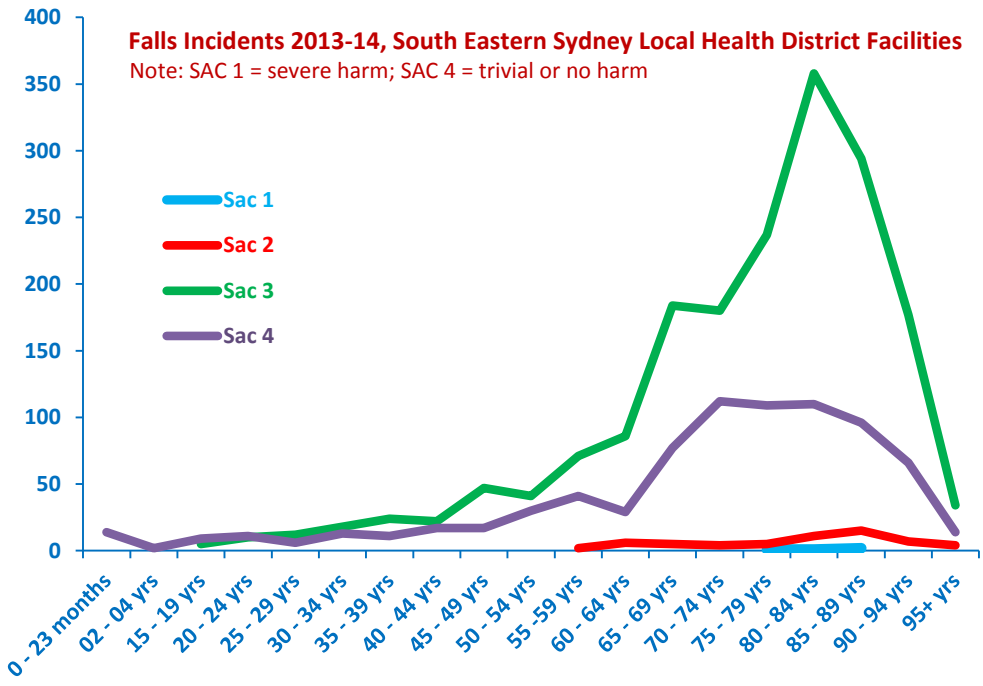
[25] National Palliative Care Strategy 2010 www.health.gov.au/internet/main/publishing.nsf/Content/palliativecare-strategy.htm

[26] NSW Ministry of Health. The NSW Government plan to increase access to palliative care 2012-2016. www.health.nsw.gov.au/palliativecare/Publications/Palliative-Care-Plan-2012-2016.pdf

[27] PEPA - Program of Experience in the Palliative Approach www.pepaeducation.com/

Falls Prevention

Falls are the leading cause of injury in older people in South East Sydney. It has been estimated that around one-third of all individuals 65 years and over, and half of those aged 80 years and over, experience one or more falls each year.[28] The Health District is committed to falls prevention and the reduction of harm from falls across the District. Although most falls occur in the community, an appropriate clinical focus on falls prevention in the hospital setting and after discharge is also important, particularly in the care of elderly patients. The District's Falls Injury Prevention Plan 2013-2018[29] has been developed to address this priority issue for our ageing population, focusing on both hospital and community settings. It highlights priority action areas and outlines key strategies and interventions for the prevention of falls and harm from falls.



The Prince of Wales Community Health Services Falls Risk Assessment and Management Program

The Prince of Wales Community Health Services has developed and routinely implements a comprehensive falls risk assessment and management program which is guided by current best practice guidelines for community care.[30] The program guides clinicians in the identification of falls risk and the actions required to reduce risks. It encompasses:

- The establishment and ongoing program oversight from the Prince of Wales Community Health Services Falls Risk Management Strategy Working Party.
- Falls risk factors assessment for all clients over the age of 65 years or for younger clients who have falls risk factors. The falls risk assessment identifies a range of factors to support a falls risk rating for each client, including: falls in last year, cognition and medical conditions, mobility and physical activity issues, medications, vision, among other factors including environmental.
- A subsequent personalised falls action plan is then developed with the client.
- A detailed letter highlighting the findings of the falls risk assessment is provided to the patient's General Practitioner (see template below).
- All new clinical staff are provided orientation and initial training in the falls risk assessment and development of the personalised action plan.

[28] Mitchell RJ, Close J, Cameron ID, Lord S. Fall-related sub-acute and non-acute care and hospitalised rehabilitation episodes of care: what is the injury burden? Aust Health Rev. 2013 Jun;37(3):348-55.
[29] SESLHD Falls Injury Prevention Plan http://www.seslhd.health.nsw.gov.au/HealthPlans
[30] The Australian Commission on Safety and Quality in Health Care, *Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Community Care*, 2009.

- All clinical staff receives annual mandatory education update in falls risk assessment and personalised action plan development.
- A bi-annual file audit of compliance with falls risk assessment, action and communication with the client's GP is undertaken.

GP LETTER from **Community Health Services, Prince of Wales Hospital**

Dear Dr (Name) …….. Re: Client name …….

The above patient was referred to Prince of Wales Community Health Services by referrer name, for__

Our treatment / management plan is _____

Falls risk factors are assessed as part of a standard comprehensive assessment. Issues identified:

- Multiple falls with no clear cause
- Dizziness of unknown cause
- Osteoporosis & has a history of falls or has a high risk of falls, but is not taking indicated medications
- Recent incontinence or not managing long-term incontinence
- Recent deterioration in vision
- Pain with foot / ankle problems; decreased lower limb sensation
- May have cognitive impairment as MMSE /RUDAS score was score/30 on date
- Symptoms of possible acute condition _____
- Symptoms of low mood, loss of interest in usual activities for > 2 weeks
- Medicines are disorganised. Please consider referral for a Home Medicines Review.
- Taking one or more psychotropic medicine. Please consider referral for a Home Medicines Review.
- Recurrent falls and: taking 4 or more regular medicines; or warfarin. Please consider referral for a Home Medicines Review.

