



SESLHD Aged Care Clinical Services Plan 2019 - 2022



Executive Sponsors: Aged Care Stream Director and Stream Manager

Guided and written by: Strategy and Planning Unit, Directorate of Planning, Population Health and Equity

South Eastern Sydney Local Health District

Locked Mail Bag 21

TAREN POINT NSW 2229

Phone: (02) 9540 8181

Fax: (02) 9540 8164

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Contents

Foreword	3
Executive Summary	4
1. Introduction.....	5
2. Aged Health Demographics.....	6
2.1 Ageing Population	7
2.2 Drivers of demand	7
2.3 Recent Activity for people aged 70+ in SESLHD	9
2.4 Activity Projections.....	11
3. What we have achieved	13
4. Current SESLHD Aged Care Services.....	17
4.1 Prince of Wales Hospital and Community Health Services	18
4.2 St George Hospital and Community Health Services	23
4.3 The Sutherland Hospital and Community Health Services	27
4.4 The Sydney and Sydney Eye Hospital	32
4.5. War Memorial Hospital Waverley	34
4.6 Calvary Health Care Kogarah	37
4.7 The Garrawarra Centre	41
4.8 Aged Care Programs supported by Primary Integrated & Community Health.....	42
5. Looking ahead: Key Areas of Focus for the Future	44
5.1 Community Innovation and Integration	44
5.1.1 Working with Consumers and Carers and Family Members.....	45
5.1.2 Central and Eastern Sydney PHN (CESPHN).....	46
5.1.3 Integrating Care with Our Partners	46
5.2. Aged Care Wellbeing.....	47
5.2.1 Dementia and Delirium	47
5.2.2 Mental Health.....	49
5.2.3 Falls and Falls Injury Prevention.....	51
5.2.4 Frailty.....	53
5.2.5 Social Isolation and Loneliness.....	54
5.2.6 Older Aboriginals.....	54
5.2.7 Medicines Safety	56
5.3. Care of the Older Surgical Patient.....	57
5.4 Advance Care Planning	59
5.5 Research.....	60
5.6 Teaching and Education	61
5.7. Infrastructure	62
6. Next Steps- Implementation and Evaluation	63
Implementation Plan.....	64
7. Draft Aboriginal Health Impact Statement.....	71
References	77

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 increasing 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

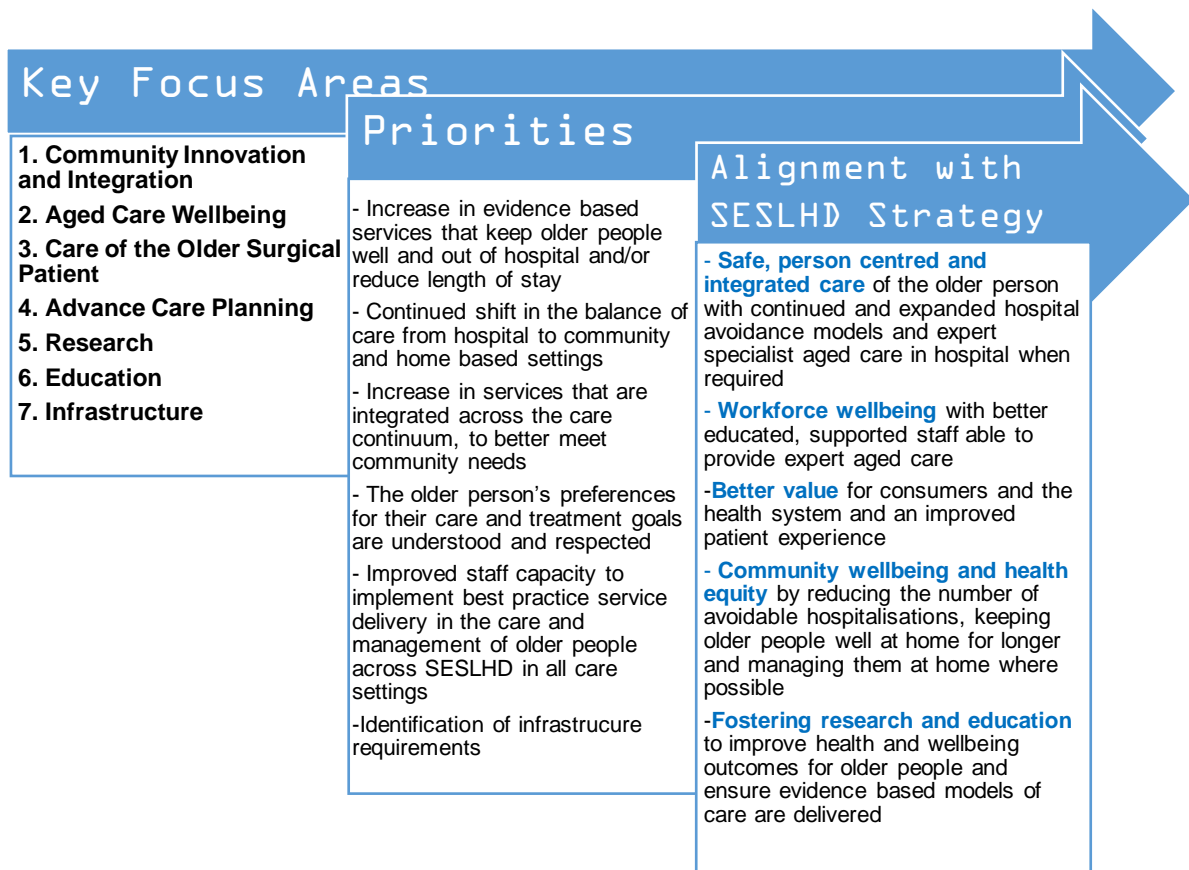
The Aged Care Services Plan 2019-22 is one of an important suite of South Eastern Sydney Local Health District (SESLHD) Clinical Stream plans, and builds upon the key priorities outlined in the Aged Care Services Plan 2015-2018. The Plan is consistent with NSW Health’s vision of delivering high quality services responsive to consumer and community needs.

The Plan also aligns with the SESLHD Journey to Excellence Strategy 2018-2021¹ and its 5 key strategic themes: safe, person-centred and integrated care; better value; community wellbeing and health equity; workforce wellbeing; and fostering research and innovation.

The Plan was developed in consultation with aged care clinicians, services and external stakeholders. The service needs identified in this Plan are based on this advice, international and national evidence, and aged care strategies, plans and policies at local, state and national levels. The Plan identifies new and emerging models of care, key strategic priorities for the development, delivery and improvement of aged care services across SESLHD, and the most effective use of available and future resources to best address our aged community’s needs.

A key focus of this Plan is to support community members to access the right services, at the right time, in the most appropriate setting. It also aims to reduce the burden and impact of chronic disease on the health system by shifting the balance of care towards more community/home based services that aim to keep older people well at home for as long as possible and avoid the need for hospital based services where possible. Our aged care services will work with other service providers across SESLHD and beyond to support a better understanding of the unique requirements of older people.

The following diagram provides a summary of the Plan’s key focus areas and future priorities.



1. Introduction

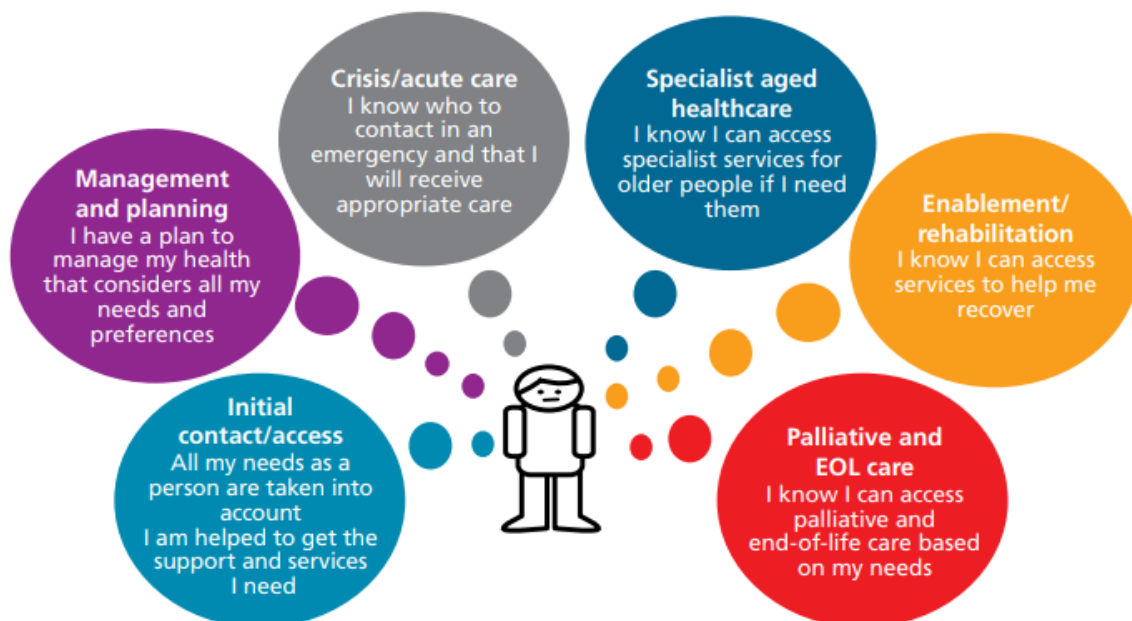
A significant and growing number of older people in SESLHD are living longer with complex health needs, including long term non communicable diseases, dementia, frailty and mental health issues. The complexity of multimorbidity in the aged population can potentially result in increased emergency presentations and admissions, longer lengths of stay and increased demand for community and home based services. This cohort of complex patients thus requires integrated management, coordinated planning and community support to:

- Avoid the need for admission where possible
- Ensure specialist aged inpatient care in a timely manner when needed
- Provide coordinated discharge support and ongoing management to prevent readmission.

Improving health outcomes and reducing healthcare costs for older people living with complex comorbidities requires a collaborative approach including:

- Care that is anticipatory and predictive in a non-admitted setting
- Early identification and risk stratification
- Coordinated and integrated care with primary care, community and social care services
- Self-management supported by general practice where possible, with urgent access to specialty services should a person's condition change
- Targeted interventions designed for older people.

The NSW ACI has outlined the components of an ideal older patient's patient health journey, as seen in the diagram below.

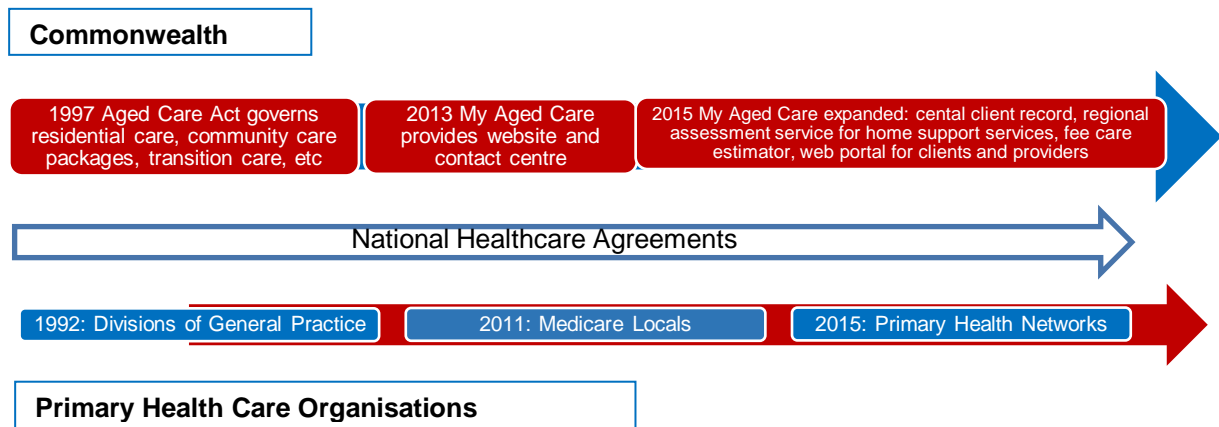


Source: NSW ACI Building Partnerships: A Framework for Integrating Care for Older People with Complex Health Needs²

SESLHD places significant importance on older community members having access to timely, high quality, evidence based, cost effective care, with an increasing shift in the balance of care to be home and community based. This Plan outlines the key focus areas and priority actions to achieve this.

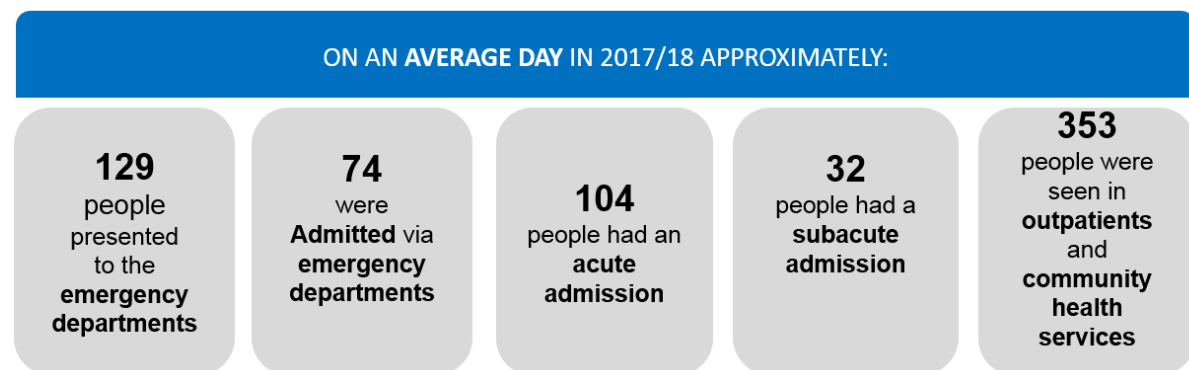
Context

Successive Australian Governments have introduced a variety of health and aged care reforms with further reforms signaled. The Government has recently announced the establishment of a Royal Commission into the aged care sector. The Royal Commission will primarily look at the quality of care provided in residential and home aged care to senior Australians, however the outcomes for SESLHD aged care services remains unknown. Keeping abreast of the wide array of national level reforms is becoming increasingly difficult. The following diagram illustrates a number of key national reforms over the past three decades.



2. Aged Health Demographics

For people aged 70 and over in SESLHD:



In terms of health burden, chronic diseases are the leading cause of ill health and death in Australia.³ In SESLHD by 2031 there may be over 140,000 people aged 70 years or older who will have multiple long-term or chronic health conditions, including diabetes, cardiovascular disease, chronic kidney disease, chronic obstructive pulmonary disease and cancer. It is estimated that 82% of residents aged over 85 have multimorbidities in SESLHD.⁴

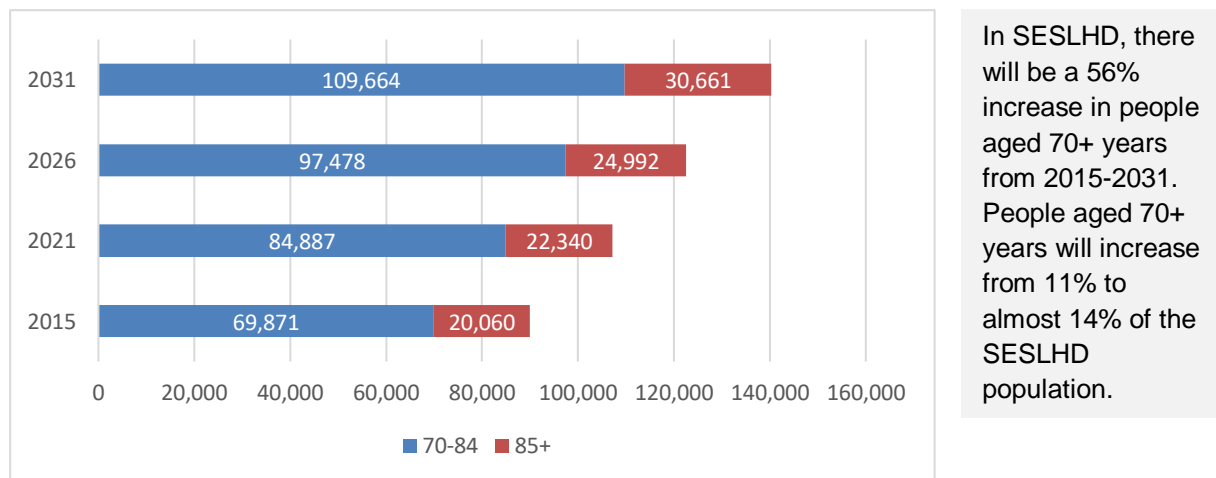
Older people represent a proportionally higher percentage of all hospital activity. Despite those aged 70 and older representing approximately 10% of our population, in 2016/17, 40% of patients cared for across all SESLHD hospitals were aged 70 years or older. Over 29% were in the 70 to 84 years age group and another 11% were aged 85 years and older, with increasing numbers of frail aged and/or having a diagnosis of dementia.

2.1 Ageing Population

The SESLHD supports a population of over 930,000 people. The estimated residential population is projected to increase to over 964,000 people by 2021 and reach over one million by 2031. The fastest growing age groups are projected to be the 70-84 age group and the 85 years and older age group. In SESLHD it is estimated that by 2021, those aged 70 and older will increase to over 107,000 (11% of the SESLHD population), and by 2031 this will reach over 140,000 people, or almost 14% of the SESLHD population. The 'older old' (aged 85 years and older) are expected to increase to over 30,000 people by 2031, an increase of almost 53% from 2015.ⁱ

Those aged 85 years or older tend to be the main users of both acute and subacute aged care services, and this demographic trend will drive a growing demand for health services.

Figure 1: Projected Population South Eastern Sydney Local Health District, 70 years+, 2011-2031



The population is also culturally and linguistically diverse, with Greece, China, Italy and Egypt being the top countries of birth for older SESLHD residents who were born outside of Australia. There is also a significant population of older residents in supported accommodation in SESLHD, with 10% of these residents aged 65 years and over.

2.2 Drivers of demand

The main drivers of demand for aged care services include:

- More people living longer with multi-morbidities and higher acuity illnesses requiring treatment for acute episodes of ill health
- More people staying at home for longer requiring ongoing care, with the resultant increased demand for community based models of care to avoid the need for Emergency Department (ED) presentation or admission and for post discharge follow up to prevent readmission
- Increasing numbers of people living with dementia in the community and in Residential Aged Care Facilities (RACFs) requiring stabilisation, including for violent behaviours
- Increasing numbers of people requiring management of delirium
- Increasing numbers of frail older people, who have poor functional reserve, so that even a relatively minor illness can present with sudden catastrophic functional decline – causing the person to fall, become immobile, acutely confused or to present non-specifically with failure to thrive or cope.⁵

ⁱ Source: NSW Health Projections Analytics Tool. Population Growth Rate by LGA, Population Projection by Age Group. Includes LGAs of Sutherland, Kogarah, Rockdale, Hurstville, Botany Bay, Randwick, Waverley, Woollahra and Sydney (inner and east). Accessed September 05, 2018

<p>An estimated 1.3% of the population are affected by dementia (approx. 12,600 people in SESLHD). In the 85 years+ age group, 30% are affected, with the prevalence higher in RACFs. The numbers of our residents with dementia is expected to reach 19,200 by 2031. In 2016/17 there were 3,147 hospitalisations in SESLHD for dementia as a principal diagnosis or comorbidity.ⁱⁱ</p>	<p>In SESLHD in 2016/17, 66% of the people with an overnight hospitalisation due to a fall related injury were aged 65 years+ (3,752 people). Over the last decade, hospitalisations for falls injury among residents aged 65+ years have increased by around 33%.ⁱⁱⁱ</p> <p>For falls within hospitals nationally, people aged 85+ years had the highest age-specific rate (13 falls per 1,000 separations).^{iv}</p>	<p>The prevalence of diabetes in SESLHD adults has increased from 6% of the population in 2007 to 7.8% in 2017. Prevalence increases with age, with 21.6% of SESLHD residents aged 75+ years having diabetes. In 2016/17, 15 people aged 70 + were hospitalised in SESLHD every day with diabetes (as a principal diagnosis or important co-morbidity).^v</p>
<p>People aged 65+ years are at an increased risk of chronic kidney disease (CKD). Diabetes and ageing increase the risk of CKD. The CKD prevalence rate is around 10% among adults aged 25 and over, however for those aged 65–74 the prevalence rate is just over 21% and for those aged 75+ years the rate is more than 42%. Over 92,000 of our residents have chronic kidney disease with most being 65+ years. Diabetes is now the most common cause of chronic kidney disease (accounting for around 34% of the disease).^{vi}</p>	<p>The development of cancer increases as people age. Australian women have a 1 in 3 lifetime risk of developing cancer while men have a 1 in 2 risk. In SESLHD, the number of new (notifiable) cancers for people aged 70+ years in 2014 was 2,035 (33% of the SESLHD total). Total new cancer diagnoses are expected to increase by 2% per year, with over 7,400 new cases in 2031. This equates to approximately 2,470 new cases for people aged 70+ years.^{vii}</p>	<p>Nearly 1 in 10 Australians aged 50+ years have osteoporosis or osteopenia. The incidence increases with age, with 5% of men and 15% of women aged 70-79 and 8% of men and 18% of women aged 80+ years osteoporotic or osteopenic.^{viii} Osteoporosis is a major cause of pain, mobility impairment and loss of independence which result from fractures and related complications. For older people with osteoporosis, even a minor bump or fall can cause a life changing fracture.</p>
<p>Increasing age is an important risk factor for cardiovascular disease (heart, stroke and blood vessel diseases). Circulatory disease is the leading cause of death in SESLHD.^{ix} Smoking, physical inactivity, poor diet, high blood pressure, high blood cholesterol and obesity are other important risk factors.</p>	<p>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.⁶</p>	<p>Adverse medication reactions account for around 3% of all hospital admissions, around 50% of which are preventable.⁷ 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.⁸</p>

ⁱⁱ HealthStats NSW: Dementia as a principle diagnosis or comorbidity, by LHD and year

ⁱⁱⁱ HealthStats NSW. Fall-related injury hospitalisations; overnight stay; by LHD and year.

^{iv} Australian Institute of Health and Welfare (AIHW). Australia's Health 2018. Falls resulting in patient harm in hospitals

^v HealthStats NSW: Diabetes Prevalence by LHD and year

^{vi} AIHW July 2018. Chronic kidney disease prevalence among Australian adults over time.

^{vii} Cancer Institute NSW. Cancer Incidence and Mortality Projections 2016-2031. Released April 2017

^{viii} AIHW. Prevalence of self-reported osteoporosis by age and sex, 2014–15

^{ix} HealthStats NSW: Deaths by category of cause, by LHD and year

2.3 Recent Activity for people aged 70+ in SESLHD

Emergency Department Activity

Between 2011/12 and 2016/17 presentations for people aged 70 years or older increased by 11% or 2.7% per year, with the higher acuity triage categories increasing the most, reflecting the increasing complexity of presentations.

Table 1: SESLHD emergency department activity for people aged 70 years and over, SESLHD, 2012/13 – 2016/17

Data	2012/13	2013/14	2014/15	2015/16	2016/17
Triage Category 1	547	518	687	734	738
Triage Category 2	5,825	6,496	6,732	6,910	6,892
Triage Category 3	17,468	18,195	19,393	21,061	23,165
Triage Category 4	14,000	14,063	14,115	13,581	13,157
Triage Category 5	4,241	3,609	3,710	3,646	2,924
Total	42,081	42,881	44,637	45,932	46,876

Source: MoH EDAA v17.0

Exclusions: not coded

Inpatient Activity

Between 2011/12 and 2016/17 inpatient separations for people aged 70 years or older increased by 15%. At the same time, bed days reduced, with the average length of stay reducing from 6.6 days in 2011/12 to 5.4 days in 2016/17. This reflects changes in the model of care for older people, improved discharge planning processes and improved access to community based services, including case management and home based services.

