Health
Southern NSW
Local Health District

BATEMANS BAY COMMUNITY HEALTH
Clinical Services Plan

May 2023

Version 0.16

SNSWLHD and Eurobodalla Health Service acknowledge the traditional custodians of the land on which the health service operates. Eurobodalla is in Yuin Nation, on Walbunga Country. The service pays respects to Elders past, present and emerging and all Aboriginal and Torres Strait Islander people living or visiting locally, and welcomes all Aboriginal and Torres Strait Islander patients and their families to the service.

Contents

Revision History

Revised by	Date	Revision Control	Revision Reason
Rebecca Moon	23/01/2023	Version 0.9	Response to Eurobodalla Development team comments v0.8
Sarah Galton	07/02/2023	Version 0.10	Further editing
Rebecca Moon	03/02/2023	Version 0.11	Added 2031 activity projections; response to Allied Health team comments v0.10
Rebecca Moon Sarah Galton	24/02/2023	Version 0.12	Mental health activity added; final edits and draft issued for final approvals
Rebecca Moon	28/03/2023	Version 0.13	Additional detail on planning assumptions
Rebecca Moon	12/05/2023	Version 0.14	MoH feedback
Rebecca Moon	18/05/2023	Version 0.15	Further MoH feedback
Sarah Galton	30/05/2023	Version 0.16	Final for resubmission to MoH

Executive Summary

Southern NSW Local Health District (SNSWLHD) mission states that 'all people across our diverse communities are able to have timely access to the right health care in the right setting to maximise their health, wellbeing and independence'. The Batemans Bay Community Health Clinical Services Plan (CSP) provides the framework to deliver on the District's mission statement with an 8 year outlook for the development and delivery of health care to the residents of the Eurobodalla LGA.

SNSWLHD planning priorities aim for care to be provided as close to the community as possible, with integrated primary and community health services that promote ongoing holistic care in partnership with local service providers.

Development of the new Eurobodalla Regional Hospital (ERH) at Moruya is underway and will see the consolidation of hospital services currently provided through Batemans Bay and Moruya Hospitals to a single site. The overarching principles of the new service will ensure that it:

- Is integrated across all disciplines,
- Reduces duplication,
- Is underpinned by the unique population needs of the Eurobodalla community.

Eurobodalla community health services will continue to be provided out of three locations – Batemans Bay, Moruya and Narooma. Planning for community health services in the Batemans Bay area, including a new Batemans Bay Community Health Centre, is being undertaken to establish future directions for a strong and sustainable community health service model for Eurobodalla LGA, that supports care as close to home as possible, embraces current and emerging technologies and models of care, is integrated with and complementary to services to be delivered through the new Eurobodalla Regional Hospital and recognises the demands of both the resident population and tourism to the area. Provision of community health services in multiple sites throughout the Eurobodalla LGA will improve access to health care, improve outcomes and avoidance of acute deterioration, and decrease hospital admission and/or readmission.

The NSW Future Health Strategy places a strong emphasis on keeping people healthy through prevention and health promotion, as well as providing access to care outside of hospital settings. The Strategy recognises that "two thirds of the disease burden in NSW is due to conditions that could be managed outside the hospital setting", and that "hospitalisation can exacerbate a condition that could have been preventable via community based approaches". The Strategy commits to delivering more services in the home, community, and virtual settings.

Development of the CSP for Batemans Bay Community Health Services presents an opportunity to plan services to meet the needs of the gorwing and ageing population with a strong emphasis on networking, the integration of services and partnering with patients and external service providers. This Clinical Services Plan outlines the needs and future directions for community health services in Batemans Bay, to provide primary and community health, and minor injury and illness management for both residents and visitors to the region.

1. Introduction and Background

The Eurobodalla Clinical Services Plan (CSP) was endorsed by the NSW Ministry of Health in early 2020. The Clinical Service Plan formed the basis for planning towards a single Eurobodalla Regional Hospital and the consolidation of hospital services provided through Batemans Bay and Moruya.

In January 2020, the Minister for Health announced a $20 million investment to support the development of a new Batemans Bay Community Health Centre. This CSP details the future directions for community health services in the Batemans Bay area inclusive of a new Community Health Centre that would provide the Batemans Bay community with access to walk in services for minor injury and illness and primary and community health services close to home. This aligns with the direction of the District's Health Care Services Plan, which aims to:

- provide appropriate and equitable services
- maintain safe and sustainable health services and hospitals
- ensure services to meet the mental health and ageing needs of communities into the future.
- think beyond our hospitals to strengthen out of hospital care
- invest in hospital avoidance programs
- deliver services at home, or as close to home as possible, and
- invest in non-infrastructure projects to support care close in the community.

Our population is growing and ageing; health needs are becoming more complex and new technology is changing how we deliver health care. It is expected that the health needs of our community will grow significantly over the next 10 years. We recognise the need to consider our vulnerable communities and care for them in ways which reflects their health needs and preferences in culturally safe environments and provide care as close to home as possible.

We also recognise the significant impact of COVID-19 on our community, along with the cumulative impact of bushfires and floods, and the long-term effects that are not yet fully understood.

The health services for Batemans Bay and surrounding areas need to support access to planned and unplanned services for the resident population and holiday season tourists.

Community health services in Batemans Bay will provide timely access to patient centred, high quality, safe primary and community health services closer to home for the local community that are integrated with other local services and the new Eurobodalla Regional Hospital. Services will be adaptable to the needs of the local population and embrace the current and future opportunities in virtual care and provision of services to patients in their own home.

2. Policy and Strategic Planning Context

2.1 National

2.1.1 National Health Reform Agreement 2020-25

The National Health Reform Agreement (NHRA) aims to improve health outcomes for all Australians and ensure that the Australian health system is sustainable. The NHRA has been signed by all

Australian governments and recognises that state and territories as system managers of public hospitals.

The goals of the NHRA are to:

- deliver safe, high-quality care in the right place at the right time
- prioritise prevention, and help people manage their health across their lifetime
- drive best-practice and performance using data and research
- improve efficiency and ensure financial sustainability.

2.1.2 The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes

Closing the Gap is a commitment by all levels of government and with Aboriginal and Torres Strait Islander communities to close the gap on Indigenous disadvantage. Four priority reform areas are identified:

- Formal partnerships and shared decision making
- Building the Community Controlled Sector
- Transforming Government Organisations
- Shared access to data and information at a regional level.

The NSW Implementation Plan 2022-2024 details the 142 initiatives being progressed across NSW to deliver on Closing the Gap commitments. NSW Health's key action areas include:

- Increasing the number of Aboriginal and Torres Strait Islander people working across the breadth and depth of roles in the NSW health workforce
- Expanding health services aligned to the needs of Aboriginal people, such as culturally safe maternity services
- Developing an approach to deliver culturally safe antenatal, post-natal and infant health services, and an increased focus on the early years and cultural safety

2.1.3 Australia's Disability Strategy 2021-2031

Australia's Disability Strategy 2021-2031 outlines a vision for a more inclusive and accessible Australian society where all people with disability can fulfil their potential as equal members of the community. Its purpose is to:

- Provide national leadership towards greater inclusion of people with disability.
- Guide activity across all areas of public policy to be inclusive and responsive to people with disability.
- Drive mainstream services and systems to improve outcomes for people with disability.
- Engage, inform and involve the whole community in achieving a more inclusive society.

2.2 New South Wales

2.2.1 Future Health: Guiding the next decade of health care in NSW 2022-2032

The NSW health plan *Future Health: Guiding the next decade of health care in NSW 2022-2032 establishes* 6 strategic outcomes for the NSW Health system:

- Patients and carers have positive outcomes that matte
- Safe care is delivered across all settings.
- People are healthy and well.

- Our staff are engaged and well supported.
- Research and innovation, and digital advances inform service delivery.
- The health system is managed sustainably.

Key objectives across all strategic outcome areas support the focus on access to care in the community and keeping people healthy and well.

Figure 1: Future Health: Guiding the next decade of health care in NSW 2022-2032

Strategic outcomes	Key objectives
Patients and carers have positive experiences and outcomes that matter: People have more control over their own health, enabling them to make decisions about their care that will achieve the outcomes that matter most to them.	1.1 **Partner with patients and communities** to make decisions about their own care 1.2 **Bring kindness and compassion** into the delivery of personalised and culturally safe care 1.3 **Drive greater health literacy** and access to information 1.4 **Partner with consumers** in co-design and implementation of models of care
Safe care is delivered across all settings: Safe, high quality reliable care is delivered by us and our partners in a sustainable and personalised way, within our hospitals, in communities, at home and virtually.	2.1 **Deliver safe, high quality reliable care** for patients in hospital and other settings 2.2 **Deliver more services** in the home, community and virtual settings 2.3 **Connect with partners** to deliver integrated care services 2.4 **Strengthen equitable outcomes and access** for rural, regional and priority populations 2.5 **Align infrastructure and service planning** around the future care needs
People are healthy and well: Investment is made in keeping people healthy to prevent ill health and tackle health inequality in our communities.	3.1 **Prevent, prepare for, respond to and recover** from pandemic and other threats to population health 3.2 **Get the best start in life** from conception through to age five 3.3 **Make progress towards zero suicides** recognising the devastating impact on society 3.4 **Support healthy ageing** ensuring people can live more years in full health and independently at home 3.5 **Close the gap** by prioritising care and programs for Aboriginal people 3.6 **Support mental health and wellbeing** for our whole community 3.7 **Partner to address the social determinants of ill health** in our communities
Our staff are engaged and well supported: Staff are supported to deliver safe, reliable person-centred care driving the best outcomes and experiences.	4.1 **Build positive work environments** that bring out the best in everyone 4.2 **Strengthen diversity** in our workforce and decision-making 4.3 **Empower staff to work to their full potential** around the future care needs 4.4 **Equip our people with the skills and capabilities** to be an agile, responsive workforce 4.5 **Attract and retain skilled people** who put patients first 4.6 **Unlock the ingenuity of our staff** to build work practices for the future
Research and innovation, and digital advances inform service delivery: Clinical service delivery continues to transform through health and medical research, digital technologies, and data analytics.	5.1 **Advance and translate research and innovation** with institutions, industry partners and patients 5.2 **Ensure health data and information** is high quality, integrated, accessible and utilised 5.3 **Enable targeted evidence-based healthcare** through precision medicine 5.4 **Accelerate digital investments** in systems, infrastructure, security and intelligence
The health system is managed sustainably: The health system is managed with an outcomes-focused lens to deliver a financially and environmentally sustainable future.	6.1 **Drive value based healthcare** that prioritises outcomes and collaboration 6.2 **Commit to an environmentally sustainable** footprint for future healthcare 6.3 **Adapt performance measurement and funding models** to targeted outcomes 6.4 **Align our governance and leaders** to support the system and deliver the outcomes of Future Health

Source: https://www.health.nsw.gov.au/about/nswhealth/Publications/future-health-report.PDF

2.2.2 NSW Regional Health Plan 2022-2032

The new Regional Health Plan establishes six priorities guiding the next decade of regional, rural and remote care in NSW:

- Strengthen the regional health workforce.
- Enable better access to safe, high quality and timely health services.
- Keep people healthy and well through prevention, early intervention, and education.
- Keep communities informed, build engagement, seek feedback.
- Expand integration of primary, community, and hospital care.
- Harness and evaluate innovation to support a sustainable health system.

The Plan recognises the unique challenges, service needs and opportunities for communities and health services in rural, regional, and remote NSW and provides the blueprint for enhancing services, improving patient experience and delivering better health outcomes.

2.2.3 ACT-NSW Memorandum of Understanding on Regional Collaboration 2020

The MOU allows both governments to develop and implement shared proposals for policy change, planning and service delivery initiatives. Priority action areas include a regional approach to health outcomes, which will ensure that all patients accessing ACT health services receive timely and high-quality care. A renewed agreement is currently in progress and will have a strong focus on work to reverse flows to the ACT for SNSW residents and sharing of data to support clinical decision making and service planning.