It would be greatly appreciated if you could discuss these issues with your patient on their next visit.

Relevant clinics at the Randwick Hospitals campus:

- Falls Clinic Tel: 9382 0400 Fax: 9382 0422
- Dizziness & Balance Clinic Tel: 9382 2414 Fax: 9382 2428
- Memory Clinic Tel: 9382 3753 Fax: 9382 3762
- Cognitive Disorders Clinic Tel: 9382 4252 Fax: 9382 4241
- Continence Clinic Tel: 9369 0400

Priority Actions

Support the effective implementation of the District's Falls Injury Prevention Plan 2013-18 through:

- Close monitoring of falls risk patients across District facilities and services, with the aim to fully deliver on the requirements of Standard 10[31] and the District's Falls Injury Prevention Plan.
- A comprehensive approach to falls identification and management with each patient 65 years or older including formally assessing and documenting individual falls risk, working with the patient to document a falls prevention action plan and supporting primary care providers to understand and deliver appropriate follow-up, monitoring and/or management.
- Increase the routine identification and management of many of the risk factors for falls (e.g. Environmental factors such as trip hazards, inadequate lighting etc.).
- Identify, and widely promote across services, and refer eligible older people as appropriate to falls prevention programs in the South East Sydney community such as the KINCARE Strength and Balance Training for elderly people project and the Stepping-On Program.

[31] Australian Safety and Quality Commission Health Care Standards 2010

- Continue working with Primary Health Care Organisations to ensure District wide systematic approaches to secondary fracture prevention via the identification, assessment and management of older people who have sustained a minimal osteoporotic trauma fracture.

Psychological Wellbeing

Dementia and Delirium

Dementia becomes increasingly common with age and primarily affects older people. In the absence of effective prevention or cure options, the Australian Institute of Health and Welfare (AIHW) projects that between 2010 and 2050, the number of people with dementia will treble.[32] The increasing number with dementia will pose numerous challenges to our health and aged care systems. Around fifty three percent (53%) of permanent residents in residential aged care facilities have dementia.[38] People with dementia are important users of hospital services, largely because dementia commonly affects older people who are more likely to have other chronic conditions. Common reasons for hospitalisation of people with dementia include hip fractures and other injuries, lower respiratory tract infections, urinary tract infections and delirium.[33] In addition, they can face numerous hazards during their stay in hospital and often experience adverse outcomes, including physical and cognitive functional decline, under-nutrition, skin tears and fall-related injuries.[34] The AIHW reports that, in 2009–10, dementia was a diagnosis for 1 in every 100 acute hospitalisations and was the principal diagnosis for 1 in every 1,000.[38] This rate is considerably higher for those aged 65 years or older.

Age specific dementia rates, by age and sex, 2011 [18]

	Summary age-specific rates[(a)] (per 100 population)		
Age	**Males**	**Females**	**Persons**
Under 65	0.1	0.1	0.1
65–74	3.1	3.4	3.2
75–84	8.8	10.4	9.7
85+	24.4	32.3	29.5
Total: 65+	**7.1**	**10.3**	**8.8**
Total	**1.0**	**1.6**	**1.3**

Hospitalisations with dementia as the principal diagnosis consume considerably more patient days than average with average length of stay with a principal diagnosis of dementia around 18 days, 6 times higher than the average length of stay of 3 days for all hospitalisations.[38] A separate AIHW investigation looking at dementia care in hospitals identified that almost half (47%) of episodes for people with dementia do not have dementia recorded as a diagnosis and those with dementia have higher associated costs of care. Research suggests delirium (an acute disturbance of attention and cognition) affects up to 56% of older people admitted to hospital.[35] It is most common in people with dementia, though it can affect any older person in hospital.[36] Delirium can be predictive of physical, functional and cognitive decline, leading to a decline in independence and a need for a higher level of care. It is important that delirium is recognised and appropriately managed early.[41] Managing delirium in an acute care setting requires prompt identification and treatment of underlying precipitating conditions such as pain, infection, sensory impairment, existing cognitive impairment, poor hydration/nutritional status, constipation, among other factors.[41]

32 Australian Institute of Health and Welfare 2012. Dementia in Australia. Cat. no. AGE 70. Canberra
33 Draper B, Karmel R, Gibson D, Peut A & Anderson P 2011. The Hospital Dementia Services Project: age differences in hospital stay for older people with and without dementia. International Psychogeriatrics 23:1649–58.
34 Australian Institute of Health and Welfare 2013. Dementia care in hospitals: costs and strategies. Cat. no. AGE 72.
35 Delirium in older people. Commonwealth of Australia 2006.
36 Agency for Clinical Innovation. Dementia and Delirium in Hospitals http://www.aci.health.nsw.gov.au/chops

The NSW Dementia Services Framework 2010-2015[37] has been developed for health, community and residential services to assist with planning and development of dementia services and programs. It provides recommendations along the service pathway of dementia care from awareness through diagnosis, assessment, community, hospital and residential care. Recommendations are practical and aim to improve access, diagnosis and continued care. It can be used as a checklist for reviewing the way services are currently provided and can encourage reflection on how services could be delivered differently to improve outcomes for people with dementia, carers and families.

The Confused Hospitalised Older Persons Study

The Agency for Clinical Innovation is leading the ***Confused Hospitalised Older Persons Study*** to improve the experiences and outcomes of confused older people in hospital. The study encompasses six key areas to help staff better manage confused older patients including: understanding cognitive assessment; risk and prevention; identification and management; transfer of care environment; carers and families. The POWH Departments of Geriatrics and Surgery/Peri-op are currently collaborating on a Confused Hospitalised Older Person project.