Table 2: SESLHD inpatient activity for people aged 70 years and over, SESLHD, 2012/13 – 2016/17

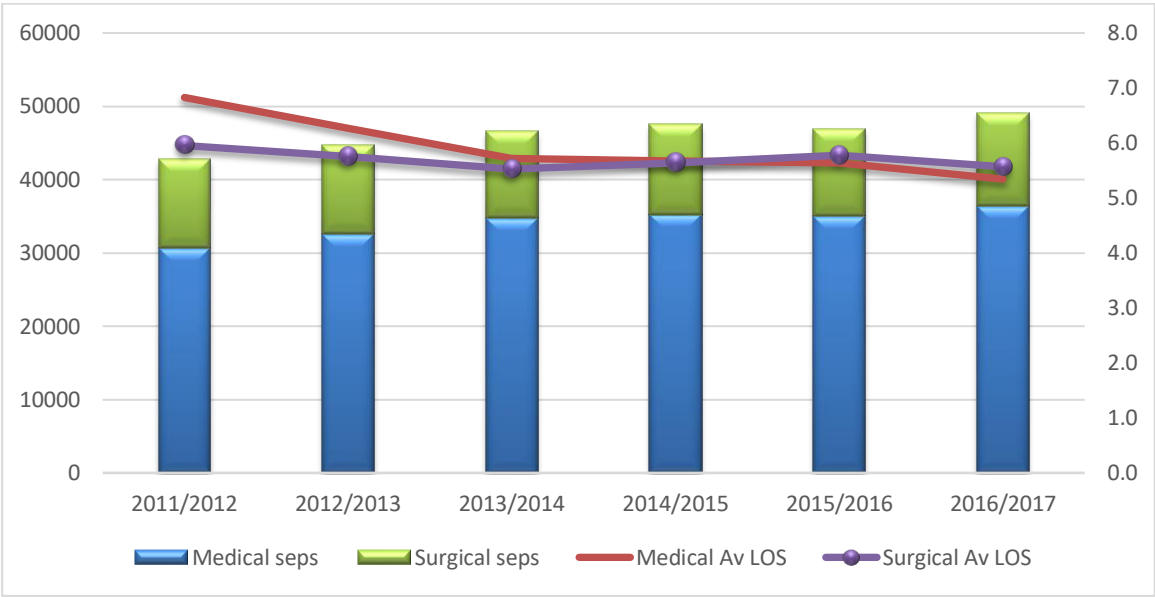
Data	2012/13	2013/14	2014/15	2015/16	2016/17
Separations	44,723	46,562	47,521	46,964	49,055
Bed days	274,059	263,889	269,142	266,251	264,892
Average length of stay	6.1	5.7	5.7	5.7	5.4
Average NWAU	1.23	1.16	1.18	1.21	1.19

Source: MoH FlowInfo v17.0, Exclusions: ED only, SRGs chemotherapy, renal dialysis, Psychiatry

Inclusions: acute and subacute

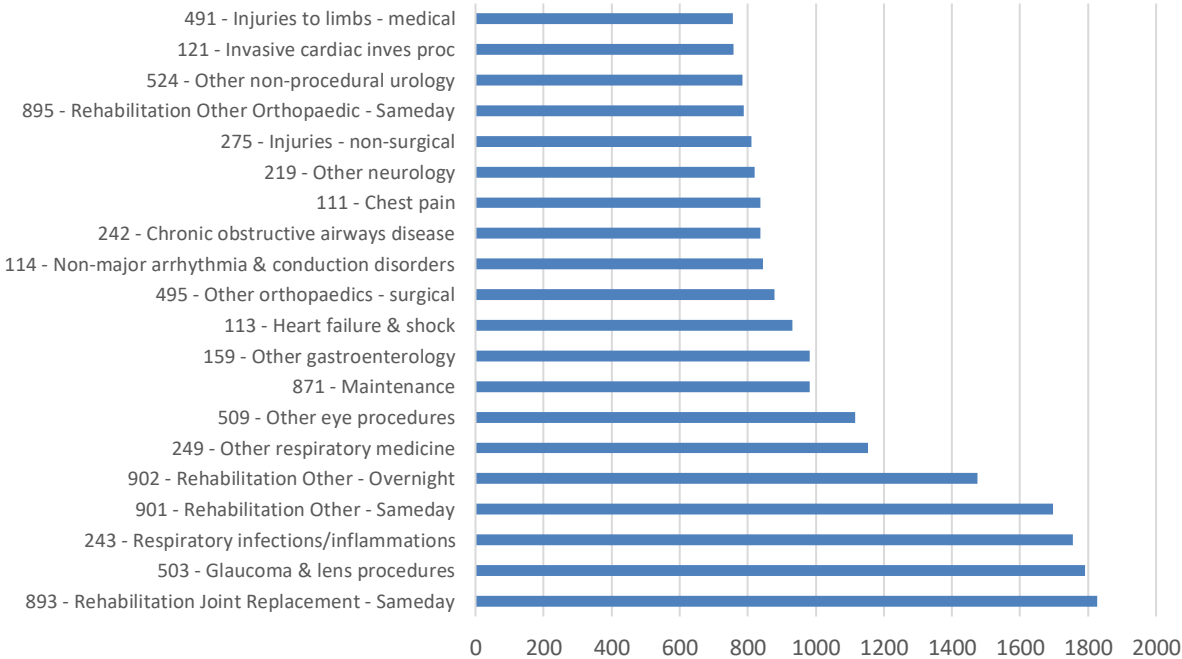
Medical separations far outnumber procedural and surgical separations in those aged 70 years and older, with the average length of stay decreasing between 2011/12 and 2016/17, as seen in Figure 2 below.

Figure 2: Medical and surgical separations and average length of stay, people aged 70 years+, SESLHD, 2011/12 -2016/17



Source: MoH FlowInfo v17.0, Exclusions: ED only, SRGs chemotherapy, renal dialysis, Psychiatry – acute and non-acute

Figure 3: Top 25 ESRGs, separations, people aged 70 years+, SESLHD 2016/17



Source: MoH FlowInfo v17.0, Exclusions: ED only, SRGs chemotherapy, renal dialysis, Psychiatry – acute and non-acute

2.4 Activity 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. These indicate a continuing increase in inpatient service demand in those aged 70 years and older if service models don't change.

Emergency Department Projections

Base case ED projections indicate that there will be more than 15,000 additional ED presentations with those subsequently admitted increasing the most (35% increase projected or 2.2% per year) reflecting the increasing complexity of presentations.

Table 3: SESLHD emergency department activity for people aged 70 years and over, SESLHD, 2012/13 – 2016/17

Data	2014/15	2015/16	2016/17	2021	2026	2031
Admitted	25,199	25,784	27,050	30,026	32,964	36,641
Not Admitted	18,834	19,293	19,028	21,205	23,256	24,999
Total	44,033	45,077	46,078	51,231	56,220	61,640

Source: EDAA V17.0, HealthAPP

Exclusions: Did Not Wait and Left at own risk

Acute Projections

Base case acute projections indicate that there will be more than 13,000 additional acute separations and despite a reduction in average length of stay, more than 56,000 additional bed days will be used. This equates to the need for 181 additional acute beds for persons aged 70 years and over, as seen in Table 4 below.

Table 4: Projected acute activity trends 2014/15 to 2031, persons 70 years+, SESLHD Hospitals

Stream	Data	2014/15	2015/16	2016/17	2021	2026	2031
Medical	Separations	23,587	24,112	24,999	27,405	30,184	33,929
	Bed days	114,726	115,456	112,450	133,892	142,780	155,658
	Average length of stay	4.7	4.5	4.3	4.9	4.7	4.6
	Beds required	370	372	362	432	460	502
Surgical/Procedural	Separations	10,967	10,621	11,314	12,607	13,984	15,539
	Bed days	62,364	61,174	63,275	68,866	70,021	76,220
	Average length of stay	5.7	5.8	5.6	3.8	3.7	3.6
	Beds	201	197	204	222	226	246
Total	Separations	34,554	34,733	36,313	40,012	44,168	49,462
	Bed days	177,090	176,630	175,725	198,758	212,801	231,878
	Average length of stay	5.1	5.1	4.8	5.0	4.8	4.7
	Beds required	571	569	566	641	686	747

Source: NSW MoH Planning tool: HealthAPP

Includes Day Only and Overnight

Excludes Collaborative care and ED Only activity; SRGs Renal Dialysis, Chemotherapy; Psychiatry- acute

Subacute Projections

Base case subacute projections indicate that there will be significant growth driven by the ageing of the population in the local catchment with nearly 10,000 additional subacute separations, and more than 82,000 additional bed days required. This equates to the need for 250 additional subacute beds for persons aged 70 years and over, as seen in Table 5 below.

Table 5: Projected subacute activity trends 2014/15 to 2031 by Service Category, persons over 70 years, SESLHD Hospitals

Service Category	Data	2014/15	2015/16	2016/17	2021	2026	2031
Rehabilitation	Separations	8,025	7,315	7,557	11,107	13,050	15,491
	Bed days	53,502	50,637	49,583	74,100	82,875	96,161
	Average length of stay	6.7	6.9	6.6	6.7	6.4	6.2
	Beds	163	154	151	226	252	293
Psychogeriatric Care	Separations	255	237	213	203	211	219
	Bed days	3,311	3,355	3,183	2,673	2,812	3,009
	Average length of stay	13.0	14.2	14.9	13.2	13.3	13.7
	Beds	10	10	10	8	9	9
Palliative Care	Separations	921	1,155	1,208	1,278	1,424	1,674
	Bed days	9,736	10,935	10,864	14,158	15,519	17,829
	Average length of stay	10.6	9.5	9.0	11.1	10.9	10.7
	Beds	30	33	33	43	47	54
Maintenance Care	Separations	1,024	913	974	1,171	1,327	1,530
	Bed days	8,839	8,502	8,018	12,232	12,318	13,031
	Average length of stay	8.6	9.3	8.2	10.4	9.3	8.5
	Beds	27	26	24	37	37	40
GEM	Separations	1,248	1,022	1,232	1,657	1,818	2,176
	Bed days	9,136	7,752	9,806	25,807	28,067	33,510
	Average length of stay	7.3	7.6	8.0	15.6	15.4	15.4
	Beds	28	24	30	79	85	102

Source: NSW MoH Planning tool: HealthAPP, Flowinfo V17.0

Inclusions: Day Only and Overnight activity

Exclusions: Collaborative Care

Non-Admitted Care Utilisation

Non-admitted patient care is provided in a variety of settings across SESLHD, including hospital based outpatient services, a variety of outreach services, and home and community based services.

Community care is increasingly the preferred mode of care for older people to avoid the need for emergency presentation or hospital admission, or to expand the time before requiring residential aged care. This trend is expected to continue into the future, as the number of older people increases and more models of care to support people at home are implemented.

Non-admitted service provision is **increasing** across SESLHD.

In 2017/18, the number of non-admitted occasions of service for those aged 70 years and older was over **518,000**, delivered from seven SESLHD facilities, community services and by Primary and Integrated Community Health (PICH) and the Directorate of Planning, Population Health and Equity (DPPHE).

3. What we have achieved

Aged Care services across SESLHD have introduced a number of innovative models of care that integrate with hospital based services and other agencies, in order to shift the balance from hospital based care to community based care where possible. These models aim to reduce the need for ED attendance and avoidable hospitalisations, frequency of hospitalisations, length of stay in hospital and ensure fewer premature admissions to RACFs.

The Aged Care Plan 2015-2018 outlined a number of District priority areas in aged care to help reduce the need for emergency presentations and hospital care. Key achievements against these priority areas are described below.

Our local Primary Health Network, the Central and Eastern Sydney PHN (CESPHN) partnered with the SESLHD Aged Care and Rehabilitation Stream to reduce unplanned hospital presentations from RACFs. Funding was enhanced to allow Geriatric Flying Squad teams to deliver acute care to RACF residents after hours and on weekends.

As a result, in 2017/18 over **90%** of residents seen by the GFS **avoided** a hospital presentation and emergency departments had an **80% reduction** in presentations from RACF residents.

Key Achievements from the Aged Care Services Plan 2015-2018

Population health

SESLHD wide:

- Maintained and improved aged care research and translation across the District by enhancing research productivity and further collaboration with external organisations and universities
- Effective implementation of the SESLHD Falls Injury Prevention Plan 2013-2018 across SESLHD facilities.

In our facilities:

- TSH: Establishment of Steady Steps, a community based falls prevention program
- CHCK: Post oncology rehabilitation for non-terminal disease processes, aiming to recommence a program through Day Rehab
- WMH: Establishment of a Day Rehabilitation Unit (iREAP) for the Northern sector.

Partnerships

SESLHD wide:

- Continued 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
- Enhanced research productivity and further collaboration with external organisations and universities
- Work is underway within CESPHN to develop a General Practitioner (GP) dementia pathway.

In our facilities:

- SGH: Developed good working 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
- POWH: Established regular meetings with the WMH Executive team, the Geriatric Flying Squad (GFS) leads and geriatricians to improve communication and flow across the different services
- TSH: CESPHN after hours funding allowed Southcare GFS extended after-hours referral and expansion of the Southcare Outreach Service (SOS)
- TSH: The Southcare 'Steady Steps' community-based falls prevention program won the SESLHD Improvement and Innovation 'patient as partners' award
- WMH: Formed a productive network between the northern hospitals to ensure optimal patient flow and service provision matching 'care need with care location'

- GC: Continued to be an effective partner in Dementia Care research and are planning to conduct research into the use of cannabinoids in end stage dementia.

Care in non hospital settings

SESLHD wide:

- Effective implementation of the District's Falls Injury Prevention Plan 2013-18 which includes universal screening and plan development for all Community Health admissions.

In our facilities:

- SGH: Enhancement of the GFS to a 7 day per week Nurse Practitioner model with one fulltime Geriatrician to support RACFs. Temporary funding was provided for rapid assessment of residents in RACFs and in the community; rapid transfer to aged care wards avoiding ED; increasing referrals back to GP and community level services
- TSH: Extension of the Southcare GFS service hours to cover extended after-hours referral to 2200 hours through CESP HN funding led to increased service to RACFs. More than 90% of clients now receive treatment at the facility and avoid ED presentations, with reduced flow on hospital admissions
- TSH: Establishment of an Infectious Diseases clinic in Southcare to review community patients on long term intravenous antibiotics - run in conjunction with Nurse led clinic
- TSH: Overall increase in referrals for Southcare services, reducing the need for inpatient services
- TSH: Successful retender to provide the ComPacks Program until 2021 to support eligible clients discharged from SGH, TSH and CHCK
- TSH: Introduction of Southcare's 'Steady Steps', a progressive 8 week program which fuses evidence-based exercise and dance moves with music for community-based participants identified at high risk of falls
- TSH: Increase in SOS service hours (via CESP HN grant) to 7pm, 7 days/week and social work support, to provide a rapid response, multidisciplinary model of care to clients at home
- CHCK: Achieved an increase in clinic patient numbers for management of Continence
- CHCK: Achieved an increase in access to ComPacks services
- WMH: GFS service hours extended with provision of a Nurse Practitioner with a Geriatrician.

Care in hospital settings

SESLHD wide:

- Participation in a District wide Advance Care Planning (ACP) Translational Research Strategy Funding (TRGS) project which resulted in staff participation in education sessions to normalize having ACP conversations. Development of ACP form and tab in Electronic Medical Record (eMR)
- Aggression minimisation role established to train staff and progress strategies to minimise and manage patient aggression.

In our facilities:

- SGH: Participation in a multicentre study on Delirium Implementation of post fall huddles which enabled review of falls documentation, investigation of cause and improvements in care provided
- SGH: Participation in The Leading Better Value care project to reduce falls and improve medication review. This now incorporates a post agitation huddle in the aged care wards, where medications are reviewed as part of the huddle process
- POWH: Development of a Vascular-Geriatric service, with a shared care model for all vascular surgical patients aged 70+ years
- POWH: Development of the Care of the Older Person in Surgery (COPS) service to support the medical management and discharge planning of complex older surgical patients, including the confused hospitalised older person
- POWH: Aboriginal Health Workers increasing education to commence end of life discussions
- POWH Community Health Pharmacist receives referrals for medicine review from community admissions and at hospital discharge
- CHCK: Increase in patients who attend the Palliative Care Unit with a broader mix of disease groups and having some active treatment
- CHCK: Increased numbers of inpatients having respite and palliative rehabilitation
- WMH: Increase in direct admissions from the community and POW ED to the WMH.

Care coordination and integration

SESLHD wide:

- Work is underway within the CESPAN to develop a GP dementia pathway.

In our facilities:

- SGH: provided case management services (funding removed) 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 severity of illness and avoidable hospitalisations
- SGH: Improved care in medicine management after discharge with hospital outreach medication management reviews through meetings involving pharmacist, RACF and GPs
- POWH: Development of a multidisciplinary shared care model for all vascular surgical patients aged 70+ years
- POWH: Development of the shared care COPS service that supports surgeons in the medical management and discharge planning of complex older surgical patients
- POWH: The establishment of regular meetings with the WMH Executive team, the GFS leads and Geriatricians to improve communication and flow across the different services
- POWH: Work undertaken with high risk Community Health clients with multiple health and social issues requiring multi-agency involvement specifically for social care and co-ordination as Commonwealth services have increased waiting times
- POWH: Established processes to more actively involve individual aged care patients (and carers and family members) in their management and support them to integrate treatment into their daily lives to improve adherence and outcomes
- TSH: Development of a new day only community facing Unit – RADIUS (Rapid Assessment, Diagnosis and Intervention Unit) within the Hospital for complex medical patients to receive rapid assessment and intervention, prior to supported discharge back into the Community or admission for further treatment
- TSH: 'An Integrated and Person Centred Approach to Aged Care Placement' project supports patients and families through the placement process and community follow up. This resulted in improved patient and family satisfaction, an integrated model between hospital and community, and hospital length of stay improvements
- TSH: The Respiratory Coordinated Care Program (RCCP) team was relocated to Southcare in 2017 to increase their integration, assisting their clients to access other services such as My Aged Care, Social Work, and the Community Liaison Pharmacist, and increasing access to continuing professional development
- TSH: SOS and NSW Ambulance Service have developed new direct referral pathways from Extended Care Paramedics to the SOS, avoiding ED presentations for complex and vulnerable clients
- CHCK: Palliative Care Nurse Practitioner is building capacity of catchment RACF staff to manage palliative care in the facility
- WMH: A productive network has been formed across the northern hospitals to ensure optimal patient flow and service provision matching 'care need with care location'
- WMH: There has been an increase in direct admissions from the community and POW ED to the WMH.

Carers and family members

SESLHD wide:

- Through District escalation to State services a faster turnaround of Guardianship services has been achieved to expedite patient discharge.

In our facilities:

- SGH: Provision of information and education to staff and carers and family members in dementia delirium which has resulted in increased skills, knowledge and improved care
- POWH: Projects implemented to train and support carers and family members via 'Guide to Living well at Home' and to involve carers and family members in care planning
- POWH: Established processes to more actively involve and support individual aged care patients (and carers and family members) in their management
- TSH: 'An Integrated and Person Centred Approach to Aged Care Placement' project had consumer representatives as part of the steering committee.

Workforce

SESLHD wide:

- Continued to build SESLHD's aged care clinical teaching role, including providing highly structured placement models and strengthening the learning culture in aged care services
- Standardised JMO education is organized and delivered across aged care
- Continued 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
- Enhancing research productivity and further collaboration with external organisations and universities
- ACP TRGS funded project which resulted in staff participation in education sessions and normalising having ACP conversations in all health settings
- An Aggression minimisation role established to train staff and progress strategies to minimise and manage patient aggression
- Development of a Dementia education module within Health Education and Training Institute (HETI) for staff to improve knowledge and skills
- Established a new position in August 2018: Behaviour Management Support, Clinical Nurse Specialist-Dementia/Delirium.

In our facilities:

- SGH: Enhancement of the GFS by establishing it as a 7 day per week Nurse Practitioner model with the provision of one fulltime Geriatrician to support RACFs
- SGH: Provision of information and education to staff and carers and family members in dementia delirium which has resulted in increased skills, knowledge and improved care
- POWH: Geriatric Outreach Service – added Geriatrician to work with Nurse Practitioner to support Aged Care Facilities
- POWH: Aboriginal Health Workers increasing education to commence end of life discussions
- TSH: Funding for a designated placement officer in the hospital setting and increased hours for the welfare officer in the community setting to support aged care placement
- TSH: SOS inclusion of a Social Worker position has further enhanced the integrated assessment of the SOS client
- CHCK: Establishment of a Palliative Care Nurse Practitioner role to work with the SGH and TSH RACF staff to build capacity to manage palliative care in the facility
- WMH: GFS service hours extended with provision of a Nurse Practitioner with a Geriatrician
- GC: Achieved acknowledgement as an Aged Care teaching facility by UTS, UOW, UWS and Sydney TAFE.

Technology

SESLHD wide:

- Development of an Advanced Care Planning documents tab in eMR
- Training and support for staff to maximise type changing and recording of SNAP (Sub acute and Non Acute Patient classification) activity.

In our facilities:

- SGH, TSH: Pre-admission clinics now screen older people for cognitive impairment using validated tools.

Psychological wellbeing

SESLHD wide:

- A District Cognitive Impairment Committee being established to manage the increasing demand of mentally and behaviourally impaired patients.

In our facilities:

- SGH: All older patients admitted to mental health services with a potential diagnosis of dementia are seen by specialist dementia staff
- SGH: Participation in a multicentre study on Delirium Implementation of post fall huddles which enabled review of falls documentation, investigation of cause and improvements in care provided

- WMH: Completion of a model of care program which enabled staff to have a clearly defined approach towards a positive patient experience
- WMH: Continuation of the Young Onset Dementia Service
- GC: Continue to be an effective partner in Dementia Care research and are planning to conduct research into the use of cannabinoids in end stage dementia.

4. Current SESLHD Aged Care Services

SESLHD's specialised aged care teams provide assessment, diagnosis and treatment of complex health conditions in older people; capacity building and advice for individuals, primary care and other providers to support the management of older people's health needs; and work in partnership with other health and social care and research partners to support the health and wellbeing of our older population.

The integrated model for aged care services across SESLHD continues to shift the balance of care towards supporting frail, older people to be managed at home for as long as possible, with community facing services for hospital avoidance and home based care. When emergency and/or inpatient care is required, timely support for early intervention and management and support for early discharge is provided.

SESLHD Aged Care service providers include a range of medical practitioners, nurses, allied health, social and welfare professionals and volunteers. Inpatient acute services are provided within the District's acute hospitals (primarily St George, Prince of Wales and Sutherland). Inpatient sub-acute services are provided by both acute hospitals and sub-acute facilities (War Memorial Hospital Waverley and Calvary Health Care Kogarah). SESLHD also has governance of one publically funded RACF (The Garrawarra Centre). A range of aged care specific community health services, including home based services, are also provided from the facilities and by the Directorate of Primary and Integrated Community Health (PICH). Aged Care Assessment Services (ACAT) are provided for access to Commonwealth funded home care packages, respite or permanent residential care.

Many supportive care services for older people are provided by agencies and programs outside of health, including Commonwealth, State and local government, as well as community and voluntary sectors (particularly carers and family members), primary care, and the private for-profit and not-for-profit sectors.

The current aged care activities and future priorities at each of our SESLHD facilities are outlined in the following pages.

4.1 Prince of Wales Hospital and Community Health Services

The Prince of Wales Hospital (POWH) is a tertiary referral teaching hospital of the University of NSW, and provides a wide range of aged care specific services – see table of services outlined on page 20. Consultant-led geriatric medicine specialty input is available for orthopaedics and other specialties 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. There are also strong links with several research institutions such as Neuroscience Research Australia (NeuRa). The POWH Community Health Team offers a comprehensive range of services for the aged.

