South Western Sydney
Local Health District

SWSLHD Older Persons and Rehabilitation Plan to 2027

South Western Sydney Local Health District

NSW GOVERNMENT

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Acknowledgement of Country

South Western Sydney Local Health District (SWSLHD) would like to acknowledge the traditional owners of the land that falls within the boundaries of our District – the peoples of the Darug, Dharawal and Gundungurra Nations. We also acknowledge that all the health facilities across the District are built on their traditional lands.

We pay our respects to Aboriginal Elders past and present and extend that respect to all Aboriginal people.

Foreword

As the South Western Sydney Local Health District (SWSLHD's) population rapidly growing and ageing, the need for aged care and rehabilitation services will increase. While the demand for rehabilitation spans all ages, it increases with age. Older people are proportionally the largest group accessing these services.

The development of various service improvements, innovations, and models of care to better support older persons and people in need of rehabilitation has occurred incrementally across the District over recent years.

The SWSLHD Older Persons and Rehabilitation Plan to 2027 provides direction for health services to maintain the quality of life of older persons with complex health and support needs and people requiring rehabilitation.

The Plan is consistent with the SWSLHD Strategic Plan 2022-2027 and strategic directions of strengthening and promoting healthier communities and delivering safe quality care and positive experience for our consumers and carers.

The Plan has been developed with the guidance of the Steering Committee and with an input of key internal and external stakeholders including clinicians, consumers, and the broader community.

The Plan identifies new and emerging models of care, key strategic priorities for the development, delivery, and improvement of services for the older persons with complex health and support needs and people requiring rehabilitation across SWSLHD, and the most effective use of available and future resources to best address our ageing community's needs. The Plan acknowledges the importance of achieving health equity for our diverse communities.

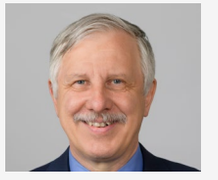
Highlighted in this plan are further service and program developments focusing on healthy ageing hospital avoidance, care in the community and alternative settings for care with the following goals:

- Reduce the burden and impact of chronic disease on the health system by shifting the balance of care towards more community and home based services to keep older person's function and independence as long as possible and avoid the need for hospital based services where possible
- Equitable access for adults who require rehabilitation to appropriate services in a timely manner with the aim of moving them rapidly back into their communities.

We would like to thank our staff, our partner organisations and communities who have contributed generously to the development of this Plan and look forward to working alongside you to achieve the best possible health outcomes for our ageing communities.

Ms Sonia Marshall, Chief Executive, South Western Sydney Local Health District

Ms Sue Colley Director, Allied Health and Community Services, SWSLHD



Prof Friedbert Kohler OAM, Clinical Director, Aged Care & Rehabilitation

Abbreviations

ACAT	Aged Care Assessment Team
ACD	Advance Care Directive
ACI	Agency for Clinical Innovation
ACP	Advance Care Planning
AIHW	Australian Institute of Health and Welfare
ARIA	Aged Care Rapid Investigation and Assessment
ASET	Aged Services Emergency Team
BHN	Bankstown Health Neighbourhood
BLH	Bankstown Lidcombe Hospital
BIRU	Brain Injury Rehabilitation Unit
BPSD	Behavioural and Psychological Symptoms of Dementia
CALD	Culturally and Linguistically Diverse
CAPS	Continence Aids Payment Scheme
CaSPA	Clinical Services Planning Analytics Portal
CFS	Clinical Frailty Scale
CHSP	Commonwealth Home Support Program
CN	Community Nursing
CNC	Clinical Nurse Consultant
CNS	Clinical Nurse Specialist
COGS	Community Outreach Geriatric Service
CRU	Camden Rehabilitation Unit
CSP	Clinical Service Plan
ED	Emergency Department
ELP	Equipment Loan Pool
eMR	Electronic Medical Record
GP	General Practitioner
HCP	Home Care Package

HITH	Hospital in the Home
ICHH	Integrated Community Health Hubs
IRRT	In-Reach Rehabilitation Team
LGA	Local Government Area
LHD	Local Health District
MAC	My Aged Care
MAU	Medical Assessment Unit
MOC	Models of Care
MDT	Multidisciplinary Team
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NMHSPF	National Mental Health Service Planning Framework
OPBU	Older People's Behaviour Unit
OPMH	Older People's Mental Health
PARS	Post Acute Rehabilitation Service
PHN	Primary Health Network
RACF	Residential Aged Care Facility
RAS	Regional Assessment Service
RITH	Rehabilitation in the Home
RRRT	Rapid Response Rehabilitation Team
SARU	Stroke and Rehabilitation Unit
SASH	Safe and Supported at Home
SCI	Spinal Cord Injury
SpACT	Specialist Aged Care Team
SpACRT	Specialist Aged Care and Rehabilitation Team
TCP	Transitional Care Program

Introduction

The *South Western Sydney Local Health District (SWSLHD) Older Persons and Rehabilitation Plan to 2027* (The Plan) responds to changing demographics, including unprecedented population growth, and ageing in SWSLHD. Additionally, the landscape of significant facility planning and redevelopment projects across the District has created a need for a detailed plan guiding provision of services for older persons and people in need of rehabilitation.

The Plan will also provide direction for health services to maximise the quality of life of people requiring rehabilitation and of older persons with complex health and psychosocial needs. The intent of the Plan is: Older persons and people in need of rehabilitation, and their carers and families will have ready access to person-centred, high quality, evidence-based programs and healthcare supporting healthy ageing and enabling independence.

The Plan aims to develop an optimal model of care (MoC) for delivery of aged health and rehabilitation services. The Plan builds on the work by the Agency of Clinical Innovation (ACI) and their documents: *Aged Health Services Model in NSW* and *The Principles to Support Rehabilitation Care* and looks to tailor them for local application. Developing a model of aged care service and rehabilitation delivery that is sustainable and integrated with the wider health system is a priority for our LHD.

An optimal aged health and rehabilitation MoC will achieve following outcomes:

- Potentially preventable hospital admissions and readmissions are reduced
- Care is provided in the community and the home in a timely fashion, when it is safe and appropriate
- Care is integrated and coordinated across multiple services and settings including collaborative and shared MoC and robust digital health connectivity
- Care is focused on health maintenance including maintenance of physical function, mental health and preventing deterioration and frailty
- Outpatient clinics will continue to be a core service with a focus on early identification and treatment of illness or functional decline, to prevent avoidable hospitalisation and/or premature admission to residential aged care, as well as post-acute care, support, and maintenance.
- Care is provided in partnership
- Telehealth technologies support virtual consultations and service delivery

For ease of reference in this document, consumers/patients have been divided into either older persons (referring to those with complex health and support needs) or adults in need of rehabilitation services. There is often significant overlap between these two cohorts.

Patient Cohort	Plan Focus
Older persons - aged 65 years and over and 50 years and over for Aboriginal and Torres Strait Islander people	• Focus on older persons with either an acute or chronic illness or with multiple medical or psychosocial concerns • Acknowledges older persons may also have particular physical or cognitive disabilities and/or issues with care, accommodation and support • Chronological age is not the main driver • Pays particular attention to frailty and other syndromes associated with frailty, including dementia
People requiring rehabilitation services – adults aged 16 years and over	• Adult rehabilitation including patients transitioning from paediatric to adult services. • Pays particular attention to the needs of people who require rehabilitation due to conditions such as stroke, neurodegenerative disorders, orthopaedic injury, spinal injury, amputation, pre-existing disability, or other degenerative conditions and reconditioning after acute illness or as a result of chronic disease particularly in the older persons • Acknowledges some clients of Rehabilitation Services have unique physical or intellectual disabilities and are also often in need of assistance with care, accommodation and/or support

Principles

The following principles underpin the delivery of SWSLHD aged health and rehabilitation services
Promote a proactive approach to health and wellness across all ages to support people to live a meaningful and functional life, maintain independence and remain living longer in their own home.
All people are valued and listened to, and treated with compassion, dignity, and respect at all times.
Care is person-centred, accessible, comprehensive, and responsive to the health needs, cultural values and other needs of individuals, families, and communities.
Care is holistic, integrated and coordinated across the continuum.
Care is provided in the most appropriate environment and modality in accordance with the needs of the patient and in consultation with them, their family, and carers.
High quality research will be embraced to optimise care provided.
The health workforce is responsive, trained, and skilled to recognise and address complexities of patients and carers health and support needs.

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Plan on a Page

Vision	**Leading safe, sustainable care for healthier communities**			
Values	**Collaboration**	**Openness**	**Respect**	**Empowerment**
Intent	Older persons and people in need of rehabilitation, and their carers and families will have ready access to person-centred, high quality, evidence-based programs and healthcare supporting healthy ageing and enabling independence			
Priorities	**Healthy Ageing, Wellness and Enabling Independence**	**Care Close to Home**		**Hospital Care Models and Pathways**
Actions	1.1 Deliver a range of targeted, culturally responsive community based healthy ageing and lifestyle programs with a focus on: • Falls and injury prevention • Memory • Nutrition and hydration • Vaccination • Health literacy and lifelong learning • Loneliness and social isolation • Pain management • Substance use • Assistive technology. 1.2 Collaborate with the PHN to increase knowledge, awareness and access to aged care services through implementation of the "Care Finder" and "Healthy Ageing" programs. 1.3 Develop and implement local protocols to identify and respond to elder abuse consistent with the NSW Policy Directive Identifying and responding to abuse of older people	**Older Persons** 2.1 Develop and implement a multidisciplinary Community Aged Health Model providing alternatives to hospital presentation and admission. Key aspects for inclusion in this model: • Frailty assessment and management • Care for people living with dementia • Falls prevention and management • Malnutrition prevention and management • Medications management • Community-based geriatric clinics and allied health services • Older people's mental health • Continuity of care with Primary Health Home Providers & RACFS • End of life planning. 2.2 Strengthen care for older persons living in residential aged care by: • Review the Community Outreach Geriatric Service model & integrate with Community-based Aged Care models. • Develop a Residential Aged Care Facility dental service as part of the Mobile Dental Services Model. 2.3 Review the aged health outpatient clinic model across the LHD to deliver consistent and equitable access to services.	**Rehabilitation** 2.4 Develop a SWSLHD Rehabilitation in the Home Model of Care. 2.5 Develop and implement a multidisciplinary model for community-based rehabilitation services. 2.6 Review the rehabilitation outpatient clinic model across the LHD to deliver consistent and equitable access to services, including specialised rehabilitation clinics. 2.7 Develop an LHD-wide Model of Care for Chronic Pain Management.	**Older Persons** 3.1 Review the management of older persons in ED to develop a District-wide approach. 3.2 Promote early mobilisation, activity and cognitive engagement of older inpatients to prevent hospital associated functional decline. 3.3 Implement Older People's Mental Health Inpatient Model of Care. 3.4 Develop and implement an LHD-wide Model of Care for the management of inpatients experiencing behavioural or psychological symptoms of dementia outside of dedicated ward models. 3.5 Strengthen management and care of older inpatients with end of life and palliative care needs.	**Rehabilitation** 3.6 Develop and implement an LHD-wide Model of Care which supports early access to rehabilitation in acute settings. 3.7 Review LHD-wide inpatient rehabilitation activity to support future service capacity planning. 3.8 Develop an LHD - wide Stroke Rehabilitation Model of Care to ensure care coordination and integration between acute and sub-acute phases. 3.9 Explore options for an LHD - wide model of service delivery for rehabilitation care of restricted weight-bearing patients. 3.10 Develop LHD-wide referral pathways and network arrangements for access to sub-specialised rehabilitation services. 3.11 Implement Navigator model to enhance timely transition for NDIS eligible patients to out of hospital care and accommodation services.
Performance Measures	• Improved quality of life and wellbeing for persons over 65 years of age • Increased Frailty Assessment and care plans developed • Increased care delivered close to home	• Reduced falls in the community resulting in hospitalisation • Increased independence to remain longer in own home • Improved Patient and Carer Experience captured through *My Experience Matters*	• Reduced rate of patients who developed a pressure injury while at hospital • Improved functional mobility in the community and during hospital stay • Increased virtual care provision of aged care & rehabilitation non-admitted services	• Reduced rate of falls in hospitals for 65+ • Reduced acute length of stay • Improved access to community and home based rehabilitation

Enablers	Evidence-based models of care	Research and innovation	Infrastructure and equipment	Technology and information	Workforce	Education and teaching

Structure

The body of this plan is presented as three key chapters.