2.2.4 Other key state-wide plans

Other state-wide plans include, but are not limited to:

- NSW Health Virtual Care Strategy 2021-2026
- Elevating the Human Experience – Our Guide to Action (2020)
- NSW HIV Strategy 2021-2025
- Oral Health 2020: A Strategic Framework for Dental Health in NSW
- End of Life and Palliative Care Framework 2019-2024
- The First 2000 Days Framework (2019)
- The First 2000 Days Implementation Strategy 2020-2025
- NSW Aboriginal Health Plan 2013 - 2023
- Strategic Framework for Suicide Prevention in NSW 2022-2027
- Bilateral Schedule on Mental health and Suicide Prevention: New South Wales
- NSW Healthy Eating & Active Living Strategy 2022-2032
- NSW Sexually Transmissible Infections Strategy 2022-2026
- Living Well in Focus 2020-2024
- NSW Older People's Mental Health Service Plan 2017-2027
- Healthy Safe and Well: Strategic Health Plan for Children, Young People and Families 2014-2024
- NSW Plan for Healthy Culturally and Linguistically Diverse Communities: 2019-2023

- Premier's Priority: Reduce Overweight and Obesity Rates of Children by 5% over 10 Years (2016)
- eHealth Strategy for NSW Health 2016-2026
- NSW Youth Health Framework 2017-2024
- Disability Inclusion Action Plan

2.3 LHD and Local Context

2.3.1 SNSWLHD Strategy 2026

SNSW Local Health District Strategy 2026 (Strategy 2026) articulates the strategic direction for the District. The strategic priorities are based on NSW Health's 10-year Future Health Strategic Framework. Strategy 2026 focuses on how we will support our patients and community, as well as our people and organisation.

The strategic priorities for SNSWLHD are:

- Elevating the human experience
- Keeping people healthy and well
- Delivering safe care in all settings
- Supporting our people

The enablers that support these strategic priorities are:

- Education, training and research
- Health data and analytics
- Leadership and governance
- Value and sustainability

2.3.2 SNSWLHD Health Care Services Plan 2021-2026

SNSWLHD Health Care Services Plan 2021-2026 details the vision and goals across the Southern NSW Local Health District (SNSWLHD) from 2021-2016. The District's vision is to be 'a leader in rural healthcare' and is underpinned by four goals to provide quality care:

- Safe
- Appropriate and effective
- Connected
- Individual

The District's vision requires a change in how healthcare services are delivered. Southern NSW LHD is shifting towards a proactive approach to keep people well and out of hospital. Examples of the changes required include embracing innovative models of care and technology.

Six key strategies outline the way in which our District will achieve this vision, with specific actions underpinning these strategies:

- Health services meet the changing needs of the community
- Invest in modern programs that are proven to work

- Prevent and manage ongoing health needs
- Reduce demand on hospital services through enhanced care in the community
- Provide health in partnership with services across the community
- Foster a learning environment

2.3.3 SNSWLHD Service Level Agreement 2022-2023

The Service Level Agreement between the NSW Ministry of Health and SNSWLHD states 'The principal purpose of the Service Agreement is to set out the service and performance expectations for the funding and other support provided to Southern NSW Local Health District (the Organisation), to ensure the provision of equitable, safe, high quality, human-centred healthcare services.'

The Agreement articulates clear direction, responsibility and accountability across the NSW Health system for the delivery of NSW Government and NSW Health priorities. Additionally, it specifies the service delivery and performance requirements expected of the organisation that will be monitored in line with the NSW Health Performance Framework.'

The Service Level Agreement is renewed each year and clearly articulates the District's local priorities, the agreed activity targets and the funding to 'purchase' the activity.

2.3.4 Leading Better Value Care (LBVC)

Leading Better Value Care is a state-wide program that aims to improve the health outcomes and experiences of people with specific conditions. LBVC uses a systematic approach to embedding good practice and measuring care, experiences and health outcomes. The Osteoarthritis Chronic Care Program (OOACP) and the Osteoporosis Refracture Prevention (ORP) program are LBVC initiatives that have been implemented at the Eurobodalla Health Services (EHS). As part of an integrated service, the EHS would provide outreach services to the Batemans Bay Community Health Service. LBVC will continue to inform service redesign and measures to improve outcomes and access to care.

3. Partnerships and Networks

3.1 South Eastern Primary Health Network (COORDINARE PHN)

COORDINARE is the Primary Health Network (PHN) for South Eastern NSW, which includes the SNSWLHD and Illawarra-Shoalhaven LHD catchments. Key objectives of COORDINARE are increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.

COORDINARE's vision is a coordinated regional health system which provides exceptional care, promotes healthy choices and supports resilient communities.

To realise this vision, COORDINARE as the local PHN is working closely with SNSWLHD on a number of initiatives to create a better integrated local health system. Examples of collaboration include:

- Development of the Southern NSW Integrated Care strategy which outlines collaborative efforts across four main areas of:
    - Aboriginal Health

  - Chronic Conditions
  - Mental Health
  - End of Life and Palliative Care
- Joint appointment of GP Liaison Officers for each of the LHD Clusters, to better link general practice with LHD hospitals and community health services.
- Development of the Regional Mental Health and Suicide Prevention Plan in collaboration with Illawarra Shoalhaven Local Health District, SNSWLHD and COORDINARE.
- Programs to support afterhours primary health care and prevent avoidable hospital presentations to the ED Programs aimed at increasing uptake of My Health Record, to ensure sharing of consumers' health information across treatment settings
- Joint partnership in the development of HealthPathways between SNSWLHD, ACT Health, Capital Health Network (ACT PHN) and COORDINARE (SENSW PHN). The benefits of using HealthPathways include:
  - more patients getting the right treatment or specialist care with reduced waiting time
  - clinician-agreed pathways both into and out of the public health system
  - support with information on appropriate referral and pre-referral work up
  - improved quality and appropriateness of referrals
  - local adaption of evidence-based health care and supporting resources
  - more appropriate use of inpatient, outpatient and community services
  - more relevant educational resources for patients available to clinicians
  - clinician engagement in identifying system problems and solutions
- Collaboration to improve the care of at-risk patients during winter.

COORDINARE's purpose is supporting primary care in the region to be:

- Comprehensive
- Person-centred
- Population oriented
- Coordinated across all parts of the health system
- Accessible
- Safe and high quality

In working towards this, COORDINARE provides high level support to local general practices, focusing on better use of practice data, quality improvement, and getting ready for changes to the primary care system such as the Patient Centred Medical Home approach. COORDINARE commissions services for communities at risk of poor health outcomes, particularly in the areas of mental health, drug and alcohol, Aboriginal health, and better care for people with chronic conditions. As a PHN, COORDINARE does not deliver services directly. Instead, commissioned services are delivered by third party providers, who are engaged under contract through a tender or application process.

3.2 General Practitioners

General Practitioner Visiting Medical Officers are of vital importance in the Eurobodalla. They provide a highly professional and valued service to the Eurobodalla community. This includes anaesthetics, obstetrics and gynaecology, neonatal resuscitation, emergency medicine, general medicine and

rehabilitation. General Practitioners in the area also provide important services from private practices in the community. A limited number of these practices operate outside standard business hours during the week and on weekends.

3.3 Katungul Aboriginal Community Corporation and Medical Service (ACC&MS)

The Katungul Aboriginal Community Corporation and Medical Service is an Aboriginal controlled community organisation, which provides clinics in Narooma, Batemans Bay and in other towns on the far south coast.

Katungul provides a range of culturally appropriate medical, dental and specialist services to the Aboriginal community. Services cover a wide variety of areas including eye health, oral health, chronic disease, women's health, maternity and drug and alcohol use. The services are provided through clinics in the region and via outreach. SNSWLHD works closely with Katungul and have a Memorandum of Understanding. One example of collaboration is the Otitis Media screening in schools in the Eurobodalla region. Katungul performs the screening tests in schools and any children that require follow-up are referred to the health service.

3.4 Tresillian

Tresillian Day Services provide a range of services for families experiencing early parenting challenges. Tresillian has recently established a family care centre at Moruya, as well as an early parenting van providing services across the Eurobodalla region.

3.5 Non-government and not for profit organisations

Non-government agencies and not for profit organisations are key players in health service delivery, particularly in the provision of services to older people and people with a disability living in the community. A range of non-government organisations operate in the Batemans Bay area providing services health and community support services including disability supports, mental health care and support, aged care, drug and alcohol services, family support

3.6 Family Case Management Interagency

Allied health and mental health participate in the Family Case Management Interagency meetings with Family and Community Services (FaCS), NSW Police, Department of Education, NGOs and department of housing to discuss system road blocks for vulnerable children and families most at risk.

4. Demographic and Service Profile

4.1 Southern NSW Local Health District

Southern NSW Local Health District provides public hospital and health care services across regional south-east NSW. The District spans 44,534 square kilometres over seven local government areas (LGAs): Bega Valley, Eurobodalla, Goulburn-Mulwaree, Queanbeyan-Palerang, Snowy Monaro, Upper Lachlan and Yass Valley. As at 2021 the resident population of the District was 219,353.

SNSWLHD adjoins the Western NSW LHD to the north-west, Victoria to the south, South Western Sydney to the north, Illawarra/Shoalhaven LHDs to the north-east, and Murrumbidgee LHD to the west. SNSWLHD also shares a border with the Australian Capital Territory (ACT) and each year there are significant flows of patients to Canberra Hospital as our main tertiary service provider. The proximity to the ACT has a major impact on the planning of health care services for LHD residents.

4.2 Eurobodalla Local Government Area

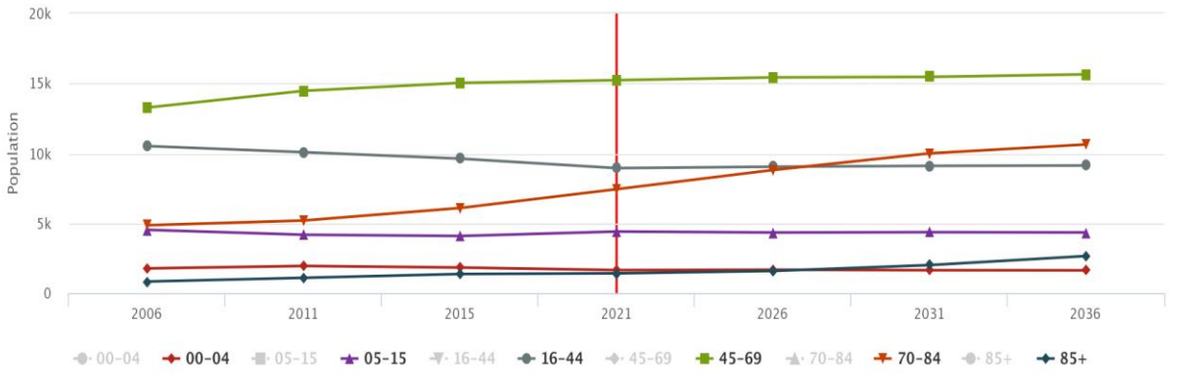
Figure 2: Eurobodalla LGA

Figure 3: Map of Aboriginal Lands in SNSWLHD

Source: ABS 2021 Census Data, August 2022

The Eurobodalla Local Government Area (LGA) covers 3,422 square kilometres, and with an estimated population of 40,593 people in 2021 and a population density of 11 residents per square km. The Eurobodalla population is projected to increase to 44,022 in 2036 (2022 DPE Population Projections). Services in the Eurobodalla are located within the traditional lands of the Yuin nation. The Yuin people have strong ties to the land, and active participation in traditional customs. Figure 4 and Table 1 below illustrate the projected growth for the Eurobodalla region.