Patients 70 years and older

In the previous decade for patients 70 years and over at POWH



ED Presentations have increased from 9,500 to 13,500, equating to a 4% growth per year. The higher acuity triage categories have grown substantially at 6.3% per year and the lower acuity triage categories are declining at -1.4% per year



Acute activity have increased from 9,500 to just over 11,100 separations, equating to a 1.6% growth per year



Significant reduction in the average length of stay across sectors:

- ✓ ED length of stay decreased from 7.1 hours to 4.8 hours
- ✓ Acute length of stay decreased from 6.3 days to 4.7 days
- ✓ Subacute length of stay decreased from 24.5 days to 11.9 days

More detailed analysis of acute activity for people aged 70 years and over at POWH indicates:

Emergency Department Activity

- People aged 70 years and over account for 22% of total presentations
- 53% arrived via ambulance followed by private vehicle
- Triage category 3 accounts for just over half of the presentations and is growing substantially at 5.7% per year
- 35% of patients are admitted, with this proportion remaining stable over the past decade
- Circulatory system illness, injury single site major, musculoskeletal/connective tissue illness, respiratory system illness and digestive system illness are top five reasons for presenting.

Acute Activity

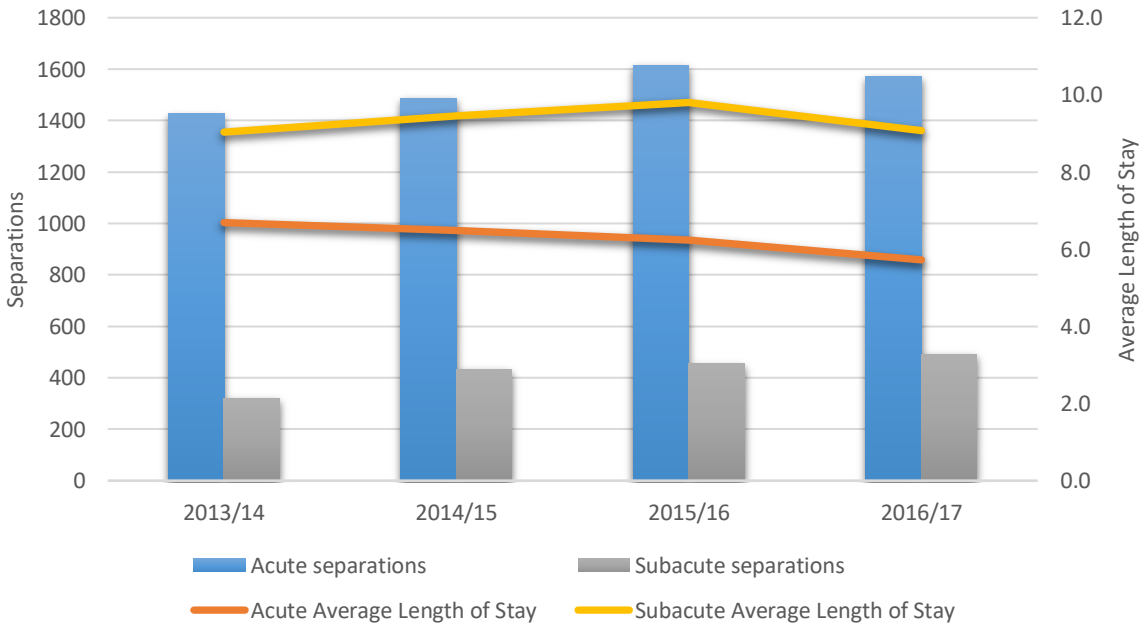
- People aged 70 years and older account for 38% of acute separations and 46% of bed days
- 72% were admitted via the ED, with 20% referred from outpatients
- Medical activity accounted for 73% of separations and 62% of bed days, with an average NWAU (National Weighted Activity Unit) of 0.97, reflecting the lower cost and complexity. Conversely, surgical activity accounted for 27% of separations and 38% of bed days, but has a higher cost and complexity with an average NWAU of 3.18
- Respiratory infections/inflammations, neurology, other orthopaedics – non-surgical, other respiratory medicine and gastroenterology are the top five reasons for admission
- Short stay separations (up to 72 hours) account for 57% of total activity reflecting changing models of care. Patients who stayed between 7 and 14 days accounted for 15% of activity, and those complex patients (length of stay greater than 21 days) represented 3% of activity
- On average people aged 70 years and older patients occupy 8 critical beds
- There were just over 508 patients who were admitted more than 3 times in the same year and 70 patients who were admitted more than 6 times in the same year.

Subacute Activity

- Patients aged 70 years and older accounted for 74% of separations and 57% of bed days
- Most patients were referred via a type change from acute to subacute care (97%) followed by medical practitioner at 1.4%
- Rehabilitation accounted for around 39% of separations and 63% bed days followed by maintenance care (34% separations and 18% of bed days)
- The most common overnight length of stay range is between 21 days and over (42%) followed by between 7 and 14 days (22%)
- Nearly half of the patients were discharged home (48%), followed by transfer to other accommodation 19% and discharge to nursing home 15%.

Aged Care Specific Activity

Figure 4: Aged care inpatient activity, admitted under a geriatrician, POWH, 2012/13 to 2016/17



Currently Implemented Aged Care Models and Services at Prince of Wales Hospital and Community Health Services

<p>Care in Non-hospital Settings</p>	<p>Integrated Care Geriatric Outreach Service: To reduce the need for transport of RACF residents to the POWH ED, the Geriatric Outreach Service facilitates care delivery within local RACFs. 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 (Hospital in the Home). 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, acute management plans and end of life planning and support.</p> <p>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 an acute admitted model, HITH, acute and sub-acute care at home and in RACFs, 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.</p> <p>Aboriginal Outreach Service: Scheduled clinics (in La Perouse, Coffs Harbour and Kempsey) provide expert consultation on the management of chronic care conditions (including dementia) in the ageing Indigenous population. This service also has a close relationship with NeuRA (Aboriginal Health and Ageing Program), to nurture existing and future translational research opportunities.</p>
<p>Care in the Hospital Setting</p>	<p>Aged Care Services Emergency Team (ASET): A seven day (0700-1930) multidisciplinary team which offers assessment of the care needs of patients aged 70 years and over 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.</p> <p>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. Six 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.</p> <p>Acute Aged Care Extension: (AACE): A six bedded secure unit located on Parkes 5, which is designed to support cognitively impaired aged care patients. These patients are generally physiologically stable but require specialised cognitive and behavioural management.</p> <p>Orthogeriatric 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.</p> <p>Geriatric Surgical Liaison: This service provides daily input into acute surgical specialties. It supports surgeons in the medical management of complex older surgical patients including management of the confused hospitalised older person.</p> <p>Care of the Older Person in Surgery (COPS): This is a shared care model that provides daily input into acute surgical specialties. It supports surgeons in the medical management and discharge planning of complex older surgical patients, including management of the confused hospitalised older person.</p> <p>Aged Care Rehabilitation: A 17 bed unit located on Parkes 5 ward which supports restoration and optimal functional independence in those aged 70 years or older through standard rehabilitation or Geriatric Evaluation and Management (GEM). The 'In Safe</p>

	<p>Hands' Standardised Interdisciplinary Bedside Rounds (SIBR) model is used to provide a patient centred focus for rounds.</p> <p>Vascular-Geriatric service: Offers a shared care model for all vascular surgical patients aged 70+ years. A pre-emptive multidisciplinary approach allows specialist identification of medical and psychosocial issues in order to plan a more effective in-hospital stay and thus avoid complications. Faster discharge through better planning may also result.</p> <p>Sydney Hospital service: POWH provides a weekly consult service to support physicians caring for older patients in Sydney Hospital. Assists with access to rehab or ACAT assessments, as well as providing advice for complex discharges.</p> <p>ReVive Aged Care Volunteer Service: Provided on the acute, rehabilitation and extension aged care wards/unit. The focus is for people who are cognitively impaired. Volunteers provide orientating information, practical assistance and compassionate support, encouragement and companionship to patients on an individual basis. Creative recreation activities (music and art) are also provided as group activities.</p>
<p>Care in the Non-admitted Setting</p>	<p>Aged Care Outpatient Clinics include: Falls, Balance and Bone Health; Cognitive Disorders; Caplan General Geriatric Medicine; Sim General Geriatric; Falls, Nutrition and Dietetics Aged Care Rehab.</p> <p>Annabel House Dementia Respite Care Day Centre (Randwick/Botany): Funded under the Commonwealth Home Support programme (CHSP) to provide centre based respite and social support group services to community clients over 65 years or over 50 years for Aboriginal clients. Refer to SESLHD services on p.42 for further information about CHSP.</p> <p>SESLHD Aged Care Assessment Program (ACAP): POWH is one of four sites which provide SESLHD ACAP services. (Refer to SESLHD services on p.42)</p> <p>POW Transitional Aged Care Programme (TACP): POWH is one of four sites within SESLHD which provide TACP services. (Refer to SESLHD services on p.42)</p> <p>Stepping On: Falls prevention program provided by the OT and PT departments (funded by MoH via Health Promotion)</p> <p>Aged Care Related Community Health Services include: Community Health Nursing; Community allied health; Transitional Aged Care; AIM For Fitness – exercise program for the aged; WAVES gentle water exercise classes for frail and well elderly people. Horizontal integration of these services results in shared care plans and enables partnerships with GPs. In response to the LHD Equity Strategy, older people experiencing social isolation, loneliness or social exclusion and who have become disconnected from the health system are referred for CNC review, then either Social Support program, linkage with Commonwealth services, and linkage with GP.</p>

Priority Actions for Prince of Wales Hospital and Community Health Services

Care in Non-Hospital Settings

To continue to meet the growing demand for aged health care across the catchment area, the POWH and Community Health Services will pursue resources and funding required to:

- Increase the Geriatric Outreach Service e.g. to include more geriatrician-led RACF and home based support, and support advanced care planning in community settings
- Expand the Hospital in the Home and other hospital avoidance and diversion services and strategies
- Expand the Aged Care Community Health Services.

Care in the hospital setting

- Review efficiencies in line with new Activity Based Funding Model. Aiming for consistent use of care types across the district
- 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, general surgery and vascular, i.e. to Plastic Surgery department
- Ensure systems and processes are in place to support staff across the hospital in delivering care for the confused older person.

Care in the Non-admitted setting

- 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
- Evaluation and further development of Community Health Services to be attended in 2019 - 2022:
 - Review of nursing workforce to care for older people with chronic diseases, to reintroduce partnerships with specialist services. Memorandum of Understanding signed
 - Re-development of some dementia support services (CCSP funding removed for National Disability Insurance Scheme) by reviewing treatment and assessment pathways for consistent protocols
 - CHSP nursing and allied health practices in process of streamlining to achieve higher outputs (and sustain funding) by increasing face to face time especially for care planning activities
 - Regional Assessment Service contract extended
 - Implement transfer of clinical prioritisation of new referrals from clinical teams to Access and Referral Centre (NNARC). This will improve client journey and patient experience. This is also expected to increase available clinical time and improve response to clinical risk
 - Continue to undertake quarterly consumer surveys.

Integrated care

- 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
- Encourage the use of professional interpreters when working with aged patients from CALD backgrounds to facilitate communication where there may be other cognitive and sensory challenges due to ageing or disease processes.

Hospital redevelopment

- Work closely with the redevelopment team to ensure that the ward designs, planned resources and up-to-date technology will appropriately support older patients and aged care staff in the new hospital.

4.2 St George Hospital and Community Health Services

St George Hospital (SGH) is a tertiary referral teaching hospital of the UNSW, and provides a wide range of aged care specific services – see table of services outlined on page 25. The hospital and associated community 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 and a Rehabilitation Unit which provides a multidisciplinary service to patients who require general rehabilitation, mostly for neurological conditions. Specific aged care rehabilitation is referred to Calvary Hospital or other facilities. Rose Cottage Day Rehabilitation Unit provides multidisciplinary rehabilitation after acute hospital admission. The St George Community Health Team offers a comprehensive range of services for the aged, and Calvary Community Health provides extensive aged and palliative care community services to St George residents.

Patients 70 years and older

In the previous decade for patients 70 years and over at SGH



ED Presentations have increased from 13,000 to 18,500, equating to a 4% growth per year. The higher acuity triage categories have grown substantially at 6.2% per year and the lower acuity triage categories are increasing at much lower rate at 0.6% per year



Acute activity have increased from 10,500 to just over 14,000 separations, equating to a 3.2% growth per year



Subacute activity has more than doubled from 923 to just over 2,000 separations, equating to a 9.5% growth per year

Significant reduction in the average length of stay across sectors:

- ✓ ED length of stay decreased from 7.6 hours to 6.0 hours
- ✓ Acute length of stay decreased from 7.5 days to 5.2 days
- ✓ Subacute length of stay decreased from 9.2 days to 6.9 days

More detailed analysis of acute activity for people aged 70 years and over at SGH indicates:

Emergency Department Activity

- People aged 70 years and older account for 23% of total presentations
- 57% arrived via ambulance followed by private vehicle (42%)
- Triage category 3 accounts for just over half of the presentations and has the second highest growth at 6.1%, with triage category 2 having the highest growth (6.5%)

- On average 35% of patients are admitted, with this proportion remaining relatively stable over the past decade (except for 2017/18 where there has been a substantial increase in the admission rate to 38%)
- Circulatory system illness, injury single site major, respiratory system illness, digestive system illness and musculoskeletal/connective tissue illness are the top five reasons for presenting.

Acute Activity

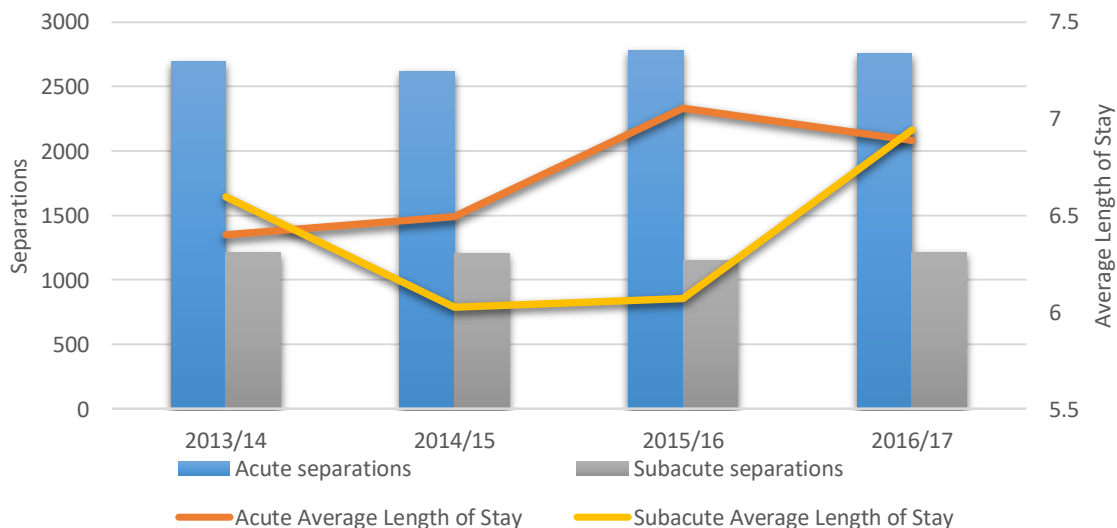
- People aged 70 years and older account for 36% of acute separations and 46% of bed days
- 77% of admitted were admitted via the ED and 19% were admitted via a medical practitioner
- Medical activity accounted for 75% of separations and 64% of bed days, with an average NWAU of 1.06, reflecting the lower cost and complexity. Conversely, surgical activity accounted for 25% of separations and 36% of bed days, but has a higher cost and complexity with an average NWAU of 3.50
- Respiratory infections/inflammations, other respiratory medicine, gastroenterology, heart failure & shock and chest pain are the top five reasons for admission
- Short stay separations (up to 72 hours) have increased from 36% in 2007/08 to 52% in 2016/17 reflecting changing models of care and account for 52% of total activity
- On average people aged 70 years and older occupy 15 critical beds
- There were just over 1500 patients who were admitted more than 3 times in the same year and 231 patients who were admitted more than six times in the same year.

Subacute Activity

- Patients aged 70 years and older accounted for 60% of separations, 72% of bed days
- Most patients were referred via a type change from acute to subacute care (81%) followed by medical practitioner at 18%
- Geriatric evaluation management accounted for around 40% of separations and 42% bed days followed by rehabilitation (28% separations and 32% of bed days)
- The most common overnight length of stay range is between less than one day (21%) which is due to the day only rehabilitation service followed between 7 and 14 days (18%)
- Nearly half of the patients were discharged home (45%) followed by type change separation 18% and transfer to nursing home 18%.

Aged Care Specific Activity

Figure 5: Aged care Inpatient Activity, admitted under a geriatrician SGH, 2012/13 to 2016/17



Currently Implemented Aged Care Models and Services at St George Hospital & Community Health Services

<p>Care in Non-hospital Settings</p>	<p>Residential Aged Care – the GFS provides early medical and nursing intervention for RACF patients flagged as potentially requiring transfer to the ED. This service has recently been extended to a 7 day model, providing GFS cover both morning and evening shifts. The GFS team consists of one fulltime geriatrician and a team of nurse practitioners & transitional nurse practitioners who review RACF clients with an acute deterioration in condition. 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.</p> <p>Aged Care Related Community Health Services – including community health nursing, community continence advisory service, ASET, Quick Response Program, ComPacks, single point of access for referral within their facility.</p> <p>St George Ageing in Place – is the sub-acute referral process for the St George area GPs to refer patients and clients who reside in RACFs to a geriatrician for review. The referral for a geriatrician is received in the Department of Aged Care where one of the Aged Care Consultants affiliated with that geographical area or RACF will accept the referral and provide a ‘home visit’ to the client in the RACF and provide ongoing sub-acute care, geriatrician review and advanced care planning.</p> <p>QRP – Quick Response Program provides short term comprehensive, acute care for those aged 65+ years/50+ years in Aboriginal or Torres Strait Islander clients with complex aged care related issues. QRP provides comprehensive multidisciplinary assessment of home environment and support networks. QRP offers a short term seven day service for clients in the St George area for up to six weeks. The attending multidisciplinary team consists of Nursing, Physiotherapy and Occupational Therapy staff.</p>
<p>Care in the Hospital Setting</p>	<p>Aged Care Services Emergency team (ASET) is a consultancy service to staff and clients of the St George ED. ASET provides clinical assessment and interventions for aged clients with a range of geriatric problems and unstable chronic and complex conditions.</p> <p>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 rapid assessment nurses that coordinate patient flow from admission to discharge and transfer into the precinct. The aged care wards manage acute, sub-acute patients and patients with challenging behaviours and delirium. This model incorporates high risk observation rooms within the wards for patients that require closer observation for clinical needs. A Rapid Assessment Liaison Nurse (RALN) assists to progress elements of care to expedite safe and timely discharge from hospital.</p>
<p>Care in the Non-admitted Setting</p>	<p>Aged Care Outpatient Clinics include: 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.</p> <p>Aged Care Related Community Health Services include: Community Health nursing, Continence Advisory Service, ASET, Quick Response Program, ComPacks, single point of access for referral.</p> <p>Frailty Team review patients prior to surgery for medical optimisation pre surgical intervention. The frailty team facilitates a comprehensive aged care assessment in the pre-operative period with access to rehabilitation prior to surgery.</p> <p>Osteoporotic Fracture Prevention Coordinator provides a service within SGH aged care who co-ordinates a fracture prevention clinic.</p>

Priority Actions for St George Hospital and Community Health Services

Care in Non-Hospital Settings

To continue to meet the growing demand for aged health care across the catchment area, the SGH and Community Health Services will pursue resources and funding required to:

- Increase integrated models of care and resources to support the provision of multidisciplinary care from the acute setting to the community e.g. the SGH Area Geriatric Assessment in Nursing Home Program
- Expand community based clinical services to address issues of chronic disease, frailty and ageing, including enhancing existing outreach services.

Care in the hospital setting

- Expand hospital and ED avoidance strategies from business hours to seven day service e.g. rapid assessment of RACFs and in the community; rapid transfer to aged care wards without going through the ED; increasing referrals back to general practice and community level services
- Provision of a purpose built dementia specific unit to be utilised for the cognitively impaired patients with behaviour management problems – as aligned with the St George Integrated Health Services Plan
- Expand the Aged Care Services Emergency Team to increase clinician availability across extended hours.

Care in the non-admitted setting

- Identify required and attain resources to extend the hours of the Quick Response Program and to include other services e.g. physiotherapy
- Increase community services with more services delivered at home.

Care integration

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

Other

- Encourage the use of professional interpreters when working with aged patients from CALD backgrounds to facilitate communication where there may be other cognitive and sensory challenges due to ageing or disease processes.

4.3 The Sutherland Hospital and Community Health Services

The Sutherland Hospital (TSH) is a teaching hospital of the University of NSW. The hospital and its community health services provide a comprehensive range of aged care services for the local community. Dedicated aged care inpatient wards predominately care for the frail elderly and those with dementia and include a nine bed Aged Care Assessment Unit and a purpose built 6 bed Behavioural Management Unit. 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 TSH, including Aged Care Assessment Team, Geriatricians; Generalist Community Nurses; Allied Health; Centre Based Socialisation / Respite; Support Services and Support & Education Groups - see table of services outlined on page 29.

Patients 70 years and older

In the previous decade for patients 70 years and over at TSH



ED Presentations have increased from 8,000 to 13,000, equating to a 5.7% growth per year. The higher acuity triage categories have grown substantially at 7.3% per year and the lower acuity triage categories are increasing at a much slower rate at 3.3% per year



Acute activity have increased from 6,000 to just over 7,000 separations, equating to a 1.2% growth per year



Significant reduction in the average length of stay across sectors:

- ✓ Acute length of stay decreased from 6.8 days to 5.5 days
- ✓ Subacute length of stay decreased from 15.9 days to 10.9 days

More detailed analysis of acute activity for people aged 70 years and over at TSH indicates:

Emergency Department Activity

- People aged 70 years and older account for 25% of total presentations
- 59% arrived via ambulance followed by private vehicle (40%)
- Triage category 3 accounts for nearly half of the presentations and has the second highest growth at 6.5%, with triage category 2 having the highest growth (10.2%)
- On average 47% of patients are admitted, with this proportion decreasing over the past decade. TSH has the lowest admission rate in SESLHD
- Circulatory system illness, injury single site major, musculoskeletal/connective tissue illness, respiratory system illness and digestive system illness and are top five reasons for presenting.