1. The Aged Care and Rehabilitation Landscape

This chapter provides a brief description of the complex aged care and rehabilitation service landscape in Australia, New South Wales (NSW) and south west Sydney (SWS). It provides the context in which the Plan must be understood and reflects key factors impacting on service development including demographic change, projected changes in demand for health services, the funding environment, and emerging models of service delivery.

2. Clinical Service Enhancement

Consistent with the population growth and ageing is the need for additional specialist clinical aged care and rehabilitation services. Clinical services planning undertaken by SWSLHD to inform hospital redevelopments and redesign and the introduction of the Integrated Community Health Hub (ICHH) model has identified the need for significant service growth and investment as below:

Inpatient services – acute and sub-acute aged care; older people's mental health; specialist inpatient units for people with behavioural and psychological symptoms of dementia, and rehabilitation services

Outpatient services – specialist hospital-based clinics provided by aged care and rehabilitation medical, nursing, and allied health specialists

Community-based services – expansion of community-based services including access to specialist care in Integrated Community Health Hubs (ICHH), in the home and in residential aged care facilities (RACFs)

Changing the way services are provided can also significantly improve health outcomes for older persons and people requiring rehabilitation services:

- Healthy Ageing, Wellness and Enabling Independence
- Care Closer to Home
- Hospital Care Models and Pathways

Enablers

- Evidence-based models of care
- Research and innovation
- Infrastructure and equipment
- Technology and information
- Workforce
- Education and teaching

The Aged Care and Rehabilitation Landscape

The Aged Care and Rehabilitation service landscape is complex as it is designed to support a rapidly growing population with diverse needs. These needs are impacted by individual health, socioeconomic circumstances, family circumstances and other factors.

As part of the SWSLHD Strategic Plan 2022 – 2027, care across the age continuum is identified as a key priority:

Strengthen and promote healthier communities	Support people of all ages to live a meaningful and functional life, ensuring the best start in life and promoting healthy ageing.

The following provides a summary of the landscape in which SWSLHD delivers health care to older persons and people requiring rehabilitation and discusses the factors that influence how these services will be provided in the future. Understanding the complexity of the landscape and the issues, challenges and opportunities which are integral to SWSLHD achieving its vision, provides context for future service planning and delivery.

Population growth and ageing

In 2021 an estimated population of 1,049,666 people were living in SWSLHD. The SWSLHD population is projected to increase to 1,193,520 people by 2031. All Local Government Areas (LGAs) in SWSLHD, with the exception of Fairfield and Bankstown, are in the top 20% of LGAs in NSW for expected growth to 2031. The population is ageing, it is estimated that there were around 148,000 older adults in SWSLHD in 2021, and this is expected to increase by 45% to around 215,000 older people by 2031.

Fairfield (33,822) and Canterbury – Bankstown LGA - SWSLHD part (32,028) have the highest number of older people of all LGAs in SWSLHD. Wingecarribee LGA has the largest proportion of older people (26%) and single person households. It is projected that the fastest growing age groups will be the 80-84 (79%) and the 85 years and over (64%), followed by 75-79 (59%) and 70-74 (36%). Geographically, the most significant increase in the ageing population will be in: Camden (88%), followed by Liverpool (58%), Wollondilly (52%), Campbelltown (41%); and Fairfield (38%).[1]

Community diversity and vulnerability

SWSLHD communities are culturally and socioeconomically diverse. Some people in our community experience increased vulnerability and complexity due to social and /or health circumstances. Vulnerable populations include Aboriginal people, people from culturally and linguistically diverse (CALD) and refugee backgrounds, people living with disability and carers. Other vulnerable groups include people from lower socioeconomic backgrounds, people living in urban fringe areas, single person households and people who identify as lesbian, gay, bisexual, transgender, intersex and queer (LGBTQI+).

This Plan will recognise the exceptional needs of vulnerable communities in accessing appropriate, culturally competent and quality aged care and rehabilitation services. Alignment with existing District and state plans supporting the needs of vulnerable groups and priority populations is a critical element. Aligned plans include: SWSLHD Disability and Carers Strategy 2017-2022, SWSLHD Equity Framework to 2025, SWSLHD Aboriginal Health Plan to 2028, SWSLHD Health Literacy Roadmap 2019 - 2021 (under review), SWSLHD Multicultural Services Implementation Plan 2021 - 2024 and NSW Refugee Health Plan 2022 - 2027, Regional Health Strategic Plan for 2022-2032 and the NSW LGBTIQ+ Health Strategy 2022 -2027. This Plan should be read in conjunction with these listed plans for additional context.

[1] 2022 Population Projections from NSW Department of Planning and Environment (DPE).

Wellness approach in care provision

A wellness approach needs to be considered as a process that takes place across the life course rather than at a particular point in time. It is crucial to maintain optimum trajectories of functional ability and capacity throughout life and into older age. Improving health literacy across the community allows for individuals to take proactive steps to develop and maintain wellness.

Patient complexity and the demand for services

If the current trajectory continues, SWSLHD will see increasing demand for aged care and rehabilitation services from people with multiple chronic health conditions, disability, and frailty. These conditions are associated with an increased risk of frequent Emergency Department (ED) presentations, admissions, and longer lengths of stay. They are also associated with an increased demand for community and home-based services.

High demand for inpatient aged care services

Older persons are more likely to be hospitalised than younger age groups. Across SWSLHD, the rate of hospitalisations for older persons is significantly higher than for younger age cohorts. Older persons account for around 40% of all hospitalisations in SWSLHD.

Older persons may be admitted under geriatric medicine or subspecialty medical services. The number of older patients admitted under geriatric medicine varies greatly across SWSLHD and is reflective of local demands, the presence of General Medicine services, the presence of subspecialty services, and the capacity of the geriatric service to care for these people. Patients may require acute or sub-acute care. Some beds are in dedicated units, whilst others are in mixed wards.

Research indicates that hospital admission poses a significant risk for older people. The immobilisation that occurs during hospitalization is a major factor in physiological deconditioning and functional decline which can contribute to increasing frailty, as well as increased risk and incidence of falls.[2] There is a known relationship between amount of time spent on bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity.

Increasing incidence and prevalence of dementia, including dementia with challenging behaviours

In 2020, an estimated 11,716 people (4,693 males and 7,022 females) living in SWS had dementia.3 These estimates vary because there is no single authoritative data source for deriving dementia prevalence in Australia, and different approaches are used to generate estimates. People living with dementia are extensive users of the health system. The rates of morbidity, mortality and length of hospital stays are much greater in people living with dementia compared to those without dementia, with length of stay four times longer. 4 Dementia has overtaken coronary heart disease as the leading cause of disease burden among Australians aged 65 and over.5

[2] Vermeiren S., et al. Frailty and the prediction of negative health outcomes: A meta-analysis. J Am Med Dir Assoc. 2016.

[3] Dementia in Australia, AIHW 2022. The AIHW estimates were derived using prevalence rates from the 2015 World Alzheimer Report and Withall et al.2014.

[4] The NSW Dementia Service Framework 2010 – 2015.

[5] Updated AIHW Dementia in Australia report released February 2023.

The term 'younger onset dementia' refers to any form of dementia diagnosed before 65 years. In 2022, there are an estimated 27,800 people with younger onset dementia are living in Australia.[6]. Persons with younger onset dementia typically experience different losses and burden due to their age i.e., loss of work and/or income, loss of future plans. Partners and children are affected, especially if behavioural symptoms are present.

In line with the overall rise in dementia, it is anticipated there will be a proportionate increase in the number of people with severe and persistent behavioural and psychological symptoms of dementia (BPSD). BPSD is often the precipitant of people entering both acute and residential aged care facilities but is also a barrier for people accessing these services. When BPSD is present, people require care across multiple settings and health teams. Sometimes the BPSD is the primary focus of care and at other times a co-morbid issue requiring management. There is an increasing level of dependency as the illness progresses, creating challenges for those delivering care in community, residential and hospital settings. There are limited specialist acute care and residential care facilities in SWSLHD able to meet the needs of people with BPSD.

Increasing prevalence of frailty

Frailty is a syndrome resulting from combination of deconditioning and acute illness with existing functional decline. Frailty is often linked to increased mortality, hospitalisation, falls, long term care needs and reduced quality of life.[7] Frailty can affect up to 25% people aged over 70 years. As the ageing population is increasing, so are the rates of frailty.

Those at high risk or in the early stages of frailty are often undetected due to slow deconditioning and only when an acute illness or event occurs is their frailty identified. Many of the causes of frailty can be managed and, in some cases at least partially reversed to create better health outcomes and quality of life. It is therefore important to identify older people who are living with frailty as early as possible and to offer appropriate intervention via a management plan. Current health guidelines suggest that people over the age of 70 should be screened routinely.

Early intervention can allow people to stay active and healthy longer, keeping them in their homes and out of hospital. Correctly managing frailty can significantly improve a person's function and quality of life. It can also provide a better chance of recovery from acute illness as it reduces vulnerability to negative health outcomes.

The impact of falls

The prevention of falls injury is a significant health issue as fall-related injury represents the single largest cause of hospital presentations.[8] One of the leading causes of hospital-acquired morbidity and mortality in older persons is injury following a fall. Falling can lead to a loss of confidence and decline in mobility which in itself increases the risk of future falls and injuries. An injurious fall in hospital can prolong length of stay and increase the likelihood of premature admission to a RACF.[9]

Minimising harm and reducing poor outcomes for older people focuses on key factors such as frailty, cognitive impairment (dementia and delirium), poor mobility, medications and nutrition. Falls prevention strategies include changes to the inpatient environment, enhanced monitoring of people

[6] Dementia Australia (2018) Dementia Prevalence Data 2018-2058, commissioned research undertaken by NATSEM, University of Canberra.

[7] Emiel, O., et al. Frailty: implications for clinical practice and public health Lancet; 394: 1365–75. 2019.

[8] https://www.cec.health.nsw.gov.au/keep-patients-safe/older-persons-patient-safety-program/falls-prevention

[9] Australian Commission on Safety and Quality in Health Care.

identified as having high falls risk and improved education about falls risks for patients, families and carers.

For falls prevention in the community, general practitioners may identify patients who will benefit from fall prevention measures, develop and implement treatment plans with other health professionals and support patient uptake of recommendations. An Enhanced Primary Care plan may facilitate implementing falls prevention strategies. This approach involves a detailed assessment, often by multiple health professionals, followed by development and implementation of a targeted intervention plan to address modifiable risk factors.[10]

Increasing impact of polypharmacy

Polypharmacy, defined as regular use of at least five medications, is common in older adults and younger at-risk populations and increases the risk of adverse medical outcomes, hospitalisations, functional impairment, geriatric syndromes and mortality.[11] Over 90% of residents in RACF nationally have at least one medication-related problem and about 80% are prescribed potentially inappropriate medicines.[12] In addition to this, it has been found that among the older persons with a chronic illness, as many as 41% use at least one non-medically prescribed complementary or alternative medicine.[13]

Increasing prevalence of mental ill health in older people

As the SWSLHD population ages, the number of older people with mental illness is projected to increase. The growing number of older people with longstanding or late-onset mental health problems is a significant driver of Older People's Mental Health (OPMH) Service demand. Social isolation and loneliness are contributing factors to the development of mental illness. It is estimated that up to 52% of older adults living in RACFs experience symptoms of depression, and less than 1% receive psychological support.[14] There are currently significant Commonwealth initiatives underway to improve care for persons with mental illness and BPSD in generalist RACF.

Suicide is a significant issue for older persons, particularly older men. Depression is an important risk factor for suicide in later life. Men aged 85 and over persistently have the highest suicide rate in Australia.[15]

Addressing the needs of older persons with mental illness in this Plan is closely aligned with the current NSW OPMH Service Plan 2017-2027, the SWSLHD Mental Health Strategic Plan 2015-2024 and the SWS Regional Mental Health and Suicide Prevention Plan to 2025 as well as with facility re-developments and mental health MoC.