Currently the District has one Dementia/Delirium CNC providing broad oversight and supporting Aged Care CNCs at each site to develop capacity to on-train staff in the identification and management of delirium. The Prince of Wales Community Health Service (Randwick-Botany Aged Care Community Health Assessment and Therapy team) provides a Dementia Nursing Assessment Service offering a dementia monitoring service, case management of complex people in community, and advice to carers and family, including the services of a community based dementia CNC. A dedicated cognitive disorders clinic (which is supported by a CNC) is available on the Prince of Wales Hospital campus to assist people with dementia and their carers. St George and Sutherland Hospitals have geriatrician led clinics where dementia clients are referred.

Mental Health

Mental health problems in older people can be complex in their presentation and management, and require specialist clinical knowledge and skills to manage issues across a range of service settings. Specialist services include aged care psychiatrists, specialist psycho-geriatric nurses and allied health professionals such as psychologists and social workers with expertise in mental health problems affecting older people.

Older Person Mental Health

Differentiating mental disorders from 'normal' aging has been one of the more important achievements of recent decades in the field of geriatric health. Depression, Alzheimer's disease, harmful alcohol use, anxiety, late-life schizophrenia, and other conditions can often go unrecognised, untreated or misdiagnosed, with severely impairing and sometimes fatal outcomes. Better diagnosis of both mental and physical health conditions and greater awareness of mental illness symptoms among older people are priorities. *Pathways of recovery: preventing further episodes of mental illness (monograph). Older adults National Mental Health Promotion and Prevention Working Party, 2006*

The St George and Sutherland Older Persons' Mental Health Service is an integrated, comprehensive service providing care for people aged 65 years and over, and for younger adults with age-related mental health disorders. The service accesses acute inpatient beds at St George and Sutherland Mental Health Units for older persons' and provides sub-acute inpatient care as required. Specialist older person's consultation/liaison services are also available to other wards (e.g. geriatric medicine) at St George and Sutherland Hospitals. The St George and Sutherland Older Persons' Mental Health Service community teams provide collaborative shared care with general practitioners, consultation/liaison services to residential aged care facilities,

37 http://www.health.nsw.gov.au/policies/gl/2011/pdf/GL2011_004.pdf

and community-based care for older persons. It also offers focused education as required to hospital and community mental health teams, hospital and community aged care teams, and residential aged care staff.

The Prince of Wales Hospital Aged Care Psychiatry Service (Euroa Centre) specialises in the assessment, management (including rehabilitation) and care of people who are aged 65 years or older, who have an emotional or mental health disorder. The team assists elderly people to live in their own home for as long as possible and offers advice and support to other aged care facilities. Services are provided both in hospital and in the community. A Community Outreach Program is also available for Psychiatry for the Elderly (COPE). This service has an intake system and assists with discharges from hospital and, in most cases, cares for elderly consumers in their own homes.

The NSW Health Service Plan for Specialist Mental Health Services for Older People (SMHSOP) 2005–2015 guides the development of Specialist Mental Health Services for Older People. It outlines the relevant policy, planning and context, key mental health issues for older people, involvement with the broader service system and strategic priorities in older people's mental health. It also provides a service reporting, monitoring and evaluation framework. The NSW SMHSOP core competencies for beginning community clinicians - A Clinician Resource Booklet to Aid Implementation[38] provides the opportunity to undertake a coordinated approach to developing the knowledge, skills and attitudes desired of the beginning clinician working within SMHSOP.

Priority Actions

- Increase skills and knowledge available in dementia/delirium assessment and management through the provision of information and education to staff and carers across District services.
- Establish service specific (e.g. pre-op screening tool etc.) and a whole of hospital management strategy for patients with dementia/delirium to ensure effective management in all relevant patients, not just those admitted in aged care wards. Develop a mandatory nursing orientation dementia/delirium education program as part of this strategy.
- Establish professional alliances with the relevant staff of St Vincent's Hospital to ensure that any northern sector community members, who are routinely serviced by this facility for Dementia care, receive appropriate continuity of care post admission to the Prince of Wales Hospital.
- Further develop partnership arrangements between aged care and mental health services to ensure all older patients admitted to mental health services with a potential diagnosis of dementia are seen by specialist dementia staff.
- Assess future workforce need and develop a business case which supports the employment of another District Dementia CNC and other specialist dementia staff to further build the capacity of all clinical staff to better identify and manage dementia; provide adequate support to carers; and access to appropriate tools and updated strategies to care for people with dementia/delirium by all relevant District staff etc. ahead of expected increases in these conditions.
- Expand the number of facilities participating in the Agency for Clinical Innovation Confused Hospitalised Older Person Study.
- Increase the availability of staff trained to assess and manage dementia/delirium in residential aged care facilities, including local General Practitioners, through targeted education programs.
- Increase access to palliative care for people with advanced dementia, including access to specialist palliative care services as required.