Acute Activity

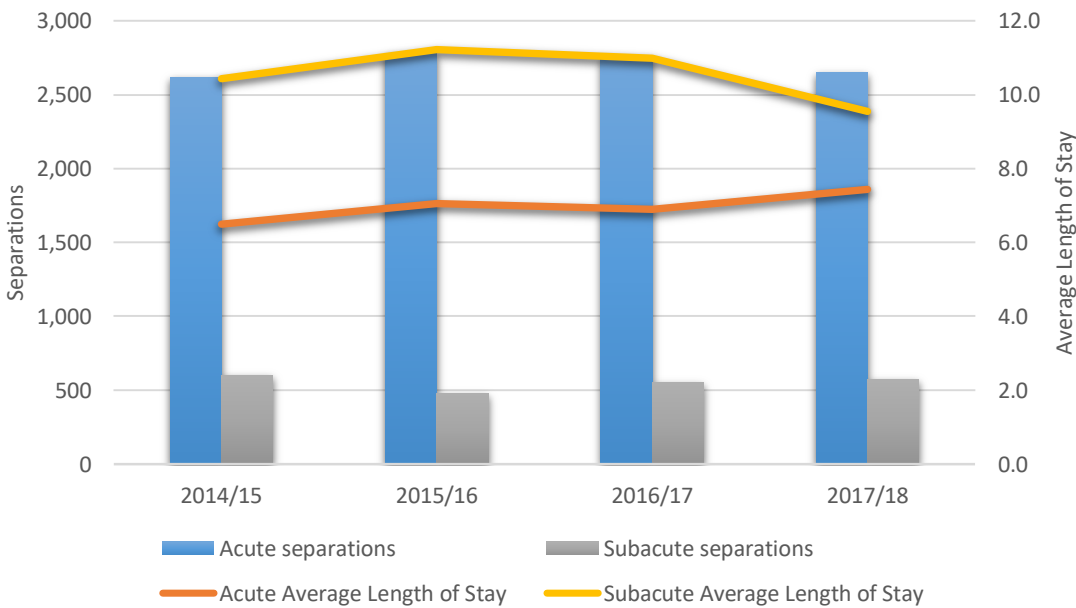
- People aged 70 years and older account for 40% of acute separations and 57% of bed days
- 79% of admitted were admitted via the ED and 19% were admitted via a medical practitioner
- Medical activity accounted for 75% of separations and 72% of bed days, with an average NWAU of 1.05, reflecting the lower cost and complexity. Conversely, surgical activity accounted for 25% of separations and 28% of bed days, but has a higher cost and complexity with an average NWAU of 2.59
- Respiratory infections/inflammations, other respiratory medicine, orthopaedics – surgical, heart failure & shock and non-major arrhythmia & conduction disorders are the top five reasons for admission
- Short stay separations (up to 72 hours) account for 43% of total activity reflecting changing models of care. Patients who stayed between 7 and 14 days accounted for 17% of activity, and those complex patients (length of stay greater than 21 days) represented 3% of activity
- On average patients aged 70 years and older occupy 8 critical beds
- There were just over 647 patients who were admitted more than 3 times in the same year and 79 patients who were admitted more than 6 times in the same year.

Subacute Activity

- Patients aged 70 years and older accounted for 86% of separations and 78% of bed days
- Most patients were referred via a type change from acute to subacute care (81%), followed by medical practitioner at 18%
- Rehabilitation accounted for 37% of separations and 51% of bed days followed by geriatric evaluation management which accounted for 24% of separations and 15% of bed days
- The most common overnight length of stay range is between 7 and 14 days (33%) followed between 14 and 21 days (13%)
- Nearly half of the patients were discharged home (44%), followed by transfer to nursing home 22%.

Aged Care Specific Activity

Figure 6: Acute aged care inpatient activity, admitted under a geriatrician, TSH 2012/13 to 2016/17



Currently Implemented Aged Care Models and Services at Sutherland Hospital and Community Health Services

Care in Non-Hospital Settings	<p>Residential Aged Care: Southcare GFS, which includes a Nurse Practitioner position provides early medical and nursing intervention for patients flagged as potentially requiring transfer to the ED. The role provides 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 RACF clients located in the Sutherland Shire who have 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.</p> <p>Sutherland Hospital Older Persons Mental Health Team offer a Psychogeriatric Service providing assessment and treatment in the community including RACFs for people 65+years with mental health problems.</p> <p>Hospital in the Home Services: The SOS 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.</p>
Care in the hospital setting	<p>Aged Care Services Emergency Team (ASET) provides a multidisciplinary consult service for patients 70 years and older who present to the ED. ASET work collaboratively with ED staff to achieve optimal management of older patients. ASET assess and identify complex issues, advocate for patients/carers and family members, refer and facilitate access to other relevant services if medically cleared from the ED.</p> <p>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.</p> <p>Barkala Acute Medical Aged Care is a 23 bed acute aged care ward where patients 65 years and older 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.</p> <p>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.</p> <p>Orthogeriatric Service provides geriatric medicine review for older fracture patients.</p> <p>Social Worker – Assisting Transitions to Residential Aged Care coordinates access and transfer to residential aged care from hospital to improve the experience of this major life transition for patients and their carers and family members and assist in the reduction of hospital length of stay.</p>
Care in the non-admitted setting	<p>The RADIUS Unit- is a newly established Community facing Unit within the Hospital for complex medical patients to receive rapid assessment and intervention (in a day only context) prior to supported discharge back into the Community or admission for further treatment.</p> <p>Aged Care Outpatient Clinics Geriatrician outpatient clinics; specialist Psychogeriatric clinic</p> <p>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.</p>

SESLHD Aged Care Assessment Program (ACAP) – Sutherland is one of four sites which provide SESLHD ACAP services. (Refer to SESLHD services on p.42)

Sutherland Transitional Aged Care Program (TACP): Sutherland is one of four sites which provide TACP services within the District. Refer to District services, p.43)

Southcare Generalist Community Nurses provide nursing care to Sutherland resident's e.g. Home assessments; medication/injections; palliative care (with Calvary community team).

Southcare Nurse Continence Service is available to all Sutherland residents via clinics and home visits.

Southcare Allied Health provides a comprehensive range of outpatient clinics and in the home including Physiotherapy, Pharmacy, Social work, Speech therapy, Dietician, Podiatry, and Amputee review, Welfare and Psychology Services.

The Retreat is a day care centre funded through the Commonwealth Home Support Program (CHSP) for frail or disabled aged people (12 per day) with low care needs. Potential clients are assessed by the Coordinator at home to determine if the centre can meet their needs. Staff include a Registered Nurse Coordinator, Assistant in Nursing (AIN), Diversional Therapist and a Bus Driver/General Assistant. (Refer to SESLHD services on p.42)

The SOS service provides a multidisciplinary rapid response model of care to clients within their home environment. Hours of operation have now been extended to 7pm seven days per week. Close consultation with NSW Ambulance Service has resulted in referral pathways directly from Extended Care Paramedics to the SOS, thereby avoiding an ED presentation for complex and vulnerable clients. The inclusion of a Social Worker position has further enhanced the integrated assessment of the SOS client.

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.

The Cottage is a day care centre funded through the Commonwealth Home Support Program for people with a diagnosed dementing illness and low care needs. Maximum 15 clients per day. Potential clients are assessed by the Coordinator at home to determine suitability. Staff include a Registered Nurse Coordinator, Assistant in Nursing (AIN), Diversional Therapist and a Bus Driver/General Assistant. (Refer to district services on p.42)

Dementia Home Monitoring Program provides Registered Nurse assessment and care plan development; for clients with a diagnosed dementing illness and low care needs; 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 CHSP services for example Domestic Assistance, Meals and Social Support group.

Priority Actions for Sutherland Hospital and Community Health Services

Care in Non-Hospital Settings

- Identify opportunities to further develop 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 GFS 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 shared care arrangements
- Identify available and pursue 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
- Increase the staff required to cover Continence referrals due to the overwhelming demand on this service.

Care in the Hospital Setting

- Enhance Radius Program to assess medical patients and discharge back with referrals to Community teams.
- 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
- Following evaluation of the “Social Work in the Death and Dying Space” forum held at TSH in November 2018 involving social workers from across NSW health settings, plan future forums to increase practice excellence in hospital social workers engaged with patients at the end of their life.

Care in the Non-admitted setting

- Enhance and streamline Community based 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 GFS beyond the aged care facilities to the community.

Integrated Care

- Improve Southcare infrastructure to enable building an Ambulatory Care Unit to provide a purpose built medical and nursing clinic space to meet the work flows and improve integration of care
- Continue to participate in aged care research and translation to improve the care we provide.

Other

- Encourage the use of professional interpreters when working with aged patients from CALD backgrounds to facilitate communication where there may be other cognitive and sensory challenges due to ageing or disease processes.

4.4 The Sydney and Sydney Eye Hospital

Sydney and Sydney Eye Hospital (SSEH), located in the Sydney CBD, provides emergency, general and specialist medical services. The hospital is a quaternary referral unit for eye diseases, providing surgical and medical management of vitreo-retinal, corneal, glaucoma, oculo-plastic, uveitis, and oculo-oncology conditions. The hospital also has a dedicated Hand Unit and is a tertiary referral centre for trauma, abnormalities and diseases of the hand. The medical ward cares for patients with Cardiology, Drug & Alcohol In-patient Detoxification, Endocrine, Gastroenterology, Neurology, Respiratory and Rheumatology conditions and non-weight bearing patients transferred from POWH Orthopaedic Ward and ED. The ward also has a 4 bed High Observation Unit. A consultative geriatric service is provided from Prince of Wales Hospital.

Nearly two-thirds of all inpatients are non-residents of SESLHD, reflecting the state-wide specialist role of the hospital.

In the previous decade for patients 70 years and over at SSEH



ED Presentations have increased from 3,500 to 4,500, equating to a 2.8% growth per year. The lower acuity triage categories represent 68% of presentations and are growing at 6.7% per year. Triage category 2 is also increasing particularly in the previous 3 years



Acute activity has increased from 3,000 to just over 3,500 separations, equating to a 2.2% growth per year. The average length of stay has declined substantially from 3.5 days to 2.5 days

More detailed analysis of acute activity for people aged 70 years and over at SSEH indicates:

Emergency Department Activity

- People aged 70 years and over account for 14% of total presentations which is a considerably lower proportion than other SESLHD facilities.
- 15% arrived via ambulance followed by private vehicle.
- Triage category 4 accounts for nearly half of the presentations and is growing substantially at 5.2% per year.
- 18% of patients are admitted, with this proportion increasing over the past decade.
- Illness of the eyes (58%), injury single site major (13%), injury single site minor (3%) illness are top three reasons for presenting.

The Emergency Department activity above excludes planned returns, as this cohort are now seen in outpatients rather than the Emergency Department.

Acute Activity

- People aged 70 years and older account for 33% of acute separations and 45% of bed days
- 54% were admitted via outpatients, with 19% referred from ED.
- Surgical activity accounted for 82% of separations and 56% bed days with an average NWAU of 1.37 while medical activity accounted for 20% of separations and 44% of bed days with a much lower cost and complexity of 0.92 average NWAU.

- Ophthalmology (glaucoma and lens procedures) followed by orthopaedics (wrist and hand procedures) are the top reasons for admission.
- Short stay separations (up to 72 hours) account for 83% of total activity reflecting changing models of care. Patients who stayed between 7 and 14 days accounted for 15% of activity, and those complex patients (length of stay greater than 21 days) represented 1% of activity
- There were 14 patients who were admitted more than 3 times in the same year.

Subacute Activity

- Overall there is a relatively small volume of subacute activity, representing 1.5% of total admitted activity.
- Patients aged 70 years and older accounted for 75% of separations and 77% of bed days
- Most patients were referred via a type change from acute to subacute care (74%) followed by hospital in the same LHD 18%.
- Maintenance care accounted for around 98% of separations and 99% bed days.
- The most common overnight length of stay range is between 7 and 14 days (30%) followed by 21 days and over (23%).
- Nearly half of the patients were discharged home (77%), followed by transfer to other hospital 13%.

Currently Implemented Aged Care Models and Services at Sydney/Sydney Eye Hospital

Care in the hospital setting	General Medicine: is a 29 bed ward providing general medical, long stay orthopedic and close observation for post-operative surgery. The hospital predominantly provides specialised ophthalmic and hand surgery services and in partnership with POWH a weekly geriatrician consultative liaison service is provided for the more complex older patients.
Care in the non-admitted setting	Older patients with comorbidities are referred to other appropriate services as required.
Integrated Care	Comprehensive discharge planning is undertaken with allied health support and referral to appropriate services e.g. TACP and ComPacks to integrate the patient back to their home, RACF or the community. Patients are referred back to POWH or other local hospitals as required. Slow stream rehab patients are referred to WMH.

Priority Actions for Sydney/Sydney Eye Hospital

Care in the hospital setting

- Optimising older patients for surgery with a nurse led preoperative clinic
- Continue relationships and strengthen collaboration with POWH, WMH and other partners
- Improve processes around end of life care and advance care planning discussions
- Improve pre-admission education for older patients for eye care post-surgery.

Integrated Care

- Investigate opportunities for the integrated management for subspecialty ophthalmic conditions in the community setting to improve access for specialised care.

4.5. War Memorial Hospital Waverley

The War Memorial Hospital Waverley (WMH) is an affiliated hospital within SESLHD, subsidised by NSW Health and owned and operated by Uniting. The primary role and specialty of the hospital is rehabilitation and assessment services for people aged over 60 years. The facility provides a 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 –see table of services outlined on page 35. There are strong clinical links with POWH, Sydney/Sydney Eye Hospital and St Vincent’s Hospital (SVH) 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 Program. Elizabeth Hunter Lodge on the hospital grounds offers cost efficient accommodation service for regional and rural patients or carers and family members 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 SESLHD and NSW Ministry of Health populations.

Patients 70 years and over

In the previous decade for patients 70 years and over at WMH



Subacute activity have increased over the period but has fluctuated between 520 to 620 separations. Bed days have declined overall but have remained between 11,000 to 12,000 bed days annually

Significant reduction in the average length of stay from 24.3 days to 18.6 days

More detailed analysis of acute activity for people over 70 years of age at WMH indicates:

Subacute Activity

- Patients aged 70 years and older accounted for 96% of separations and bed days. The average age of patients is 84 years of age
- The majority of activity came from surrounding LGAs (Local Government Areas) of Waverley, Randwick and Sydney (SESLHD part) at 81%. The highest inflows were from Sydney (SLHD part) at 8%
- Most patients were referred from other hospitals (43%) followed by 27% hospital in same LHD
- Rehabilitation accounted for around 89% of separations and bed days
- Nearly 60% are admitted for reconditioning followed by orthopaedic fractures 27% and orthopaedic replacements 4%
- The most common overnight length of stay range is 21+ days followed by patients who stay between 14 and 21 days
- Half of the patients are discharged home, followed by type change separation (21%) and 10% are discharged to a nursing home
- Nearly 60% were non-chargeable with 36% being private and 4% Department of Veterans Affairs (DVA).

Currently Implemented Aged Care Models and Services at the War Memorial Hospital Waverley

<p>Care in Non-hospital Settings</p>	<p>Geriatric Flying Service is a rapid response multidisciplinary team who assess and treat patients in their homes and RACFs. The GFS facilitate an improved quality of life, functional ability, increased confidence and safety to enable independent living, avoiding unnecessary hospitalisation and premature aged care placement.</p> <p>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. This program is a unique model, targeting physical activity, socialisation and carer and family members support to improve the quality of life and independence and reduce carer and family member stress.</p> <p>Day Centre offers structured individual and small group activities for patients with dementia, frailty and functional decline. This seven day per week service improves the lives of vulnerable older people through targeted leisure and diversional therapy programs to encourage physical activity, sociability and cognitive retraining. There are targeted activities for our key Culturally and Linguistically Diverse (CALD) communities.</p> <p>Waverley Transitional Aged Care Program (TACP) WMH is a provider of both Community and Residential TACP packages. The residential service is the only one available within the South Eastern Sydney region and is accommodated at Ronald Coleman Lodge, an exclusive 10 bed unit accessible to eligible clients from across South East Sydney Area. (Refer to SESLHD services on p.42).</p> <p>SESLHD Aged Care Assessment Program (ACAP) WMH is one of four sites which provide SESLHD ACAP services. Refer to District services on p.42 for further information.</p> <p>Northern Network Access and Referral Centre is a shared WMH and POW service providing a single point of access and triage service for the northern sector of SESLHD.</p>
<p>Care in the Hospital Setting</p>	<p>Inpatient Rehabilitation Unit is a 35 bed unit providing specialist aged rehabilitation partnering the patient with a multidisciplinary team including geriatricians, nurses, the full range of allied health and support staff. The inpatient model of care is focused on early agreed patient generated goal setting, through enablement <i>with</i> the patient rather than <i>for</i> the patient. Our recently implemented Patient Experience Project has identified active projects from admission through to discharge to ensure best patient outcomes and robust discharge planning. We link the patient in with community services according to their individual need with the ultimate goal of living longer and living better in the community.</p>
<p>Care in the Non-admitted Setting</p>	<p>Geriatric Medical Assessment Service offers specialist medical assessment and recommendations with particular expertise in Frailty, Dementia and Parkinson’s Disease.</p> <p>Outpatient Clinics include: Continence Clinic; Falls Assessment & Injury Prevention Clinic; Multidisciplinary Cognitive Assessment And Treatment; Parkinson’s Disease Multidisciplinary Assessment Clinic and services.</p> <p>Outpatient Services: A suite of single discipline services are available including Clinical Psychology, Physiotherapy, Occupational Therapy (including hand therapy), Social Work, Speech Pathology, Hydrotherapy and Health Promotion (including Stepping On Falls Prevention Program and monthly education). The Men’s Shed and Uniting Seniors Gym are also present on campus.</p>
<p>Integrated care</p>	<p>Day Rehabilitation iREAP: integrated Rehabilitation and Enablement Programme (iREAP) partners with primary health, community providers and EDs to provide an anticipatory multidisciplinary day rehabilitation program targeting those at risk of frailty, falls or with complex health needs including neurodegenerative conditions. The innovative model focuses on enablement strategies post program, health coaching and patients generated goals setting principles to improve quality of life and prevent crisis admissions.</p> <p>Geriatric Flying Squad: In partnership with the CESPHN, the GFS provides specialised holistic and comprehensive rehabilitation services to RACF patients ‘at-risk’ of unnecessary hospital admission. GFS have partnered with NSW Ambulance to design and implement a referral pathway, providing paramedics with an alternative destination for treatment and care of patients</p>

meeting specific criteria, thus avoiding emergency presentation. The ambulance collaboration had been broadened to other areas and extended to Botany Bay Police. The benefits include better patient care for patients in their own home, ensuring best practice multidisciplinary input for vulnerable people, and improved utilisation of health and emergency service resources.

Priority Actions for the War Memorial Hospital Waverley

Hospital Care in Non-Hospital Settings

- A focus on integrated care models to improve co-ordination and access, empowering older people through improved information and community enablement. Particular target areas include geriatric syndromes including frailty, dementia, falls and neurodegenerative conditions
- To build on existing partnerships with the GFS, CESP HN, NSW Ambulance and Police and create a further pathway with Fire and Rescue to provide rapid response, multidisciplinary input for older people in both community and residential care settings, preventing unnecessary hospital admission.

Care in the Hospital Settings

- Build on existing strategies to further improve inpatient flow between SESLHD hospitals, optimise transport options, deliver the WMH Patient Experience Project from admission to discharge inclusive of early goal setting in partnership with the patient, SIBR rounds and innovative falls prevention strategies
- Create a dementia hub to enable co-ordination of dementia care services across the Northern half of SESLHD, providing a suite of services to meet the needs of people with dementia through their journey including Younger Onset Dementia service, carer and family member support groups, education and physical activity programs, care co-ordination and individualized care programs through rapid response, outpatient, day rehabilitation and subacute inpatient services
- Create an outdoor gym and physical activity space on campus to encourage rehabilitation and exercise for older people
- Using risk stratification to identify at-risk groups to prevent admission and readmission and improve quality of life for community-dwelling older people
- 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 POWH and Uniting.

Integrated care

- Foster links with young people and the general community through linkages with schools and community groups, using technology to enable intergenerational connectedness
- Partner with local driving school to provide a pre-emptive approach for patients to have access to driver education
- Continue collaboration and integration with our SESLHD colleagues especially POWH, 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, through services including iREAP, GFS and Residential and Community TAC
- Utilise the benefits of War Memorial Hospital as an agile Affiliated Health Organisation to enable integration across the acute, sub-acute and primary care sectors and test new models of care.

Other

- As per the 2018 WMH Strategic Plan, develop a sustainable research culture through partnerships and co-design, building translational research to inform best practice in the care of the older person
- Developing technology as a health tool, exploring the use of virtual reality, health monitoring, devices, and wearables to create innovative solutions to enable older person's wellbeing, social connectedness, access and health literacy
- Work with the SESLHD Sustainability resource to map cost effectiveness of innovative preventative community care models in comparison to the cost of an acute hospital admission
- Encourage the use of professional interpreters when working with aged patients from CALD backgrounds to facilitate communication where there may be other cognitive and sensory challenges due to ageing or disease processes.

4.6 Calvary Health Care Kogarah

Calvary Health Care Kogarah (CHCK) is an affiliated hospital with SESLHD which is owned and operated by Little Company of Mary Health Care, specialising in multidisciplinary aged care medical and surgical rehabilitation and palliative care. The facility also provides outpatient, community, ambulatory and home care services – see table of services outlined on page 38. CHCK 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 and family members by providing community support, education and respite in order to prevent premature admission to RACFs.

Patients 70 years and older

In the previous decade for patients 70 years and over at CHCK



Subacute activity has doubled from just over 3,000 to 6,000 separations, equating to a 7.5% growth per year. However, more recent activity (last 4 years) shows rate of growth has slowed

Day only activity has increased the most at 9.5% per year and overnight activity is increasing at a much lower rate of 2.2%



Significant reduction in the average overnight length of stay across from 20.1 days to 16.5 days

More detailed analysis of subacute activity for people over 70 years of age at CHCK indicates:

- Patients aged 70 years and older accounted for 68% of separations and 78% of bed days
- The majority of activity came from surrounding LGAs of Rockdale, Hurstville and Kogarah LGAs at 84%. 38% came from Rockdale, 26% from Hurstville and 22% from Kogarah. The highest inflows were from Canterbury LGA at 2%

- Most patients were referred by a medical practitioner at 76% however the referrals from SGH account for the majority of bed days at 63% compared with medical practitioners at 18%
- Rehabilitation accounted for around 92% of separations and 76% bed days followed by palliative care (8% separations and 24% of bed days)
- Day only activity accounted for 76% of separations but overnight activity accounted for 84% of bed days
- For multiple night separations, the most common length of stay bracket is between 7 and 14 days followed by 14 to 21 days
- Just over 91% of patients were discharged home followed by death without autopsy 5%
- The rates of patients with private health insurance and those non chargeable are similar – 48% respectively.