Increasing community acceptance of Advanced Care Planning and Advanced Care Directives

Advance Care Planning (ACP) and the use of Advance Care Directives (ACD) is recognised as a fundamental component of health service delivery, particularly for frail, older persons who often have progressive and ultimately terminal, conditions Including dementia. Once in their 'end of life' stage, people with dementia face frequent hospitalisations and may be given unnecessary procedures and treatment. Advance care planning is paramount for people diagnosed with dementia and needs to occur early,

[10] Waldron N, Hill A, Barker A. Falls prevention in older adults – assessment and management. Australian Family Physician Vol. 41, No. 12, December 2012.

[11] Maher et al. Clinical Consequences of Polypharmacy in Elderly. 2014.

[12] Pharmaceutical Society of Australia 2019. Medicine Safety: Take Care. Canberra: PSA.

[13] MacLennan AH, Myers SP, Taylor AW. The continuing use of complementary and alternative medicine in South Australia: costs and beliefs in 2004. Med J Aust 2006; 184: 27-31

[14] SWSPHN website 2022.

[15] Australian Bureau of Statistics 2016, Causes of Death, Australia, 2014, cat. no. 3303.0, ABS, Canberra.

considering the cognitive decline nature of the disease.[16] ACPs are designed to meet patients' wishes for treatment and care and to reduce anxiety for patients and family. Systematic implementation of a plan can significantly improve the quality of end-of-life care, reduce hospitalisations, and reduce the cost of unwanted interventions. [17]

RACFs, General Practitioners (GPs), medical specialists and other health staff all have a potential role in increasing the uptake of ACD through educating individuals and families of the benefits. Besides health staff, a number of other professional including lawyers have a potential role in facilitating decision making and supporting patient involvement in end of life choices. Systems for discussing, documenting, recording, and implementing plans are well developed. Clinicians have wide access to validated resources and training to explain them. SWSLHD has developed an ACP Guideline and Procedure linked to the Electronic Medical Record (eMR) system to ensure the patients end of life care wishes are identified, respected, and followed.

Increasing rates of lower limb amputation

Annually in NSW, more than 2000 amputation procedures are performed. Over two thirds of these surgical procedures occur in people over 60 years of age. Amputations generally affect adults with type 2 diabetes and peripheral vascular disease with other causes being trauma or tumours. People undergoing a planned amputation should have a care plan developed pre-operatively between clinical services involved in the care of people with an amputation including surgical, rehabilitation, endocrinology, orthopaedic and vascular, primary care and community health. The National Disability Insurance Scheme (NDIS) Coordinator will be involved following the surgical procedure. People with and amputation will require access to a range of rehabilitation services and supports in hospital and the community.

Increasing prevalence of chronic pain

There is an increasing number of patients presenting to hospital for management of complex chronic pain syndromes. However, there are limited outpatient multidisciplinary and multispecialty services available in the District.

Malnutrition

The term malnutrition can be used to describe any nutritional imbalance and includes over and under-nutrition. With an ageing population there is an increased prevalence of age-associated conditions such as protein-energy malnutrition, frailty and sarcopenia.[18] Common and overlapping problems impact the functional and health outcomes of older persons that are often left unidentified and untreated in community settings.[19] Early identification, documentation and management of malnutrition is critical. The community health intervention is where we can avoid/reduce the prevalence of malnutrition. Prevention and early intervention are key because it is difficult to reverse the effects of undernutrition and weight loss. Screening for undernutrition among elderly patients in general practice should be incorporated into routine practice wherever possible, to help focus time and resources on intervention for those identified as at greatest risk.[20] Many studies have found a direct relationship between the

[16] Dementia Australia. Dying Well – Improving Palliative and End of Life care for people with dementia. 2019

[17] Detering, et al. (2010); Molloy, et al. (2000); Zhang, et al. (2009).

[18] Sarcopenia is an age-related skeletal muscle disorder characterized by loss of lean mass and function.

[19] Dwyer J.T., Gahche J.J., Weiler M., Arensberg M.B. Screening community-living older adults for protein energy malnutrition and frailty: Update and next steps. J. Community Health. 2020.

[20] Flanagan D, Fisher T, Murray M, et al. Managing undernutrition in the elderly Prevention is better than cure Australian Family Physician Vol. 41, No. 9, September 2012.

degree of malnutrition and increased length of stay, treatment costs, return to usual life, and re-admission to hospital rates. Providing quality nutrition care upon and/or after hospital discharge has been shown to reduce avoidable readmissions.[21]

Incontinence and its impact on independence

Urinary and bowel (faecal) incontinence are very common in the older population, yet many older people and health care practitioners may wrongly consider incontinence a normal part of ageing. With advancing age, incontinence becomes increasingly complex because comorbidities, polypharmacy, cognitive impairment, and functional impairment can often make the diagnosis less clear.

Incontinence also puts people at greater risk of health issues such as infections, falls, pressure injuries including pressure ulcers and depression. Urinary tract infections in older people can be severe and associated with extreme confusion, sepsis and delirium. Incontinence has an enormous impact on a person's quality of life and can contribute to social isolation due to embarrassment. It adds significant burden on family and carers and is a contributing factor in deciding to go into residential care.[22] Incontinence also has financial implications due to the cost of continence aids.

Accessibility of Commonwealth funded Residential Aged Care and Home Care Package Services

Across SWSLHD there can be waiting lists to access Australian Government funded RACFs and Home Care Packages (HCPs). Between 2017 and 2021, the availability of RACF places in SWS decreased from 81.8 to 75.2 per 1,000 people. The rate of residential care recipients across SWS as of 30 June 2021 was 61.4 per 1,000 people, whilst the rate of home care recipients in the same period was 34.1 per 1,000 people.

A lack of availability of services results in delays in discharging patients who are medically stable and prolonged unnecessary hospitalisation may result in further deconditioning of patients. Further, a lack of service availability may also result in an increase in avoidable hospital presentations.

Accessibility of Home Support Services

Accessible home support services such as community transport, meals and lawn maintenance enable people to stay in their own homes longer through providing support to undertake basic tasks that the person is unable to do independently. When these services are unavailable people may deteriorate at home, requiring a hospital admission or may be unable to be safely discharged from hospital. There were 7,004 people in SWS with a HCP as of 30 June 2022. A further 1,318 were waiting for a HCP at their approved level.[23]

Accessibility of Disability Support services

Some people requiring rehabilitation may require access to a range of disability-related rehabilitation services in the community. The National Disability Insurance Scheme (NDIS) is the Commonwealth government's Scheme for supporting people with a "permanent and significant disability", who are under the age of 65 at the time of application and are Australian

[21] Roberts, S.; Collins, P.; Rattray, M. Identifying and Managing Malnutrition, Frailty and Sarcopenia in the Community: A Narrative Review. Nutrients 2021.

[22] Holroyd-Leduc J. M., Mehta K. M., Covinsky K. E. Urinary incontinence and its association with death, nursing home admission, and functional decline. Journal of the American Geriatrics Society; 52(5):712–718. 2004.

[23] www.gen-agedcaredata.gov.au/www_aihwgen/media/Home_care_report/Home-care-packages-program-data-report-1-_April-30-June-2022.pdf

citizens or permanent residents. To access the NDIS, the person's impairment(s) must result in permanent and substantially reduced functional capacity in at least one of the following: Communication, social interaction, learning, mobility, self-care or self-management.

The NDIS funds "reasonable and necessary" supports and services that help a person in their daily life and help them participate in the community and reach their goals. Participants use their funding to purchase their supports from a selected provider. The National Disability Insurance Agency (NDIA) is the independent Commonwealth government that runs the NDIS. The NDIA determines whether a person is eligible for the NDIS and how much funding they receive. As of September 2022, over 160,000 people in NSW were benefiting from the NDIS[24]. There were 24,908 active NDIS participants in SWS and 6,095 have been from the CALD background. About 1,322 lived in supported accommodation.[25] Similar to aged care, a lack of specialist disability accommodation (SDA) in SWS also prolongs unnecessary hospitalisation and may result in deconditioning. This shortfall will grow with increased longevity and survival into late adulthood with ageing parents and family carers who are unable to provide ongoing support. In addition, government policy enacted to move people under 65 years of age out of RACFs.

Reforms in the Aged Care sector

Major reforms to the Aged Care sector, including to funding models are impending as a result of recommendations made by the Royal Commission into Aged Care Quality and Safety. These changes will have an impact on local provision of aged care and rehabilitation services.

In-home aged care currently consists of several programs which have different approaches to assessment, eligibility, service providers, funding and fees.

In its response to the Royal Commission's recommendations, the Australian Government will establish a new 'Support at Home Program' to replace the Commonwealth Home Support Program (CHSP), HCP and Short Term Restorative Care Program. The new Support at Home Program will reform all aspects of the delivery of in-home aged care including assessment, reablement and restorative care, to individualised support plans, clarity on service inclusions and funding of providers.

Aged care assessments are currently completed by the Aged Care Assessment Team (ACAT) and Regional Assessment Service (RAS) using the National Screening and Assessment Form. A new assessment tool will be introduced in July 2024 under a single assessment system. Following assessment, eligible participants will receive an Individualised Support Plan. The Plan will outline the service types the senior Australian is eligible for and the frequency and duration in which they should receive them.

A new Support at Home Program[26] will aim to provide better support for all older persons, with a specific focus on people requiring re-enablement and restorative care, people with dementia, Aboriginal and Torres Strait Islander people and carers.

Reforms are also expected in health care of people with disability as an outcome of Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

[24] New South Wales | NDIS website. December 2022.

[25] NDIS Explore Data tool. Accessed on 28 February 2023.

[26] Australian Government Department of Health. Support at Home Program Overview. January 2022.
support-at-home-program-overview.docx (live.com)

Infrastructure Redevelopments

Major facility redevelopments are underway at Campbelltown, Liverpool and Bowral & District Hospitals and capital investment is planned for a new Hospital in Bankstown. Planning is also underway for the development of a series of ICHHs capable of delivering a broad range of services, including some traditionally delivered in hospitals. All projects are shaped around a planning horizon of 2031 requirements.

Impact of Covid-19

The COVID-19 pandemic has had a significant impact on the way services are provided. Some services were ceased or modified, and public behaviour changed with less people seeking services.

Despite many challenges, COVID-19 has facilitated the adoption and embedding of virtual care as a core component of service delivery and focus on hospital avoidance and alternatives to hospital care. For SWSLHD specifically, the value of our partnerships with our multicultural communities was highlighted as we sought to share health information and ensure access to services. Current evidence suggests approximately 10-20% of people experience a variety of mid and long-term effects after they recover from their acute COVID infection. Recovery from the pandemic will require attention to changing patterns of access to health care and delayed engagement with services, and the associated impact on health outcomes including on mental health, aged care and rehabilitation. This is particularly pertinent for existing vulnerable cohorts of the population, including those where health outcomes are already poorer than the rest of NSW. The recommended management and model of care for people diagnosed with COVID-19 in the first 12 weeks post-diagnosis is outlined in the NSW Health document Management of adults with COVID-19 in the post-acute phase – a model of care for NSW Health clinicians, developed by the ACI Rehabilitation and Respiratory Communities of Practice. People experiencing fatigue and deconditioning after a long hospital stay will benefit from a supervised rehabilitation program. An increasing demand for rehabilitation services by long COVID patients will potentially effect rehabilitation resources to treat this.

Advances in technology supporting virtual care

The health sector is undergoing significant change in the way technology is used to deliver better clinical and operational performance and to improve patient and carer experiences and outcomes. Telehealth and digital technology will become more prevalent for remote monitoring and support in delivering clinical services in the community. The increased use of virtual care, particularly virtual consultations, also has implications for infrastructure design into the future, as well as the way in which communities are engaged about their health. Virtual care is designed to complement existing services by connecting patients with clinical expertise. Virtual care will support care delivery where appropriate, noting suitability and patient acceptance as key considerations.