Figure 4: Population projections for Eurobodalla LGA by age group



HealthAPP v1.1 – Population projections with 2022 DPE data

Table 1: Eurobodalla LGA - Projected Population by Age, 2016 to 2041

Eurobodalla LGA	2016	2021	2026	2031	2036	2041	Change 2016 - 2041	% Change 2016 - 2041	Annual Growth Rate 2016 - 2041
0 to 4 years	1,652	1,642	1,669	1,636	1,627	1,659	6	0.4	0.02%
5 to 15 years	4,367	4,403	4,334	4,357	4,338	4,337	-31	-0.7	-0.03%
16 to 44 years	9,221	8,940	9,040	9,101	9,126	9,162	-59	-0.6	0.21%
45 to 69 years	15,103	15,230	15,429	15,466	15,648	15,911	808	5	2.41%
70 to 84 years	6,074	7,431	8,805	9,997	10,633	11,018	4945	81	3.58%
85 years and over	1,323	1,411	1,583	2,002	2,650	3,184	1861	141	2.64%
Total	**37,741**	**39,056**	**40,860**	**42,559**	**44,022**	**45,271**	**7,530**	**19.95**	**0.73%**

Source: 2022 DPE CPA Population Projections by LGA

The Eurobodalla population is projected to increase to 44,022 in 2036 (DPE), with the most significant increase in projected data for ages 70 and over. The population is projected to increase by almost 20% between 2016 and 2041.

4.3 Batemans Bay

Population Profile

In 2021, the estimated population of Batemans Bay was 17,519. The Batemans Bay area population data was defined by SAL2 areas: Batemans Bay and Batemans Bay South. The residents of Batemans Bay account for 43% of the Eurobodalla LGA.

Figure 5: Map of Batemans Bay and Batemans Bay South

Source: ABS 2021 Census Data

Batemans Bay has an ageing population, with one of the highest proportions of older residents in NSW. The median age for Batemans Bay is 52 years, with residents aged 65+ years old making up 32.2% of the population. This is much higher than the NSW average of 17.7% and will have a significant impact on health service demand in the region over time

Aboriginal Population

In 2021, there were a higher proportion of Aboriginal and Torres Strait Islander people in Batemans Bay (6.9%), compared to the NSW average (3.4%) and 50.9% of the population were aged 0-24. The median age in 2021 was 23 years old. Aboriginal and Torres Strait Islander people in the Batemans Bay community have higher rates of kidney disease, lung disease and mental health conditions, compared to the NSW average.

Socio-economic Status

The average income for Batemans Bay residents is lower than the NSW average for all types of households, as indicated in the table below (see Table 2 below). Analysis of the Census 2021 data also highlights that, compared to the NSW average, residents in Batemans Bay have a higher incidence of living alone, as well as having a low income (see Table 3 below). Transport disadvantage is also significant, with 5.32% of Batemans Bay households not having access to a private motor vehicle and limited access to public transport.

Table 2: Median income for households in Batemans Bay, compared to the NSW average

Median income	Batemans Bay	NSW Average
Household	$1167	$1829
Family	$1409	$2185
Personal	$617	$813

Source: Australian Bureau of Statistics – 2021 Census All Persons Quickstats, Batemans Bay and Batemans Bay South (SAL2)

Table 3: Household data for Batemans Bay

Household Data	Batemans Bay	NSW
Single (lone) person	31.4%	25%
No car for household	5.32%	9%
Income < $650/week for household	23.3%	16.3%

Source: Australian Bureau of Statistics – 2021 Census All Persons Quickstats, Batemans Bay and Batemans Bay South (SAL2)

Relative disadvantage

The Index of Relative Socioeconomic Disadvantage (IRSD) score is derived from Census variables related to income, educational attainment and employment. The average national IRSD score is 1000.

The Eurobodalla LGA have IRSD scores <970. This means there are fewer residents with high incomes, tertiary education, and skilled occupations than Australia as a whole (Source: ABS Socio-Economic Areas for Australia (SEIFA), 2016).

Health Status Indicators

The health status of Batemans Bay residents is generally poorer compared to the NSW average. This is associated with higher rates of long-term conditions and an ageing population. In addition to the overall poorer health status, Aboriginal and Torres Strait Islander people in Batemans Bay have a further increase in long-term conditions. Of most significance is their rate of Asthma and mental health conditions, as shown in the table below.

Table 4: Occurrence of long-term conditions in Batemans Bay residents, compared to the state average

Type of long-term health condition	Non-Aboriginal % of population	Aboriginal and Torres Strait Islander % of population	% of total population	New South Wales % of population
Arthritis	16.9%	7.0%	15.3%	8.4%
Asthma	9.6%	13.8%	9.3%	7.8%
Cancer	5.5%	1.7%	4.9%	2.8%
Heart disease	6.9%	4.1%	6.3%	3.9%
Kidney disease	1.8%	1.7%	1.7%	1.0%
Lung condition	3.5%	2.8%	3.3%	1.7%
Mental health condition	11.8%	15.7%	11.4%	8%
No long-term health conditions	50.6%	55.8%	47.9%	61%

Source: Australian Bureau of Statistics – 2021 Census All Persons QuickStats, Batemans Bay and Batemans Bay South (SAL2); 2021 Census Aboriginal and/or Torres Strait Islander people QuickStats, Batemans Bay and Batemans Bay South (SAL2).

The residents of the Eurobodalla have high rates of unhealthy lifestyle factors (Table 5), which will contribute to the prevalence of long-term conditions. Around one in five women (20.5%) who are pregnant smoke during their pregnancy, compared to the NSW rate of 9.0% (PHIDU, 2017-2019). Residents in the Eurobodalla LGA have higher rates of smoking, alcohol intake, overweight and obesity, compared to the whole of NSW.

Table 5: Health risk factors for Eurobodalla residents, 2017-2018

	Age standardised rate (ASR) per 100 population				
	Estimated # adult smokers	**Estimated adults 2+ alcoholic drinks/day**	**Estimated # adults inadequate exercise**	**Estimated # adults overweight and obesity**	**Estimated # children overweight and obesity**
Eurobodalla LGA	18.9	21.4	61	70.8	27.9
NSW	**14.4**	**15.5**	**65.3**	**65.9**	**24.4**

Source: PHIDU, Social Health Atlas (figures from 2017-2018)

Hospitalisations

Hospitalisation due to chronic conditions can have a significant effect on the health system. Lifestyle factors, such as smoking, alcohol intake and diet, play a large part in the development of chronic conditions. Preventative healthcare is an important priority, as an improvement in unhealthy lifestyle choices will lead to a decrease in avoidable hospitalisations. Residents of Eurobodalla LGA have higher levels of hospitalisation than the NSW average, for the following health status indicators:

Table 6: Eurobodalla LGA Hospitalisations health status indicators, 2019/2020 - 2020/2021

Measure	**Number of Separations per Year**	**Rate per 100,000 Population**	**Rate per 100,000 all of NSW**
Hospitalisation for all causes	17,295	35,648	35,494
Smoking attributable hospitalisations	220	565	592
Alcohol attributable hospitalisations	211	544	527
Intentional self-harm hospitalisations	74	191	91
Diabetes hospitalisations – principal diagnosis	76	195	154

Source: HealthStats NSW (Available at healthstats.nsw.gov.au)

Hospitalisations for intentional self-harm is a cause for concern for the Eurobodalla LGA, with the rate over 100,000 population well above the NSW rate. Presentations for mental and behavioural disorders to the emergency departments in the Eurobodalla LGA are higher than the NSW rate for most age groups (see table below).

Table 7: ED presentations for mental and behavioural disorders, by age group, 2019-2020

	Age standardised rate (ASR) per 100 population					
	Ages 0 to 14 years	**Ages 15 to 24 years**	**Ages 25 to 44 years**	**Ages 45 to 64 years**	**Ages 65 to 74 years**	**Ages 75 years +**
Eurobodalla LGA	248.7	3986.4	4,171.7	2205.7	689	1,428
NSW	**261.2**	**1,972.7**	**1625.7**	**1228.3**	**641**	**1,184.8**

Source: PHIDU, Torrens University Australia, 2022

Life Expectancy and Mortality

Residents of the Eurobodalla LGA have a life expectancy at birth of 82.8 years, lower than overall NSW (Table 8). The average annual age standardised rates for premature deaths and deaths from all avoidable causes in Eurobodalla are higher than overall NSW.

Table 8: Life expectancy and mortality rates

	Life expectancy at birth (2020)	**Median age at death of persons (2016-2020)**		**Deaths, all causes (2019-2020)**		**Deaths from all avoidable causes, persons aged 0 to 74 years (2016-2020)**	
	Years	Number of deaths	Median age (years)	Average number	Rate per 100,000	Number	Average annual ASR per 100,000
Eurobodalla	82.8	2,440	81.0	491	615.4	387	183.1
NSW	**84.5**	**268,637**	**82.0**	**53,509**	**484.9**	**43,037**	**115.3**

Source for Deaths, all causes: HealthStats NSW; Source: PHIDU, Torrens University Australia, 2022

Tourism

Tourism Research Australia notes 1.3 million visitors to the region (four-year average to 2019). Non-residents accounted for 17% of all presentations to the Batemans Bay Emergency Department, over a 5-year period (EDAA V21.0). Tourism levels fluctuate during the year, with the peak tourism periods causing an increase in demand on health services. The Batemans Bay Community Health Services CSP has factored increased activity due to tourism into the projection modelling.

As the planning for Batemans Bay Community Health Services evolves, significant work will need to be undertaken to ensure both residents and visitors to Batemans Bay have a sound understanding of the scope of the Urgent Care Service and the ERH emergency department. This will be achieved through a strategic communication plan and consumer engagement.

5. Current Community Health Services and Activity Profile

Key focus areas for primary and community health services in Batemans Bay and the Eurobodalla LGA, include:

- Population growth within the older age groups
- The increasing burden of chronic disease conditions
- Closing the Gap for Aboriginal and Torres Strait Islander people in the region
- Opportunities to provide care closer to home including through virtual care

This will require new models of care, including multidisciplinary and integrated approaches to care.

5.1 Current Service Profile

The Eurobodalla Health Service is a networked service spread over three locations: Batemans Bay, Narooma and Moruya.

Patients can access a comprehensive range of community-based services across the Eurobodalla. Allied health and community nursing services are provided to the patient in the most appropriate setting, which may be from community health centres, hospital-based clinics or in the home. There are three community health centres across the Eurobodalla LGA, in Narooma, Moruya and Batemans Bay. The community health centres in Moruya and Batemans Bay are currently co-located with the Hospitals. The service is an integrated service across the three sites. Some of the community health services also provide care to inpatients and in particular allied health. Access into community-based services is aligned with the existing referral pathways including the district-wide Central Intake Service.

5.2 Community Based Health Services Provided across the Eurobodalla

The Table below highlights the services available by teams across the Eurobodalla. Similar services are provided in Batemans Bay and Moruya, with oral health and cancer care services provided at Moruya. Patients who require services not provided locally are linked into a service provided at an alternate location.

Table 9: Community health services available in the Eurobodalla LGA

Services	Batemans Bay	Moruya	Narooma
Aboriginal health services	✓	✓	✓
Older persons health services (including Aged Care Assessment, Transitional Aged Care Program (TACP), Falls prevention, Geriatric Evaluation and Management (GEM), Geriatric Medicine)	✓	✓	✓
Cancer care		✓	
Child and Family services	✓	✓	✓
Community health central intake service	✓	✓	✓
Community Nursing services	✓	✓	✓
Diabetes services	✓	✓	✓
Dental health services		✓	
Drug and Alcohol	✓	✓	✓
Cardiac rehabilitation services		✓	✓
HIV services	✓	✓	✓
Immunisation and vaccination services	✓	✓	✓
Renal health services	✓	✓	
Respiratory rehabilitation services	✓	✓	✓
Maternity services (pre and post-natal)	✓	✓	
Mental health services	✓	✓	✓
Needle Syringe program shopping room	✓	✓	✓
Nutrition and dietetics	✓	✓	✓

Occupational therapy services	✓	✓	✓
Palliative care services	✓	✓	✓
Pathology services	✓	✓	✓
Physiotherapy	✓	✓	✓
Sexual health services	✓	✓	✓
Social work services	✓	✓	✓
Speech pathology	✓	✓	
Women's health	✓	✓	✓

Source: Southern NSW LHD Website (snswlhd.health.nsw.gov.au)

5.3 Overview of Current Infrastructure – Batemans Bay Community Health Centre

Batemans Bay Hospital was constructed in 1970 with 2 wings as the main acute building and community health centre. Community health services operate out of a mix of bookable rooms and shared office spaces. There are 8 bookable rooms, three of which are also used as office spaces and a gymnasium for physiotherapy that has limited space for group sessions. There is also no formal waiting area available for physiotherapy, which is a particular issue for patients on crutches and using other mobility aids.