Currently Implemented Aged Care Models and Services at Calvary Health Care Kogarah

<p>Care in Non-hospital Settings</p>	<p>Community Palliative Care Services: are offered in the home and in RACFs in the St George and Sutherland areas. This service operates within a multidisciplinary team model and includes specialist medical staff, vocational trainee medical staff, nursing staff, and allied health staff (physiotherapists, occupational therapists and social workers).</p> <p>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 area.</p>
<p>Care in the Hospital Setting</p>	<p>Inpatient Rehabilitation: is delivered across two inpatient units (32 beds each unit) providing orthopaedic, general and aged care rehabilitation. The highly skilled multidisciplinary team 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. The program is tailored to meet individual goals and needs. CHCK offers a fully equipped gymnasium and modern hydrotherapy pool for use by inpatients and outpatients and a 6 day per week physiotherapy service.</p> <p>Day Rehabilitation Unit: provides a service for people who require rehabilitation for orthopaedic, reconditioning, aged care, frail and neurodegenerative disorders 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.</p> <p>Inpatient Service Palliative Care: operates within a multidisciplinary team model and includes specialist medical staff, vocational trainee medical staff, nursing staff, allied health staff (physiotherapists, occupational therapists, social workers, dietitians and speech therapists), pastoral care, and a volunteer service. Calvary Palliative Care Service is a specialist service providing care and symptom management for people experiencing complex physical and psychosocial needs. Calvary participates in the Palliative Care Clinical Studies Collaborative and has a Research Unit located on the campus.</p> <p>Bereavement Service: 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.</p> <p>Pastoral Care: is provided within the inpatient and community services</p> <p>Overnight Dementia Respite: is a service which reduces the burden on carers and family members of people with dementia.</p>

<p>Care in the Non-admitted Setting</p>	<p>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 Georges River and Bayside LGAs. Rehabilitation services include Driver Assessment & Rehabilitation Service and Continence Advisory Service.</p> <p>Residential Care Placement Service: maintains lists of current RACF vacancies across both local areas.</p> <p>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 (see further information on page 42). ACAT staff also provide referral to services for complex issues such as dementia care, suspected elder abuse, Guardianship applications etc.</p> <p>Transitional Aged Care Service (TACS): Calvary has 41 community TACS packages for the St George area. A multidisciplinary team delivers slow stream goal orientated rehabilitation with an emphasis on case management. The MDT partners with clients to avoid unnecessary presentation to hospital and premature entry into RACFs through future planning and empowerment of clients and carers and family members to negotiate health and aged care systems/services to meet their individual needs.</p> <p>Ambulatory and Community Aged Care includes: Commonwealth Home Support Programme (CHSP) funded Nursing, Continence, Podiatry, Dietitian, OT; Transitional Aged Care Service ; Aged Care Assessment Team (St George area only) ; Physiotherapy ; Neuropsychology; Speech Therapy, Holistic Healing (all ages); Aged Care Specialists, including Psychogeriatrician services.</p> <p>Mary Potter House: is a 6 day respite centre for residents living within the St George area who have a diagnosis of a moderate to advanced dementia. Overnight respite is also available at weekends (maximum 2 clients per overnight stay).</p> <p>Community Palliative Care Team (CPCT): 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, and a volunteer service. Provides a multidisciplinary outreach service that includes Nurse Practitioner support and interventions within RACFs. The Palliative Care Service also provides a palliative care ambulatory multidisciplinary team assessment program undertaken in the outpatient clinic) and an outpatient physiotherapy program. The service also have a dedicated Clinical Nurse Consultant (CNC) for people with Motor Neurone Disease and other progressive neurological disorders. This role is part of a broader team of specialist staff that includes a Specialist Palliative Care Physician, a Rehabilitation Physician and a Speech Therapist, and hydrotherapy program. Calvary provides 24hrs telephone advice for CPCT clients, GPs and other SESLHD hospitals.</p> <p>Outpatient Clinics include: Rehabilitation; Palliative Care (at SGH and TSH); Aged Care; Chronic pain management; Motor Neurone Disease; Podiatry; Psychogeriatrics.</p>
<p>Integrated care</p>	<p>Discharge Planning: comprehensive discharge planning to provide a safe and smooth transition from hospital to home, including making referrals to appropriate providers to promote a seamless transition to home and promote ongoing recovery and detailed GP letter is provided from Calvary Hospital.</p> <p>Advance Care Planning: Patients being discharged home with ongoing support from the Palliative Care Service are supported to complete an Ambulance Palliative Care Plan to ensure the patient's and family's wishes are met in terms of end of life care preferences.</p>

Priority Actions for Calvary Healthcare Kogarah

Sub-acute and Outpatient

- Ensure the service delivery models for all inpatient, outpatient and ambulatory service types are meeting the needs of the population we serve and that they are equitable and accessible. This will be completed as part of the clinical service planning process

- Identify new models of care and patient groups for inpatient services including:
 - post oncology rehabilitation for non-terminal disease processes (Ambulatory and Inpatient) including developing partnership models with relevant organisations to increase survivorship rehabilitation programs
 - 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, grow and embed the Palliative Care Aged Care Program Needs Rounds in RACFs with the addition of the two Palliative Care Nurse Practitioner (NP)/Transition Nurse Practitioner (TNP) roles. This model involves the NP/TNP developing relationships with RACFs and attending needs rounds with RACF to build capacity in managing the care of residents requiring end of life care symptom management. The NP/TNP work closely with the GFSs based at TSH and SGH
- 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 Patient Access Unit for all inpatient and CPCT referrals. Develop and implement relationships with other Local Health Districts in Sydney providing services to patients with Motor Neurone Disease and expand this to include other neurodegenerative disorders. Work with the NSW Agency for Clinical Innovation Palliative Care Network to identify opportunities to lobby for funding and a more streamlined State-wide Service for this group of patients
- Embed and further develop the After Hours Inpatient Medical Service commenced in early 2018 to ensure transfers to acute care are minimised where possible and extend the admission and discharge processes to a 7 day a week service
- Review and redesign the Calvary Palliative Care Consultation Service at Sutherland Hospital to ensure the inpatient population has access to specialist palliative care services
- Examine options for private health insurance funding of prehabilitation in the model of care review of the Day Rehabilitation Program in the second half of 2019.

Integrated Care

- Undertake a clinical services planning process and develop a long range plan that takes in to account our specialty practice areas and those of the teams we work closely with while ensuring the needs of the population are met
- Identify opportunities across public, private, primary care, social services and non-government sectors to grow the service to ensure long term sustainability
- Ongoing strengthening of relationships with WMH, POWH, TSH, SGH 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 GFS in RACFs
- Develop an improved communication plan for GPs and Practices
- Develop marketing tools and strategies to ensure all current and potential stakeholders are aware of the full range of services at CHCK
- Develop improved communication with CESPHN to develop clear pathways for GPs to access services at CHCK.

Other

- Encourage the use of professional interpreters when working with aged patients from CALD backgrounds to facilitate communication where there may be other cognitive and sensory challenges due to ageing or disease processes.

4.7 The Garrawarra Centre

The Garrawarra Centre is a 104 bed public dementia specific RACF 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. A mobile dental van services Garrawarra residents annually, with assessments and treatment on-site.

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 provide specialist on-site care for residents. Local GPs also provide a regular service to the Centre.

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 for the Garrawarra Centre

- 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 RACF for the District
- Continue to be an effective partner in dementia care research
- Encourage the use of professional interpreters when working with aged patients from CALD backgrounds to facilitate communication where there may be other cognitive and sensory challenges due to ageing or disease processes.

4.8 Aged Care Programs supported by Primary Integrated & Community Health

The Directorate of Primary, Integrated and Community Health is responsible for the provision of Commonwealth funded community services to adults across SESLHD. Most of these services are provided to people aged 65 and over (50 years and over for the Aboriginal population). These services are outlined below.

Program/Service Name	Program/Service Description
Aged Care Assessment Program (ACAP)	<p>ACAP is a Commonwealth funded program which provides a nationally consistent comprehensive aged care assessment of older people to identify their care needs. ACAP staff provide information on suitable care options and can help arrange access or referral to appropriate residential or community care services. The ACAT determine eligibility for Permanent Residential Care, Respite, Home Care Packages, Transitional Aged Care Programme (TACP) and Short Term Restorative Care (STRC).</p> <p>The SESLHD ACAP service has one of the highest referral rates in NSW and completed 6,502 assessments in 2017/18. SESLHD ACAP operates as a single entity from the following 4 sites:</p> <ul style="list-style-type: none"> • Sutherland Hospital • Calvary Community Health • Prince of Wales Community Health • War Memorial Hospital <p>All ACAP referrals are generated electronically from the My Aged Care system and delivered to the SESLHD ACAP Intake Service located at War Memorial Hospital. NSW Ministry of Health are the approved providers of ACAT services in NSW and funding agreements are in place with the Commonwealth until 30 June 2020.</p>
Commonwealth Home Support Programme (CHSP)	<p>CHSP is a Commonwealth funded program which provides entry level services to support community dwelling people over 65 years (or over 50 years for Aboriginal people) to remain living at home.</p> <p>SESLHD receives approximately \$8.39 million per year to provide Allied Health, Community Nursing, Social Support Individual, Social Support Group and Centre Based Respite under CHSP. These services are delivered across Prince of Wales Community Health, Calvary Community Health, Southcare Community Health and St George Hospital.</p> <p>CHSP services are required to operate within a wellness and reablement context and are aimed to support clients with low level care needs. Clients requiring post-acute care, rehabilitation and palliative care services are non- eligible for CHSP.</p> <p>In recent years the Commonwealth have released several discussion papers which propose significant reforms to the Home Care system. SESLHD is currently contracted to provide CHSP until 30 June 2020.</p>
Regional Assessment Service (RAS)	<p>The RAS is a Commonwealth funded national assessment workforce, operating at regional level and responsible for conducting face-to-face assessments of older people seeking entry to CHSP. The SESLHD RAS service is located at Prince of Wales Hospital and provides services on behalf of the district throughout the SES region. Two other RAS providers also operate within SES.</p> <p>Assessments are conducted using the National Screening and Assessment Form (NSAF) via the My Aged Care assessor portal. RAS assessors generate electronic</p>

	referrals for service(s) to CHSP providers. Clients needing a more comprehensive assessment are referred to ACAT.
Transitional Aged Care Programme (TACP)	<p>TACP is a Commonwealth funded service which provides time-limited (up to 12 weeks) packaged multidisciplinary services to clients in a community based or residential setting immediately following discharge from hospital. The mix of services may include low intensity therapy, nursing, personal care, case management and medical support/oversight.</p> <p>TACP generally targets older clients who might otherwise be eligible for entry into residential care and aims to support their discharge from hospital to achieve identifiable short term goals. SESLHD provides 136 TACP places distributed across the following 4 sites:</p> <ul style="list-style-type: none"> • Sutherland Hospital • Calvary Community Health • Prince of Wales Community Health • War Memorial Hospital <p>Ten places are provided in a residential setting operated by WMH at Ronald Coleman Lodge and available to all clients within the South Eastern Sydney region. A review of NSW TACP services is scheduled to occur over the coming 6-12 months.</p>
ComPacks	<p>ComPacks is a NSW Health funded service which provides a non-clinical case managed package of community services to people being discharged home from hospital for up to 6 weeks. Examples of support services may include personal care, domestic assistance, transport and social support.</p> <p>The current providers of ComPacks within SESLHD are Southcare Community Health and Care Connect Limited. The Manager Aged Care strategy, PICH provides the ComPacks relationship manager function for SESLHD.</p>
Oral Health Services	<p>A mobile dental van services Garrawarra residents annually – assessments and treatment on-site. The van also services a number of RACFs in SESLHD. Our dental services also provide some domiciliary care to elderly people.</p>
Metro Regional Disability Service	<p>The SESLHD Metro Regional Intellectual Disability Teams (MRID) provide assessment and care planning for people of all ages with intellectual disability (ID) living in SESLHD and ISHLHD. The MRID currently have 366 clients aged 45 years of age and older. These clients frequently have complex illness as well as diseases associated with ageing.</p> <p>The MRID is also responsible for capacity building of mainstream services to enable appropriate safe care and increase access to mainstream services for people with ID. This includes capacity building for staff in supported accommodation and aged care facilities who frequently lack confidence and skills to manage people with intellectual disability who are ageing.</p>

5. Looking ahead: Key Areas of Focus for the Future

5.1 Community Innovation and Integration

Integrated care is a system transformation that “involves the provision of seamless, effective and efficient care that reflects the whole of a person’s health needs; from prevention through to end of life, across both physical and mental health, and in partnership with the individual, their carers and family members. It requires greater focus on a person’s needs, better communication and connectivity between health care providers in primary care, community and hospital settings, and better access to community-based services close to home.”⁹ Ageing and long-term and complex conditions are the key drivers for care integration.

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.¹⁰

The WHO *Integrated Care for Older People* approach recommends comprehensive assessments and integrated care plans; shared decision-making and goal setting; support for self-management; multidisciplinary teams; unified information or data-sharing systems; community linkages or integration; and supportive leadership, governance and financing mechanisms.

Briggs AM, Valentijn PP, Thiyagarajan JA, et al Elements of integrated care approaches for older people: a review of reviews *BMJ Open* 2018;8:e021194. doi: 10.1136/bmjopen-2017-021194

A lack of integration in a complex healthcare system causes enormous inefficiencies in healthcare delivery. SESLHD has commenced on a journey of healthcare integration and has collaborated with partner organisations to create a whole-of-system integrated care model, adopting the “House of Care” model,¹¹ with a focus on person-centred coordinated care to reduce avoidable hospitalisations, frequency of hospital admissions and ED attendance, and length of stay in hospital.

This model aims to provide sustainable care coordination for people with long-term conditions; localised needs analysis and risk assessment; system enablers such as clinical pathways and single point of access; staff training in health coaching and motivational interviewing; and improved patient self-management through health behavioural change techniques.¹²

The Kings Fund¹³ outlined the components of integrated care that contribute to an overall goal of high-quality, person-centred co-ordinated care for older people, as seen in the adjacent diagram.



5.1.1 Working with Consumers and Carers and Family Members^{14,15}

The experience of consumers and carers and family members can be improved through better integration, coordination and the encouragement of a person-led approach.

The Australian National Safety and Quality Health Service Standards include a standard which requires and signifies the importance of Partnering with Consumers (Standard 2). Standard 2 supports the NSW Parliament NSW Carers (Recognition) Act 2010, which formally recognises the significant economic and social contribution of carers and family members and to commit the public sector and human service agencies to key obligations and reporting.

The Act's Key Directions support NSW Health policy including the NSW State Health Plan – Towards 2021.

The focus on partnering with consumers is also strongly reflected in the other standards, particularly Standard 5 Comprehensive Care, which outlines the requirement for coordinated delivery of care required or requested by a patient, and aligned with the patient's expressed goals of care.

Involving consumers and carers and family members as partners in the delivery of seamless, effective and efficient care embraces a range of areas, including (but not limited to):

- Patients and carers and family members playing an active informed role in health care decision making (they are placed at the centre of health care)
- Patients and carers and family members 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 and family members into organisational governance, strategy and everyday 'ways of working'.

The effectiveness of aged care services in Australia relies heavily on informal and family members, friends, etc. who directly care for older people and play an important role in coordinating and facilitating formal community care services. In 2015, over 1 in 8 Australians (2.86 million people) are estimated to be providing informal care. 825,000 informal carers and family members are 'primary carers', people who provide the majority of the recipient's care. In absolute terms, there were approximately 10,000 fewer carers in 2015 than there were in 2010 due to a declining propensity to care. The composition of carer types among carers and family members has also changed. There are 285,000 more primary carers in 2015 than there were in 2010 and 294,000 fewer non-primary carers.

The availability of informal carers and family members 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 and family members 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 2014-2019¹⁶ identifies needed reforms across areas such as

To ensure the safe and effective delivery of healthcare services Standard 2 recommends that:

- Patients and carers, in partnership with health service organisations and their healthcare providers, participate in making decisions about their own health care. They need to know and exercise their healthcare rights, be engaged in their healthcare, and participate in treatment decisions.
- Patients and carers need to have access to information about options and agreed treatment plans.

carers and family member's health and wellbeing, and carers and family member's engagement. The NSW Clinical Excellence Commission is also committed to partnering with patients.¹⁷

5.1.2 Central and Eastern Sydney PHN (CESPHN)

The Central and Eastern Sydney PHN commissions effective, responsive and integrated health care services. These are informed by an annual needs assessment conducted by CESPHN where aged care has been identified as a key local health priority. Integration is a key component of CESPHN's commissioning activities. In 2018 the program 'Staying Healthy Living Well'¹⁸ was commissioned. Delivered by Feros Care, the aim of this program is to support older people with a chronic disease to improve their confidence, knowledge and engagement in managing their chronic conditions and general wellbeing. The program includes a health literacy component, 1:1 coaching sessions and vital signs monitoring. If a GP believes their patient would benefit from the program they can be referred via HealthLink, fax or email. This program is a prime example of an integrated care and population health commissioned activity. Additionally, CESPHN attends a large number of integrated care meetings across the SESLHD region to ensure greater coordination of care.

Another commissioned activity that CESPHN has a commitment to is falls prevention. The program Stay Standing delivers multi-disciplinary falls risk reduction strategies over six weeks and runs Train the Trainer sessions for capacity building to ensure sustainability. The programs have a strong focus on equity and are primarily delivered to culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander communities.

CESPHN has a keen interest in dementia. There is a newly commissioned project for dementia education and training. It is designed to provide residential aged care facility care staff and those caring for residents with dementia an opportunity to engage in a training and education program. CESPHN recognises the importance of informal carers and family members and also the carer workforce, specifically in RACFs, and seeks to provide education and development to those caring for people with dementia.

5.1.3 Integrating Care with Our Partners

To ensure the health and wellbeing of our older population, SESLHD aged care services cannot work alone and partnerships are crucial to delivering better population health for older people. SESLHD aged care services work with an array of health and social care partners, including CESPHN, GPs, Ambulance NSW, local Councils, other Government health and social care agencies, and non-government and community-managed organisations. It is also recognised that health and education partners are crucial to enhance the delivery of care to older people.

Engaging with patients, carers and families in the design and management of care is another important partnership. Acknowledging the strengths and resources of people and communities in a co-production and asset based approach empowers people to make decisions about their own health and where possible, be more responsible for their own health care.

Priority Actions for Community Innovation and Integration

- Work with the District Carer Program Manager to identify and implement strategies to ensure aged care staff engagement with carers and family members and consumers by:
 - Ensuring routine identification of carers and family members on intake / assessment
 - Assess the willingness and capacity of carers and family members to partner with us in the care of the patient
 - Provide carer and family members with support information across SESLHD aged care facilities and services

- Support training for aged care health staff to deliver minimum standard of engagement and support to carers and family members
- Increasing the number of patient, carers and or family member's participation in completing satisfaction surveys that will assist with service planning and improvements to aged care services. Fostering partnerships with a variety of agencies to improve the health and wellbeing of our older people and reduce the need for hospital care
- Recognising and acknowledging what matters to patients, families and carers and family members
- Work with NDIS and carers and family members on strategies to address impact of carer ageing on health services and availability of respite for older people requiring care
- Increasing engagement with CESPHN and general practice, and effective communication across the GP to hospital interface, e.g. CESPHN digital health and HealthPathways initiatives
- Continuous quality improvement to ensure existing models of care are provided equitably across SESLHD, for example enhancement of current outreach models such as GFS and SOS
- Investigate potential for new and innovative models of care to continue to shift the balance of care to community based care where possible, for example prehabilitation programs for those identified at risk of frailty or decline, or prior to surgery
- Investigate potential networking between SESLHD Aged Care Services and the MRID to facilitate sharing of expertise, and to develop stronger links between Aged Care, MRID and NDIS support services to meet the physical and psychosocial needs of a frail person with intellectual disability
- Investigate feasibility in partnership with CAC and Disaster Management of Aged care clients having an individual Emergency Contact List, e.g. RediPlan, in place
- Within SESLHD, working with our hospitals, other clinical streams, Mental Health, Directorate of Primary and Integrated Health and Directorate of Planning, Population Health and Equity to ensure the integration of services across the aged care continuum.

5.2. Aged Care Wellbeing

5.2.1 Dementia and Delirium

Dementia

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)¹⁹ projects that between 2010 and 2050, the number of people with dementia will treble. This increase will pose numerous challenges to our health and aged care systems. Dementia is the third leading cause of all deaths in Australia. The number of people with dementia in NSW is projected to increase fourfold from 84,000 in 2009 to 341,000 in 2050 and corresponds with the diagnosis of near 26,000 new cases annually in NSW increasing to 116,000 new cases in 2050.

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.²⁰ For instance, people with dementia account for 29% of people admitted to hospital with hip fractures²¹ and are hospitalised for unintentional poisoning at twice the rate of people without dementia²² and, once hospitalised, are more than twice as likely to develop complications such as pneumonia as people without dementia.²³ 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. The

average cost of hospital care for people with dementia is generally higher than for people without dementia.²⁴ Research shows that people with intellectual disability develop dementia at an earlier age than the general population and this also needs to be recognised when planning services.

Delirium

Research suggests delirium (an acute disturbance of attention and cognition) affects up to 56% of older people admitted to hospital. It is most common in people with dementia, though it can affect any older person in hospital.²⁵

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. 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.²⁶

The NSW Dementia Services Framework 2010-2015²⁷ 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.

Currently SESLHD 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 and dementia care. The CNC participates in the planning, implementation and evaluation of care to patients based on evidence and recognised standards; and collaborates with consumers, managers and multidisciplinary teams to develop and deliver safe, effective and efficient delirium/dementia models of care and clinical practice that best meet the health needs of patients consistent with the strategic directions of SESLHD.

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 members, including the services of a community based Dementia CNC. A dedicated cognitive disorders clinic supported by the POWH Aged Care CNC is available on the POWH campus to assist people with dementia and their carers and family members. SGH and TSHs have geriatrician led clinics where dementia clients are referred.

The District launched a new position in August 2018: Behaviour Management Support, Clinical Nurse Specialist - Dementia/Delirium. The primary purpose of this role is to provide education and support to nurses and health care professionals working with patients who may exhibit behavioral responses related to dementia and /or delirium. Secondly central to this position is the capacity to communicate and collaborate with consumers and health care professionals to identify and manage risk relating to behavioral changes in the acute and sub-acute settings. The Behavioural Management Support CNS2 positions incorporates the Management of Actual and Potential Aggression (MAPA) and the Music and Memory program in their portfolio.

Priority Actions for Dementia and Delirium

- Increase skills and knowledge available in dementia/delirium assessment and management through the provision of information and education to staff and carers and family members across SESLHD 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
- Focus on the identification of people at risk of delirium and the provision of care that will help reduce the risk of developing a delirium in hospital, as per NSQS Standard 5, Action 5.29: Preventing delirium and managing cognitive impairment
- 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 family members; 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 NSW Agency for Clinical Innovation Confused Hospitalised Older Person Study (CHOPS)
- Increase the availability of staff trained to assess and manage dementia/delirium in RACFs, including local GPs, through targeted education programs
- Increase access to palliative care for people with advanced dementia, including access to specialist palliative care services as required
- 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.

5.2.2 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 people from CALD backgrounds have a higher risk of mental health problems than the Australian born population and are less likely to access mental health services. These communities may have additional challenges to Australian born due to poor understanding of mental health; cultural stigma around mental health; language barriers to accessing help and information; and delay in help seeking behaviours.²⁸

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 SESLHD Older Persons Mental Health Service (OPMHS) specialist clinical multidisciplinary teams provide assessments, management and care of people aged 65 years and over or Aboriginal people over the age of 50 years who are

- at risk of or who are experiencing a psychological disorder or mental illness, such as depression, anxiety or psychosis, or
- have severe and persistent behavioural and psychological symptoms of dementia.

The OPMHS aims to improve the mental health, wellbeing and quality of life of older people with mental health problems and is guided by the principles of recovery, consumer-led care to partner with consumers, carers and family members, GPs and other key services and supports. The OPMHS provide both inpatient and community outreach, including RACFs.

The OPMHS services are not generally the primary provider of specialist services for older persons presenting with cognitive impairment in the absence of comorbid psychiatric symptoms; older people with a presenting diagnosis of alcohol and/or other drug disorder; older people with a presenting diagnosis of delirium; and younger people with a static cognitive impairment (i.e. not suffering from a progressive, neurodegenerative condition).

The OPMHS consists of two geographically defined sectors covering the SESLHD: Eastern Suburbs Mental Health Service (known as Northern Sector), and St George/Sutherland Mental Health Service (known as Southern Sector). The Sectors are supported by a District Mental Health Office which has overall responsibility for mental health service delivery, quality and service development, budget and capital works.

The Northern Sector, situated at the Euroa Centre, POWH is an integrated community outreach program with in-reach to an OPMHS acute inpatient ward with six dedicated beds. A consultation liaison service is offered to the aged care inpatient units at The POWH.

The Southern Sector incorporates SGH and TSH and community services. The service includes community outreach programs based at each site, consultation liaison to the aged care wards and a 16-bed subacute unit at SGH.

The NSW Older People's Mental Health Services Plan 2017-2027 and the SESLHD Mental Health Service Plan 2013 – 2018 guide the purpose, scope, target group and key elements of OPMHS, the context in which they operate and current developments in the service environment. They identify evidence-based service models and key strategic priorities for the development, delivery and improvement of OPMHS.