In addition, data analytics and informatics will support integrated clinical care. This Plan aligns with the NSW Virtual Care Strategy and the SWSLHD Digital Health Strategy 2023-2028 which includes a future vision for the adoption of virtual care in SWSLHD.

Empowering consumers and carers

It is of paramount importance to empower consumers, carers, and family members to participate in care planning and decision-making at an individual, service, and system level in order to deliver person-centred care that is respectful and responsive to the needs, preferences, and personal circumstances.[27]

This Plan strongly supports the District's commitment to engaging with consumers and carers to guide the development, implementation, and improvement of local health services. The SWSLHD Transforming Your Experience Action Plan, is the Plan to positively transform how patients, consumers, staff, and communities experience SWSLHD and its services.

Consumer participation is supported through the Consumer and Community Participation structures and guided by SWSLHD Consumer and Community Participation Framework 2020-2024. SWSLHD Carers Program provides professional support to carers in their interactions with the health system and facilitates the responsiveness of health services to the needs of carers including the District staff with caring responsibilities. Carers are acknowledged as providing valuable care and support to older and frail persons, those with chronic health conditions, and people with disabilities. Given that both older persons and people requiring rehabilitation usually have a strong reliance on carers, the needs of carers are considered and supported by this Plan. However, the needs of these groups are well documented in the SWSLHD Disability and Carers Strategy 2017 - 2022 and therefore detailed information on future disability and carers services is not provided within this Plan.

[27] Australian Government Department of Health. Support at Home Program Overview. January 2022.
support-at-home-program-overview.docx (live.com)

[28] World Health Organization. Coronavirus disease (COVID-19): Post COVID-19 condition. December 2021.

[29] ACI Patient Experience and Consumer Engagement: A Framework for Action. 2015.

Current Aged Health and Rehabilitation Service System in SWSLHD

The current provision (as of January 2023) of aged health and rehabilitation services for people living in SWSLHD is highly complex. As previously noted, funding arrangements across different levels of government add to this complexity.

Aged Health and Rehabilitation Services governance

Clinical governance and leadership in SWSLHD is provided through three main organisational structures

Aged Care and Rehabilitation Clinical Stream:	○ Hospital based inpatient and outpatient services ○ Residential aged care outreach services (Community Outreach Geriatrics Service (COGS))
Allied Health and Community Services:	○ Community based services including those funded through the Commonwealth and other programs: ACAT, RAS and Transition Care Program (TCP) ○ Primary and Community Health Services delivering a range of services and supports for older people living in the community and in RACF, including Community Nursing (Continence Nursing, Palliative Care and Wound Care) ○ The Equipment Loan Pool providing temporary access to a range of equipment to enable independence
Mental Health Services:	○ Hospital based OPMH inpatient and outpatient services ○ Community OPMH services

Table 1 below provides a brief description of the aged care and rehabilitation service provision for people living in south west Sydney.

Table 1: SWSLHD Aged Care & Rehabilitation Service by Service Category and Service Type as at Jan 2023

Service Category	Service Type
Commonwealth Funded Information and Support Programs Note: SWSLHD delivers some of these services with non-recurrent funding provided by the Commonwealth government. Whilst noted for completeness, these services have strict funding guidelines and therefore are not considered in detail as part of this plan.	• My Aged Care • Carer Gateway • ACAT – SWSLHD as sole provider • RAS – SWSLHD as one provider • TCP – SWSLHD as sole provider • Commonwealth Home Support Program (CHSP) – SWSLHD as a provider of some community nursing and allied health services via Primary and Community Health including Allied Health Reablement Team (AHRT). CHSP and HCP will be replaced by Support at Home program from July 2024. • Home Care Package Program (HCP) • Short Term Restorative Care Program (STRC) • Residential Aged Care Facilities • South Western Sydney Primary Health Network (SWSPHN) and GPs
Emergency Department and Rapid Assessment Services	• Aged Care Services in Emergency Teams (ASET) • Aged Care Rapid Investigation and Assessment (ARIA) • Rapid Response Service
Community and Outpatient Aged Care and Rehabilitation Services	• COGS in Residential Aged Care Facilities • Specialist Aged Care & Rehabilitation Team (SpACRT) locally funded and servicing Liverpool and Fairfield LGAs • Rehabilitation in the Home • Outpatient Clinics
Inpatient Services	• Acute and Sub-Acute Aged Care Units (including dementia/delirium units) • Inpatient Rehabilitation Units • Inpatient Geriatric and Rehabilitation Consultation

	• In-reach to Acute Rehabilitation Service • Dementia and Delirium Clinical Nurse Consultant • Older People's Mental Health	
State – wide Services	• Inpatient Brain Injury Unit at Liverpool Hospital • Community based Brain Injury services	
Core Partnership Services	• Medical and Surgical sub-specialities • Allied Health disciplines and Equipment Loan Pool • Aboriginal Health Unit • Multicultural Health Services and Health Language Services	• Primary and Community Health • Palliative Care • Health Promotion Service • HammondCare • Residential Aged Care Facilities • Oral Health • Drug Health
Disability Services (Aged Care and Rehabilitation and Primary and Community Health)	• Specialist Intellectual Disability Health Team (SIDHT) • Safe and Supported at Home (SASH) • NDIS Support including NDIS Coordinator, Disability Liaison & Navigators and NDIS Facility Champions	

Planned Clinical Service Enhancements

Clinical Services Planning undertaken to inform the capital redevelopment projects at Campbelltown, Bowral & District, Liverpool, and the new Bankstown Hospital has proposed the expansion of inpatient and outpatient clinical services to meet the needs of the community to 2031. The proposed expansion of clinical services in hospitals will be complemented by growth in a range of community-based services, as well as a range of service development initiatives to be undertaken by 2027 (see Service Development and Redesign section).

Table 2 below highlights the key planned service enhancements to 2031.

Table 2: Key Planned Service Enhancements to 2031

Clinical Service	New or Expansion	Facility	Delivery
Hospital Settings			
Older Person's Mental Health	New	Campbelltown Hospital	2023
	New	New Bankstown Hospital	2028
Older Person's Behaviour Unit (Behavioural and Psychological Symptoms of Dementia)	Expansion	New Bankstown Hospital	2028
Acute Aged Care	Expansion	New Bankstown Hospital	2028
	New	Fairfield Hospital	2031
Stroke rehabilitation	Expansion	New Bankstown Hospital	2028
Rehabilitation	New Expansion	Liverpool Hospital New Bankstown Hospital	2026 2028
In-reach Rehabilitation Models of Care	Expansion	All	2026
Community Settings			
Expansion of geriatric outreach services provided to residents of RACFs and people in their homes	Expansion	LHD-wide	2024
Commence delivery of a comprehensive SWSLHD Community Aged Health Service	Service Redesign	LHD-wide	2024
Rehabilitation in the Home	Expansion	LHD-wide	2026

Figure 1 below provides mapping of current and future services by 2027/28

Current and Future Services Map

Figure 1: SWSLHD current and future services map

South Western Sydney Local Health District

Service Category		Availability in Hospitals/ Catchment Areas					
		Bankstown-Lidcombe	Fairfield	Liverpool	Campbelltown & Camden	Bowral & District	Braeside
Community and Outpatients (preventative, early intervention, post cute care, maintenance and support)	ACAT (1 LHD- wide service operating out of 4 sites)						
	TCP (1 LHD- wide service operating out of 4 sites)						
	SpACT						
	SpACRT						
	Community Outreach Geriatric Services				Campbelltown	Nursing model	
	Aged Care Services in Emergency Teams				Campbelltown		
	Aged Care Rapid Investigation and Assessment				ED Aged Care Pod model		
	Geriatric Outpatient Clinics				Camden Campbelltown- Older Persons Specialty Service		
	Rehabilitation Outpatients				Camden		
	Home-based Rehabilitation Models						
	Community Rehabilitation Models						
	Older Persons Mental Health Community		Covered by Braeside				
	Community Nursing						
Inpatient Services	Acute Geriatric					Combined	
	Subacute Geriatric		Combined			Combined	
	Geriatric Consultation						
	Rehabilitation – In reach				Campbelltown ↗		
	Rehabilitation Units		Combined		Camden		
	Rehabilitation Consultation						
	Older Persons Mental Health Inpatient				Campbelltown		

	Inpatient Dementia Units (May also be identified as *Older Persons Behavioural Unit*)	New Bankstown Hospital					
State-wide Services	**Brain Injury Unit**						
	Spinal Cord Injury Services	Liverpool as non-specialist spoke site in state-wide hub-and-spoke model					
Disability Services	**Specialist Intellectual Disability Health Team (SIDHT)**	District wide service based at Fairfield Community Health at Carramar					
	Safe and Supported at Home (SASH)						
	NDIS Support	NDIS Coordinator, Disability Liaison & Navigators and NDIS Facility Champions					

Key:	**Continuing Service**	**New Service by 2027/28**

Service Development and Redesign

To meet the challenges of the future, new and innovative ways of providing health services are required. With patient centred care at its core, the vision for this Plan is to deliver services in an integrated framework, providing a continuum of care across community-based and hospital-based services.

The development and enhancement of services through the implementation of contemporary evidence based MoCs supported by advancements in technology will allow for optimal service delivery at the right time and in the right place for the patient.

New and evolving technologies will need to be continually assessed and introduced. Virtual care and digital technologies will continue to make significant changes to both the way services are delivered and the settings in which services can be delivered. This will increasingly include alternative non-hospital options either at home or other community settings, ensuring consumer choice and the quality and safety of care while reducing demand on acute hospital settings.

Strong clinical linkages and defined roles of health services across SWSLHD will allow for the sharing of knowledge, skills and expertise including implementation capability for system-wide impact.

The future models outlined in this Plan align with the *One Service, Multiple Sites Networking Approach* which aims to deliver a seamless network of services across the LHD and across the care continuum supported by formal enabling structures and functions including:

- Agreed District-wide protocols for networked service arrangements
- Clearly defined leadership, governance and operational structures which outline the tiered scope, role and responsibilities across the network of services
- Evidence-based and standardised policies, procedures and guidelines supported by cohesive LHD Networked MoC
- Digital capability which enables data sharing, connected patient care and advanced analytics
- Optimised capacity across the District with resources being allocated on the basis of population and clinical need
- Workforce planning and recruitment considers requirements across the LHD
- Education and training of workforce considers service skill mix and professional development across the LHD
- Partnerships and broad engagement with consumers and carers, clinicians, internal and external partners including SWSPHN

A brief description of the key factors in delivering aged care and rehabilitation service delivery models into the future is provided below.

Aged Care – Service Delivery Model

The delivery of NSW Health aged health services is complex and is characterised by numerous interdependent and dynamic interactions between health services, providers, and care teams.

Across the District, aged health services consist of a range of different models, approaches and programs provided in varied care settings. Without appropriate care coordination and transition between service settings, there is risk of duplication in assessment, and care provision or omissions of important information which may inform care decisions.

A significant focus of the future model for Geriatric Medicine will relate to ED avoidance through the delivery of highly responsive outreach services working across RACFs and the community to avoid unnecessary transfers to hospital and to enhance the availability of acute care in the community for frail older patients. Further, the model will support rapid assessment of patients referred by GPs and other health services with strong links to Hospital in the Home (HITH) and other community-based services to facilitate access to appropriate out of hospital care and support.

Aged health services alone will not be able to respond to the anticipated increase in demand. Collaborative ways of working will be required across the hospital and community sectors to ensure the right care is provided in the right place at the right time.

Rehabilitation - Service Delivery Model

The Australasian Faculty of Rehabilitation Medicine describes a client of rehabilitation medicine as those people with a loss of function or ability due to injury or disease who can reach the highest possible level of independence (physically, psychologically, socially, and economically) through a combined and co-ordinated use of medical, nursing, and allied health professional skills.

The Principles to Support Rehabilitation Care document[28] by ACI describes the various care settings in which rehabilitation services are delivered including in-reach to acute care, inpatient subacute, outreach and ambulatory care (day hospital, outpatient and home based).