5.4 Activity for Batemans Bay Community Health Services

Given the impacts of the COVID-19 pandemic on access to community and outpatient services in recent years, 2018/19 activity has been used as the base for establishing the service activity profile and as the base year for projecting future activity.

In 2018/19, there were 80,570 occasions of service provided through non-admitted and community based services in Eurobodalla (2019/20 data used for mental health), with 37,339 of these occasions of service provided for residents of Batemans Bay (Note: Moruya Hospital OOS not included as these are not considered to be in the scope of this CSP). Approximately 28% of client-based service occasions were delivered via virtual care modalities. A breakdown of clinical activity by service stream is at Appendix 1.

Table 10: Occasions of Service by contact mode

Service Contact Mode	Occasions of Service
In Person	22,225
By phone	8,089
Virtual care (Audio-visual)	70
Other technology (not elsewhere classified)	305
Email, case conference (not involving client)	6,650
Total activity	**37,339**

Source: NAP data for 2018/2019, filtered to 2536 postcode (Excludes General Practice and Primary Care OOS)
Note: 2019/20 data used for mental health OOS; does not include non-clinical OOS
Note: Mental Health only filtered to Eurobodalla residents – 43% of activity used for calculations
Note: Does not include postal/courier service OOS

6. Projected activity

The development of the Eurobodalla Regional Hospital (ERH) in Moruya will see the consolidation of hospital services currently provided through Batemans Bay and Moruya Hospitals to a single site. Community based services would be provided across the Eurobodalla through an integrated model of care through a mix of virtual, home based, outreach and facility based care modalities. Services will be provided to Batemans Bay residents through this integrated approach, with a new Batemans Bay Community Health Service supporting facility based services and providing a base for staff to operate from. Community health services delivered at Moruya will be based out of the ERH site, while services provided at Narooma Community Health Centre will remain as they currently are. The Batemans Bay Service will consist of a Community Health Centre and Urgent Care Centre, with a mixture of permanent on-site staff, and an outreach service from ERH. Current workforce arrangements will continue, with staff working across all three sites as required, to ensure residents can access care closer to home. Staffing at Batemans Bay CHC will consist of allied health staff, mental health and alcohol and other drugs staff, nursing staff, and Aboriginal health workers.

6.1 Key services identified for potential growth

The below services have been flagged for growth beyond estimated Compound Annual Growth Rate (CAGR). These loadings take account of anticipated increased demand relating to the ageing population, health status indicators and assessment of unmet need for community based services indicated by ALOS, higher relative utilisation for inpatient services in the 70 and over age groups, an imbalance of new:review appointments and identified service gaps. Projected increases in CAGR have been estimated conservatively noting the limitations associated with non-admitted data, the difficulty in predicting accurately and the potential for changes.

Table 11: Tier 2 Clinics identified for potential growth

IHPA Tier 2 Clinic Type	Local Clinic Name	Additional growth rate to 2031 applied
Alcohol and Other Drugs	Alcohol & Other Drug Allied Health / Pain Management Allied Health / Nursing Unit Pharmacotherapy Allied Health/ Nursing Unit	10%
Breast	Breast Allied Health / Nursing Unit	10%
Cardiac Rehabilitation	Cardiac Rehabilitation Allied Health / Nursing Unit	20%
Endocrinology	Diabetes Allied Health / Nursing Unit	10%
Mental Health	Older Persons Child and Adolescent Adult	20%
Nephrology	Nephrology Medical Consultation Unit	10%
Occupational Therapy	Occupational Therapy Allied Health	20%
Palliative care	Palliative Care Medical Consultation Unit Palliative Care Allied Health / Nursing Unit	20%
Physiotherapy	Physiotherapy Allied Health	10%
Post-acute care	Post-Acute Care Allied Health / Nursing Unit	10%
Sexual health	Sexual Assault Allied Health / Nursing Unit	10%

Social Work	Social Work Allied Health / Nursing Unit	10%
Speech Pathology	Speech Pathology Allied Health / Nursing Unit	10%
Wound Management	Wound Management Allied Health / Nursing Unit	20%
Aged Care Assessment	Aged Care Assessment	20%
Geriatric Medicine	Geriatric Medicine Medical Consultation Unit	10%
Geriatric Evaluation and Management (GEM)	Geriatric Evaluation and Management Medical Consultation Unit	20%
Rehabilitation	Transitional Aged Care Allied Health / Nursing Unit	20%
Nutrition/Dietetics	Nutrition / Dietetics Allied Health / Nursing Unit	10%
Falls prevention	Falls Prevention Allied Health / Nursing Unit	20%

Residents of the Eurobodalla LGA aged 70 and over, in 2021, comprised 18.9% of the population (7,397 people). In 2036, older persons are projected to make up 30.2% of the LGA's population (13,283 people). Planning now, for the future population of the Eurobodalla LGA, will ensure that community services are located close to home and will be appropriate for the community, leading to improved outcomes and avoidance of acute deterioration and hospital admission.

Consultations and data analysis indicate that demand is greater than supply for older persons outpatient services in the Eurobodalla LGA. High relative utilisation for SRGs such as Cardiology in the inpatient setting may be reflective of an undersupply of outpatient services. Allowing for additional growth in the outpatient setting will increase capacity in the workforce and increase supply for residents, thereby improving avoidance of hospital admissions and lead to better outcomes for older persons.

Eurobodalla LGA has a higher rate of overweight and obese adults (70.9 per 100 people) compared to NSW (65.9 per 100). Dietetic services have been identified as a service likely to see increased demand and projected activity has been modelled on an assumption of increased growth on this basis.

Mental health services have been flagged for additional growth, due to the high rate of residents with a mental health condition (11.3%), compared to NSW (8.0%), as well as a high incidence of hospitalisations due to self-harm (191 per 100,000), compared to NSW (91 per 100,000). Eurobodalla also has a much higher rate of ED presentations due to mental and behavioural disorders, especially in the age groups 15-64 years.

The Guideline for Planning Non-Admitted Patient Services and the Non-Admitted Service Planning Tool have been used for the purpose of modelling projections. The Non-Admitted Service Planning Tool uses current reported activity in the Non-Admitted Patient data mart to extrapolate projections according to SRG growth relating to each service.

There are significant data integrity concerns that will impact ability to reflect current state and projections. The data quality for the NAP has improved but the following issues present particular limitations:

- Did Not Attend (DNA) patients are not consistently reporting within the current information systems. It is anticipated that particularly highly vulnerable groups (Mental Health, Sexual Assault and such) would have significant rates of DNA.
- Privately referred activity for visiting specialists who are likely to utilise this facility is not currently available.
- Mental health data will need to be added separately as this activity is not captured in the NAP information management systems used.
- Complete and accurate activity capture for all services.

6.2 Projected Activity for Community Health Services

In 2018-19, Batemans Bay residents accessed 28,041 service occasions in person and via telehealth (OOS restricted to those used for room projections). This is anticipated to increase to 39,549 occasions of service per year in 2036. This considers specific SRGs that have been flagged as high growth areas and has built in the additional growth for the above-mentioned service streams.

It is noted that the EHS CSP projected a requirement for 77 ambulatory care spaces and the proposed requirement was 63+7 spaces. This has now reduced further to 50 spaces in the final scope of works. The projected number of rooms required for the Batemans Bay facility is less than the difference between the projected and proposed spaces at EHS.

Table 12: Projections for number of rooms required for Batemans Bay Community Health Services, 2031

	Base Year New OOS	Base Year Repeat OOS	Total Base OOS	Projected Year New OOS (2030-31)	Projected Year Repeat OOS (2030-31)	Total Projected OOS (2030-31)	Number of Rooms Required (2030-31)
Group session	606	2,907	3,513	858	4,136	4,994	2.2
Individual session	7,227	17,301	24,528	10,471	24,084	34,555	10.6
Grand Total	**7,833**	**20,208**	**28,041**	**11,329**	**28,220**	**39,549**	**12.7**

Note: Number of Rooms Required @ 240 days per year, 7 available hours per day, 80% occupancy. Excludes enteral nutrition. Includes areas for additional growth, listed above.

Note: Shifts to account for an increase in in-home/virtual modalities applied to projected room calculation.

Note: 2018-19 data used for general outpatient services; 2019-20 data used for mental health/alcohol & other drugs data.

Source: NSW Health Non-admitted Service Planning Tool (excludes General Practice and Primary Care OOS and enteral nutrition, as well as clinic types with minimal activity)

7. Batemans Bay Health Services - Urgent Care Services

7.1 Current ED Activity

Whilst ED activity is not entirely reflective of the type of activity that might be seen at an urgent care service, in the interests of modelling the needs of this type of centre, it is the best available source of data for this purpose and allowances are made in the modelling for variations that would see higher or lower levels of activity on a daily and seasonal basis.

Given the impacts of the COVID-19 pandemic on access to Emergency Department type services in recent years, 2018-19 activity has been used as the base for establishing the service activity profile and as the base year for projecting future activity.

In 2018-19 there were 18,158 presentations to the Batemans Bay Emergency Department. This figure is expected to grow to approximately 18,493 per annum by 2036. Table 14 provides a breakdown of the number of presentations to Batemans Bay ED, by triage category. In 2018-19:

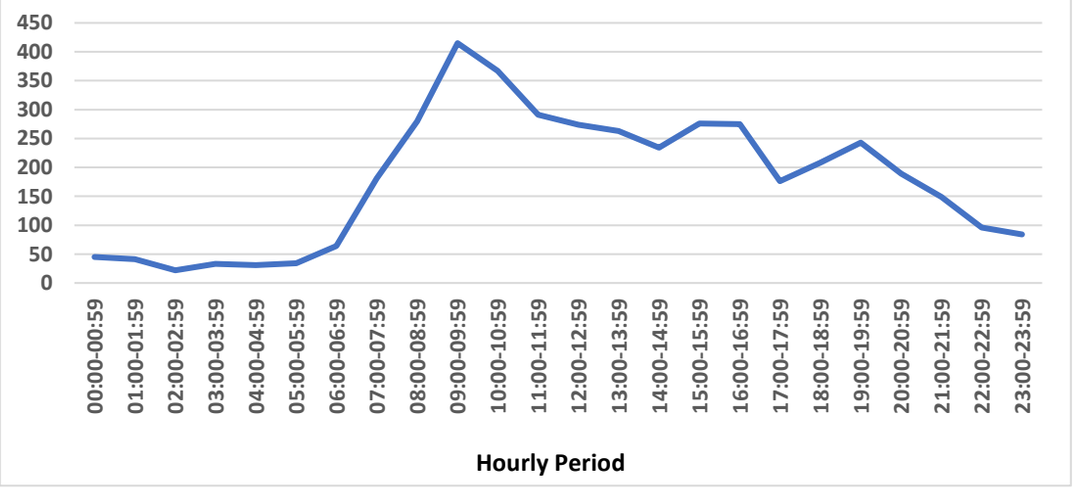
- 62% (11,272) were in Triage Categories 4 (semi-urgent) and 5 (non-urgent)
- 92% of triage category 4 and 5 presentations were between 07:00hrs and 23:00hrs (Figure 6)
- 20% of triage category 4 and 5 presentations were by non-residents (see Table 16 below)

Table 14: Presentations to Batemans Bay ED by Triage Category

Triage Category	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
1	52	47	56	56	70	71	43	34
2	1389	1416	1293	1328	1518	1623	1304	1432
3	3819	4176	4292	4347	4821	5192	4593	4618
4	7290	5878	6241	7683	8717	8790	6242	6001
5	2849	1707	1699	2458	2326	2482	1573	1606
Grand Total	**15399**	**13224**	**13581**	**15872**	**17452**	**18158**	**13755**	**13691**

Source: EDAA V21.0 – Includes all activity, excludes Ages: NA, not recorded

Figure 6: Presentations to Batemans Bay ED – Hourly Buckets 2018-19



Source: FACT – filtered by age (2+ years), triage category 4 and 5, completed treatment and departed, mode of arrival – private, community transport, walked in

Table 15: ED presentations in Triage categories 4 and 5, filtered to those suitable for a Urgent Care Centre

Triage Category	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
4	4111	2471	2781	4224	4955	4698
5	1275	798	696	1142	1330	1364
Grand Total	**5386**	**3269**	**3477**	**5366**	**6285**	**6062**

Source: FACT – filtered by age (2+ years), triage category 4 and 5, completed treatment and departed, mode of arrival – private, community transport, walked in

Table 16: ED presentations for the resident and non-resident population

Batemans Bay ED Presentations	2016-17	2017-18	2018-19	2019-20	2020-21
Eurobodalla LGA residents	2573	2643	4285	5304	4677
Non-residents	713	854	1097	981	1385
All residents	3286	3497	5382	6285	6062
% Of non-residents	**22%**	**24%**	**20%**	**16%**	**23%**

Source: EDAA V21.0 – filtered for Triage 4 & 5, ages 2+ years, treatment completed in ED and people who walked/drove to the ED.