[38] http://www.health.nsw.gov.au/resources/mhdao/smhsop_core_competencies_pdf.asp

- Work with internal and external services and organisations to develop and implement a regional integrated dementia plan, which includes agreed service coordination arrangements and enhancements to improve the early detection of dementia and the timely provision of support programs that allow affected people to live in the community for as long as possible.
- Ensure dedicated behaviour units are utilised in all three acute facilities.
- Identify opportunities and partnerships to support long term improvements in the community based management of increasing numbers of people living with younger onset dementia.
- Implement recommendations from the Delirium Quality Self-Assessment and Delirium Care Pathways across the District.
- Identify and embed effective access/referral mechanisms to multidisciplinary mental health care for older patients across the District.
- Develop targeted and indicated mental health promotion, prevention and early intervention initiatives for older people
- Identify barriers and establish protocols for effective ongoing collaboration between SMHSOP and other District aged care services.
- Further develop SMHSOP consultation/liaison and case management outreach capacity with the residential aged care sector, to support sustainable long-term care for this group.
- Ensure prevention, identification, early intervention on older adult's mental health issues, as well as information on available District services is readily available to community members, and primary care and other relevant community providers.
- Support better outcomes for older people with co-occurring mental and physical problems and complex needs, through integrated planning and protocols, common assessment frameworks and joint programs.

Consumers and Carers

The Australian National Safety and Quality Health Service Standards include a standard which requires and signifies the importance of ***Partnering with Consumers*** (Standard 2). Involving consumers and carers in health care is a fast growing field that embraces a range of areas, including (but not limited to):

- Patients and carers playing an active informed role in health care decision making (they are placed at the centre of health care).
- Patients and carers are provided and seek out informed health advice and information on disease prevention/screening and health care options, and associated costs and are empowered to take fair and reasonable responsibility for their own health.
- Health care providers and organisations incorporate the views, concerns and advice of patients and carers into organisational governance, strategy and everyday 'ways of working'.

Changing Context

In a context of rising levels of complex and chronic illness and a growing array of prevention and treatment interventions that require public acceptance and uptake, it is becoming increasingly recognised that a considerable proportion of health care can only be applied in, and emerge from, processes that are shaped by societal values, behaviours and settings. Health consumers are now recognised by many as being the inevitable key to both cost reduction and health improvement.

The effectiveness of aged care services in Australia relies heavily on informal carers (family members, friends etc.) who directly care for older people and play an important role in coordinating and facilitating

formal community care services. The availability of informal carers is expected to decline over the coming decades at the same time as the demand is expected to rise by as much as 160% between 2001 and 2031. In the absence of a significant change in circumstances, such a shortfall could undermine the sustainability of community and home care and increase the demand for acute and residential care. Recent reviews suggest that key areas of concern for informal carers of the aged include access to information about support services for those they care for and for themselves, access to respite and other care services and training and assistive technologies. It is important to note that a patient may have more than one carer and the primary carer may not always live with the patient. The ***NSW Carers Strategy 2014-19*** identifies needed reforms across areas such as carer health and wellbeing, and carer engagement. The NSW Clinical Excellence Commission is also committed to partnering with patients, family and carers as consumers of health care services to improve health care safety and quality.[39]

Priority Actions

- Work with the District Carer Program Manager to identify and implement strategies to ensure quality ongoing aged care staff engagement with carers and consumers.
- Provide carer/consumer support information across District aged care facilities and services, including the erection of carer/consumer information notice boards in prominent locations.
- Establish processes to more actively involve individual aged care patients (and carers) in their management and support them to integrate treatment into their daily lives to improve adherence and outcomes.
- Establish systems to ensure carers are identified on admission and discharge documentation and involved in discharge planning from admission.
- Identify and act on opportunities to improve older person carer respite throughout the District
- Increase patient and carer participation in the development/improvement of aged care services.
- Provide training for the aged care workforce in shared decision making with aged care patients and carers.

Older Aboriginals

There are currently over 2,300 older Aboriginal people (50 years and over) living in the South Eastern Sydney Local Health District[40] and this number is growing, as is the number of older Aboriginal people accessing District health services.

The aged care needs of older Aboriginal people differ from those of their non-Aboriginal counterparts. The most notable difference is that older Aboriginal people tend to use dementia and aged care services at a younger age than other Australians.[41] The prevalence of dementia in Aboriginal Australians has, on average, been found to be around 3 times higher than in the overall Australian population.[42]

Generally, older Aboriginal people face ongoing challenges finding services that are appropriate to their needs and circumstances, and often have problems accessing services where they exist. These problems

[39] http://www.cec.health.nsw.gov.au/programs/partnering-with-patients

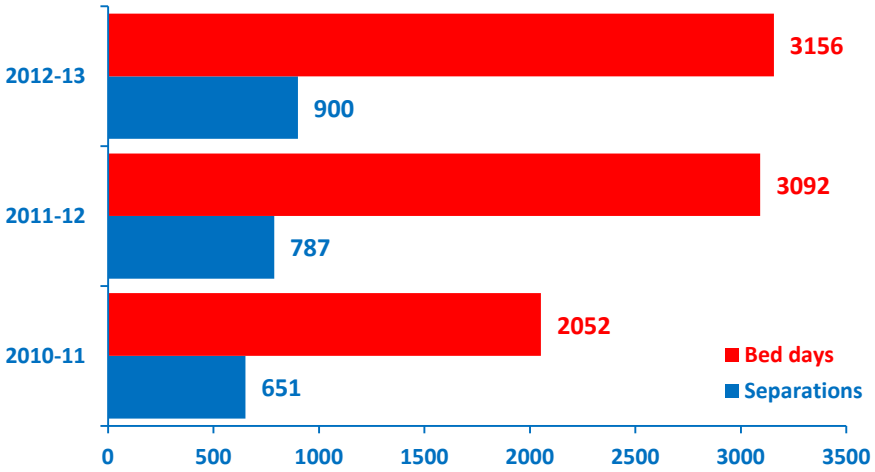
[40] Source: PHIDU Accessed 15 May, 2014

[41] Arkles RS, Jackson Pulver LR, Robertson H, Draper B, Chalkley S & Broe GA 2010. Ageing, cognition and dementia in Australian Aboriginal and Torres Strait Islander peoples: a life cycle approach. A review of the literature. Sydney: Neuroscience research Australia and Muru Marri Indigenous Health Unit, University of New South Wales.