[30] Principles to Support Rehabilitation Care. ACI Rehabilitation Network 2019

Rehabilitation services are provided across these care settings to help people achieve following:

- Prevention of the loss of function
- Slowing the rate of loss of function
- Improvement or restoration of function
- Compensation for lost function
- Maintenance of current function

Central to the provision of rehabilitation services is the collaboration between multidisciplinary teams, patients, and carers. Coordination with a range of other community-based services including those funded through the NDIS, the Commonwealth Government's Aged Care services such as the CHSP, TCP, HCF and RACF.

While the demand for rehabilitation spans all ages, it increases with age. Older people are proportionally the largest group accessing these services. Many older patients will have complex medical requirements during their rehabilitation in hospital. Their rehabilitation needs must be addressed in parallel with management of their medical issues and requires close collaboration between the Rehabilitation Physician and Geriatrician.

The *Older Persons and Rehabilitation Plan to 2027* supports development of new MoC for rehabilitation. SWSLHD requires an integrated, modern rehabilitation model of service delivery to ensure that adult patients who require rehabilitation have access to appropriate services in a timely manner with the aim of moving them rapidly back into their communities by minimizing over-reliance on expensive in-patient rehabilitation. Expanded ambulatory services allow rehabilitation to occur early in the patient journey and where possible in a patient's home.

The model has a multi-disciplinary focus and incorporates elements of teamwork, interdisciplinary communication strategies and care planning to engage the patient/family/carer in all aspects of the patient's care. It outlines the need to allow rehabilitation to occur early in the patient journey and where possible in a patient's home. The Rehabilitation MoC outlined within this Plan aligns with the *One Service, Multiple Sites Networking Approach* which aims to deliver a seamless network of services across the LHD.

The future MoC will improve patient care by:

- Streamlining care and developing best practice protocols and pathways across care settings
- Supporting early detection and prevention of complications that might adversely impact rehabilitation outcomes
- Providing early assessment and intervention to prevent de-conditioning, maintain and improve function while in the hospital, and potentially reducing length of stay and improving patient outcomes.

The future model will also aim to optimise bed management and the patient journey by:

- Providing early specialist rehabilitation assessment and management and referral to the optimal services for continuation of rehabilitation as required
- Allowing continued treatment of an acute illness in parallel with the provision of rehabilitation
- Providing early transfer from an acute bed and reducing total length of stay
- Providing community-based rehabilitation services optimally to reduce demand for inpatient rehabilitation and provide a greater choice in care delivery modalities

- Providing care in partnership with the primary and community health
- Providing care in partnership with private care providers (e.g., GPs, specialists, allied health, nursing) and the non-government sector
- Providing information technology and biomedical engineering support to implement telehealth, virtual and robotics-based models.

Service development priorities are described under three Priority Areas:

1. **Healthy Ageing, Wellness and Enabling Independence**
2. **Care Closer to Home**
    - Older Persons
    - Rehabilitation
3. **Hospital Care Models and Pathways**
    - Older Persons
    - Rehabilitation

Healthy Ageing, Wellness and

Staying healthy and well involves people and communities having a wellness approach throughout the life course. Being healthy and active throughout life increases the opportunity for individuals to experience good health as they age.

The increasing prevalence and cost of long-term health conditions means that prevention is important at all ages, with an emphasis on healthy lifestyle choices, timely intervention and 'healthy' ageing combined with 'ageing in place', i.e., keeping older persons healthy at home for as long as possible. These concepts are supported throughout this plan and underpin many of the priority actions. They are also the focus of the SWSLHD Keeping People Healthy Prevention Strategy.

Healthy Environments

The SWSLHD Population Health Service works with other government agencies to create communities where there are opportunities for residents to lead active and healthy lifestyles, with a focus on physical activity, nutrition and environmental impacts on health e.g., climate risk.

Health Promotion and Primary Prevention

A range of health promotion and primary prevention initiatives are conducted within the broader community, focusing on key health issues that impact on longevity and quality of life. These include initiatives focused on smoking, obesity, physical activity, and nutrition as well as mental wellbeing.

Mainstream health promotion and disease prevention programs, as well as activities specifically tailored to benefit the older person include:

- Get Healthy – health coaching service

- Exercise and Falls Prevention Programs such as the Stepping on Falls Prevention program

Active and Healthy - provides links to a broad range of local exercise programs which are tailored to older persons.

Preventative Care in the Community

Early detection and proactive interventions to support healthy ageing and wellbeing are available through the public and private health services in community settings and general practice. For example, services are available to:

- Assess and address visual and hearing impairment
- Assess and address incontinence and malnutrition
- Medication management to reduce the impacts of polypharmacy
- Vaccinations to prevent acute illnesses e.g. Influenza and pneumonia and COVID- 19 as per recommendations from the National Immunisations for older Australians
- Screening programs and health checks to identify health risk factors in older persons, e.g. for cardiovascular disease, renal disease, osteoporosis, falls risk, diabetes, dementia and cancers.

Strategy		Responsible	Timeframe
1.1	Deliver a range of targeted, culturally responsive community based healthy ageing and lifestyle programs with a focus on: • Falls and injury prevention • Loneliness and social isolation	Director Pop Health Director, AH & CS	Dec 2027
	• Memory • Nutrition and hydration • Incontinence • Vaccination • Health literacy and lifelong learning • Pain management • Substance use • Assistive technology		

General Practice and Primary Care

Older persons are significant users of the primary care system. GPs are well placed to support early identification of deterioration and frailty through long term monitoring of patients and through completion of regular health assessments. The 75+ health assessment is a comprehensive medical review structured to identify health issues and conditions that are preventable or amenable to interventions to improve health and or quality of life by preventing further decline in function or complications associated with chronic conditions".[29]

In 2017-2018, in SWS:

- 28% of people over 80 years of age received a 75+ health assessment
- 45% of people in the 65-79 age group received chronic disease management/case conference by GPs and 53% in the over 80 age group compared to 17% for all ages.[30]

The SWSPHN supports provision of primary care services through three core functions – commissioning of services based on population need, capacity building of primary care providers and integration of primary, secondary and social services.

[31] Gray and Newbury 2004.
[32] Department of Health. Medicare Benefits Schedule book. Canberra 2018.

[33] https://sws.communityhealthpathways.org/14452.htm
[30] Department of Health. Medicare Benefits Schedule book. Canberra 2018.

Aged care has been identified as a key local priority by the SWSPHN and the organisation is working collaboratively with all health care providers to improve the way services are provided to older persons. This is being done through a range of initiatives including development of Health Pathways pertaining to the aged health care to support local GPs in providing care of older people[31] and provide information for consumers and carers on healthy ageing.

Health Literacy and Access to Health and Service Information

A health literate community is more likely to engage in healthy behaviours and to access the health information and services they require in a proactive and timely manner. People who have a high level of health literacy are also more likely to effectively self-manage their chronic conditions and recovery from illness or injury. SWSLHD's approach to improving health literacy includes ensuring the community has access to information and resources on health topics and available services to enable them to make informed decisions and better manage their health.

Older persons and people with disability often experience complex diseases that are dynamic in nature requiring a range of interventions and support approaches at different times through their journey. Access to services including health, community aged care, NDIS and social services can be difficult to understand to navigate particularly in stressful or difficult times. Consumers and carers require access to high quality information regarding services in a range of formats to suit their individual needs.

In 2023, the SWSPHN will implement the *Care Finder Program* to establish and maintain a network of care finders to provide specialist and intensive help to people who are requiring intensive support to interact with My Aged Care and access aged care services. In July 2024, the *Support at Home Program* will commence. This new program will aim to support senior Australians to remain independent and in their own homes for longer. *Support at Home* will reform the delivery of in-home aged care. This includes assessment, provider funding, and regulation of the market. *Support at Home* will put a greater focus on reablement and restorative care.

The SWSPHN is also implementing the Live Well - Healthy Ageing program to support older people as they work with their healthcare providers to invest in their health and develop habits to improve health and stay well for longer. The Live Well program has six key areas: staying physically active, eating healthy food, staying connected, keeping your brain active, being able to relax your mind and, positive thinking and optimism. The program encourages older people to make small changes to build a healthier lifestyle over time.

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[31] https://sws.communityhealthpathways.org/14452.htm

Strategy		Responsible	Timeframe
1.2	Collaborate with the SWSPHN to increase knowledge, awareness and access to aged care services through implementation of the 'Care Finder' and 'Support at Home' Programs.	Clinical Manager, AC&RS Director, AH & CS	June 2024

Elder Abuse

Elder abuse includes physical, psychological, sexual, emotional, material, or financial abuse, neglect or abandonment and may be intentional or unintentional. It violates basic legal and human rights. [32] Abuse can occur anywhere, including the home, institutions, or health care settings. Currently, there are no data on the prevalence of elder abuse in Australia, with best estimates suggesting that between 2% and 14% of older Australians may experience some form of abuse every year. As the existing research literature makes clear, there is a wide range of factors relating to victims, perpetrators, relationships, and contexts that may be associated with elder abuse. However, very little research is available to help inform practical responses to prevent or intervene to mitigate these risks and reduce the occurrence or recurrence of abuse.[33] Even with mandatory reporting laws, elder abuse is believed to be an underreported crime. Some of the reasons that elders may not report include being unable to report due to physical or mental ability, depending on the abuser for care and basic needs and fearing retaliation from the abuser.
The NSW Government Ageing and Disability Commission recognises that the adverse outcomes for the victims include physical health problems, increased hospitalisation and mortality; psychological distress; loss of property and security. Research suggests that the failure to report the cases and the substantially higher risk of death during the first year after hospitalisation indicates the need for improved identification, reporting, and intervention. [34]

The NSW Policy Directive Identifying and responding to abuse of older people requires NSW Health organisations to develop and implement local protocols and provide staff training. Abuse of older people may be identified anywhere in the health system. It is the responsibility of all NSW Health staff to identify and respond to abuse of older people.

Strategy		Responsible	Timeframe
1.3	Develop and implement local protocols to identify and respond to elder abuse consistent with the NSW Policy Directive Identifying and responding to abuse of older people.	Clinical Manager, AC&RS	Dec 2024

Care Closer to Home – Older Persons

Community – based care is increasingly becoming the preferred MoC for older persons. This Plan strongly advocates for a continued shift in the balance of care from hospital to the community and home settings including virtual care, to keep people well and out of hospital and reduce length of stay.

[34] World Health Organization; 2018 Available from: http://www.who.int/ageing/projects/elder_abuse/en/
[35] Elder abuse Key issues and emerging evidence. Child Family Community Australia | information exchange. 2019. https://aifs.gov.au/sites/default/files/publication-documents/51_elder_abuse_0_0.pdf
[36] Dong X, Chen R, Chang ES, Simon M. Elder abuse and psychological well-being: a systematic review and implications for research and policy–a mini review. Gerontology. 2013.

Primary care is often the first layer of services encountered by the older person, either through a GP, nurse (including general practice nurses, community nurses and nurse practitioners), allied health professional, pharmacist, or Aboriginal health worker. Services delivered include health maintenance, falls prevention, screening, assessment, early intervention, treatment, management, and referral to specialist services.

General Practice

GPs and Practice Nurses are uniquely positioned to support early identification of functional decline and frailty, particularly where the clinician and patient have an ongoing relationship.

GPs are able to support older persons to build and maintain independence through making appropriate referrals to support services and through ongoing monitoring. Ensuring older people participate in the annual 75+ Health Assessment or Aboriginal Health Assessment for Aboriginal and Torres Strait Islander people, aged over 55 years is a key component of proactive service delivery. The HealthPathways program supports GPs to make appropriate referrals to specialist services.

Primary and Community Health

The SWSLHD Primary and Community Health (P&CH) Service, in partnership with other service providers supports older persons on discharge from hospital who are at risk of rehospitalisation, including building the capacity of patients and carers to better understand and self-manage chronic conditions. P&CH services work closely with other community based and hospital specialist services e.g., Palliative Care and HITH to ensure the provision of high quality clinical care, close to home.