Priority Actions for Mental Health

- Consumers and their carers and family members can expect to be provided with care that is consistent with the *Mental Health Statement of Rights and Responsibilities*
- OPMHS services are accessible and equitable across SESLHD
- 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
- Identify barriers and establish protocols for effective ongoing collaboration between the OPMHS and other SESLHD aged care services
- Work in partnership with GPs, private psychiatrists and psychologists, and other key health care and aged care providers both within and external to NSW Health, with a focus on recovery and supporting integrated care across different settings
- Develop OPMHS consultation/liason and case management outreach capacity with the residential aged care sector, to support sustainable long-term care for this group

- Develop targeted and indicated mental health promotion, prevention and early intervention initiatives for older people
- Respond to the particular needs of specific population groups and older people with mental illness and co-occurring problems. These groups include:
 - Older Aboriginal people
 - Older people from Culturally and Linguistically Diverse backgrounds
 - Residents of RACFs
 - Older people with co-existing mental health and alcohol and drug issues
 - Older people with co-existing mental health problems & intellectual disability
 - Older people in the criminal justice system
 - Older people who are homeless
 - Older people living in domestic squalor
 - Older LGBTI people
 - Carers and family members
- Staff training, skills development and workforce planning is supported, supportive organisational and team structures are promoted, and there is a focus on research and evaluation
- Innovation and new models of care and ways of working are embraced.

5.2.3 Falls and Falls Injury Prevention

Falls-related injury is one of the leading causes of morbidity and mortality in older Australians with more than 80% of injury-related hospital admissions in people aged 65 years and over due to falls and falls-related injuries.²⁹ In SESLHD in 2016/17, 66% of the people with an overnight hospitalisation due to a fall related injury were aged 65+ (3,752 people). Over the last decade, hospitalisations for falls injury among residents aged 65 years and over have increased by around 33%.³⁰

Falls within our hospitals are one of the largest causes of harm in health care and are a national safety and quality priority.³¹ People aged 85 and over have the highest age-specific rate of falls in hospital (13 falls per 1,000 separations).³²

Osteoporosis, and the associated fractures, is also a major cause of pain, mobility impairment and loss of independence. For older people with osteoporosis, even a minor injury or fall can cause a life-changing fracture. The incidence of osteoporosis increases with age, with 5% of men and 15% of women aged 70-79 and 8% of men and 18% of women aged 80+ osteoporotic or osteopenic.³³

Prevention in Community Settings

Many falls can be prevented. There is strong evidence that balance exercises and functional training as a single intervention prevents falls in older people living in the community.³⁴ Recent evidence suggests the additional benefits of the types of interventions added to exercise as part of a multifactorial or multiple component interventions (e.g. medication review) are unclear.³⁵

Key Principles:

- Take an evidence-based approach to prioritise, develop and implement fall and injury prevention interventions
- Embed falls prevention within broader whole-of-life and healthy ageing strategies to build a resilient future population
- Support the development of healthy built environments
- Strengthen partnerships with key stakeholder groups including but not limited to
 - SESLHD hospital and community health teams

- Relevant teams within the Directorate of Planning, Population Health and Equity (DPPHE) including Health Promotion, Community Partnerships Unit and Equity Coordinator
- Primary Health Networks
- Primary health practitioners, including General Practitioners and Practice Nurses
- Local Governments
- First responders including NSW Ambulance, Police and Fire and Rescue services
- Physical activity coordinators and providers, including but not limited to Stepping On, SHARE, AIM for Fitness, Strengthening for Over 60s,
- The NSW Falls Prevention Program (CEC)
- NSW Office of Preventive Health
- Community stakeholders including carers and family members groups
- Involve the older person and, where appropriate, their carers and family members, in developing falls prevention plans and ensure they are provided with information on reducing falls and harm from falls.

Priority Actions for Falls Prevention in Community Settings

- DPPHE frailty and falls strategic projects including outdoor exercise parks for older people and Fire and Rescue reciprocal referral pathways
- Identify opportunities to implement falls prevention strategies as part of the place-based equity and well-being initiatives in Maroubra and South Coogee
- Increase physical activity both through organised groups and healthy built environments
- Support training to upskill fitness leaders and providers of community-based group exercise on the types of exercise known to prevent falls e.g. balance and functional training
- Offer a range of evidence-based falls prevention services including but not limited to:
 - Exercise that focuses on challenging balance and improving leg strength
 - Multi-component falls prevention programs e.g. Stepping On, including programs to specific language communities
 - Multi-disciplinary assessment and targeted interventions for people at risk of falls and fractures.

Prevention in Hospitals and Health Care Services

Key Principles:

The aim of the National Safety and Quality Health Service (NSQHS) Standard 5, Comprehensive Care, is to ensure patients receive the coordinated delivery of the total health care required or requested by a patient. This care is aligned with the patient's expressed goals of care and healthcare needs, considers the impact of the patient's health issues on their life and wellbeing, and is clinically appropriate. Comprehensive Care also requires that risks of harm to patients are identified, prevented and managed.

Priority Actions for Falls Prevention in Hospitals and Health Care Services

- In line with Standard 5, Health service organisations will:
 - Have systems that are consistent with best-practice guidelines for:
 - i. Falls prevention
 - ii. Minimising harm from falls
 - iii. Post-fall management
- Ensure that equipment, devices and tools are available to promote safe mobility and manage the risks of falls
- In line with Standard 5, clinicians caring for patients at risk of falls will:
 - Conduct comprehensive risk assessments

- Incorporate falls prevention strategies into the patient's comprehensive care plan, ensuring the care provided to the patient is person-centred and meets their specific clinical and personal needs
- Provide patients, families and carers and family members with information about reducing falls risks and falls prevention strategies
- Support and implement initiatives in line with State-wide priorities and programs, such as Leading Better Value Care (LBVC)
- Support and implement improvement and innovation within our health facilities in line with District priorities and programs, such as the SESLHD Patient Safety Program
- Encourage the use of professional interpreters and approved translated communication aids to convey safety information to aged CALD patients. In situations where falls occur, staff should include information such as Country of Birth, Language and Interpreter Required status on incident reports to assist in data collection to further identify falls risks and areas of potential preventative interventions.

5.2.4 Frailty

Frailty is “a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10 per cent of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85.”³⁶ How to diagnose and manage frailty is crucial in an aged care strategy and a key issue for modern health and social care services. As the total number of older people increases, so will the number of frail older people.

Frailty is common in people requiring care and support at home, those who are housebound, long-term care residents, recipients of home care, and among older people admitted to hospital. They may have greater risks from polypharmacy, under-nutrition, falls and deconditioning, with personal cost to patients, their carers and families. Clinically, older people who are frail have poor functional reserve, so that even a relatively minor illness can present with sudden catastrophic functional decline – causing the person to fall, become immobile or rapidly confused, or to present non-specifically with failure to thrive.

Frailty may present with nonspecific symptoms, such as fatigue, unexplained weight loss and frequent infections; with falls as a result of balance and gait impairment, fear and visual disturbance; delirium; and fluctuating disability.

Frail elderly patients are more prone to adverse events as inpatients in hospital, and wherever possible, should have their health issues ‘managed in place’. Frail people are also more likely to have a longer length of stay. Where dementia occurs, it usually corresponds to the degree of frailty. For older people admitted to hospital, early identification of frailty and intervention to promote enablement and prevent functional decline is thus essential.

Different degrees of frailty require different supportive services and interventions. Proactively identifying and assessing frailty will improve patient risk assessment and allow specifically designed pathways to ensure safe and effective care. Using frailty indexes and outcome measures are important tools for prevention of deterioration of functional capacity.

Priority Actions for Frailty

- Introduce standardised frailty screening and assessment tools and pathways across all healthcare settings to improve the quality of life of community dwellers, decrease frailty-related admissions, reduce length of stay, and improve function and independence, with:
 - Early identification of frailty risk

- Facilitation of timely referrals
- Intervention strategies and care plans
- Measurement of patient related outcomes
- Consider opportunity for holding a multidisciplinary Frailty forum.

5.2.5 Social Isolation and Loneliness

Social isolation and loneliness can be an issue for individuals of any age, however for older people it is often exacerbated by social circumstances such as living alone (approximately 1 in 4 older people live alone) and many older people may be carers of their partners or family members. Physical problems such as impaired mobility, foot health, balance, osteoporosis, chronic pain, visual and hearing impairment, incontinence and malnutrition may also limit independence, wellbeing and social engagement. Long periods of social isolation and/or loneliness can have a negative impact on physical and mental health and wellbeing.

Social isolation and loneliness may also impact on the way people access support and services, their health literacy, health skills and their life choices, and may increase their risk of early death. Reducing social isolation and loneliness requires partnering with other agencies (government and non-government) to work together with communities to foster stronger social relationships and community connections that allow people to develop social networks and a sense of belonging and trust.

Priority actions to reduce social isolation and loneliness

- Work in partnership with DPPHE, NGOs and local councils to address the psychosocial needs of the elderly in our community, e.g. with social prescribing to refer people to non-clinical services to improve their health and wellbeing and foster activities that promote health and community connection and active social participation to prevent social isolation.

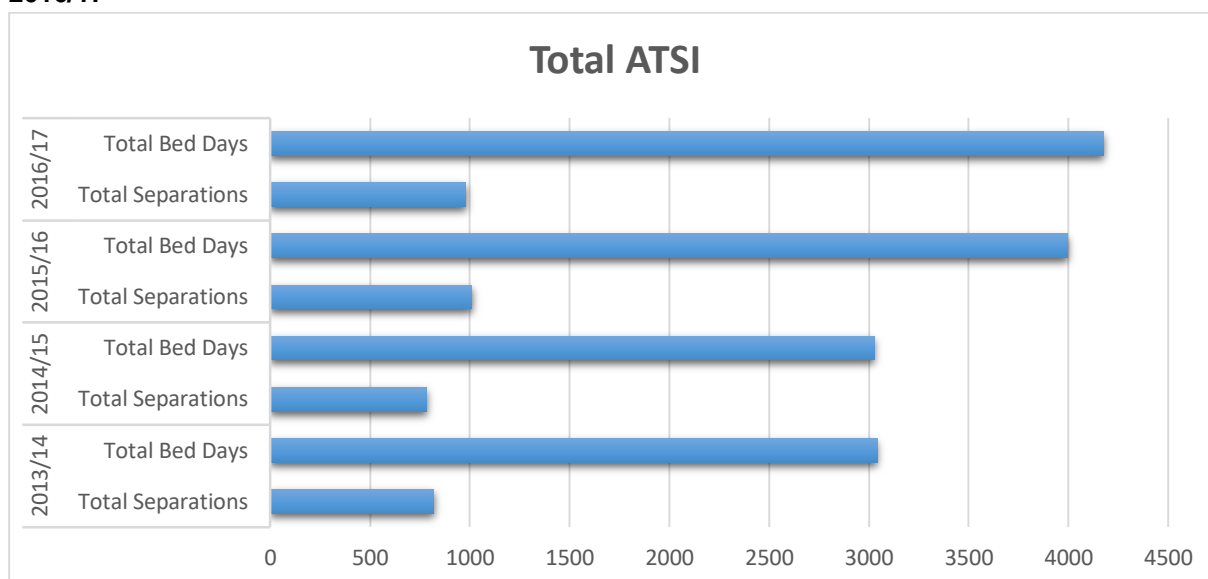
5.2.6 Older Aboriginals

There are currently over 1,800 older Aboriginal people (50 years and over) living in the South Eastern Sydney Local Health District.^x While Aboriginal people are reaching older ages, and this is reflected in an increased number of older Aboriginal people access SESLHD health services, the obvious gap in life expectancy between Aboriginal and Non Aboriginal people is still observed in SESLHD. The Aboriginal population has a higher mortality rate and a lower life expectancy than other Australians, reflected in the younger age profile of Indigenous Australians—in Australia in 2016, just 5% (31,000) of the Indigenous population were aged 65 and over compared with 16% (3.4 million) of the non-Indigenous population.³⁷

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 with more Aboriginal people in their 40s and 50s and even sometimes much younger also experiencing dementia.³⁸ Aboriginal and Torres Strait islander people experience dementia at a rate three to five times higher than the general population.³⁹

^x Source: Usual resident population by LGA. Compiled by PHIDU based on the ABS Census of Population and Housing, August 2016. (Note that 42.5% of Sydney LGA is included in SESLHD). Accessed.20/03/19. URL: <http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlases-of-australia-local-government-areas>

Table 6: Older Aboriginal People (50 years and over) Hospitalisations, SESLHD 2013/14-2016/17



Source: FlowInfo v17.0. Accessed 15 January, 2019

Includes Indigenous status: Aboriginal, both Aboriginal and Torres Strait Islander, Torres Strait Islander, Age Groups 50+. Excludes: ED Only, Collaborative care

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 include transport to services, and staff and services capable of delivering care adapted to their language, culture and local circumstances. 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.⁴⁰

A 2016 Australian Institute of Health and Welfare report highlighted that older Aboriginal and Torres Strait Islander people tend to be more highly represented in community-based care programs, such as Home Support and Home Care, compared with RACFs.⁴¹

A 2011 Australian Institute of Health and Welfare report⁴² showed 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. 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.

Priority Actions for Older Aboriginals

- 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 SESLHD Aged Care and Rehabilitation 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.

5.2.7 Medicines Safety

Medicines are an essential component of clinical care for older patients. Older people are recognised as the largest users of medicines; for Australians over the age of 75 years, around two-thirds use 5 or more regular medicines, and 20% reported use of 10 or more regular medicines⁴³. 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.⁴⁴ 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.⁴⁵ Unplanned readmission to hospital following discharge is also a major problem in the elderly, with 29 to 35% of unplanned readmissions medication related.

In Australian hospitals, the average number of medicines prescribed for older patients is 9-10 per patient, with an average of five to seven medicine changes being made between admission and discharge. Polypharmacy is common in older patients discharged from hospital (where many changes are often made to medications) to home-based care, and research recommends improved efforts to encourage regular medication reviews and, where possible, rationalisation of medications.⁴⁶

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 and family members 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 for Medication Safety

- Establish effective processes to ensure an accurate record is taken of all medications in use among elderly patients (including over the counter) and ensure it is readily available to all clinicians
- Establish mechanisms to improve rates of medication reconciliation for high risk patients at hospital admission, and undertake work to improve the accuracy of medicines information provided to primary care providers after hospitalisation
- 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 RACFs
- Establish mechanisms to ensure older patients and their carers and family members 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
- Encourage the use of professional health care interpreters in all discussions around medication with patients from CALD backgrounds with low English proficiency or low health literacy, and inclusion where appropriate of questions pertaining to use of alternative/complementary medicines and medicines that have been prescribed or obtained from someone other than the regular GP or health service.

5.3. Care of the Older Surgical Patient

The number of older people undergoing both elective and emergent surgical intervention continues to increase and will do so for the foreseeable future. Evidence to support the role of geriatric medicine in the orthopaedic setting is strong whilst evidence to support the role of geriatricians in other surgical settings continues to emerge. There is strong evidence that both frailty and cognitive impairment are important determinants of outcome in older people undergoing surgical intervention. Frailty and cognitive impairment are associated with increased mortality, increased length of stay, increased risk of complications including delirium and increased risk of institutionalisation.

Over the life of this service plan, it will be important for geriatric medicine services to implement, evaluate and put in place effective service models that add value to patient care and to the performance of the respective health care organisations.

Care in the orthopaedic setting

Hip fracture patients are predominantly frail, have a median age of 84 years, 29% are already living in a RACF and 39% have pre-existing cognitive impairment. The evidence base for the involvement of geriatric medicine specialists in the care of older orthopaedic hip fracture patients and particularly hip fracture patients is robust. A National Guideline and a Clinical Care Standard dictate that hospitals should have access to an orthogeriatric model of care. The POWH, SGH and TSH all have well established orthogeriatric models of care and all contribute data to the Australian and New Zealand Hip Fracture Registry which facilitates benchmarking at a State and National level. Opportunities exist to improve aspects of care at all 3 sites and the potential to share best practice across sites. The 2018 Hip Fracture Report demonstrated a number of areas where care can be improved at each site including domains of care where orthogeriatrics takes a lead role – pain management, delirium prevention and management, rehabilitation and secondary fracture prevention.

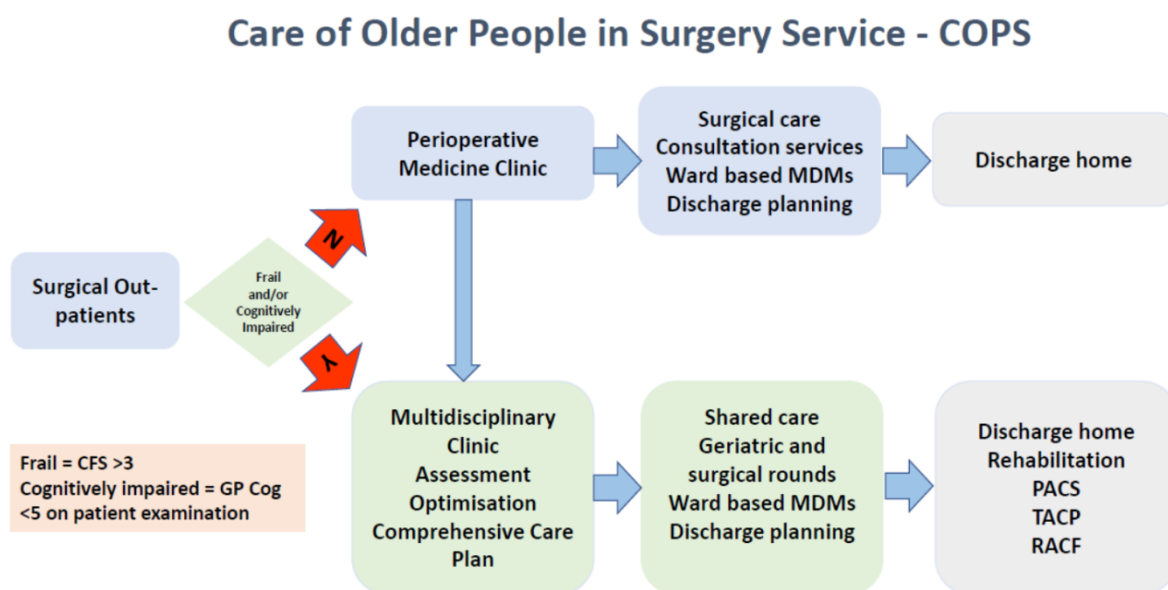
Care in other surgical settings

Whilst the evidence linking frailty with poor surgical outcomes is robust, there is less evidence about intervention strategies that can alter outcomes in older surgical patients outside of the orthopaedic setting. Guys and St Thomas' hospital in the UK has the most advanced and comprehensive range of services for older people in the surgical setting in the world. Through a series of translational research projects they have been able to implement and evaluate the impact of geriatric medicine input in to a range of surgical services including general, vascular, cardiothoracic, urology and orthopaedic surgery. In a recently published Randomised Control Trial in vascular surgery, they provide evidence of benefit of comprehensive geriatric assessment in advance of surgery in relation to length of stay and complications including delirium.

In round 1 of the NSW TRGS, POWH secured funds to explore the value of a shared care model between general surgery and geriatrics in the emergency surgical setting. Partnering with Nepean Hospital, shared care was delivered to 802 patients in the intervention period. Benefits have included a reduction in acute and total length of stay, fewer complications and better documentation and coding. Staff and patient satisfaction was overwhelmingly positive and the model has continued in both hospitals.

The next stage for this work is to consider the role of geriatric medicine for elective older surgical patients with a focus on frailty as the identifier of the at risk target population. SGH have already undertaken work in this field in the pre-operative anaesthetic clinic. Older people who are frail are referred to Aged Care or General Medicine services for a comprehensive Geriatric Assessment.

The figure below highlights the potential way forward for service development in the elective surgical setting.



Priority Actions for care of the older surgical patient

Orthogeriatric services

- Use national hip fracture benchmarking data to identify areas where care of the older hip fracture patient can be improved.
- The three acute sites to work collaboratively to improve the care of hip fracture patients and deliver care consistent with existing national standards.
- Ensure that secondary fracture prevention services targeted at hip fracture patients aligns / dovetails with the existing secondary fracture prevention services across the local health district
- Contribute to ongoing and future research in the area of hip fracture care.

Other surgical services

- Roll out the COPS model of care across the three acute hospitals and continue to evaluate the impact
- Develop pathways of care to support frail older people undergoing elective surgical intervention, including discharge planning

- Undertake further research to determine the optimal model of care for SESLHD
- Encourage the use of professional health care interpreters when obtaining informed consent from patients from CALD backgrounds who have difficulty understanding or communicating in English.

5.4 Advance Care Planning

Advance Care Planning (ACP) provides the opportunity for people to plan ahead for health care related decisions for a time when they may not have capacity to make 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 ED and inpatient services in the last year of life by people whose deaths are clinically expected.⁴⁷ The widespread use of advance care and end of life planning are yet to be realised across health care providers in the community and SESLHD services. Acknowledgement of the need for end of life and ACP 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."⁴⁸

Several agencies have a focus on normalising advance care and end of life planning. The Ministry of Health has developed a downloadable Advance Care Directive Information booklet, an Advance Care Directive form and a resource page for staff and the community.⁴⁹ 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.⁵⁰ 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 to ensure appropriate services are delivered and improvements made. A Health Education and Training Institute education module is also available to provide special skills to assist Health Professionals in having end of life conversations.⁵¹ Similarly, the Royal Australian College of General Practitioners supports the incorporation of ACP into routine general practice and provides information, tools and support to this sector.⁵²

In 2017, SESLHD received MoH funding to support a Translational Research Study in Advance Care Planning (ACP). This funding supported health professionals to be trained to identify and assist their patients and carers with their ACP needs. The pragmatic randomised controlled trial was completed across five sites within two Local Health Districts. Outcome data from the study is still being analysed, however initial findings suggest that patients are more likely to consider ACP when supported by a health professional.

Further research is underway to obtain family and carer feedback on the process of completing the documents and to ascertain outcomes on the utilisation of health service resources.

This research will assist to inform the way forward within SESLHD services. The NSW Health Information Booklet and Form "Making an Advance Care Directive" was evaluated by the participants in the study and the recommendations have been provided to the MoH who have made changes to the form to make it more patient centred and user friendly. The revised version has been published on the MoH website:

<https://www.health.nsw.gov.au/patients/acp/Publications/acd-form-info-book.pdf>

SESLHD has developed an Advance Care Planning Guideline and a Procedure for the upload of these documents within the Electronic Medical Record system to ensure the patients end of life care

wishes are respected and followed.⁵³ For community members, a public website has been established by the NSW Government to support end of life decision making.⁵⁴

Advance Care Planning Consultant Service

Prince of Wales Hospital provides a nurse consultancy service to local residents (45 years and over) wishing to consider their own ACP 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 on the patient's behalf. The Plan called a "Statement of Values and Wishes" identifies the decision-maker, and describes the known values and wishes of the patient. It does not include treatment restrictions or refusals, as currently only appointed guardians may consent to withholding and withdrawing treatment. 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 ACP knowledge and scope of practice.

Priority Actions for Advance Care Planning

- Normalise ACP within the SESLHD by establishing support systems and approaches to ensure all patients, including CALD groups, with advanced illness who are admitted are offered an ACP conversation.
- Work across systems and services to systemise admission, clinical review and discharge procedures to ensure advance care plans are identified, used in clinical decision making, and transferred between care settings
- Routine ACP in general practice, aged care outpatient clinics and for residents of aged care settings which integrate with the acute care facilities
- Widely promote and routinely adopt end of life/ACP tools that support staff to effectively undertake ACP with patients. Provide training and mentorship to support staff to have ACP conversations
- Ensure that information in all ACP documents are incorporated in the electronic health records
- Monitor progress in implementing ACP across the District
- Encourage the use of professional health care interpreters when discussing Advance Care Planning with patients, carers and family members from CALD backgrounds

5.5 Research

SESLHD supports a large number of researchers and health professionals involved in the care and research of aspects related to the elderly population. Research is guided by the SESLHD Research Strategy 2017-2021,⁵⁵ which focuses on applied and translational research that is directly relevant to improving health care system performance and the wellbeing of patients and the community.