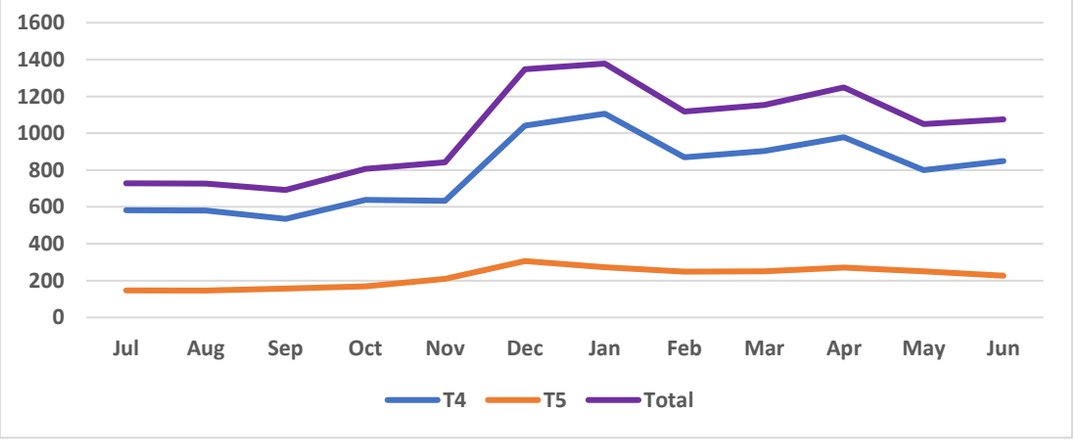
From 2016-17 to 2018-19, tourists accounted for 20-24% of triage 4 and 5 presentations to Batemans Bay ED (using the filters for urgent care centre). When this is broken down to monthly presentations, there is a clear seasonal increase in activity (see Table 17). December and January, over the 3-year period, saw a 34% increase in presentations, compared to the average monthly presentations.

Table 17: Presentations to Batemans Bay ED by Month, 2016-17 to 2018-19

2016-17 to 2018-19	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Triage 4	582	580	535	638	633	1042	1106	869	903	979	799	849
Triage 5	147	146	157	168	210	306	272	248	250	270	250	226
Total	**729**	**726**	**692**	**806**	**843**	**1348**	**1378**	**1117**	**1153**	**1249**	**1049**	**1075**

Source: EDAA V21.0 – filtered by patients who presented by private/low acuity transport, referred by private/low acuity source, ages 2+ and over, triage 4 and 5, mode of separation: departed, treatment completed.

Figure 7: Presentations to Batemans Bay ED by Month, 2016-17 to 2018-19



Source: EDAA V21.0 – filtered by patients who presented by private/low acuity transport, referred by private/low acuity source, ages 2+ and over, triage 4 and 5, mode of separation: departed, treatment completed.

For the purposes of modelling activity, the subset of ED presentations applied to this CSP as suitable for the UCC are:

- Patients presenting to Batemans Bay ED and assessed as Triage Category 4 or 5 with a mode of arrival as walk in (i.e., presented via low acuity transport) and mode of departure not admitted. A further subset of diagnostic groups has been removed as not being suitable.
- Batemans Bay residents presenting to Moruya ED and assessed as Triage Category 4 or 5 with a mode of arrival as walk in and mode of departure not admitted. A further subset of diagnostic groups has been removed as not being suitable.
- Those who arrived by private vehicle, or another low acuity option
- Those who referred by a low acuity source, such as themselves/family, or another community/community health provider, for example
- Patients aged 2 years and older.

The peak times to provide a service would be between the hours of 07:00-22:00hrs and allowance is made for seasonal variation in demand.

Not all patients in the triage categories 4 and 5 are appropriate for an urgent care centre. Presentations were analysed at the URG level to identify the medical conditions that would be suitable for an urgent care centre. Approximately 73% (average from 2015-16 to 2020-21) of presentations are expected to have been suitable for an urgent care centre (see Table 18). In addition to this, 298 Batemans Bay residents in Triage categories 4 and 5 attended Moruya Hospital per year (average from 2015/16 to 2020/21), with 80% of these presentations included for activity projections, to reflect the potential reverse flow to the urgent care centre.

Table 18: Presentations to Batemans Bay ED, further filtered by URG, 2015-16 to 2020-21

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Triage 4	4119	2480	2794	4228	4960	4702
Triage 5	1280	803	700	1144	1333	1367
Triage 4 and 5	**5399**	**3283**	**3494**	**5372**	**6293**	**6069**
Triage 4 - filtered URGs	2920	1684	1972	3060	3835	3575
Triage 5 - filtered URGs	911	538	486	845	1103	1106
Total Triage 4 and 5 (URGs)	**3831**	**2222**	**2458**	**3905**	**4938**	**4681**
% of suitable Triage 4/5	71.0%	67.7%	70.3%	72.7%	78.5%	77.1%

Source: EDAA V21.0 – filtered for Triage 4 & 5, ages 2+ years, treatment completed in ED and people who walked/drove to the ED. Further filtered by URG to determine appropriate Triage 4 and 5 presentations.

7.2 Projected activity for urgent care services

Table 19: Projected activity for Urgent care service

Triage Category	2021	2026	2031	2036
Triage 4	3723	4139	4348	4742
Triage 5	1196	1130	1397	1523
Total Projected activity	**4919**	**5269**	**5745**	**6265**

Source: EDAA v21.0; Actual activity 2021. CAGR for actual used for 2021-2026; further projections used HealthAPP V1.1 projections

The number of Minor injury and illness type presentation projections was calculated using a combination of actual CAGR, as well as the CAGR taken from HealthAPP, which factors in the 2022 population projections. There were 3,905 presentations in 2018-19, which would have been appropriate for an urgent care centre. In 2021 there was approximately 4,681 presentations, however when reverse flow from Moruya Hospital ED is considered (238 presentations per year), this calculates to 4,919. The projected activity for a urgent care centre is 5,745 presentations by 2031 (see Table 19 above).

- The average time spent in ED for non-admitted patients was 1.68 hours, or 100 minutes (Table 20), with 92% of people presenting between 7am and 10pm.
- It is projected that Batemans Bay minor injury and illness type presentations require a total of 3 treatment spaces in 2031. MoH ED treatment space methodology was used (see Appendix 2), resulting in a requirement of 2.1 treatment bays. Provisions were then made to account for significant increase in activity during tourism peak periods.
- 3 bays will accommodate the flexing up of services during high tourist activity. An additional 34% activity during summer periods equates to a requirement of an additional 0.6 beds.
- Analysis of December 2022 FACT data highlights that there will potentially be up to 4 people at one time in the urgent care centre, with the busiest time in December 2022 being between the hours of 10:00 and11:00hrs (See Appendix 3).

Table 20: ALOS in Batemans Bay ED

Average Time in ED Hours **Triage Category**	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**
4	1.96	1.49	1.56	1.78	1.73	1.72
5	1.3	0.97	0.98	1.31	1.36	1.38
Grand Total	**1.80**	**1.36**	**1.44**	**1.68**	**1.65**	**1.64**

Source: EDAA V21.0 – filtered for Triage 4 & 5, ages 2+ years, treatment completed in ED and people who walked/drove to the ED.

Table 21: Projected ED bays 2031

Projected 2031	**ALOS**	**15hrs**	**Bays required**
5,745	1.68	92%	3

Source: 2014 MoH ED Treatment Space Calculation

Note: Bays required is the total of 2.1 bays for presentations and 0.6 bays for flexing up during high tourist activity.

8. Identified challenges

There are a number of challenges to meeting the health service needs of the population:

- Ageing population placing extra demand on health services.
- Providing the right services for the complex health needs of the Aboriginal population.
- Adapting to and incorporating ever increasing advances in technology.
- Realisation of District-wide ICT strategies to inform future opportunities to support more services remotely based on workforce constraints and a lack of critical mass for some specific services.
- Attracting and retaining a skilled clinical workforce.
- Establishing relationships and networks with education providers.

9. Key Barriers and Enablers to Service Provision

Planning for future community health services in Batemans Bay and Eurobodalla more broadly requires consideration of the key barriers and enablers to service access and improved outcomes.

The geography and lack of public transport in Batemans Bay presents a challenge for residents and visitors accessing health services. The location of facility based services and provision of services through care in the home and virtual care needs to support access along with appropriate transport services.

The Eurobodalla has a well-regarded Aboriginal Health Service and collaborates with Aboriginal Medical Service Katungul, local non-government agencies and the Aboriginal community to develop and expand leading models of care for Aboriginal residents, to overcome access barriers identified by these communities. Ongoing efforts to further develop these relationships and collaborations, improve the cultural security across all services, grow our Aboriginal workforce and work collaboratively to improve access will be critical for future provision of services in the community.

Community Health services in the Eurobodalla already operate as a single service across three facilities. There are opportunities to better link service delivery and share information across community health and primary care, to overcome challenges in engaging with government and non-government service partners at a local level and to strengthen integration across the care continuum with acute care services.

Enabling work to improve the experience and delivery of care in the community includes improvements in formalised data linkage and sharing between the LHD and General Practice, and the development of an Integrated Care Strategy to drive the coordinated delivery of out-of-hospital services to our local community.

There have been significant advances in services and consumers adapting to and incorporating technology during the pandemic. Further opportunities exist for community health services to expand the use of technology and virtual care.

The SNSWLHD Health Care Services Plan 2021-2026 highlights the need for infrastructure to be flexible and multi-purpose to enable redesign of modalities of care into the future. It is important that the new Batemans Bay Community Health Service Facility is designed with this flexible and multi-purpose use in mind.

Continuing to collaborate with the South Eastern Primary Health Network (COORDINARE) has the capacity to further support the implementation of hospital avoidance and integration of care strategies. The Southern NSW Integrated Care Strategy 2019 is a joint initiative currently in place. Identified priorities for attention include Aboriginal health, chronic care, mental health, drug and alcohol, suicide prevention, and end of life care.

The integration of care across hospital and community-based settings is paramount to the success of hospital avoidance strategies and improved patient outcomes prior to undergoing surgery (such as obesity or smoking) and the management of chronic disease (such as diabetes). The role of community

based services in Batemans Bay in preventing hospital admission and supporting discharge from hospital will continue to be critical for ensuring patient centred care as close to home as possible. The integration of the urgent care service with the ERH ED will be essential to supporting appropriate clinical decision making and patient care pathways.