[42] Koori Growing Old Well Study (KGOWS). www.neura.edu.au/aboriginal-ageing.

include transport to services, and staff and services capable of delivering care adapted to their language, culture and local circumstances.[40] At an organisational level, building genuine relationships with Aboriginal and Torres Strait Islander communities through respectful consultation is the cornerstone of developing appropriate, targeted and responsive services.[43]

Older Aboriginal People (50 years and over) Hospitalisations, SESLHD 2010-2013[44]



A 2011 Australian Institute of Health and Welfare report that around 16% of older Aboriginal people have a profound or severe core activity limitations and suggest that these limitations mean that they sometimes or always need help with self-care, mobility, or communication tasks.[45] Moreover, while few Aboriginal people identify themselves as 'carers', many have significant caring responsibilities. Similarly, a number of people may share the role of carer of an older person. The concept of 'primary carer' may not therefore be relevant.[42]

Priority Actions

- Work with the District's Aboriginal Health Unit to build genuine relationships with Aboriginal and Torres Strait Islander communities to identify needs and preferences in aged care service design and delivery/support.
- Take a leading role across NSW in the provision of appropriate quality aged care services for Aboriginal people including services that address health literacy and end of life preferences among older Aboriginal populations in our community.
- Work with the District's Aboriginal Health Unit to establish relevant policies and protocols to reduce delays in diagnosis of dementia among older Aboriginal people to ensure early medical and social interventions for those suffering dementia and their families
- Ensure cultural competence is reflected in the District aged care stream leadership and in the knowledge, values, skills and attributes of all aged care staff via a requirement for cultural competence training to increase the likelihood that aged care services are sensitive to the needs of Aboriginal and Torres Strait Islander people.

[43] Sharon Wall et al. Working with older Aboriginal and Torres Strait Islander people. Research to Practice Briefing 8. Benevolent Society
[44] Source: Flowinfo V 13.0 Excludes ED only and Collaborative Care.
[45] Australian Institute of Health and Welfare 2011. Older Aboriginal and Torres Strait Islander people. Canberra: AIHW.

Medicines Safety

Medicines are an essential component of clinical care for older patients, and around two-thirds of Australians over the age of 60 years use 4 or more medicines regularly.[46] In addition to this, it has been found that among the elderly with a chronic illness, as many as 41% use at least one non-medically prescribed complementary and alternative medicine.[47] It has been estimated that around 20% of unplanned hospital admissions in patients aged 75 years or older are most likely drug-related, while another 12% are possibly drug-related.[48] Unplanned readmission to hospital following discharge is also a major problem in the elderly, with 29 to 35% of unplanned readmissions medication related.[26] Recent Australian research has found that polypharmacy is common in older patients discharged from hospital (where many changes are often made to medications) to home-based care, and recommends efforts are made to encourage regular medication reviews and, where possible, rationalisation of medications.[49]

Quality Use of Medicines is a focus of the *National Medicines Policy and* involves selecting treatment options wisely and improving medicine use, including prescription, non-prescription and complementary medicines, by health professionals and consumers. It also ensures that patients and carers are afforded the knowledge and skills to use medicines safely and effectively. Quality Use of Medicines approaches provide an assurance of quality and safety with regard to:

- Medication history assessment
- Medication review and reconciliation
- Medication action plan
- Medicines information for patients
- Communicating medicines information to other health care professionals
- Continuity in medication management which occurs when all components of the medication management cycle relevant to the episode of care, are completed and information is transferred to the next care setting

Priority Actions

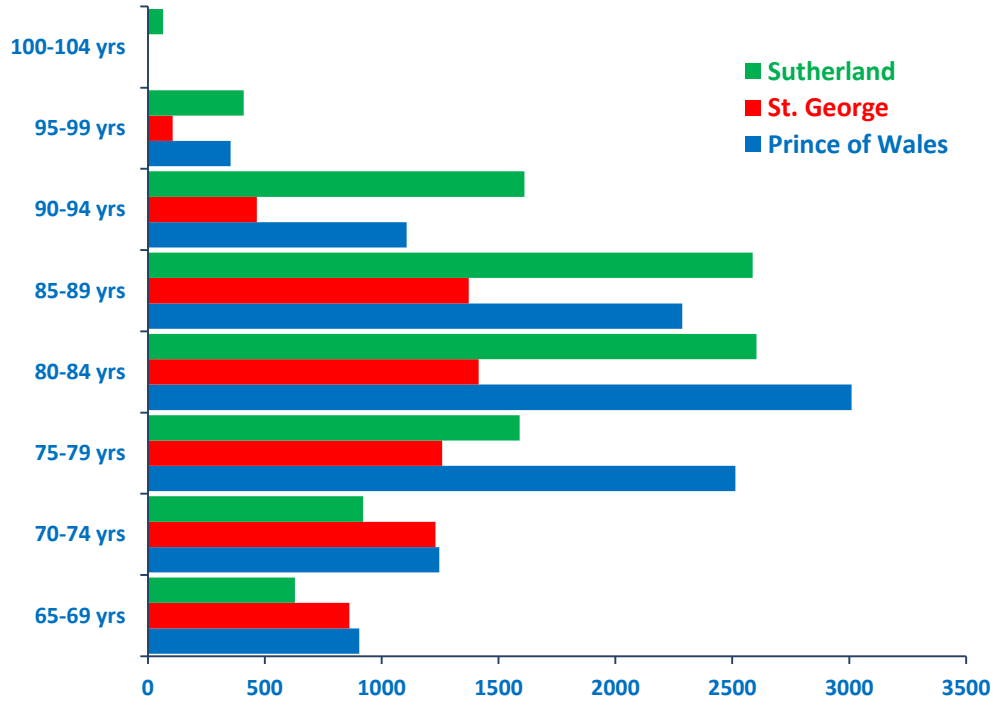
- Establish effective processes to ensure an accurate record is taken of all medications in use among elderly patients (incl. over the counter) and ensure it is readily available to all clinicians.
- Routinely assess patient capacity to safely managing their medications through the provision of hospital outreach medication management reviews (post discharge) and/or work with the primary care sector to undertake reviews.
- Undertake and/or work with the primary care sector to ensure regular medication management reviews in local residential aged care facilities.
- Establish mechanisms to ensure older patients and their carers acquire a full explanation about medications, potential side effects and dosage instructions prior to discharge. Support older patients to have an up-to-date written record/understanding of their medications.