Primary and Community Health provide a range of specialist care services for older people and people requiring rehabilitation including:

- Triple I Hub – SWSLHD's Centralised Intake, Information, and Intervention centre for P&CH Services. It is a point of access/contact for the general public, private and public hospitals, GPs, other Government and Non-Government Organisations. The Triple I Hub facilitates the transfer of referrals to appropriate community services. SWSLHD currently has a Command Centre project underway. Triple I Hub requirements will be considered as part of this process
- Community Nursing – encompasses both generalist and highly specialised nursing services (e.g., Continence Nursing, Palliative Care Nursing, and Wound Care Nursing)
- Keeping Well in Community (Integrated Care) – Focuses on managing persons at risk of preventable ED presentation or hospital admissions. This is achieved through the provision of care navigation, care coordination and alternate referral pathways. The service also facilitates earlier discharge from hospital and supports transition of care.

Community Aged Health Models

Innovative models of community-based care for frail older persons have started to demonstrate significant clinical benefits leading to reduced hospitalisations and ED presentations. It is proposed that a comprehensive community-based Aged Health model be developed in SWSLHD. This model would bring together key elements of care and support for older persons providing a joined-up and opportunistic provision of services. This “one-stop shop” model responds to the often fragmented service provision for older persons and seeks to improve the patient experience of care while also improving outcomes and avoiding hospitalisation. The growth in community based assessment/treatment options will allow some frail older persons and others with serious illness and disabilities to have options to receive needed health care and social supports while remaining in their homes and living as independently as possible.

Expanding community-based and integrated service models for older persons is consistent with the District's strategic vision to develop integrated community-based services delivered from a network of ICHHs and Community Health Centres.

Strategy		Responsible	Timeframe
2.1	Develop and implement a multidisciplinary Community Aged Health Model providing alternatives to hospital presentation and admission. Key aspects for inclusion in this model: • Frailty assessment and management • Care for people living with dementia • Falls prevention and management • Malnutrition prevention and management • Medication management • Community-based geriatric clinics and allied health services • Older people's mental health	Director, AH & CS Clinical Director, AC&RS	Dec 2024
	• Continuity of care with Primary Health Home Providers and RACFs • End of life planning.		

Care delivered to people living in Residential Aged Care Facilities

Older persons residing in RACFs have high demands for acute medical services, frequently presenting to EDs with many requiring hospital admission.35 Unnecessary presentations to EDs, owing to relatively minor and repeated health problems, or lack of appropriate end-of-life care plans can be prevented with timely provision of care in RACFs.36

The COGS is an acute aged care outreach service providing rapid access to medical and nursing care to people living in RACFs. Once assessed in situ, residents may be transferred to hospital with a direct admission to the ward, enabling the ED to be bypassed and better care to be provided to the older person. Figure 2 below shows health conditions and aspects of care provided by COGS.

[35] Arendts G, Quine S, Howard K. Decision to transfer to an emergency department from residential aged care: A systematic review of qualitative research. Geriatric Gerontology Int. 2013; 13(4):825–33.

[36] Fan L, Hou X-Y, Zhao J, et al. Hospital in the Nursing Home program reduces emergency department presentations and hospital

[37] Arendts G, Quine S, Howard K. Decision to transfer to an emergency department from residential aged care: A systematic review of qualitative research. Geriatric Gerontology Int. 2013; 13(4):825–33.

[38] Fan L, Hou X-Y, Zhao J, et al. Hospital in the Nursing Home program reduces emergency department presentations and hospital admissions from residential aged care facilities in Queensland, Australia: A quasi-experimental study. BMC Health Services Research. 2016; 16(1):46.

[39] Royal Commission into Aged Care Quality and Safety: Care, Dignity and Respect. Final Report. March 2021.

[40] Dental statistics and research series 34. Cat. no. DEN 165. Canberra: Australian Institute of Health and Welfare; 2007.

[41] Petersen PE, Bourgeois D, Ogawa H, Estupinan-Day S, Ndiaye C Bull World Health Organ. 2005.

Figure 2: COGS Inclusion criteria – Conditions and Aspects of Care

The COGS teams are available across SWSLHD seven days per week with some variations in working hours between sites. Referrals are generally via the GP or RACF staff. Nursing and medical consultations are provided face to face and via telehealth. COGS staff also collaborate with specialist staff across community and hospital settings to deliver a seamless service.

The COGS model has demonstrated benefits across the COVID-19 Pandemic response reducing ED presentations from RACFs and supporting RACFs management of patients. Continued evaluation and refinement of the COGS model will likely bring additional benefits. Expansion plans are focused on integrating the model within community-based Aged Care models and expansion of scope to service beyond RACF residents, consistent governance and resourcing structures, refinements of referral pathways and enhancements of capacity.

Poor oral health and dental pain was identified as a key issue in the Royal Commission into Aged Care Final Report.[37] Older persons tend to have higher rates of oral health problems than younger people[40] [41] .

[42] Royal Commission into Aged Care Quality and Safety Future Design of the Aged Care System. Australian Dental Association NSW. January 2020.

For older persons living with dementia, with low incomes and/or living in an RACF, there is a higher risk of poor oral health. Poor oral health has an impact on the physical health and wellbeing of older people e.g., malnutrition, depression.

The report noted the absence of timely oral health assessments, oral care planning, education, and access to qualified dental practitioners for older Australians living both in RACFs and in the community. Mandatory oral health assessments by a registered dental practitioner for every resident entering a RACF is one of the recommendations from the Royal Commission.[42]

Strategy		Responsible	Timeframe
2.2	Strengthen care for older persons living in residential aged care by: • Review the COGS model and integrate with community-based Aged Care models • Developing RACF dental services as part of the Mobile Dental Services Model.	Director, AH & CS Director, Oral Health Services	Dec 2024

Geriatric Clinics and Aged Care Outpatient Services

Geriatric clinics and aged care outpatient services support older persons and others who experience frailty or dementia by providing early

identification of deterioration and referral to appropriate services including community support services aimed to improving quality of life and enabling independence.

Referrals to outpatient clinics come from a variety of sources including GPs, ASET/ ED based services, ACAT and inpatient units. The majority of outpatient clinics are delivered via face-to-face modalities, although telehealth is being increasingly utilised for patients when appropriate, particularly as a result of change in practice and more recently due to policy related to COVID 19.
Outpatient Geriatric Clinics are available to varying degrees across SWSLHD and have developed in response to local circumstances and opportunities. As a result, there is inequity in service availability and service models across the District.

Future model of service provision by outpatient clinics will ensure equitable access to services across the District, based on a hierarchy of need. Highly specialised services should be accessible to all but provided at locations where synergies with other services allow for the best possible care to be provided. Consideration should also be given to ensuring the availability of rapid access models, streamlining referral and priority of access criteria and delivery an MDT approach within the clinic environment.

Strategy		Responsible	Timeframe
2.3	Review the aged health outpatient clinic model across the LHD to deliver consistent and equitable access to services..	Clinical Director, AC&RS	Dec 2027
		Facility HODs Geriatrics	

Care Closer to Home – Rehabilitation

Providing rehabilitation care closer to home enables people to undertake periods of recovery in a setting that is comfortable to them. People requiring rehabilitation services often experience barriers to accessing hospital-based outpatient services due to challenges with transport and mobility and costs.

Rehabilitation in the Home

There is evidence of improved outcomes from home-based rehabilitation care in a geriatric patient cohort compared to hospital-based care, including lower odds of developing delirium, fewer hospital bed days and greater satisfaction regarding rehabilitation quality.[38] Similar positive results have been shown following orthopaedic surgery[39] and stroke[40] [41]. The Travis Review into Victorian Hospital capacity recommended an expansion of home-based care options due to 'the potential benefits in patient outcomes and cost-effectiveness support further development of these models across the system'.

Within SWSLHD, Rehabilitation in the home (RITH) is currently provided to people living in the Macarthur area who have been assessed as requiring time-limited, community-based rehabilitation to assist them to regain and maintain optimal function. Without this approach these people would remain as an inpatient to receive equivalent care. Although trials of rehabilitation in the home environment indicate cost effectiveness for many conditions, there is lack of robust evidence toward comparability of the effect of the hospital versus alternative environments.[42]

[38] Caplan GA, Coconis J, Board N, Sayers A, Woods J. Does home treatment affect delirium? A randomised controlled trial of rehabilitation of elderly and care at home or usual treatment (The REACH-OUT trial.

[39] Buhagiar MA, Naylor JM, Harris IA, et al. Effect of inpatient rehabilitation vs a monitored home-based program on mobility in patients with total knee arthroplasty: the HIHO randomized clinical trial. JAMA. 2017.

[40] Langhorne P, Taylor G, Murray G, et al. Early supported discharge services for stroke patients: a meta-analysis of individual patients' data. Lancet. 2005.

[41] Bharadwaj S, Bruce D. Effectiveness of 'rehabilitation in the home' service. Aust Health Rev. 2014.

[42] Ward D, Drahota A, Gal D, Severs M, Dean TP. Care home versus hospital and own home environments for rehabilitation of older people. Cochrane Database Syst Rev 2008.

Strategy		Responsible	Timeframe
2.4	Develop a SWSLHD Rehabilitation in the Home Model of Care.	Clinical Director, AC&RS	June 2024

Community-based Rehabilitation Services

This Plan supports further development of rehabilitation services to be provided in a broad range of settings to improve accessibility for service users including ICHHs as proposed by SWSLHD Care in the Community planning.

There is evidence that community rehabilitation provides benefits through reduced presentations to hospital, reduced length of stay and reduced presentations to GPs.[43] It also provides patients/carers with a greater flexibility in service delivery and reduces demand for inpatient rehabilitation.

Older people are the largest users of rehabilitation services, particularly for restoration of function after an acute hospitalisation. Supporting patients to mobilise as soon as possible after an acute illness is a fundamental part of recovery, and a pivotal role of nurses and caregivers as part of a whole team approach. It is also vital to prevent complications associated with prolonged bedrest. Follow up programs in the community such as TCP and SpACT/ SpACRT prevent further decline and improve their function.

[43] National Guideline Centre. NICE Guidelines Community Rehabilitation. 2018.

Strategy		Responsible	Timeframe
2.5	Develop and implement a multidisciplinary model for community-based rehabilitation services.	Clinical Director, AC&RS Facility HODs Rehabilitation	Dec 2024

Outpatient Rehabilitation Services

Outpatient clinics provide patients with the opportunity to access specialist assessment, review or intervention by medical, nursing, and allied health specialists either individually or through a multidisciplinary team model. The range and scope of clinics varies between facilities, based on local demand and the local service system, including access to medical, allied health or nursing expertise.

Outpatient rehabilitation clinics are established across SWSLHD facilities with the exception of Campbelltown and Fairfield Hospitals. Braeside Hospital provides outpatient rehabilitation, however there is a gap for patients who are not suitable for a review at Braeside but who would benefit from post discharge follow up.

Future model of service provision by outpatient clinics will ensure equitable access to services across the District, based on a hierarchy of need. Highly specialised services should be accessible to all but provided at locations where synergies with other services allow for the best possible care to be provided.

Strategy		Responsible	Timeframe
2.6	Review the rehabilitation outpatient clinic model across the LHD to deliver consistent and equitable access to services, including specialised rehabilitation clinics.	Clinical Director, AC&RS Facility HODs Rehabilitation	Dec 2027

Chronic Pain Services

An increasing number of patients are presenting to hospital for management of complex chronic pain syndromes. The lack of a comprehensive outpatient multidisciplinary and multispecialty chronic pain services means that these patients have limited options and are only being managed by primary care providers, individual specialists, or have to travel long distances to access multidisciplinary chronic pain service.

Patients with cancer pain can be managed by palliative care team, but may be referred to the Pain Service where refractory cancer pain may be an issue or when cancer pain is not related to a terminal condition.

Chronic Pain Service in the District is provided only at Liverpool Hospital managed by Neurosurgery Consultants. Consultation process with key stakeholders has indicated a need for the development of an LHD-wide MoC for chronic pain management with a shared governance between Critical Care and Aged Care and Rehabilitation Clinical Streams.

Strategy		Responsible	Timeframe
2.7	Develop an LHD-wide Model of Care for Chronic Pain Management.	Clinical Manager, AC&RS Clinical Manager, Critical Care	Dec 2025

Hospital Care Models and Pathways – Older Persons

Even with the development of services providing care close to home, hospital care will remain a fundamental part of service delivery for older people.