10. Anticipated Benefits of Meeting Service Need

Future service directions for the Batemans Bay Community Health Service will:

- Strengthen the interface between community health and the acute facilities
  - Develop clear pathways to enhance patient flow and promote reduced lengths of stay, promote continuity of care and hospital avoidance strategies.
  - Enhance and establish multidisciplinary, community-based clinics for chronic disease in collaboration with specialists e.g., diabetes educators/clinics.
  - Strengthen hospital in the home partnered with community follow up and health coaching.
  - Enhance continuity of care through Community Health staff early involvement from inpatient wards for 'at risk' and vulnerable clients.
  - Provide an urgent care, minor injury and illness service, to reduce avoidable ED presentations

- Strengthen community health services
  - Enhance flexible hours of service delivery across seven days and after hours.
  - Strengthen targeted services for target groups in collaboration with Aboriginal Health.
  - Identify further opportunities for co-location with partner organisations, neighbourhood centres, general practices, schools etc.
  - Integrate health promotion into all aspects of care e.g., speech information at developmental checks.
  - Co-location of a number of services will improve access for patients and will create a more integrated approach to patient management.

- Strengthen partnerships
  - Strengthen partnerships with key stakeholders such as COORDINARE, Katungul Aboriginal Medical Health Service, general practitioners, non-government organisations and private allied health providers (particularly for addressing long wait lists).
  - Work collaboratively to map services and identify gaps and duplication to develop an integrated model of complementary services, delineating clear roles for community health that complements other services both in the public and private arena.
  - Establish management of services by a coalition of partners inclusive of consumer groups.
  - Promote hubs providing women's health, parenting and baby health checks, joining with pharmacies, general practitioners, non-government organisations, schools and childcare facilities.

- Strengthen technology
  - Support strengthening technology and uptake of contemporary and flexible models of care (including virtual care/telehealth). This aligns with the NSW Virtual Care Strategy 2021-2026

priorities including providing care closer to home, improving accessibility for patients and reducing travel-related carbon emissions.
    - Electronic systems that communicate with each other for information sharing, especially care plans and with an interface between record systems.
    - Embrace the use of apps and virtual care to enhance health care, such as service directory, self-management, videoconferencing for case reviews within the multidisciplinary team, including the general practitioners, online staff discussion and managing appointments.
    - Increase efficiency of room bookings, both clinical and non-clinical, through the use of technology.
    - Staff and patient wi-fi availability at the Batemans Bay CHS, to prevent blackspots for mobile and/or wi-fi access.

- Strengthen sustainability
    - Support NSW Health's commitment to deliver an environmentally sustainable footprint, which is a key objective in the Future Health Strategy.
    - Facility design Environmentally Sustainable Development (ESD) considerations will include:
        - Solar installation
        - Water tanks
        - LED lighting
    - Operational ESD considerations will include:
        - Waste management
        - Provision for transition to hybrid and electric vehicle fleet
    - Proximity to public transport is a key consideration for the site selection process.

- Strengthen innovation
    - Develop innovative models of care which address the ongoing health needs of the local community while applying best practice.
    - Embrace research in the development of contemporary, evidence-based services.

Realising benefits for community health will be long term and will rely on clear project, change and governance structures that support the development of patient centred and sustainable models of care (see Appendix 4).

11. Proposed Service Configuration and Operational Model

Our priority is to provide services that are appropriate, safe accessible, equitable and comprehensive. It is proposed that Batemans Bay Community Health Services will provide targeted care for the Batemans Bay community and surrounds, networked closely with the services across Eurobodalla and the new Eurobodalla Regional Hospital. To support provision of facility based services and as a home base for community staff delivering services into peoples homes and virtually, a new Community Health Service Centre will provide for designated consultation spaces for planned clinics, with a mix of individual and group consultation rooms to allow the provision of care close to home for residents in Batemans Bay. Community health care will be provided across nursing, allied health, Aboriginal health and specialist medical streams, along with a range of flexible, bookable consultation rooms to facilitate improved access to health and community care for the Batemans Bay population. In addition,

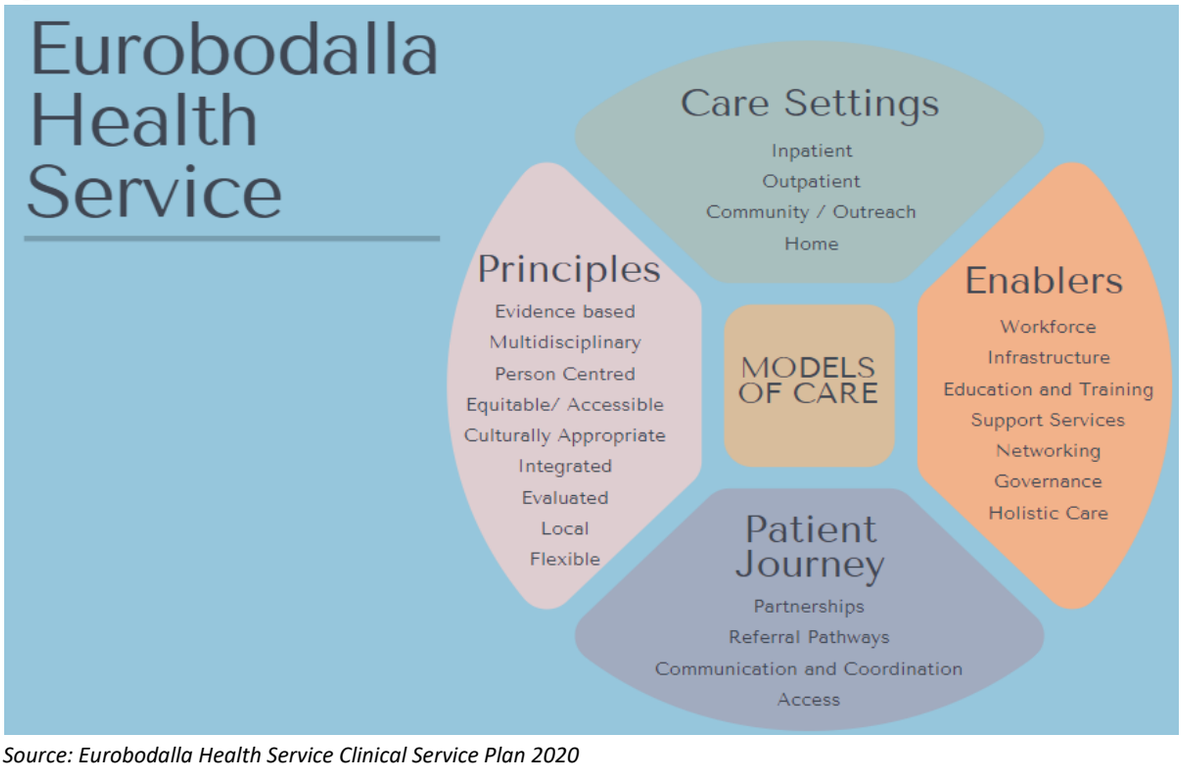
the service will provide unplanned care for minor injury and illness presentations through an urgent care centre. The Community Health Services building will also contain office space for District non-clinical staff, who require space to conduct their office-based work.

12. Proposed Model of Care

12.1 Community Health Service

Care in the Batemans Bay Community Health Service will align with the Eurobodalla Regional Hospital models of care, currently under development as part of the new development project. Models will continue to be refined throughout the development project. The consistent key themes for ERH models of care are illustrated below.

Figure 8: Eurobodalla Health Service Models of Care



Source: Eurobodalla Health Service Clinical Service Plan 2020

To complement the development of models of care, communication for residents will be developed and distributed to ensure that residents within the catchment area understand the clinical pathways available to them.

12.2 Urgent Care Centre

The Batemans Bay Community Health Service will implement a Nurse Practitioner-led urgent care centre to manage the presentation of non-life-threatening illness and minor injuries. This leadership will afford the clinic a level of autonomy, however, will be closely networked with the ERH emergency department to appropriately support presentation of patients with sudden acute deterioration. The Batemans Bay Community Health Service will offer innovative models of care, in which allied health services will be integrated

The urgent care centre will:

- Provide care between the hours of 07:00-22:00hrs, with no further patient presentations after 21:30hrs.
- Increase service capability during seasonal peaks in demand due to tourism, such as over Summer and Winter
- Network with the EHS to ensure safe care is provided to consumers who attend the urgent care centre and concerns are escalated in an appropriate manner.

Patient presentations to the urgent care centre

- Patients will self-present; the UCC operating with a no wrong door philosophy, accepting walk-in patients, as well as those referred via Healthdirect or the SNSWLHD Central Intake Service.
- There will be no provision for Ambulance drop-off. These patients will be transferred directly to Eurobodalla Hospital.
- Patients aged 2 years and older will be able to attend. Any child under 2 years old who self-presents will be triaged and assessed, as per the no-wrong door approach, however may be required to present at ERH for further care. There will be a clear communication plan to ensure that the community understands where they can take their children to seek health care.
- Patients requiring assessment by a medical officer will be referred to the ERH
- Patients presenting to the urgent care centre will either be:
    - Assessed, treated and discharged
    - Assessed and referred to a local GP Surgery
    - Assessed and transferred to the Eurobodalla Hospital
- Patients requiring transfer to Eurobodalla Hospital will be assessed and the safest mode of transportation determined. The drop off zone for the facility will be configured suitably for Ambulance and other vehicle pick up and drop off.
- Follow-up clinics or visits may be arranged by the Community Health Service.
- Presenting patients will be seen in order of arrival, with prioritisation given to more serious presentations, e.g., pain, however no formal triage will be required.
- If medical imaging is required, patients will be referred to ERH ED or for an outpatient appointment.
- If pathology is required outside the scope, or outside the pathology hours at the Batemans Bay Community Health Service, patients will be referred to ERH.

In partnership with the Clinical Governance Unit (CGU), a clinical governance structure will be implemented to ensure the clinic remains safe and appropriate for the type and volume of presentations. It is noted that presentations which fall beyond the Nurse Practitioner scope of practice will be immediately transferred to the ERH, to mitigate scope creep. Further work will be completed with the ERH Site Manager/DoNM, Nursing and Midwifery Department, Clinical Governance Unit and Nurse Practitioner to finalise the governance structure, based on the Nurse Practitioner scope of practice, including how and when the urgent care centre will refer to the ERH for support, transfers and referrals.

13. Proposed services for the Batemans Bay CHS

Table 22: Overview of proposed services for Batemans Bay Community Health Service

Service Stream / Team	New / Existing	Service Name	Service Type	Who will provide the service?	Where will the service be provided?
Aboriginal Health	Existing	Aboriginal Health	Local	Aboriginal Health Workers	In facility Virtual/telehealth Home visit
Aged care	Existing	Falls Prevention ("Stepping On")	Local	Allied Health Nurses	In facility Virtual/telehealth Home visit
Aged Care	New	Geriatric Medicine	Visiting	Consultant	Virtual/telehealth In facility
Aged Care	Existing	Aged Care Assessment Service	Local	Nurses Allied Health	Virtual/telehealth Home visit
Aged Care	Existing	Transitional Aged Care Program (TACP)	In-reach from EHS	Allied Health Nurses	In facility (new) Virtual/Telehealth Home visits
Addiction Medicine	Existing	Addiction Medicine	Local	Consultant	In facility Virtual/telehealth
Alcohol and Other Drugs	New	Substance Use in Pregnancy and Parenting (SUPPS)	Local	Allied Health Nurses	In facility Virtual/telehealth Home visit
Alcohol and Other Drugs	New	Assertive Case Management (ACM) Team	Local	Allied Health Nurses	In facility Virtual/telehealth Home visit
Alcohol and Other Drugs	New	Magistrate's Early Referral into Treatment Program (MERIT)	Local	Allied Health Nurses	In facility Virtual/telehealth Home visit
Alcohol and Other Drugs	Existing	Opioid Treatment Program (OTP)	Local	Allied Health Nurses	In facility Virtual/telehealth Home visit
Child, Youth and Family Care	Existing	Child and Family Nursing	Local	Nurses	In facility
Child, Youth and Family Care	New	Paediatric Outpatient Service	In-reach from ERH	Consultant	In facility Virtual/telehealth
Child, Youth and Family Care	Existing	Child, Youth and Family Services	Local	Allied Health Nurses	In facility Home visit Virtual/telehealth
Child, Youth and Family Care	Antenatal - Existing Postnatal - New	Midwifery and Maternity: Antenatal and Postnatal Services	In-reach from ERH	Midwives	In facility Home visit Virtual/telehealth
Integrated Violence and Neglect	Existing	IVANS	Local	Allied Health Nurses	In facility Virtual/telehealth