[46] Elliott, R.A. Problems with Medication Use in the Elderly: An Australian Perspective. J. Pharmacy Practice & Research 36: 1, 2006
[47] MacLennan AH, Myers SP, Taylor AW. The continuing use of complementary and alternative medicine in South Australia: costs and beliefs in 2004. Med J Aust 2006; 184: 27-31.
[48] Chan M, Nicklason F, et. al. Adverse drug events as a cause of hospital admission in the elderly. Intern Med J 2001; 31: 199-205.
[49] Runganga M, Peel NM, Hubbard RE. (2014).Multiple medication use in older patients in post-acute transitional care: a prospective cohort study. Clinical Interventions in Aging, 9, 1453-1462

Rehabilitation

The primary focus of hospital based rehabilitation is to return the patient to their usual place of residence safely and enable independence in activities of daily living. The provision of rehabilitation services continues to grow in volume across South Eastern Sydney Local Health District. Rehabilitation is now among the top two inpatient diagnoses in those aged 65 years and older among our District's acute facilities. Collectively across Sutherland, St George and Prince of Wales Hospitals there were over 30,000 rehabilitation specific inpatient overnight bed days in 2012/13.[50] The casemix of patients requiring rehabilitation treatment is also increasing in terms of severity (acuity) and complexity. The NSW Agency for Clinical Innovation recently found the average length of stay for rehabilitation to be just over 18 days in public hospitals.[51] They also found that the majority of growth in rehabilitation volume in recent years has been in the reconditioning impairment group. The average age of patients in this group was found to be 79 years with a mean length of stay of 17.6 days.[40]

Rehabilitation Bed Days 65 years+, SESLHD Facilities, 2012/13



Source: FlowInfo V13 (excludes ED only and Collaborative Care episodes)

Access to rehabilitation is crucial for efficient hospital patient flow. Patient flow considerations include those from the acute care setting to the sub-acute care setting and flow from the sub-acute care setting into an ambulatory care setting, and ultimately the patient's residence. Problems in timely patient flow from acute to rehabilitation services have been found to be common and often due to discharge barriers in rehabilitation.[52] A recent Australian study identified that barriers to discharge from inpatient rehabilitation represent an important opportunity for improvement. [41] The researchers identified the need to resolve existing internal organisational discharge barriers and alert relevant decision makers of identified external barriers. They also recommend establishing and communicating the patient's estimated date of discharge

[50] FLOWINFO Version 13.0 has been used to analyse and collate admitted (inpatient) service utilisation.

[51] NSW Health. *Rehabilitation Redesign Project.* Final Report – Model of Care. Version 1.4 Issued 21/02/11

[52] Peter W New, Damien J Jolley, Peter A Cameron, et al. A prospective multicentre study of barriers to discharge from inpatient rehabilitation. Med J Aust 2013; 198 (2): 104-108.

and expected destination within a week of admission as one strategy that can potentially help prevent barriers arising from family negotiations.[41]

The ***NSW Rehabilitation Model of Care*** provides the basis for support the necessary change and implementing consistent approaches for rehabilitation services.[53] The Model supports services to:

- work with acute services to promote patient independence and an enablement model of care;
- integrate aged care and rehabilitation services to maximise independence and minimise ongoing health care needs of the ageing population;
- integrate assessment and care coordination of patients to create a better flow of patients across the continuum and between settings;
- provide ambulatory care services to potentially avoid hospitalisation for some impairments, enable transfer of care at an earlier date from sub-acute rehabilitation areas and facilitate an earlier discharge from hospital;
- provide ambulatory care services enabling a structured program and the continuation of care following a stay in the acute or sub-acute setting;
- establish hub and spoke models and work collaboratively with rural neighbouring hospitals to provide rehabilitation services facilitating ongoing goal attainment;
- utilise care coordinators or case managers to support the patient journey across the continuum and involve primary care and community services at an earlier stage of this journey; and
- integrating research and educational and quality activities to improve efficiencies of introducing new evidence based care.

Similarly, the NSW Agency for Clinical Innovation ***Orthogeriatrics Model of Care*** provides a clear, practical guide to the care of frail older orthopaedic patients.[54]

Priority Actions

- Review existing and maintain a watching brief on new models of aged care rehabilitation for acute care facilities with a view to ensuring recommended models (that suit the local environment) are fully and effectively utilised.
- Further develop collaborative models that support improvements in aged care rehabilitation and reductions in preventable hospital presentations/admissions, such as the Orthogeriatric model.
- Investigate opportunities to establish/commission additional aged care rehabilitation day hospital, outpatient and community based services to ensure timely, appropriate aged care rehabilitation is available to all who need it in the future.
- Work with community partners to identify all available avenues for alternative rehabilitation care to reduce delays in discharging older people from hospital, particularly those who no longer require acute hospital care.
- Work with community partners to establish regular communications with the community about the availability of and pathways for accessing and navigating rehabilitation services which have a restorative and preventative focus to reduce the likelihood of falls and hospital presentations/admissions.