The core components of hospital care for older people requiring specialist aged care services are described below. It should be noted that older people also access a broad range of speciality services outside of Aged Care e.g., cardiology, respiratory however this plan focuses specifically on the provision of Aged Care specialist services.

Emergency Department Care and Rapid Assessment

Older persons require emergency care more often than other populations. In SWSLHD, people aged over 65 accounted for 23% of all ED presentations in 2020. New MoC such as COGS, have resulted in a reduction in presentation of older people living in RACF to the ED. Older people are known to have longer ED lengths of stay than younger people, often because of complex medical and psychosocial presentations.

Management of older patients in the ED is focused on delivery of appropriate evidence-based care with particular regards to rapid and

comprehensive multidisciplinary assessment that includes screening for delirium/dementia, behavioural and falls risks and identification of care plans and/or advance care directives. Across SWSLHD there are multiple approaches to delivery of emergency or rapid response care. The ASET model provides ED based early geriatric assessment of appropriate patients and streamlined discharge or admission. The ASET team liaises with the geriatric medicine staff and the ED staff to facilitate the best care for older persons in the ED. The operation of ASET has improved ED responsiveness to older patients and diverted hospital admissions. However, an addition of a standardised allied health staff to the ASET team will be essential across SWSLHD.

The model varies across the District. Bankstown-Lidcombe Hospital has a medical ASET model, supported by the Rapid Response Service (RRS) providing multidisciplinary allied health assessment and treatment for older people who would benefit from short term interventions to enable them to be safely discharged home. The RRS at Bankstown-Lidcombe Hospital also supports patients in the Medical Assessment Unit (MAU). Liverpool and Campbelltown Hospitals have ASET teams. Fairfield Hospital's ASET has one Clinical Nurse Consultant (CNC) and works closely with Ambulatory Care. The Aged Care CNC at Bowral & District Hospital covers the ED. ASET teams work closely with the COGS.
The Aged Care Rapid Investigation and Assessment (ARIA) Unit in Liverpool Hospital located in the MAU is part of the Department of Geriatric Medicine. A specialist-led multidisciplinary team actively case-finds frail, older patients presenting to the ED through early identification, rapid upfront multidisciplinary comprehensive geriatric assessment and management. Through this assessment and access to rapid diagnostics, ARIA can discharge people home with appropriate follow up or admit those that require inpatient management in ARIA or geriatric home wards.

Strategy		Responsible	Timeframe
3.1	Review the management of older person's in the ED to develop a District-wide approach.	Clinical Manager, AC&RS Clinical Manager, Critical Care	Dec 2024

Acute and Sub-Acute Inpatient Aged Care

Aged Care Inpatient Services provide multidisciplinary assessment and treatment of frail older persons who require acute and sub-acute hospital care and who have functional, medical, cognitive, or social problems. The aim of the units is to help older persons recover from acute illness and maintain or achieve independence in self-care, through multi-disciplinary assessment, prevention of complications, early mobilisation and rehabilitation, and comprehensive discharge planning. Referrals to the Aged Care Inpatient Units come from ED, Ambulatory Care, COGS, outpatient clinics and other medical and surgical units.
Inpatient care within the aged care environment should be delivered consistent with the recommendations of the National Safety and Quality Health Service Standards in relation to comprehensive care planning, preventing falls and harm from falls, nutrition, and hydration, preventing delirium and managing cognitive impairment, and preventing and managing pressure injuries, in addition to reducing the use of restraints (physical and chemical).

Deconditioning and decline in an older person's functional abilities while in hospital may be due to a range of factors: pain, fatigue, immobility, side-effects of drugs or changed mental status. Older patients in particular benefit from participation in programs of reablement and restorative care. Offering a range of evidence-based interventions could form components

of such programs, for example, multicomponent exercise interventions, progressive resistance training, occupational therapy interventions, interventions targeting people with frailty and interventions that might positively affect function in people living with dementia. While the intent of a rehabilitation program is primarily centred on the individual's specific functional deficits, reablement and restorative care programs often have additional aims, such as to reduce the need for premature placement into residential care[12] or to delay or reduce the need for community support services.

Discharge planning includes determining need for inpatient rehabilitation, community-based services or therapy, respite, or RACF placement. People can return to their usual accommodation - home/RACF or to new RACF or other accommodation. Some RACFs residents may avoid future hospital admission through accessing services provided through COGS. The involvement of referring specialists and services including ACAT, OPMH, community service providers, and GPs also plays an integral role in transfer of care back to community. Ongoing specialist review may be provided via outpatient services (face to face or telehealth) and/or the COGS team.

Strategy		Responsible	Timeframe
3.2	Deliver, measure, and evaluate early mobilisation, activity, and cognitive engagement of older inpatients to prevent hospital associated functional decline.	Clinical Director, AC&RS Director, AH & CS	Dec 2027

Older People's Mental Health Inpatient Services

Mental health planning frameworks indicate that approximately 86% of the target/treatment population for OPMH services can be cared for by OPMH community services only and/or in community settings (including RACF, supported accommodation and home settings) along with other care and support.

However, the ageing of the population and increasing prevalence of mental ill health in older people has resulted in the need for additional inpatient OPMH services to be established in the District. The OPMH unit at Campbelltown Hospital is a new 20 bed specialist service for people who present with acute, severe symptoms of mental illness. The unit provides care for people with non-dementia-related mental health problems. However, there may be agreement to admit an older person with BPSD to the OPMH unit following consultation. There is a close relationship and an alignment in service provision between Campbelltown Hospital and Braeside Hospital including uniform admission criteria for OPMH units. The OPMH unit will provide tertiary Consultation-Liaison support as part of the broader Mental Health Service.

Both the inpatient and community services offer assessment, diagnosis, and treatment. OPMH services are delivered by a range of health professionals such as psychiatrists, nurses and allied health professionals (e.g. psychologists, occupational therapists, diversional therapists and social workers) with skills and expertise in mental health problems affecting older persons and people with age related frailty.

To support clinical recovery including restoring function and mobility, service coordination, integration and continuity of care, OPMH services need to work in partnerships with other key services, such as adult mental health, geriatric medical services, aged care assessment services, allied health, community and residential aged care, SWSPHN and GPs.

Further collaboration between Aged Care & Rehabilitation Clinical Stream and Mental Health will support holistic assessment and care planning of the older person, with care delivered in the most suitable location for the older person's needs.

Strategy		Responsible	Timeframe
3.3	Implement Older People's Mental Health Inpatient Model of Care.	DOPMHS	Dec 2023

Caring for Inpatients with Behavioural and Psychological Symptoms of Dementia

Delirium and dementia are the most common causes of altered mental status in older patients. Delirium is relatively common in the inpatient environment, particularly in older people. Dementia is also one of the predisposing factors for delirium. SWSLHD is responding to the need to provide specialised care for people at risk of or experiencing delirium and their families/carers through implementing the Delirium Clinical Care Standard and associated protocols.

Although the number of people in hospital with dementia or delirium is growing, most can be accommodated in a general ward, with appropriate changes to staffing, the environment or care protocols. However, a small proportion of people with BPSD or a delirium that is difficult to resolve present significant challenges for inpatient staff due to their complex and challenging behaviours. These behaviours have the potential to impact on the health and safety of staff and other patients. Therefore, facilities must develop models that enable safe cohorting of these patient groups.

Bankstown-Lidcombe Hospital and Braeside Hospital provide specialist inpatient care for people with BPSD to assist in resolving symptoms and securing appropriate long term supports, including admission to appropriate RACFs. The availability of these beds is limited, though there is additional capacity planned as part of the new Bankstown Hospital. In addition, the District-wide Dementia/Delirium CNC role supports the care of patients with dementia/ delirium, as required. The CNC role includes support to staff in inpatient units, as well as family and carers. The demand for this role is increasing due to the growing number of people diagnosed with dementia.

Strategy		Responsible	Timeframe
3.4	Develop and implement an LHD-wide Model of Care for the management of inpatients experiencing behavioural or psychological symptoms of dementia outside of dedicated BPSD wards.	Clinical Director, AC&RS Facility HODs Geriatrics DMHS DOPMHS	June 2024

Geriatric Surgery and Orthogeriatrics

Each year the number of older people undergoing surgical and procedural services increases. Between 2007 and 2017, the demand for surgical and procedural services in people aged 65 years and over in SWSLHD has increased by 26% compared to 17% for the general adult population.[44]

Geriatric surgical admissions can be complicated pre-operatively, during intervention and post-operatively. It is well established that older age and frailty are associated with a greater risk of poorer postoperative outcomes including delirium.[45] Therefore, input from surgical, geriatric, and

[44] SWSLHD Surgical and Procedural Services Plan to 2031.

[45] Inouye, S.K., R.G.J. Westendorp, and J.S. Saczynski, Delirium in elderly people. The Lancet, 2014.

anaesthetic care teams is required including risk stratification in the pre-operative period.

To date research into the care of older surgical patients has been largely limited to orthopaedic patients, in particular those with hip fractures. The delivery of a shared care models has shown benefits in improving functional outcomes, and reducing complications, mortality and length of stay.

Refer to the Surgical and Procedural Services Plan to 2031 which includes an action to pilot and evaluate a Geriatric Surgery Model initially at Bankstown-Lidcombe Hospital and subsequently across the LHD.

End of Life and Palliative Care

The care of persons at the end of their life has becoming increasingly complex and can be difficult for patients, their carers and families to discuss. 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. [46] A recent Australian report 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." Seventy per cent of Australians want to die at home yet only 14% do so. Despite their wishes, about half of people die in hospital and a third in residential care. [47]

SWSLHD Palliative Care Service (PCS) is a multidisciplinary service which operates within a District networked model of care. The PCS works in partnership with other clinical services to ensure the best care and support is provided for people at the end of their life.

A state-wide portal for palliative and end of life care supported by the NSW ACI and the NSW Clinical Excellence Commission has resources to support clinicians to deliver care in the last year of life.
The NSW End of Life and Palliative Care Framework 2019-2024 articulates the vision and direction for an integrated approach to end of life and palliative care planning and services within the NSW health system. The Government has recently announced the Enhancing End of Life Care budget of $743 million for activities under the Framework over five years to ensure that people across NSW have equitable access to high quality end of life and palliative care. Funding will enhance palliative care, pain management and other specialist services in hospitals and community settings. SWSLHD are currently undertaking planning to identify priorities for further funding.

Strategy		Responsible	Timeframe
3.6	Strengthen management and care of older inpatients with end of life and palliative care needs.	LHD Manager, Palliative Care Clinical Manager, AC&RS	Dec 2024

[46] Lorna K. et al. Hospital and emergency department use in the last year of life: A baseline for future modifications to end-of-life care. Med J Aust 2011.

[47] Swerissen, H and Duckett, S. Dying Well. Grattan Institute. 2014.

Hospital Care Models and Pathways - Rehabilitation

Even with the development of services providing care close to home, hospital care will remain a fundamental part of rehabilitation service delivery, particularly for patients with complex needs.
The core components of hospital-based rehabilitation care include mobility training, self-care training and arranging appropriate short and long term support to maximise independence.

Rehabilitation in Acute Inpatient Units
Better outcomes for patients have been correlated with earlier access to rehabilitation. Early rehabilitation is important to maximise recovery, prevent de-conditioning, optimize function while in the acute hospital setting, enable earlier assessment, intervention, and discharge planning.

In-reach rehabilitation, or formal rehabilitation provided in the acute setting, is an emerging model of care in Australia. Under this model, rehabilitation occurs earlier as an adjunct to acute treatment with patients remaining in the acute unit where relevant medical, surgical, critical care and support service expertise is readily available.

Using the in-reach rehabilitation approach, medical specialists provide a consultation-liaison service and allied health teams provide comprehensive support to identified patients, regardless of their home ward. The program involves multidisciplinary assessment and intervention to support mobility, functional activities, falls prevention and discharge planning.