Services (IVANS)					
Medical Care	Existing	Community Nursing	Local	Nurses	In facility Home visit Virtual/telehealth
Medical Care	New	Medical Outpatient Service	Visiting	Consultant	In facility Virtual/telehealth
Medical Care	Existing	Wound Management	Local	Nurses	In facility Home visit
Medical Care	New	Hospital in the Home	In-reach from ERH	Nurses	Home visit
Medical Care	Existing	Diabetes Education	Local	Nurse	In facility Virtual/telehealth Home visit
Medical Care	New	Continence	Local	Allied Health Nurses	In facility Virtual/telehealth Home visit
Medical Care	Existing	Chronic disease management and hospital avoidance programs	Local	Allied Health Nurses	In facility Virtual/telehealth Home visits
Mental Health	Existing	Child and Adolescent Mental Health Service (CAMHS)	Local	Allied Health	In facility Virtual/telehealth Home visit
Mental Health	Existing	Adult Mental Health Service	Local	Allied Health	In facility Virtual/telehealth Home visit
Mental Health	Existing	Older Persons Mental Health Service	Local	Allied Health	In facility Virtual/telehealth Home visit
Nephrology	Existing	Renal Supportive Care	Local	Allied Health Nurses	In facility Virtual/telehealth Home visits
Nephrology	Existing	Outpatient Service	Visiting / In-reach from ERH	Consultant	In facility Virtual/Telehealth
Nutrition / Dietetics	Existing	Nutrition / Dietetics Service	Local	Dietician	In facility Virtual/telehealth Home visits
Occupational Therapy	Existing	Occupational Therapy Service	Local	Occupational Therapist	In facility Virtual/telehealth Home visits
Physiotherapy	Existing	Physiotherapy Service	Local	Physiotherapist	In facility Virtual/telehealth Home visits
Public Health	Existing	Needle Syringe Program	Local		In facility
Social Work	New	Social Work Service	Local	Social Worker	In facility Virtual/telehealth Home visits

Speech Therapy	Existing	Speech Therapy Service	Local	Speech Therapist	In facility Virtual/telehealth Home visits
Sub-Acute Care	Existing	Palliative Care	Local	Nurses Allied Health	In facility Home visit
Sub-Acute Care	Existing	Pre-habilitation / Rehabilitation	Local	Allied Health	In facility Virtual/Telehealth
Surgical Service		Pre-habilitation / Fit for Surgery Service	Local	Allied Health	In facility Virtual/telehealth
Surgical Service		Rehabilitation / Post-acute care	Local	Allied Health Nurses	In facility Virtual/telehealth
Women's Health	Existing	Women's Health / Sexual Health	Local	Nurses Allied Health	In facility

Older Person's Care

The significantly ageing population of Eurobodalla is one of the most critical elements of the population profile and as such a whole system approach needs to be considered to address issues and challenges faced by the population to keep them well and healthy in their homes longer and prevent avoidable hospital admissions.

The older person's care service will provide care navigation for people with complex and/or multiple needs. The team will consist of highly skilled clinicians, such as a Geriatrician, nursing staff, allied health staff and Aboriginal health workers, who specialise in the care needs of older people. The team will complete a range of comprehensive aged and functional assessments for clients and provide follow up. To enable greater access to healthcare for the elderly population, a mixture of face to face, virtual/telehealth and in-home care will be offered. Older persons care will be well integrated with most other service streams in the Batemans Bay CHS. Older persons services will include services and programs such as falls prevention, chronic disease management and hospital avoidance programs and older persons mental health. Older persons care will be well integrated with most other service streams in the Batemans Bay CHS.

The Transitional Aged Care Program (TACP) team provides short-term care that seeks to optimise the functioning and independence of older people after a hospital stay. Transition care is goal-oriented, time-limited and therapy-focused. TACP will be primarily based at the EHS and will outreach to Batemans Bay, in which they will base themselves at the Batemans Bay CHC.

The Aged Care Assessment Service assists frail, older persons living in the community to maximise their independence in their own homes and supports family/carers. The Aged Care Assessment team consists of:

- Regional Assessment Service (RAS) – this service is for clients that require an entry-level assessment for single services, such as domestic services, social support, allied health services, specialist service linkage with such services as Dementia Australia and community transportation assistance. These services are funded under Commonwealth Home Support Program (CHSP)
- Aged Care Assessment Team (ACAT) – this service is for more comprehensive assessments and long-term services, such as home care packages, residential care both permanent and

respite, Transitional Aged Care Program (TACP), and can also approve clients for the Commonwealth Home Support Programme (CHSP).

Surgical Care

The CHS will provide a prehabilitation program, as part of its integration with ERH. This model is an early intervention model with a focus on improving an individual's health to reduce the likelihood of need for surgery or admission to medical services in a hospital. The goal is also to reduce post-operative complications and length of stay post-surgery and facilitate return to home without the need for inpatient rehabilitation or delay in waiting for equipment/home modifications. The service also improves outcomes for patients as recovery time is reduced.

The Batemans Bay CHS will also provide planned consultations, as well as post-acute surgical follow up with the appropriate clinician, whether this is with a consultant (outreach from ERH or via virtual care), allied health or nursing staff.

Medical Care

Community nursing will continue in the Community Health Centre, with patients being cared for in their home, virtually, or able to attend the treatment room at the CHC. The primary health care service promotes self-management, re-enablement, and secondary prevention. Care is aimed at reducing avoidable hospital admissions and facilitating timely discharge from acute facilities. The service provides care to clients of all ages and includes acute/post-acute, palliative, wound, catheter, central line management, aged, chronic and complex care, with goal-oriented plans. Care is provided using a case-management framework where all clients are holistically assessed, vulnerabilities identified, and prioritisation applied according to need. Priority will be given to the following:

- Risk of infection/complications
- Clients assessed as at risk; e.g. risk of hospitalisation, high risk of falling
- Client unable to self-care/manage or does not have access to an alternate provider
- Palliative care; deteriorating condition; symptom management
- Post chemotherapy symptom management
- Management of central lines (non-HiTH)

Hospital in the Home (HiTH) will be provided as an in-home service for the residents of Batemans Bay, with a shift to in-home infusions. Care requiring HiTH patients to attend a facility in person along with other same day infusion services will be provided at the ERH.

Child, Youth and Family Care

The Henry Review reported that the demand for allied health services far exceeds the supply of services throughout the system. A comprehensive consultation process with allied health staff in the Eurobodalla LGA supports this finding, with waiting lists for some allied health services up to 12 months for low priority children and young people. In the ABS Census 2021, 14.6% of children in Eurobodalla were developmentally vulnerable in the physical health and wellbeing domain, the highest proportion of all LGAs in the South Eastern Primary Health Network (PHN). The integration of the Batemans Bay Community Health Service with the ERH will assist in servicing the unmet needs of the community.

Teams will provide continuity of care across the continuum for children and their families/carers from prenatal care to youth. Services include:

- Child and family services
- Paediatric services
- Maternity and neonatal services

Child and family services will provide education, guidance and support to parents in the care of infants (0-5 years) and young families. Home visits and clinic services will be available, to ensure that all consumers can access care. Services provided to children and youth will include:

- Childhood and school-based immunisations
- Child and Adolescent Mental Health Services (CAMHS).
- Primary health assessments of children.
- Allied health services for children aged 0-17 years as per mandated legislation and policy and where intervention will have a high to moderate impact on health outcomes. Allied health will provide support for review and management at crucial points of development according to evidence based best practice in each discipline e.g. school readiness, speech impairment, medically diagnosed food allergies.
- Coordinated care and home visiting for parents expecting or caring for a baby.
- Paediatric outpatient clinic 1 to 2 days per week; this will be an outreach service from ERH.
- Improving mental health outcomes for parents and infants (Safe Start)
- SNSWLHD Child Protection Counselling Service (CPCS) - this is a specialist child or young person, family and carer centred, therapeutic counselling service.
- Maternity services will be located at Batemans Bay CHS as an outreach service from ERH. Currently Midwives at Moruya Hospital provide an outreach service at Batemans Bay CHC for antenatal services only. With the new Batemans Bay CHS, midwives will provide an outreach service from ERH for both antenatal and postnatal care.

Batemans Bay Community Health services will continue to utilise programs specifically targeting Aboriginal and/or Torres Strait Islander children, such as:

- Building Strong Foundations (BSF) – a culturally appropriate outreach service for Aboriginal children from birth to 5 years, which consists of an Aboriginal health worker and child and family nurse.
- New Directions (Allied Health) – provides culturally sensitive and appropriate care to pregnant Aboriginal and Torres Strait Islander women from conception until the baby is two years of age. The team also works in very close collaboration with the AMIHS, BSF and general Aboriginal Health teams.

Aboriginal Maternal Infant Health Service (AMIHS) will provide ante-natal and post-natal care for Aboriginal and/or Torres Strait Islander families. As well as the SNSWLHD Aboriginal health workers, the CHS at Batemans Bay will also network with external service providers, to ensure best outcomes for Aboriginal children and youth. Examples of this includes Tresillian and Katungul.

Integrated Violence Abuse and Neglect Services (IVANS)

IVANS provide specialised support to people dealing with experiences of violence, abuse and neglect (VAN). Services provided by IVANS at the Batemans Bay CHS will include:

- Child Protection Counselling Services (CPCS)
- Child Wellbeing Co-ordinator (CWC)
- Joint Child Protection Response program (JCPRP)
- New Street Service (NSS)
- Out of Home Care Health Pathway (OOHC HP)

- Safe Wayz program
- Sexual Assault Services (SAS)

Women's Health/Sexual Health

Women's Health is conducted by women's health nurses and provides women from priority populations with health checks and the opportunity to access health information on a wide range of women's health issues. The service targets women who experience social disadvantage or who do not access mainstream health services. Clinical services can be delivered in the woman's home if ability/mobility issues are present. Services provided at the CHS will include:

- Cervical screening
- Pelvic examination
- Breast examination
- Postnatal checks
- Advice/information about contraception
- Provision of emergency contraception
- Menopause counselling
- Opportunistic chlamydia screening
- CVD risk assessment
- Information/referral
- Gynaecological health

Sexual Health is a nurse-led clinic that provides testing, treatment and prevention strategies for Sexually Transmitted Infections (STIs) and Blood Borne Viruses (BBVs) including Hepatitis C. Further, the service provides ongoing clinical management for people living with HIV.

Sub-Acute Care

This stream will provide the right level of care at the right time to enhance and maintain a patient's functional independence. The service will provide a pre-surgery 'fit for surgery' program, outpatient rehabilitation, geriatric evaluation and management and palliative care. Transitional Aged Care community places will support restorative care.

Palliative Care

Palliative care specialist nurses, community nurses and allied health professionals work closely with GPs and other providers to support clients and their families through assessment and care planning and coordination in the community setting. The specialist nursing team also provides a consultative service to all residential aged care facilities in Eurobodalla and works with acute care staff to assist with symptom management and care coordination in the inpatient setting. The team comprises a Nurse Practitioner and registered nursing staff, with support of a district Clinical Nurse Consultant. The palliative care team at the Batemans Bay Community CHS will provide a mixture of in-home, virtual telehealth and in the clinic.