SESLHD is a member of SPHERE - the Sydney Partnership for Health, Education, Research and Enterprise, which brings together three universities, two Local Health Districts, two Specialty Health Networks, seven medical research institutes, nine major teaching hospitals, and the NSW Ministry of Health to enable collaborative research. One of the twelve Clinical Academic Streams of SPHERE is age and ageing. With links formed through SPHERE and networks with other universities and LHDs, SESLHD clinicians will be better supported to more effectively translate new research to clinical practice and use healthcare data to support clinical practice and the implementation of quality improvement programs.

SESLHD Aged Care services also have close research ties and affiliations with a number of 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

- CHCK has research ties with the University of NSW, Palliative Care NSW, a range of aged care facilities and others
- POW 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
- SGH 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 and a range of aged care facilities and others.
- WMH has established its own WMH Research Committee as part of its endorsed Clinical Strategic Plan 2018. WMH has research related ties with University of NSW, Macquarie University, Sydney University, St Vincent's Hospital, SEaRCH, NSW Agency for Clinical Innovation and Uniting and Centre for Healthy Brain Ageing.

In addition to collaborative research arrangements, aged care services across SESLHD 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 SESLHD 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.

Priority Action

- Continue to support, facilitate and promote the undertaking of high quality research into issues relating to older people and translation to improve the care we provide.

5.6 Teaching and Education

The changing nature of the aged care patient means that SESLHD'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. SESLHD 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 for nursing, junior medical staff and advanced trainees in geriatric medicine, and allied health) professional development, work experience and a range of other development opportunities to 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 community, hospital, outpatients, and aged care facilities and areas of care across SESLHD.

Priority Actions

- Continue to build SESLHD'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 all 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 inter-professional 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
- Continuing and maturing teaching and research partnerships across SESLHD with universities and other institutions.

5.7. Infrastructure

Infrastructure suitable for aged care must consider the needs of frail older people and those with dementia and delirium, and be able to support the latest clinician-led models of care to allow staff to deliver effective and efficient services across all settings.

To support the shift to community facing care, an enhancement of aged care appropriate ambulatory facilities is required across SESLHD. This includes good access to clinic space, group rooms, rehabilitation spaces and technology enabled spaces for education for both staff and patients, carers and their families. Ambulatory facilities should also include a base for community staff with suitable amenities (access to hot desks, computers, storage, parking, etc.) to foster integrated links with other aged care services.

Suitably designed aged care precincts enhance patient care and reduce potential harm. Mobility and balance difficulties as well as vision and hearing impairment are common characteristics of older patients that should be catered for in facility design. The unfamiliar hospital environment and disruption of normal routines and habits are significant sources of stress. To lessen the impact of these factors design should consider:

- Providing good visual access so consumers can see everywhere they need to go
- Maximising penetration of natural light and, where possible, views.
- Ensuring sufficient storage for mobility aids such as walking frames, wheel chairs, and lifters
- Discouraging long corridors as they cause echoes and orientation difficulties that may confuse the elderly
- Creating clear hospital wayfinding and signage with appropriate contrasting colour, lettering size and font type, and other orientation cues
- Ensuring enough space for walking with mobility aids as well as rest areas
- Providing parking and drop-off areas with limited distance to major entrances and seating
- Consider the needs of CALD patients, carers and families, including where appropriate multilingual signage and inclusion of communication devices such as three way phones in patient areas to facilitate use of professional health care interpreters.

According to the NSW Agency for Clinical Innovation, for people with dementia “a poorly designed or inappropriately set-up physical environment increases confusion and problem behaviours, slows or negates rehabilitation and contributes to the stress experienced by staff and families involved in providing care to these patients with complex needs. On the other hand, a well-designed environment can reduce confusion and agitation, improve orientation, encourage social interaction, reduce depression and speed healing.”⁵⁶

Good access to suitable rehabilitation services and to palliative care (inpatient and ambulatory services) is also a critical component of effective, patient centred aged care.

The technological requirements for aged care into the future should also be considered. This includes access to telemetry on aged care wards, digital monitoring of inpatients and increasingly, telehealth and digital monitoring of aged care patients at home.

Previous clinical service planning for the Randwick campus, SGH and TSH indicates there will be a shortfall of age care specific acute and subacute beds across SESLHD. Building stock is also ageing and may no longer be fit for purpose. For example the Southcare building on the grounds of Sutherland Hospital, which houses a range of outpatient and community services, is in disrepair. The building no longer meets minimum standards for disabled access, security, communications and fire safety. It needs major refurbishment or rebuild to become compliant and enable Southcare to continue to provide expanded community programs and ensure integration of its services. The building is also too small for the current staffing levels, with no room for expansion.

For our hospitals to improve whole of hospital flow, meet future demand and avoid the use of outlier beds, enhanced access to community facing aged care services to prevent admission and sufficient inpatient aged care beds are essential. This includes the enhancement of supporting models for early assessment (ACAU) and behaviour management, including for younger onset dementia patients.

Priority Actions

- Ensure sufficient inpatient aged care beds across SESLHD facilities. This includes the enhancement of supporting models for early assessment (ACAU) and behaviour management, including for younger onset dementia patients.
- Ensure building stock is fit for purpose
- Ensure the technological requirements for aged care into the future are considered. This includes access to telemetry on aged care wards, digital monitoring of inpatients and increasingly, telehealth and digital monitoring of aged care patients at home.

6. Next Steps- Implementation and Evaluation

In order to enable successful delivery of the Plan's key focus areas and to monitor the progress of its priority actions, an ongoing review process will be undertaken at the Aged Care and Rehabilitation Stream meetings on a bi-monthly basis.

There will be an opportunity to enter these activities into the SESLHD Management and Planning System (MAPS), SESLHD's web-based integrated planning framework that allows facilities, wards and service units to document their business plans and quality improvement initiatives, projects and other initiatives which align with SESLHD's Journey to Excellence.

This Plan was developed with the understanding that priorities will be addressed in different ways in different facilities and in accordance with the needs of local people.

A three year review will be undertaken to identify the achievements against the Plan and determine priorities to be included in the next 3 year plan.

Implementation Plan

1. Community Innovation and Integration					
SESLHD Strategy Priority Alignment	Priority Action	Outcomes	Activity Lead	Partner/Activity Shared	Review date
Safe, person centred and integrated care; Community wellbeing and health equity	<p>Work with the District Carer Program Manager to identify and implement strategies to ensure aged care staff engagement with carers and family members and consumers by:</p> <ul style="list-style-type: none"> o Ensuring routine identification of carers and family members on intake / assessment o Assess the willingness and capacity of carers and family members to partner with us in the care of the patient o Provide carer and family members with support information across SESLHD aged care facilities and services o Support training for aged care health staff to deliver minimum standard of engagement and support to carers and family members o Increasing the number of patient, carers and or family member's participation in completing satisfaction surveys that will assist with service planning and improvements to aged care services. Fostering partnerships with a variety of agencies to improve the health and wellbeing of our older people and reduce the need for hospital care o Recognising and acknowledging what matters to patients, families and carers and family members o Work with NDIS and carers and family members on strategies to address impact of carer ageing on health services and availability of respite for older people requiring care 	<p>Carers are routinely identified at entry into SESLHD Services. Carers are aware of the available supports and entitlements. Carers have access to experience-based advice and support in their role. All carers will receive the minimum standard of engagement and support - 'Domains of Action' Carers are routinely included in care making discussions and decision-making. Staff are confident working with carers as partners. Carer accommodation is considered in future SESLHD facility design.</p>	SESLHD Manager of the Carer Program	MoH and eMR	2022
Safe, person centred and integrated care; Community wellbeing and health equity	<p>Increasing engagement with CESPHN and general practice, and effective communication across the GP to hospital interface, e.g. CESPHN digital health and HealthPathways initiatives</p>	<p>Improved communication processes between primary and acute services reducing duplication of care and improving patient and staff satisfaction</p>	Nurse Manager Clinical Stream Aged Care Rehab	CESPHN	2019
Better value; Community wellbeing and health equity; Foster research and innovation	<p>Continuous quality improvement to ensure existing models of care are provided equitably across SESLHD, for example enhancement of current outreach models such as GFS and SOS</p>	<p>More patients residing within SESLHD have access to outreach services</p>	Nurse Manager Clinical Stream Aged Care Rehab	CESPHN, RACFs, GPs	2019
Better value; Foster research and innovation	<p>Investigate potential for new and innovative models of care to continue to shift the balance of care to community based care where possible, for example prehabilitation programs for those identified at risk of frailty or decline, or prior to surgery</p>	<p>New evidenced based models of care are developed to shift the care from the acute to the community improving patient satisfaction, reducing or minimising the need for an acute hospital admission. Reducing LOS if an admission is unavoidable.</p>	Nurse Manager Clinical Stream Aged	CESPHN	2019
Safe, person centred and integrated care; Community wellbeing and health equity	<p>Investigate potential networking between SESLHD Aged Care Services and the MRID to facilitate sharing of expertise</p>	<p>Stronger links between Aged Care, MRID and NDIS support services to meet the physical and psychosocial needs of a frail person with intellectual disability</p>	Nurse Manager Clinical Stream Aged MRID	NDIS support services	2019
Safe, person centred and integrated care; Community wellbeing and health equity	<p>Investigate feasibility in partnership with CAC and Disaster Management of Aged care clients having an individual Emergency Contact List, e.g RedPlan, in place</p>	<p>Older people in the community and in RACFs will be prepared and more resilient to cope with disaster</p>	Nurse Manager Clinical Stream, Disaster Manager	CAC,RACFs	2019
Safe, person centred and integrated care	<p>Within SESLHD, working with our hospitals, other clinical streams, Mental Health, Directorate of Primary and Integrated Health and Directorate of Planning, Population Health and Equity to ensure the integration of services across the aged care continuum.</p>	<p>Aged care services continue to be more integrated through the establishment of improved communication pathways between SESLHD services.</p>	Nurse Manager Clinical Stream Aged Care Rehab	General Managers, OPMHS, PICH, DPPHE	2019

2. Aged Care Wellbeing

SES-LHD Strategy Priority Alignment		Priority Action		Outcomes	Activity lead	Partner	Start date	Review date
2.1 Dementia and delirium		Increase skills and knowledge available in dementia/delirium assessment and management through the provision of information and education to staff and carers across SESLHD services		Implementation of a dementia/delirium webpage including vignettes. Expansion of Dementia experience across district with regular evaluation. Whole hospital in servicing specific to dementia/delirium. Included as Mandatory Nursing orientation.	SESLHD Dementia and Delirium CNCs	SESLHD Managers of Education	2019	2022
Safe, person centred and integrated care		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		AMTS, CAM And DRAT screening of all patients >65 on admission, pre- post op and when there is a change in behaviour	SESLHD Dementia and Delirium CNCs	Partner with SESLHD Aged Care CNCs and Managers of Education.	2019	2022
Safe, person centred and integrated care		Focus on the identification of people at risk of delirium and the provision of care that will help reduce the risk of developing a delirium in hospital, as per NSQS Standard 5, Action 5.29; Preventing delirium and managing cognitive impairment		People at risk of delirium will be identified in SESLHD facilities	SESLHD Dementia and Delirium CNCs	Partner with SESLHD Aged Care CNCs and Managers of Education.	2019	2022
Community wellbeing and health equity		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		Referral pathway for patients admitted under mental with a cognitive impairment to either a Geriatrician or Aged Care CNC	SESLHD Dementia and Delirium CNCs	Aged Care Geriatricians and Older Persons Mental Health team	2019	2022
Safe, person centred and integrated care		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		Commencement of Behaviour Management Support CNS2	SESLHD Dementia and Delirium CNCs	Nurse Manager Clinical Stream Aged Care Rehab	2019	2022
Foster research and innovation; Safe, person centred and integrated care		Expand the number of facilities participating in the ACI Confused Hospitalised Older Person Study (CHOPS)		Implement CHOPs with all sites within SESLHD	SESLHD Dementia and Delirium CNCs	Surgical Stream CNCs	2019	2022
Safe, person centred and integrated care		Increase the availability of staff trained to assess and manage dementia/delirium in RACFs, including local GPs, through targeted education programs		Increase in education of GPs and implementation of a Dementia HealthPathways	SESLHD Dementia and Delirium CNCs	CESPHN, GFS teams.	2019	2022
Safe, person centred and integrated care		Increase access to palliative care for people with advanced dementia, including access to specialist palliative care services as required		Dialogue commenced with Community Pal Care teams, GPs and Geriatricians	SESLHD Dementia and Delirium CNCs	Community Palliative Care CNCs, GPs and Geriatricians	2019	2022
Community wellbeing and health equity		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.		District Aged care CNC and CNS2 are on Dementia Alliance committee run by 3Bridges	SESLHD Dementia and Delirium CNCs	Outreach teams, CESPHN 3Bridges	2019	2022
Safe, person centred and integrated care		Ensure dedicated behaviour units are utilised in all three acute facilities		Establish communications between specialised units regarding discharges and bed vacancies	SESLHD Dementia and Delirium CNCs	SESLHD GMs, Geriatricians	2019	2022
Community wellbeing and health equity		Identify opportunities and partnerships to support long term improvements in the community based management of increasing numbers of people living with younger onset dementia		Engage with community based dementia services, to identify gaps in care	SESLHD Dementia and Delirium CNCs	WMH, CESPHN	2019	2022
Foster research and innovation; Safe, person centred and integrated care		Implement recommendations from the Delirium Quality Self-Assessment and Delirium Care Pathways across the District.		Regular evaluation of education in alignment with ACSQH Delirium Clinical Care Standards.	SESLHD Dementia and Delirium CNCs	Nurse Manager Clinical Stream Aged Care Rehab	2019	2022

2. Aged Care Wellbeing					
SESLHD Strategy Priority Alignment 2.2 Mental Health	Priority Action	Outcomes	Activity lead	Partner	Review date
Safe, person centred and integrated care	Consumers and their families and carers can expect to be provided with care that is consistent with the Mental Health Statement of Rights and Responsibilities	Adopt a person-centred, recovery-oriented, biopsychosocial philosophy of care, and ensure that care environments, processes and practices reflect this philosophy. Implement strategies to increase the participation and representation of consumers and carers in OPMHS design, development and delivery, and evaluation and quality improvement processes. Promote uptake of YES (Your Experience of Care) surveys	A/Director Mental Health	Consumers, families and carers	2019
Community wellbeing and health equity	OPMHS services are accessible and equitable across SESLHD	Implement the NSW Health Older People's Mental Health Acute Inpatient and Community Models of Care. Build capacity and capability to provide accessible, equitable, effective and efficient OPMHS through planning, funding, service redesign and workforce strategies.	A/Director Mental Health	Facilities, Community Services	2019
Community wellbeing and health equity	Support better outcomes for older people with co-occurring mental and physical problems and complex needs, through integrated planning and protocols, common as assessment frameworks and joint programs	Provide appropriate assessments and care for people with complex mental health issues and cognitive impairment/dementia. Develop capacity and capability to assess and care for people with Behavioural and Psychological Symptoms of Dementia. Ensure regular geriatric consultations and access to other medical and surgical care as required. Reduce risk of development of secondary comorbidity, such as referral to falls prevention strategies. Physical health audits.	A/Director Mental Health	OPMHS, Aged Care services, CESPIN	2022
Community wellbeing and health equity	Identify barriers and establish protocols for effective ongoing collaboration between the OPMHS and other SESLHD aged care services	Participate in coordinated planning with aged care services, Primary Health Networks and other relevant services to develop joint initiatives and coordinated responses to the needs of older people with mental health problems.	A/Director Mental Health	OPMHS, Aged Care Services	2019
Community wellbeing and health equity	Work in partnership with GPs, private psychiatrists and psychologists, and other key health care and aged care providers both within and external to NSW Health, with a focus on recovery and supporting integrated care across different settings	Develop pathways for consultation, referrals and escalation points between OPMHS and SESLHD aged care services. Strengthen inter-agency and inter-sectoral collaborative arrangements to improve older people's access to mental health community care and support services/programs.	A/Director Mental Health	OPMHS, Aged Care Services, CESPIN, RACFs, NGOs	2019
Community wellbeing and health equity	Develop OPMHS consultation/liaison and case management, our each capacity with the residential aged care sector, to support sustainable long-term care for this group	Work with the aged care assessment services, community and residential aged care sectors, PHNs and other key services to support early identification of mental health problems in older people and appropriate referral to OPMHS. Develop the capacity and practice of OPMH community services to support appropriate transitions and outreach to, and partnerships with, Residential aged Care Facilities in line with NSW mental health reform directions	A/Director Mental Health	OPMHS, RACFs	2019
Community wellbeing and health equity	Develop targeted and indicated mental health promotion, prevention and early intervention initiatives for older people	Maximise opportunities for older people with mental illness to be appropriately supported in community settings by promoting recognition of mental health issues and access to community services/programs and supporting this through collaboration and partnerships. Promote partnerships, collaboration and integration of care in a changing service landscape, in line with recovery-oriented practice and key NSW mental health policy and reform directions, including maximising opportunities for partnerships between OPMH and community mental health, aged care, disability services and drug and alcohol services.	A/Director Mental Health	OPMHS and community mental health, aged care, disability services and drug and alcohol services.	2022
Community wellbeing and health equity	Respond to the particular needs of specific population groups and older people with mental illness and co-occurring problems. These groups include: <ul style="list-style-type: none"> o Older Aboriginal people o Older people from Culturally and Linguistically Diverse backgrounds o Residents of RACFs o Older people with co-existing mental health and alcohol and drug issues o Older people with co-existing mental health problems & intellectual disability o Older people in the criminal justice system o Older people who are homeless o Older people living in domestic squalor o Older LGBTI people o Families & carers 	Address carer needs by facilitating access to appropriate carer support services/programs and providing information and advice to support carers in their caring role.	A/Director Mental Health	OPMHS and community mental health, aged care, carers	2019
Workforce wellbeing; Foster research and innovation	Staff training, skills development and workforce planning is supported, supportive organisational and team structures are promoted, and there is a focus on research and evaluation	Implement recruitment strategies to increase the supply of appropriately qualified medical, nursing and allied health staff for OPMHS. Promote access to appropriate education, training, leadership development, and skills and practice development initiatives, in partnership with HETI and other education and training organisations and peak professional bodies. Promote Bronze, Silver and Gold Level Training	A/Director Mental Health	OPMHS, HETI, CPU	2019
Foster research and innovation	Innovation and new models of care and ways of working are embraced.	Adoption of evidence based practice and new research into OPMHS. Promote translation of research findings and evidence into practice through: <ul style="list-style-type: none"> • supporting practitioner researchers • building collaborative partnerships among policy makers, practitioners/clinicians and researchers • rigorous evaluation of policies and programs • maximising the use of research in policy, practice and health service delivery practice and new research into OPMHS. 	A/Director Mental Health	OPMHS, research organisations	2019

2. Aged Care Wellbeing

SESLHD Strategy		Priority Action		Outcomes		Activity lead		Partner		Review date	
Priority Alignment		Priority Action		Outcomes		Activity lead		Partner		Review date	
2.3 Falls and Falls Injury Prevention		2.3.1 In Community Settings									
Community wellbeing and health equity	DPPHE frailty and falls strategic projects including outdoor exercise parks for older people and Fire and Rescue reciprocal referral pathways	Establishment of an outdoor exercise park in SESLHD Evidence of engagement with local council to identify suitable green space for exercise parks Evidence of grant applications with partner organisations for dedicated funding for exercise parks Establishment of a formalised referral pathway between Fire and Rescue and Geriatric Flying Squad	SESLHD Health Promotion Service SESLHD Falls Prevention Co-ordinator SESLHD Health Promotion Service SESLHD Community Partnerships Unit	2019	2022						
Community wellbeing and health equity	Identify opportunities to implement falls prevention strategies as part of the place-based equity and well-being initiatives in Maroubra and South Coogee	Stepping On program completion in Lexington Place Cross-agency collaboration including implementation of falls risk screening by FACS Client Service Officers in people over the aged of 65	SESLHD Falls Prevention Co-ordinator	2019	2022						
Community wellbeing and health equity	Increase physical activity both through organised groups and healthy built environments	Establishment of exercise parks as per DPPHE frailty and falls strategic projects Increase options for physical activity through promotion of NSW Active and Healthy website Review of existing exercise programs provided by SESLHD to promote inclusion of exercise known to prevent falls	SESLHD Falls Prevention Co-ordinator SESLHD Health Promotion Service SESLHD Health Manager - Healthy Ageing Program (AIMS and WAVES) POWH	2019	2022						
Community wellbeing and health equity	Support training to upskill fitness leaders and providers of community-based group exercise on the types of exercise known to prevent falls e.g. balance and functional training	Training provided to fitness leaders in types of exercise known to prevent falls	SESLHD Falls Prevention Co-ordinator	2019	2022						
Community wellbeing and health equity	Offer a range of evidence-based falls prevention services including but not limited to: o Exercise that focuses on challenging balance and improving strength o Multi-component falls prevention programs e.g. Stepping On o Multi-disciplinary assessment and targeted interventions for people at risk of falls and fractures.	Service directory identifying falls prevention services in SESLHD	SESLHD Health Promotion Service Community Health Services e.g. POW Community Health, Southcare	2019	2022						
2.3.2 In Hospital Settings											
Safe, person centred and integrated care	In line with Standard 5, Health service organisations will: i. Have systems that are consistent with best-practice guidelines for: i. Falls prevention ii. Minimising harm from falls iii. Post-fall management	LHD Falls prevention procedure that aligns with Standard 5 and current evidence-base, with evidence of review Sites meet Standard 5 as per formal accreditation process	District Steering Committee for Falls Injury Prevention in Health Facilities	2019	2022						
Safe, person centred and integrated care	Ensure that equipment, devices and tools are available to promote safe mobility and manage the risks of falls In line with Standard 5, clinicians caring for patients at risk of falls will: o Conduct comprehensive risk assessments o Incorporate falls prevention strategies into the patient's comprehensive care plan, ensuring the care provided to the patient is person-centred and meets their specific clinical and personal needs o Provide patients, families and carers with information about reducing falls risks and falls prevention strategies	SESLHD falls prevention equipment log Processes to identify and monitor equipment at site level	District Steering Committee for Falls Injury Prevention in Health Facilities SESLHD falls prevention and management committees	2019	2022						
Safe, person centred and integrated care	Support and implement initiatives in line with State-wide priorities and programs, such as Leading Better Value Care (LBVC)	OARS audit results showing adherence to relevant elements of Standard 5 and corresponding action plans Sites meet Standard 5 as per formal accreditation process	District Steering Committee for Falls Injury Prevention in Health Facilities	2019	2022						
Better value	Support and implement initiatives in line with State-wide priorities and programs, such as Leading Better Value Care (LBVC)	Implementation of State-wide programs such as Leading Better Value Care in SESLHD	District Steering Committee for Falls Injury Prevention in Health Facilities	2019	2022						
Foster research and innovation	Support and implement improvement and innovation within our health facilities in line with District priorities and programs, such as the SESLHD Patient Safety Program.	Implementation of improvement programs to prevent falls in SESLHD Site-based register of quality improvement activities e.g. MAPS	District Steering Committee for Falls Injury Prevention in Health Facilities	2019	2022						
Safe, person centred and integrated care	Encourage the use of professional interpreters and approved translated communication aids to convey safety information to aged CALD patients. In situations where falls occur, staff should include information such as Country of Birth, Language and Interpreter Required status on incident reports to assist in data collection to further identify falls risks and areas of potential preventative interventions.	CALD patients are better supported with information on safety	District Steering Committee for Falls Injury Prevention in Health Facilities Respite in Multicultural Health Services, SESLHD	2019	2022						