There are three slightly different approaches to in-reach rehabilitation in SWSLHD hospitals including:

- Rehabilitation Acceleration Program at Campbelltown Hospital
- Rapid Response Rehabilitation Team at Liverpool Hospital
- In – Reach Rehabilitation Team at Bankstown-Lidcombe Hospital

With limited access to inpatient rehabilitation beds and an increasing acute bed base across the District, new models of care will be required to meet the demand for rehabilitation services.

Strategy		Responsible	Timeframe
3.7	*Develop and implement an LHD-wide Model of Care which supports timely access to rehabilitation in acute settings.*	*Clinical Director, AC&RS Facility HODs Rehabilitation*	*June 2024*

Specialist Inpatient Rehabilitation Services
Patients may be admitted to an inpatient rehabilitation unit following acute events such as amputation or traumatic injury or following surgical intervention. Patients may also be admitted to a rehabilitation unit if they are experiencing progressive deterioration associated with a chronic condition e.g., neurological condition or are experiencing reversible functional decline e.g., geriatric admission. Patients accessing specialist inpatient rehabilitation beds are generally those who have their care stepped down from an acute inpatient unit, although direct admissions to rehabilitation units may occur occasionally. Rehabilitation inpatients are:

- medically stable
- assessed as being medically, psychologically, and functionally requiring rehabilitation and able to participate in the rehabilitation program
- assessed as having achievable rehabilitation goals collaboratively developed and agreed between the patient, their family/carer and the MDT including Allied Health, Nursing and Medical staff.

Inpatient rehabilitation services provided in the SWSLHD:

HOSPITAL	SERVICES
Fairfield Hospital	• Provides a subacute geriatric and rehabilitation service, accepting referrals from Fairfield and other tertiary hospitals within the area. • Patients are frailer, have multiple co-morbidities and are therefore less medically stable than those who receive rehabilitation in a general unit.
Camden Hospital	• Camden Rehabilitation Unit (CRU): Admitted patients generally have a higher degree of complexity in terms of diagnosis, therapy needs, discharge planning, accommodation and community supports due to the complex diagnoses and resultant level of disability. • Medical Transit Unit (MTU): Patients admitted to MTU are not yet ready to progress into rehabilitation (such as non-weight bearing) or who can only tolerate low intensity slow stream therapy following deconditioning, orthopaedic conditions or falls. MTU currently also accepts patients awaiting accommodation for RACF or group homes, home modifications or services funded by NDIS. • Camden Hospital provides services primarily to residents of Campbelltown, Camden, Wollondilly and Wingecarribee LGAs.
Bankstown-Lidcombe Hospital	• Provides rehabilitation beds, including specialised orthopaedic/amputee. • Rehabilitation is currently co-located with the Stroke Unit.
Braeside Hospital	• HammondCare Health Rehabilitation Service at Braeside provides the largest rehabilitation service in the south west Sydney, focussing on specialist rehabilitation services for younger and complex rehabilitation patients, primarily from the Liverpool and Fairfield LGAs.

As noted above, there are limited rehabilitation beds available within SWSLHD.

Strategy		Responsible	Timeframe
3.8	Review LHD-wide inpatient rehabilitation activity to support future service capacity planning.	Planning Unit	June 2024

Stroke Rehabilitation

The incidence of stroke and many neurological conditions increases with age. There is a high rate of disability associated with stroke and neurodegenerative conditions, requiring long term access to rehabilitation and disability support services.

A significant portion of the inpatient care for people who have had a stroke occurs in the inpatient setting, however the number of dedicated stroke rehabilitation beds is limited across the District. Across the District, a patient presenting with stroke has their rehabilitation needs and goals assessed by staff trained in rehabilitation within 48 hours of admission to an acute stroke unit. However, commencement of rehabilitation could be dependent on staffing and competing hospital demands. Provision of a standardised approach to confirm eligibility for rehabilitation, integration of rehabilitation review within the stroke pathway, and better integration between neurology and rehabilitation services is required.

Strategy		Responsible	Timeframe
3.9	Develop an LHD - wide Stroke Rehabilitation Model of Care to ensure care coordination and integration between acute and sub-acute phases.	Clinical Director, AC&RS Clinical Director, Internal Medicine	June 2025

Patients with Restricted Weight Bearing Status

Restricted weight bearing status refers to the amount of weight that a patient is allowed to put through the affected limb after surgery or an injury such as a fracture. In the ageing population there is a higher incidence of fragility fractures including: hip fractures, upper limb (humerus and wrist), lower limb (ankle) and periprosthetic fractures. Restrictions may be applied for up to 12 weeks. This can increase the risk of overall deconditioning and deterioration in older patients who have limited functional reserves. There is no standardised District approach to the management of patients during a period of weight bearing restrictions.

Strategy		Responsible	Timeframe
3.10	Explore options for an LHD - wide model of service delivery for rehabilitation or maintenance care of restricted weight-bearing patients.	Clinical Director, AC&RS Director, AH & CS	Dec 2024

Sub-specialised Rehabilitation Services

As the complexity of the patient population changes, there is an increasing need for rehabilitation medicine to develop expertise in the needs of particular patient groups. These include people with cancer, people undergoing renal dialysis, brain injury rehabilitation and spinal cord rehabilitation. Sub-specialisation may ensure improved accessibility to services addressing neuromuscular and musculoskeletal pain, spasticity, stroke, myopathy, neuropathy, spinal cord injury, bowel and bladder dysfunction, amputation, fatigue, lymphedema and abnormalities of gait.

Liverpool Hospital provides a state-wide brain injury rehabilitation service. Other sub-specialty rehabilitation services are provided in a limited capacity in SWSLHD. Networked arrangements between sites within and external to the District are required.

Liverpool Hospital operates a non-specialist spoke site in the state-wide hub-and-spoke model for spinal cord injury. Patients may be treated acutely at Liverpool Hospital and in some cases, may also be treated with rehabilitation in the LHD. Future governance, clinical management and funding arrangements are under review by the ACI.

Strategy		Responsible	Timeframe
3.11	Develop LHD-wide referral pathways and network arrangements for access to specialised rehabilitation services.	Clinical Manager, AC&RS	Dec 2025

Transfer of Care

Plans for transfer of care are discussed and agreed with patients and carers, with transfer of care discussions commencing early within the admission and continuing to evolve as goals are met or revised. Some patients within the rehabilitation system will live with short term or ongoing functional impairment or disability, requiring access to additional support. Where short term assistance is required, patients may access ComPacks or Primary and Community Health services to assist them to return to

independent living. These services may also be provided in conjunction with home-based rehabilitation programs such as RITH.

Patients who are likely to require ongoing care may be discharged directly to a RACF, may utilise the TCP or may require community-based support through the Aged Care or Disability Care sectors. As appropriate, referrals will be made to My Aged Care or the NDIS. The NDIS Coordinator will assist services in completing timely and appropriate assessments and in facilitating NDIS approvals. Patients who need interim support at home whilst awaiting NDIS approval may also access the SASH program.

Strategy		Responsible	Timeframe
3.12	Implement & Review Navigator model to enhance timely transition for NDIS eligible patients to out of hospital care and accommodation services.	Director, AH & CS	Sept 2024

NSW GOVERNMENT

Enablers

Infrastructure and Equipment	Evidence Based Models of Care	Technology and information	Education and Training	Research and Innovation
In line with the capital developments and facility redevelopments, special consideration include: Key Principles for Improving Healthcare Environments for People with Dementia and access to telemetry and digital monitoring of inpatients The Royal Australian College of Physicians Standards for Rehabilitation Services with an adequate physical space and equipment to allow for the provision of a comprehensive rehabilitation service Designing IHH for delivering outpatients and non-admitted services, ensuring care integration of key functions and the efficient use of resources and equipment Inclusion of communications devices and telehealth design to facilitate virtual care.	In conjunction with the review and development of new MoC across AC&RS, this Plan supports: District's approach -'One Service Multiple Sites' within integrated network of hospitals and services. Development and implementation of MoC designed to coordinate transition of care from hospital to community including integration of services across health neighbourhood in line with the develpment of Care in the Community CSP to 2031 Development and implementation of community based models of care to promote the enablement, reablement and wellness approaches Development and implementation of community based models of care for rehabilitation.	In line with the NSW Virtual Care Strategy and the development of SWSLHD ICT Strategy, the Plan supports: A shared health record for carers, consumers and care providers to collaborate and share information across services Use of virtual reality, health monitoring, devices, and wearables to create innovative solutions to enable changes in aged care and rehabilitation care delivery Telehealth strategies to support aged care and rehabilitation clinics and health consultation and education Automated medication reviews when new medications are prescribed to reduce impacts of polypharmacy Use of technology in the management of clinical information, access to clinical protocols, clinical decision making supports, bed management and patient tracking systems.	In line with the development of SWSLHD 2022-2027 Education and Training Strategic Plan and SWSLHD's commitments to building fit for purpose education and training, the Plan considers: AC&RS to have an active role in teaching medical, nursing and allied health students and junior doctors Providing education to GP's and Practice Nurses in collaboration wth SWSPHN Involvement of an advanced Trainee role to support Aged Care and Rehabilitation MoC Providing clinical placements within AC&RS to effectively prepare future clinicians to work with frail older persons and with adults in a need for rehabilitation Strengthening collaboration with key state quality agencies including the ACI and involvement in quality improvement initiatives and projects Strengthening collaboration with universities and other education and training organisations and peak professional bodies e.g. Australian and New Zealand Society for Geriatric Medicine and Australasian Faculty of Rehabilitation Medicine to suport and lead innovations in the aged care and rehabilitation.	Research and innovation in SWSLHD is guided by the SWSLHD Research Strategy to 2023 which supports significant research work around aged care and rehabilitation including: Research with the Sydney Partnership for Health, Education, Research and Enterprise (SPHERE). In addition to the Age and Ageing, other areas such as Musculoskeletal Health and Palliative Care are among the Clinical Academic Groups of SPHERE. The Brain Injury Rehabilitation Research Group (BIRRG) focuses on improving physical function, strengthening pathways for vocational re-integration and addressing challenging behaviours The Whitlam Orthopaedic Research Centre focuses on hip and knee surgeries, and the impliactions of these procedures The Australia and New Zealand Hip Fracture Registry has been established within rehabilitation research stream to measure outcomes in SWS Hospitals Research into stroke and neurology in collaboration with the Ingham Institute for Applied Medical Research's Stroke and Neurology Research Unit. The South West Sydney Allied Health Research Collaboration guides innovative and impactful research projects including pain management, disability and dementia care.

WORKFORCE	**Workforce Training & Education**	**Build the capacity of the SWSLHD clinicians outside of AC&RS to respond adequately to the needs of frail older patients Expand Clinical Academic roles with AC&RS to enhance research and teaching**
	Capability Requirements	**The health workforce is responsive, trained and skilled to recognise and address complexities of patients of carers health and support needs**
	Workforce Composition	**Consider new or expanded clinical roles and clinical suppport role such as Nurse Practitioners and Allied Health Assistants**
	Workforce Demand	**Support attraction and retention of a sustainable workforce across all disciplines Expand Allied Health workforce across disciplines and care settings**
	Multidiciplinary Teams	**Ensure a multidisciplinary approach to education and training to improve collaboration and care integration**

Implementation, monitoring and evaluation

The Older Persons and Rehabilitation Plan to 2027 provides direction for health services to maintain the quality of life of older persons with complex health and social care needs and people requiring rehabilitation.

Implementation of this Plan is a shared responsibility between Clinical Director of Aged Care and Rehabilitation and Director of Allied Health and Community Services and will be reported through the Aged Care and Rehabilitation Clinical Stream and SWSLHD Executive. To enable successful delivery of the Plan's key focus areas and to monitor the progress of its priority actions, an ongoing quarterly review process will be undertaken.

The implementation approach will include:
Establishment of an Implementation Group consisting of key stakeholders responsible for the strategies and their implementation.
Development of a detailed Implementation Plan including specific performance measures for the strategies in this Plan. (An initial list of performance measures is included in the Plan on a Page.)
A mid-term point review (2025-26) to identify the achievements against the Plan and review and update SWSLHD priorities as required.

Monitoring, evaluation and reporting on success is vital to understand our achievement of the goals of the Plan and to inform service changes over the life of the Plan.