[53] NSW Health. *Rehabilitation Redesign Project.* Final Report – Model of Care. Version 1.4 Issued 21/02/11

[54] ACI Aged Care Network Orthogeriatric Group. The Orthogeriatric Model of Care Clinical Practice Guide 2010

Teaching

The changing nature of the aged care patient means that the South Eastern Sydney Local Health District's health workforce will need to have the breadth of skills that allows them to work effectively with aged patients that have multiple chronic illnesses and increasing levels of acuity. The District currently plays a critical role as an **Aged Care Learning Organisation** which includes:

- The provision of high quality health workforce training via clinical placement (including advanced trainees in Geriatric Medicine), professional development, work experience and a range of other development opportunities to ensure that aged care health professionals are able to practice to the full extent of their professional capabilities and develop their skills over their career.
- Offering the right mix of education and clinical practice to develop more effective approaches to aged care service provision that are tailored to the local environment.
- Creating opportunities for inter-professional learning across health workforce disciplines that are well suited to the provision of comprehensive multidisciplinary approaches to aged care.
- Clinical placement in aged care services that effectively prepare clinicians to work with older people in all services and areas of care across the district.

Teaching Provision Summary by Facility

St George Hospital Aged Care Services

Undergraduate Training Supervision:

- Associate teaching hospital of UNSW (Medical, nursing, allied).
- Nursing and Allied Health Students from various other universities
- Over 100 medical students yearly

Postgraduate Training Supervision:

- 16 Junior Medical Officers yearly
- 12 Basic Physician Training Medical Registrars yearly
- 6 Advanced Medical Trainees yearly

Garrawarra Centre

Clinical Education Placements for:

- University of Wollongong
- University of Wollongong College
- University of Technology Sydney
- TAFE NSW Sydney Institute
- University of Western Sydney
- Australian Catholic University
- Charles Sturt University
- University of New England

Interprofessional learning and practice

War Memorial Hospital

Undergraduate Training Supervision:

- Australian Catholic University and UTS Nursing students
- Enrolled Nurse Trainees
- Medical students from UNSW
- Nursing and Allied Health Students from various other universities

Postgraduate Training Supervision

- Experienced nursing graduates provided further training within the Transition Support Program.
- Other clinical experience and training supervision is available across all inpatient and outpatient services via affiliations with a range of other teaching institutions.

POW Hospital Aged Care Services

Undergraduate Training Supervision:

- Associate teaching hospital of UNSW (Medical, nursing, allied).
- Nursing and Allied Health Students from various other universities

Postgraduate Training Supervision:

- 30 Junior Medical Officers yearly
- 12 Basic Physician Training Medical Registrars yearly
- 6 Advanced Medical Trainees yearly

Sutherland Hospital Aged and Extended Care Services

Undergraduate Training Supervision:

Part of the St George and Sutherland Clinical School, UNSW

- Associate teaching hospital of UNSW (Medical, nursing, allied)
- Nursing and Allied Health Students from various universities

Postgraduate Training Supervision:

- Four Advanced Aged Care Registrar Trainees yearly

Calvary Health Care

- Associate teaching hospital of UNSW (Medical, nursing, allied)
- Other clinical experience and training supervision is available via affiliations with a range of other teaching institutions.

South Eastern Sydney Local Health District is an Aged Care Learning Organisation

Priority Actions

- Continue to build the District's aged care clinical teaching role, including providing highly structured placement models and strengthening the learning culture in aged care services.
- Continue to work with universities and other training providers to redesign training and mentoring programs to ensure health professionals have the knowledge and skills required to effectively meet the needs of older people into the future. An adaptable aged care workforce equipped with the requisite competencies and support to provide collaborative, integrated models of aged care service delivery is required.
- Increase opportunities for interprofessional learning and work practices, where different health professionals learn together to improve collaboration and quality of aged care.
- Increase engagement of health professionals working in aged care services, in workforce teaching initiatives including undertaking a professional development needs analysis.
- Further develop teaching leadership capacity to support and lead aged care workforce innovation and reform capacity.

Research

The South Eastern Sydney Local Health District boasts a large number of researchers and health professionals involved in the care and research of the elderly. District Aged care services have close research ties and affiliations with one or more external organisations and routinely supervise research students, for example:

- The Garrawarra Centre has close ties with the University of Wollongong as a partner in dementia research.
- Calvary Health Care has research ties with the University of NSW, Palliative Care NSW, a range of aged care facilities and others.
- Prince of Wales aged care services have research ties with the University of NSW, the Garvan Institute and Neuroscience Research Australia, the Black Dog Institute, the Cancer Institute NSW, the NSW Agency for Clinical Innovation, NSW Clinical Excellence Commission , Dementia Collaborative Research Centre, HammondCare and others.
- St George aged care services have research ties with the University of NSW, Neuroscience Research Australia, the Cancer Institute NSW, the NSW Agency for Clinical Innovation, Clinical Excellence Commission NSW, the Black Dog Institute and others.
- Sutherland aged and extended care services have research ties with the University of NSW, Macquarie University, Queensland University of Technology, Cancer Institute NSW, and the NSW Agency for Clinical Innovation, Clinical Excellence Commission NSW, a range of aged care facilities and others.

In addition to collaborative research arrangements, aged care services across the District also investigate the effectiveness of their services and the resultant outcomes. For example, Southcare is currently evaluating the effectiveness and outcomes of their Geriatric Flying Squad to support future advancements. Clinical staff working in District aged care services are encouraged, practically assisted and supported to undertake research degrees and Doctorates, work on research projects, and write for publication and present research and clinical findings.