2. Aged Care Wellbeing

SES-LHD Strategy Priority Alignment	Priority Action	Outcomes	Activity lead	Partner	Start date	Review date
2.4 Frailty	<p>Introduce standardised frailty screening and assessment tools and pathways across all healthcare settings to improve the quality of life of community dwellers, decrease frailty-related admissions, reduce length of stay, and improve function and independence, with:</p> <ul style="list-style-type: none"> o Early identification of frailty risk o Facilitation of timely referrals o Intervention strategies and care plans o Measurement of patient related outcomes. 	<p>Frailty screening is routine practice and processes intervention strategies put in place</p>	<p>Nurse Manager Clinical Stream Aged Care Rehab</p>	<p>Facilities, Aged Care Services</p>	<p>2019</p>	<p>2022</p>
	<p>Foster research and innovation; Safe, person centred and integrated care</p>	<p>Multidisciplinary input into the management of frailty across SES-LHD</p>	<p>Nurse Manager Clinical Stream Aged Care Rehab</p>	<p>Allied Health</p>	<p>2019</p>	<p>2022</p>
2.5 Social Isolation and Loneliness	<p>Consider opportunity for holding a multidisciplinary Frailty forum</p>					
	<p>Work in partnership with DPPHE, NGOs and local councils to address the psychosocial needs of the elderly in our community and prevent social isolation and loneliness, e.g. with social prescribing to refer people to non-clinical services to improve their health and wellbeing and foster activities that promote health and community connection and active social participation.</p>	<p>The impact of social isolation and loneliness in our older residents will be recognised and strategies for prevention put in place</p>	<p>Nurse Manager Clinical Stream Rehab</p>	<p>DPPHE, NGOs, Councils carers</p>	<p>2019</p>	<p>2022</p>
2.6 Older Aboriginals	<p>Safe, person centred and integrated care; Community wellbeing and health equity</p>	<ul style="list-style-type: none"> • Engage with Local Aboriginal Community Controlled Organisations (ACCOS) who work with the aged in the Aboriginal community and in the Cairns space. • This includes ACCOS - Kurramulla Aboriginal Corp and Guivival Elders Corporation. • Membership opportunities for Carers on SES-LHD consumer advisory committees. 	<p>Manager of Aboriginal Health Unit</p>	<p>Aged care Services, ACCOS, carers</p>	<p>2019</p>	<p>2022</p>
	<p>Foster research and innovation</p>	<p>Research is co-designed with Aboriginal people and communities in SES-LHD, e.g. there is a current collaborative research project being undertaken by the South Eastern Sydney Research Collaboration Hub, Carers Program/ Priority Populations Unit and Aboriginal Health Unit</p>	<p>Manager of Aboriginal Health Unit</p>	<p>AHU, SES-LHD researchers</p>	<p>2019</p>	<p>2022</p>
	<p>Safe, person centred and integrated care</p>	<p>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</p>	<p>Manager of Aboriginal Health Unit</p>	<p>AHU, Aged Care Services</p>	<p>2019</p>	<p>2022</p>
	<p>Workforce wellbeing; Community wellbeing and health equity</p>	<p>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</p> <p>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</p> <p>Ensure cultural competence is reflected in the SES-LHD Aged Care and Rehabilitation Stream leadership and in the knowledge, values, skills and attitudes 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.</p>	<p>Manager of Aboriginal Health Unit</p>	<p>AHU, Aged Care Services</p>	<p>2019</p>	<p>2022</p>
2.7 Medication Safety	<p>Establish effective processes to ensure an accurate record is taken of all medications in use among elderly patients (including over the counter) and ensure it is readily available to all clinicians</p>	<p>Regular audits of medication recording on admission with governance processes in place.</p>	<p>Aged Care & Rehab Clinical Stream</p>	<p>SES-LHD Site Lead Pharmacists Directors of Medical Services</p>	<p>2019</p>	<p>2022</p>
	<p>Establish mechanisms to improve rates of medication reconciliation for high risk patients at hospital admission, and undertake work to improve the accuracy of medicines information provided to primary care providers after hospitalisation</p>	<p>Continue to audit and undertake quality improvement activities to improve medication reconciliation on admission and discharge</p>	<p>Aged Care & Rehab Clinical Stream</p>	<p>SES-LHD Site Lead Pharmacists</p>	<p>2019</p>	<p>2022</p>
	<p>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</p>	<p>Mechanisms are established to improve safe aged care medication management.</p>	<p>Aged Care & Rehab Clinical Stream</p>	<p>SES-LHD Site Lead Pharmacists CESP HN/GPs, RACFs, Aged Care Services</p>	<p>2019</p>	<p>2022</p>
	<p>Undertake and/or work with the primary care sector to ensure regular medication management reviews in local RACFs</p>	<p>Regular reviews are undertaken to ensure RACF clients are being prescribed appropriate medications</p>	<p>Aged Care & Rehab Clinical Stream</p>	<p>Aged Care Services, CESP, RACF's, Aged Care Services, SES-LHD</p>	<p>2019</p>	<p>2022</p>
	<p>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.</p>	<p>Continuation of quality improvement activities to ensure aged care patients and their carers and families have a full understanding and up to date record of their medications</p>	<p>Aged Care & Rehab Clinical Stream</p>	<p>Site Lead Pharmacists, consumers, families and carers</p>	<p>2019</p>	<p>2022</p>
	<p>Encourage the use of professional health care interpreters in all discussions around medication with patients from CALD backgrounds with low English proficiency or low health literacy, and inclusion where appropriate of questions pertaining to use of alternative/complementary medicines and medicines that have been prescribed or obtained from someone other than the regular GP or health service.</p>	<p>CALD patients will have access to information regarding medication use and safety</p>	<p>Aged Care & Rehab Clinical Stream</p>	<p>Site Lead Pharmacists, CALD consumers, families and carers, Multicultural Health Services, SES-LHD</p>	<p>2019</p>	<p>2022</p>

3. Care of the Older Surgical Patient						
SES/LHD Strategy Alignment	Priority Action	Outcomes	Activity lead	Partner	Start date	Review date
3.1 Orthogeriatric Services						
Safe, person centred and integrated care; Foster research and innovation	Use national hip fracture benchmarking data to identify areas where care of the older hip fracture patient can be improved.	Targeted approach to improving care	Geriatrician lead at POWH	SES/LHD Aged Care and Rehabilitation Stream	2019	2022
Safe, person centred and integrated care	The three acute sites to work collaboratively to improve the care of hip fracture patients and deliver care consistent with existing national standards.	Improved adherence to National Hip Fracture Care Clinical Care Standard across the three sites	Geriatrician lead at POWH	POWH, SGH and TSH Geriatricians	2019	2022
Community wellbeing and health equity	Ensure that secondary fracture prevention services targeted at hip fracture patients aligns / dovetails with the existing secondary fracture prevention services across SES/LHD	Increased uptake of treatment for osteoporosis for hip fracture patients	Geriatrician lead at POWH	SES/LHD Geriatricians	2019	2022
Foster research and innovation	Contribute to ongoing and future research in the area of hip fracture care.	Research funding and publications relating to hip fracture care	Geriatrician lead at POWH	SES/LHD Geriatricians	2019	2022
3.2 other Surgical Services						
Safe, person centred and integrated care; Foster research and innovation	Roll out the COPS model of care across the three acute hospitals and continue to evaluate the impact	Frail older surgical patients will routinely have a geriatrician involved in their care	Geriatrician lead at POWH	SES/LHD Nursing and Midwifery	2019	2022
Foster research and innovation	Develop pathways of care to support frail older people undergoing elective surgical intervention, including discharge planning	Pathways will be in place to identify patients likely to benefit from comprehensive geriatric assessment in the peri-operative setting.	Geriatrician lead at POWH	Surgical Stream	2019	2022
Foster research and innovation	Undertake further research to determine the optimal model of care for SES/LHD. Encourage the use of professional health care interpreters when obtaining informed consent from patients from CALD backgrounds who have difficulty understanding or communicating in English.	Data to support a business plan for COPs services in the emergency and elective setting. Publications that highlight the benefit of this shared approach to care.	Geriatrician lead at POWH	SES/LHD Geriatricians	2019	2022
Safe, person centred and integrated care		Interpreters are used to support informed consent of CALD patients	SES/LHD Geriatricians	Surgical Stream, Multicultural Health Services, SES/LHD	2019	2022
4. Advance Care Planning (ACP)						
SES/LHD Strategy Alignment	Priority Action	Outcomes	Activity lead	Partner	Start date	Review date
Safe, person centred and integrated care; Foster research and innovation	Normalise ACP within the SES/LHD by establishing support systems and approaches to ensure all patients with advanced illness who are admitted are offered an ACP conversation.	Establish governance and an electronic tool so eligible patients are offered an ACP conversation as part of routine care.	Advance Care Planning site leads	SES/LHD EoL Committees and Aged Care and Rehab Stream Committee	2019	2022
Safe, person centred and integrated care; Foster research and innovation	Work across systems and services to systemise admission, clinical review and discharge procedures to ensure advance care plans are identified, used in clinical decision making, and transferred between care settings	Develop SES/LHD policies to guide staff in development review and upload of ACP documents	Advance Care Planning site leads	SES/LHD EoL Committees and Aged Care and Rehab Stream Committee	2019	2022
Better value	Routine ACP in general practice, aged care outpatient clinics and for residents of aged care settings which integrate with the acute care facilities	Continue to provide education to GPs on ACP with ongoing evaluation. Develop an electronic platform so GPs/RACFs and acute setting can view an ACP.	Advance Care Planning site leads	SES/LHD EoL Committees and Aged Care and Rehab Stream Committee	2019	2022
Foster research and innovation	Widely promote and routinely adopt end of life/ACP tools that support staff to effectively undertake ACP with patients. Provide training and mentorship to support staff to have ACP conversations	Develop educational opportunities and SES/LHD leads to provide ACP education/mentoring sessions in different formats to SES/LHD staff	Advance Care Planning site leads	SES/LHD EoL Committees and Aged Care and Rehab Stream Committee	2019	2022
Safe, person centred and integrated care	Ensure that information in all ACP documents are incorporated in the electronic health records	Improve upload processes through the audit of HLU upload.	Advance Care Planning site leads	SES/LHD Forms Committee	2019	2022
Safe, person centred and integrated care	Monitor progress in implementing ACP across the District.	Monitor progress of SES/LHD ACP through facility EoL Committees. Make changes to ACP processes according to TRGS outcomes.	Advance Care Planning site leads	SES/LHD EoL Committees and Aged Care and Rehab Stream Committee	2019	2022
Safe, person centred and integrated care	Encourage the use of professional health care interpreters when discussing Advance Care Planning with patients, carers and family members from CALD backgrounds	professional health interpreters are used with CALD patients when discussing ACPs	Advance Care Planning site leads	SES/LHD EoL Committees and Aged Care and Rehab Stream Committee, Multicultural Health	2019	2022
Safe, person centred and integrated care	Normalise ACP within the SES/LHD by establishing support systems and approaches to ensure all patients, including CALD groups, with advanced illness who are admitted are offered an ACP conversation.	All patients with advanced illness are offered an ACP conversation	Advance Care Planning site leads	SES/LHD EoL Committees and Aged Care and Rehab Stream Committee	2019	2022

5. Research						
SESLHD Strategy Priority Alignment	Priority Action	Outcomes	Partner	Start date	Review date	
Foster research and innovation	Continue to support, facilitate and promote the undertaking of high quality research into issues relating to older people and transition to improve the care we provide	A strong research culture is encouraged within the aged care services and will be reported at the annual research forum	SESLHD Aged Care and Rehabilitation Stream Clinical Committee, SPHERE	2019	2022	
6. Teaching and Education						
SESLHD Strategy Priority Alignment	Priority Action	Outcomes	Activity lead	Partner	Start date	Review date
Foster research and innovation	Continue to build SESLHD's aged care clinical teaching role, including providing highly structured placement models and strengthening the learning culture in aged care services	A teaching and learning culture is embedded in SESLHD Aged Care services.	SGH Geriatrician	SESLHD Aged Care and Rehabilitation Stream, Universities, Committees, SESLHD Aged Care and Rehabilitation Stream	2019	2022
Workforce wellbeing	Continue to work with universities and other training providers to redesign training and mentoring programs to ensure all 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	SESLHD Aged Care Services staff are provided with education and training opportunities to enable SESLHD aged care patients to receive the best available care	SESLHD Aged Care and Rehabilitation Stream	SESLHD Aged Care and Rehabilitation Stream, Universities, Heli and other training organisations	2019	2022
Foster research and innovation	Increase opportunities for inter-professional learning and work practices, where different health professionals learn together to improve collaboration and quality of aged care	Support is provided for a collaborative inter-professional teaching and learning culture to be embedded in Aged care services in SESLHD	Aged Care and Rehabilitation Stream	SESLHD Aged Care and Rehabilitation Stream, Committees	2019	2022
Foster research and innovation	Increase engagement of health professionals working in aged care services, in workforce teaching initiatives including undertaking a professional development needs analysis	A professional development needs analysis is undertaken for SESLHD Aged Care Services staff	Aged Care and Rehabilitation Stream	SESLHD Aged Care and Rehabilitation Stream, Committees	2019	2022
Foster research and innovation	Further develop teaching leadership capacity to support and lead aged care workforce innovation and reform capacity	Improved teaching capacity	SGH Geriatricians, Facility leads	Care and Rehabilitation Stream, Committees	2019	2022
Foster research and innovation	Continuing and maturing teaching and research partnerships across SESLHD with universities and other institutions.	Improved partnerships between SESLHD and tertiary institutions	SESLHD Aged Care and Rehabilitation Stream	SESLHD Aged Care and Rehabilitation Stream, Committees, Universities, and other training	2019	2022
6. Infrastructure						
SESLHD Strategy Priority Alignment	Priority Action	Outcomes	Activity lead	Partner	Start date	Review date
Safe, person-centred and integrated care	Ensure sufficient inpatient aged care beds across SESLHD facilities. This includes the enhancement of supporting models for early assessment (ACAU) and behaviour management, including for younger onset dementia patients.	Current and future development and models of care are evidenced based and meet the needs of the older person to ensure safe and appropriate care. Capital planning reflects infrastructure requirements	Nurse Manager Clinical Stream Aged Care Rehab	SESLHD Aged Care and Rehabilitation Stream, Committees, Facility GMs, MoH	2019	2022
Safe, person-centred and integrated care, Better value	Ensure building stock is fit for purpose	All new builds are planned according to Aged Care guidelines with expert consultation.	Nurse Manager Clinical Stream Aged Care Rehab	SESLHD Aged Care and Rehabilitation Stream, Committees, Facility GMs, MoH, Health Infrastructure	2019	2022
Safe, person-centred and integrated care	Ensure the technological requirements for aged care into the future are considered. This includes access to telemetry on aged care wards, digital monitoring of inpatients and increasingly, telehealth and digital monitoring of aged care patients at home.	Enhancements of Aged Care areas will include latest technology.	Nurse Manager Clinical Stream Aged Care Rehab	SESLHD Aged Care and Rehabilitation Stream, Committees, Facilities	2019	2022

7. Aboriginal Health Impact Statement



Aboriginal Health Impact Statement

SESLHD Aged Care Services Plan 2019-2022

Title of the initiative:	South Eastern Sydney Local Health District Aged Care Clinical Services Plan 2019-2022
Organisation/Department/Centre:	South Eastern Sydney Local Health District Aged Care and Rehabilitation Stream
Contact name and title:	Associate Professor Peter Gonski, Aged Care and Rehabilitation Stream Director
Contact phone number:	9540 7173
Date completed:	

Once approval has been received from your Organisation please provide a copy of the finalised Aboriginal Health Impact Statement to the Centre for Aboriginal Health by email: CAH@moh.health.nsw.gov.au

Summary

The SESLHD Journey to Excellence Strategy 2018-2021 outlines the District's ambitions to empower communities to optimise their health and wellbeing along the life course and provide safe, person centred and integrated care. The District's Equity Strategy notes although the health of residents as a whole compares favorably with other parts of NSW, there are substantial differences in access to services and health outcomes for different groups, including Aboriginal people.

The SESLHD Aged Care Clinical Services Plan 2019-2022 further articulates these strategies, with a key focus on supporting older community members to access the right services, at the right time, in the most appropriate setting. It also aims to reduce the burden and impact of chronic disease on the health system by shifting the balance of care towards more community/home based services that aim to keep older people well at home for as long as possible and avoid the need for hospital admission where possible.

For Aboriginal people, the Aged Care Clinical Services Plan 2019-2022 builds upon the work initiated in the Aged Care Clinical Services Plan 2015 -2018, which recognised the specific health needs of older Aboriginal people and actions to support access and care, particularly for dementia diagnosis and support. The Plan seeks to maintain the dialogue between the Aboriginal Health Unit and the District's Aged Care Services to continue to address key issues affecting the health and wellbeing of older Aboriginal people in our community and the wider Aboriginal community we serve.

1. The health context for Aboriginal people

There are currently over 1,800 older Aboriginal people (50 years and over) living in the South Eastern Sydney Local Health District.^{xi} While Aboriginal people are reaching older ages, and this is reflected in an increased number of older Aboriginal people accessing SESLHD health services, the obvious gap in life expectancy between Aboriginal and Non Aboriginal people is still observed in SESLHD. The Aboriginal population has a higher mortality rate and a lower life expectancy than other Australians - in Australia in 2016, just 5% of the Indigenous population were aged 65 and over compared with 16% of the non-Indigenous population,^{xii} and this is reflected similarly in SESLHD.

The SESLHD Equity Indicator Baseline report (2017) highlights the life expectancy gap for Aboriginal people in SESLHD. The gap in many LGAs is greater than the National gap where the gap compared to the non-Aboriginal population is 8.6 years for Aboriginal males and 7.8 years for Aboriginal females respectively. Nationally these gaps are smaller than they were in 2010-12.^{xiii} Whilst it is confronting in nature, SESLHD has been advised to consider how to best “Close the Gap” in Aboriginal health outcomes and should consider this as an important measure.

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, with more Aboriginal people in their 40s and 50s and even sometimes much younger also experiencing dementia.^{xiv} Aboriginal and Torres Strait islander people experience dementia at a rate three to five times higher than the general population.^{xv}

Aboriginal people are also over-represented for potentially preventable hospitalisations, with the rates of hospitalisation for all causes increasing at a higher rate in Aboriginal people than in non-Aboriginal people.^{xvi} Admission rates for conditions in SESLHD, including diseases of the circulatory, endocrine and respiratory system, are similar to the rates in NSW and Australia, except for mental health disorders where rates can be two times higher within SESLHD when compared to NSW and Australia.^{xvii}

In SESLHD in 2016/17, people aged 50 years and over represented 38% of all admissions and 41% of all bed days for Aboriginal people, as opposed to 66% and 70% respectively for non-Aboriginal people, reflecting the difference in age structure for Aboriginal and non-Aboriginal populations. For people aged 70 years and over, the contrast is even starker: 8% of separations and 9% of bed days for Aboriginal people, compared to 40% and 46% respectively for non-Aboriginal people.^{xviii}

^{xi} Usual resident population by LGA. Compiled by PHIDU based on the ABS Census of Population and Housing, August 2016. (Note that 42.5% of Sydney LGA is included in SESLHD). URL: <http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlases-of-australia-local-government-areas>

^{xii} Australia Institute of Health and Welfare. Older Australia at a glance. 2017. <https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/diverse-groups-of-older-australians/aboriginal-and-torres-strait-islander-people>

^{xiii} This data has only recently been captured for the first time (2009-2012) and it should be noted with caution that data for Aboriginal people in each LGA is based on small numbers.

^{xiv} 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.

^{xv} Dementia Australia. Dementia help sheets for Aboriginal and Torres Strait Islander people. Accessed from https://www.dementia.org.au/files/helpsheets/Helpsheet-AboriginalAndTorresStraitIslanderPeople01-WhatsDementia_english.pdf Dec 10, 2018

^{xvi} Centre for Epidemiology and Evidence, HealthStats NSW (2006-7 to 2015-16).

^{xvii} R Schwanz (2018) Final Burden of chronic disease among Aboriginal people in SESLHD.

^{xviii} Source: CaSPA FlowInfo v. 17, including day only and excluding ED only.

More than 25% of the Aboriginal people aged 50 years and over admitted to SESLHD facilities were from other metro and rural LHDs. These people generally had a longer average length of stay and higher average Public Equivalent Model (reflecting more costly and/or complex care) than Aboriginal residents from SESLHD.

For more information refer to:

- SESLHD Aged Care Services Plan 2019-2022 – Section 5.2.5 Older Aboriginals
- SESLHD, 2017, Journey to Excellence Strategy 2018 - 2021
- SESLHD, 2015, Equity Strategy
- NSW Aboriginal Health Plan 2013 – 2023 (PD 2012_066)
- National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health 2017
- NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.

2. The potential impact of the policy, program or strategy on Aboriginal people including approaches to mitigate any potential undesired effects

There is evidence of a significant inequity in health access and outcomes between Aboriginal and non-Aboriginal Australians. It is thus an imperative to ensure our Aged Care Services meet the unique health and wellbeing needs of older Aboriginal people, including consideration of their level of comorbidities, their age at diagnosis, their socioeconomic position, their health literacy and their preferences for service delivery.

This Plan supports the continuation of a range of existing Aboriginal Health services and programs serving the SESLHD community that provide integrated care for older Aboriginal people. These include the South East Aboriginal Health Care program, which aims to address the chronic care needs and improve health outcomes of Aboriginal people in SESLHD through better access to coordinated and multidisciplinary care; Aboriginal Hospital Liaison Officers; Aboriginal Health Education Officers; Supplementary Services Program for Aboriginal and Torres Strait Islander people; Care Co Coordinators; Aboriginal Health Outreach Workers and SESLHD Oral Health services for Aboriginal people. SESLHD Aged Care Services will also continue to support the specific health care needs of older Aboriginal people living at home and in RACFs and those requiring hospital care.

For older Aboriginal people, the Plan proposes:

- Working with the District's Aboriginal Health Unit to build genuine relationships with Aboriginal communities to identify needs and preferences in aged care service design and delivery/support
- Taking 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
- Working 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
- Ensuring cultural competence is reflected in the SESLHD Aged Care and Rehabilitation 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.

The Plan also provides an opportunity to continue advocating to “close the gap” and improve equity in health access and outcomes for older Aboriginal people in our community.

3. Engagement with Aboriginal people

During the development process of this Plan, SESLHD's Manager, Aboriginal Health was asked to review the previous Plan content relevant to Aboriginal people and achievements against this. Updated content was provided and incorporated into the Plan, and key issues and priority actions were identified for the future. This informed the Implementation Plan, to ensure that SESLHD's Aged Care Services are culturally appropriate and address the health and wellbeing needs of older Aboriginal people into the future.

At facilities, if any funding for capital redevelopment is provided for Aged Care Services, it is intended ongoing advice will be sought from the Aboriginal Health Unit and with representatives of the local Aboriginal community to ensure a welcoming environment that is suitable for older Aboriginal people, particularly those who are frail and/or have dementia.

Approved by:

TIM CROSS JANGARA

Date:

18/4/19

Title/position:

MANAGER ABORIGINAL HEALTH UNIT-

Organisation/Department/Centre:

ABORIGINAL HEALTH UNIT/
PRIMARY INTEGRATED & COMMUNITY/
HEALTH.

Contact phone number:

02. 95408251

Signature:



By signing this document you agree that the initiative satisfactorily meets the three key components of the Aboriginal Health Impact Statement.

Note: Must be approved by the relevant Executive Director or Director of the local health district, pillar organisation or Centre within the NSW Ministry of Health.

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