Ageing Research Centre

The Prince of Wales Department of Geriatric Medicine has a strong research focus via an active Ageing Research Centre. The purpose of the centre is to research, develop and promote clinical and community understanding of neurodegenerative diseases associated with population ageing, and their impact on the delivery of health care, community services and residential care. The centre is a registered not-for-profit organisation with strong links to NeuRA and is an important part of the Mind Gardens vision.

Cunningham Centre for Palliative Care

The Cunningham Centre for Palliative Care was established in late 2007 to promote and enable excellence in palliative care research, education, clinical practice and quality care throughout NSW and beyond. The Centre represents a collaboration of Sacred Heart Hospice, UNSW, University of Notre Dame Australia and Calvary Health Care Sydney. The Centre has been involved in a wide range of palliative care research and education projects including clinical trials that seek to identify the impact of a number of different medications on symptom management; studies that explore the impact of videoconferencing and telemedicine interventions on education and clinical care in rural settings; and studies exploring the psychological impact of cancer and poor prognosis on patients/carers.

The Sydney Alliance for Healthcare, Research and Training

A number of the District aged care services work with the Sydney Alliance for Healthcare, Research and Training which combines with universities, hospitals and research centres, allowing opportunities for large, collaborative research to be carried out where appropriate. It also facilitates development of consistent, "best practices" across a State or region. Some of the many aspects of neuroscience explored by the alliance include degenerative brain diseases such as Parkinson's, Alzheimer's and other dementias; Balance and falls in the elderly and rehabilitation after stroke and spinal cord injury.

The Euroa Centre

The Euroa Centre is an Aged Care Psychiatry Unit specialising in the assessment, management and care of people aged 65 years or over who have a psychological disorder or mental illness. The Centre investigates areas which include:

- The effectiveness of treatments for mood disorders of late life including depression, suicide and bipolar disorder.
- The overlap between depression and dementia in late life.
- Prevalence and types of substance use in older patients.

Priority Actions

- Maintain and improve aged care research across the District by enhancing research productivity and further collaboration with external organisations and universities.
- Increase aged care research in the District's Southern Sector.
- Continue to be a key player in dementia care research.
- Undertake local research on effective approaches and deliver highly-functional integrated care to patients accessing District aged care services.
- Keep informed of new research findings and ensure their timely translation into quality local models of aged care service delivery and practice.
- Implement and evaluate the effectiveness of cross site integrated models of care in partnership with private rehabilitation units (e.g. via translational research).

Appendices

Appendix A: Plan Contributors

The SESLHD Aged Care Plan 2014 -2019 has been developed through a wide consultative process. The following list acknowledges the contributions of a large number of people who have given of their time and expertise to develop this Plan.

Director of Aged Care	Nursing Co-Directors
Aged Care and Rehabilitation Stream Advisory Group	CEO's private RACF's
Aged Care Stream Managers (past and present)	Managers Ambulatory &Primary Care Units/Services
Service Managers	Medicare Locals
Manager COAG Programs	Agency for Clinical Innovation
Nurse Unit Managers	Clinical Excellence Commission
Carers Program Manager	Health Consumers NSW
Connecting Care Program Manager	Palliative Care NSW
NSW Ministry of Health	Falls Program Coordinator

Appendix B: Aged Care Policies, Plans and Groups

National	SESLHD
• Living Longer Living Better, a 10 year plan from 2012 to reshape aged care. • The National Framework for Action on Dementia 2013-2017 • The National Palliative Care Policy • Commonwealth HACC Program • National Disability Strategy 2010-2020 • National service improvement framework for diabetes • National Safety and Quality Commission Standards	• Falls Injury Prevention Plan 2013-2018 • Cancer - Clinical Services Plan 2013-2018 • Surgical, Perioperative and Anesthetic Clinical Services Plan 2013-2018 • Mental Health Service Plan 2013-2018 • NSW Carers (Recognition) Act 2010 Implementation Plan 2014-15 • Implementation Plan for the NSW Refugee Health Plan 2011-16 • Multicultural Health Service Strategic Plan 2010-2012
State	**Professional and Community Based Groups**

• NSW 2021 (State Plan) • NSW Ageing Strategy • NSW Dementia Services Framework 2010–2015 • The NSW Refugee Health Plan 2011-2016 • NSW Service Plan for Specialist Mental Health Services for Older People 2005 – 2015 • NSW Health Prevention of Falls and Harm from Falls among Older People: 2011-2015 • Healthy Culturally Diverse Communities 2012-2016 • NSW Government Plan to increase access to palliative care 2012 - 2016 • Culturally & Linguistically Diverse Carer Framework: Strategies to Meet the Needs of Carers • NSW Carers Strategy 2014-2019 • NSW Carers (Recognition) Act 2010	• Australian and New Zealand Society for Geriatric Medicine • Australian Association of Gerontology • Alzheimer's Australia and Alzheimer's NSW • Parkinson's NSW • Aged and Community Services Australia Inc

Aboriginal Health Impact Statement

Introduction

This Aboriginal Health Impact Statement has been produced to accompany the South Eastern Sydney LHD Aged Care Services Plan 2015-2018.

This Impact Statement is based on the NSW Aboriginal Health Impact Statement and Guidelines and aims to document the health needs and interests of Aboriginal people have been imbedded into the development, implementation and evaluation of the Plan.

Declaration

Title of Initiative

The South Eastern Sydney LHD Aged Care Services Plan 2015-2018

☑ The health needs and interests of Aboriginal people have been considered and appropriately addressed in the development of this initiative.

☐ Appropriate engagement and collaboration with Aboriginal people has occurred in the development and implementation of this initiative

☐ Complete checklist is attached.

Name of Manager: Gail Daylight
Title: Manager
Unit Name: Aboriginal Health
Local Health District: South Eastern Sydney

Signature: Daylight Date: 7/11/14