Mental Health

The mental health teams in Eurobodalla LGA provide a range of services for their communities and see clients in all three community health centres. Teams that make up the mental health service include:

- Mental Health for Older People – This service provides public specialist mental health clinical care to older people and includes a multidisciplinary team.
- Child and Adolescent Mental Health Services (CAMHS) – This team provides a range of services to children, adolescents, and their families.
- Adult Mental Health

Services provided by the mental health teams include:

- Assessment of persons with suspected mental health problems
- Case management and other therapeutic interventions
- Assistance/support to families and carers
- Assistance/support to other health professionals (including inpatient staff, GPs, allied health)
- Specialist services including crisis assessment and intervention.
- Liaison between services (inpatient Mental Health, general hospital, GPs, government, and non-government organisations) and Drug and Alcohol Services.
- Towards Zero Suicide Initiatives (TZSI):
    - Suicide Prevention Outreach Team (SPOT) – These teams are located in Bega and Queanbeyan and will provide outreach services to the Batemans Bay community.
    - Rural counsellors – located in Moruya, this is an enhancement to rural counsellors, due to the high rate of suicide in rural areas, compared to metropolitan areas.
- Getting on Track in Time – Got It! Service – Early intervention mental health program, which is delivered in schools by the CAMHS teams throughout the LHD.

Referrals from the community health service into the inpatient units, and from the inpatient units to the community will occur in alignment with the transfer of care policy (PD2019_045 – Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services), to ensure safe and effective discharge planning and transfer of care. Eurobodalla residents requiring Mental Health acute inpatient services are transferred to the Chisholm Ross Centre (CRC) in Goulburn or to the Mental Health inpatient unit in South East Regional Hospital (SERH). Inpatient rehabilitation services and inpatient psychogeriatric services are provided at Kenmore Hospital Goulburn. Referral into the community mental health service is through the SNSWLHD Central Intake Service, and consumers are also able to call a 24/7 mental health phone number.

There is currently a dedicated Mental Health and Alcohol and Other Drugs (MHAOD) Aboriginal Coordinator who works across the LHD, providing oversight for the Aboriginal trainees and consultancy and high-level clinical support for Aboriginal consumers. There are currently two Aboriginal mental health trainee positions and the Aboriginal Health workers and mental health teams at Batemans Bay CHC work collaboratively, to ensure that the service is accessible and culturally appropriate.

Drug and Alcohol

The Drug and Alcohol service at the Batemans Bay CHS will be equipped to respond to the needs of people with drug and alcohol problems, using a trauma informed approach and recovery-oriented practice. The Drug and Alcohol team will be well integrated with other services at the community health service and will work closely with the mental health team.

Drug and alcohol services provided will include:

- Opioid Treatment Program (OTP) – This service provides support to people who have an opioid dependence and will continue in the new Batemans Bay CHC. Long-acting injections can be administered, if prescribed by SNSWLHD.
- Magistrates' Early Referral into Treatment Program (MERIT) – This court diversion program is a voluntary, pre-plea program for adults in the Local Court. Those who have issues related to alcohol and other drug use can access alcohol and other drug treatment services for 12 weeks.
- Outpatient withdrawal management – The Alcohol and Other Drugs team will provide services for withdrawal management in the community where possible, to avoid hospitalisation.
- Community engagement activities
- Addiction Medicine clinics – This service is a clinic that is run by addiction medicine specialists and will continue to operate in the new Batemans Bay CHC.
- Assertive Case Management (ACM) – This will be a new service, commencing in 2023/24, for Eurobodalla LGA. The service provide outreach, comprehensive multi-disciplinary and multiple sector services to clients where at present very complex, very unwell people with socioeconomic deprivation are unable to have their needs met. This team will consist of a team leader and AOD clinicians and will be available at the Batemans Bay CHC.
- Substance Use in Pregnancy and Parenting Service (SUPPS) - This service will be implemented in SNSWLHD, with a CNS position to be recruited to for the Coastal area (Eurobodalla and Bega Valley LGAs). This service will resolve a significant service gap across the LHD, with the CNS working collaboratively with the local midwifery service and be an expert and support resource for the staff. It is expected that this service will be provided at all Eurobodalla CHCs, including Batemans Bay.

Aboriginal Health

In collaboration with other health service staff, Aboriginal Health workers provide primary and preventative health education and health promotion programs to Aboriginal and Torres Strait Islander clients. A range of Aboriginal specific services can be accessed, which provide appropriate emotional, social and welfare support for clients and their families. Their role extends to supporting mainstream health providers, such as mental health and child and family, to provide culturally appropriate services. Targeted and mainstream programs and services for Aboriginal and Torres Strait Islander peoples include:

- Aboriginal Maternal Infant Health Strategy (AMIHS)
- Building Strong Foundations (BSF)
- New Directions
- Chronic Care 48hr follow up – this program improves health outcomes of Aboriginal patients with chronic disease by providing follow up within 2 working days of discharge from hospital, and covers medication issues, referrals, and general well-being.

- Aunty Jeans Chronic Disease program – this program supports Aboriginal clients that have chronic and complex care needs. Aunty Jeans will be undertaken in the community, including at the Batemans Bay CHS. This program bring clients together annually with other LHD clients to participate in the Mini Olympics.
- Healthy Ears Better Hearing Better Listening (HEBHBL)– This program is funded by the Rural Doctors Network and assists to reduce barriers for Aboriginal children to access timely and appropriate ENT surgical procedures across NSW.

Allied Health

Allied Health staff will be well integrated throughout all care streams in the Eurobodalla LGA and will be located in the Batemans Bay CHS. Allied health teams will include physiotherapists, occupational therapists, speech pathologists, social workers and dieticians.

Physiotherapy

Physiotherapists at the Batemans Bay CHS will provide community based services to patients at home, including those recently discharged from hospital. Services will primarily be based in the gymnasium, however, will utilise other areas of the health centre as well. Services provided to the community will include:

- Adult Physiotherapy - individual appointments, as well as exercise groups
- Paediatric physiotherapy – individual appointments
- Community Home Support Program – As part of this program, Physiotherapists undertake assessments and run exercises groups.
- "Stepping On" program – OT and Physiotherapy run a falls prevention program. This is a community-based 8-week program aimed at giving older people the confidence and independence to undertake their everyday activities safely.
- Fracture/cast management

Occupational Therapy

Occupational Therapists at the Batemans Bay CHS will provide care to clients who are recovering from injury or illness or having problems performing their activities of daily living due to accident or a long-term disorder. Services provided to the community will include:

- Occupational Therapy for adults - Recommendation and interventions might include:
    - Home modifications
    - Provision of simple and complex adaptive equipment
    - Assistive technology
    - Strategies for skill development
    - Pressure care prevention strategies
    - Wheelchair assessments and provision
    - Falls prevention strategies and education
    - Hand splinting and upper limb therapy
    - Personal energy conservation and fatigue management techniques
    - Relaxation and stress management education
    - Therapy to improve functional and performance in daily tasks.
    - Referrals to other programs, specialist agencies or services are completed as required.
- Occupational Therapy for children – Paediatric OT services provide assessment and goal-oriented, time-limited therapy for children having difficulty with:
    - Fine motor tasks
    - Self-care skills
    - Play and social skills

- General school readiness (for pre-schoolers)
- Physical, emotional, or sensory regulation where this is impacting on a child's ability to play and make friends, learn or participate in everyday family and school activities.

Based on assessment outcomes, goal-based OT recommendations are then made to the child's carers and/or teachers with the aim of improving task performance.

- Transitional Aged Care Program (TACP)
- "Stepping On" program – OT and Physiotherapy run a falls prevention program. This is a community-based program aimed at giving older people the confidence and independence to undertake their everyday activities safely.
- Early Years Assessment Service (EYAS) – Multidisciplinary team that focuses on functional, cognitive and behavioural assessments for those up to the age of 3 years.

Referrals to other services will be completed as required. Paediatric services include occupational therapy involvement in the local Early Years Assessment Team and occupational assessment and treatment for children 0-17 years. Occupational therapists also provide service to clients in the Transitional Aged Care Program and the 'Stepping On' falls prevention program.

New Directions, Aboriginal Health Service – Occupational Therapists are part of a multi-disciplinary team that provide culturally appropriate allied health services to Aboriginal and Torres Strait Islander children.

Dietetics

Dieticians at the Batemans Bay CHS will improve health outcomes by providing support and education relating to food and diet. This can be done in the patient's home, via virtual care/telehealth or in the health centre. The nutrition and dietetics service will care for people who are referred with the following clinical conditions or changes in clinical conditions:

- Adults Referred with the following clinical conditions or changes in clinical conditions:
  - Requiring enteral or parenteral nutrition support
  - Gestational diabetes mellitus or diabetes in pregnancy
  - Identified at risk of malnutrition
  - Type 1 diabetes mellitus (new diagnosis or frequent hyperglycaemia / hypoglycaemia)
  - Cancer with nutrition impact symptoms
  - New diagnosed coeliac disease
  - Post recent major gastrointestinal surgery
  - Type 2 diabetes mellitus commencing insulin
  - Food allergies and/or intolerances
  - Wounds/pressure injuries
  - Obesity with comorbidities (BMI > 40)
- Paediatrics Referred with the following clinical conditions or changes in clinical conditions:
  - Requiring enteral or parenteral nutrition support
  - Faltering growth or high risk of malnutrition
  - Low birth weight, pre-term and/or small for gestational age
  - Diagnosed food allergies or intolerances
  - Newly diagnosed coeliac disease
  - Diagnosed eating disorders or disordered eating

- Restrictive eaters
- Gastrointestinal conditions with significant nutritional risk
- Obesity (BMI > 99th percentile)

Speech Pathology

Speech pathologists at the Batemans Bay CHS will provide assessment and support for paediatric and adult patients.

Paediatric services include:

- Assessment and intervention for children presenting with swallowing/feeding and/or communication support needs.
- Speech pathology involvement in the local Early Years Assessment Team
- Pre-school visits

Adult outpatient services include:

- Assessment and intervention for adults referred with swallowing and or communication support needs.

Social Work

Social Workers provide counselling and support, psychoeducation, as well as information and referrals to community counselling, housing, financial, legal and other service providers. Services provided at the Batemans Bay Community Health Service will include:

- Domestic and family violence
- Elder abuse
- Vulnerable families and child wellbeing concerns
- Child and family health
- Women's health, including termination and pregnancy support
- Recent trauma, e.g., MVA or other accident, chronic and complex health conditions or disability; practical assistance where lack of such support will impact health care
- Bereavement and complex grief and loss, including adjustment to diagnosis, sudden death and perinatal loss
- Palliative care and other end of life matters
- Carer support
- Psychosocial support, information and referral related to NDIS

Generalist social workers will work at the Batemans Bay CHS, with specific funded positions for New Directions, Indigenous Chronic Disease, renal supportive care and oncology.

14. Workforce Requirements

Developing technology, growing community expectations and the ageing population will increase demand on our workforce.

Strategies to reduce workforce fatigue include the delineation of roles, task delegation (which professional completes which task) and task substitution (where a person from one professional background performs a task traditionally performed by another type of health professional) to maximise the use of the various skills of the team in order to provide effective and efficient care.

Detailed workforce planning will be completed as an enabler for implementation of this CSP and will reflect the principle of flexible care models as close to home as possible and the mix of facility, outreach and virtual care modalities. The workforce required for the Community Health Service will include:

- Nursing staff for the community health centre, including, but not limited to community nursing, palliative care, women's health, sexual health, child and family.
- Allied health staff, including physiotherapists, occupational therapists, speech pathologists, dieticians, social workers for the Batemans Bay community health centre.
- Mental health and alcohol and other drugs staff.
- Aboriginal health workers.
- Nurse Practitioner with appropriate scope of practice to lead the team managing presentation of minor illness and injury to the urgent care centre.
- Registered Nurses to staff the urgent care centre. These nurses will be trained in advanced emergency care, however, will not be required to complete FLECC training.
- Potential GP/rural generalist workforce to staff the UCC (pending outcome of EOI to PHN Urgent Care Centres)
- Physiotherapists and social workers for the UCC will be rostered seven days a week during business hours, to increase hospital avoidance.
- Additional Pharmacy staffing will be engaged by SNSWLHD to support the urgent care service.
- Administration/reception staff will manage scheduling of spaces and be a first point of contact for patients and clients, across all hours of operation.
- It is intended that at any given time approximately 40 clinical and non-clinical District staff working out of Batemans Bay will also utilise office space in the Batemans Bay CHS.

15. Supporting Infrastructure Requirements

A Schedule of Accommodation will be developed to reflect the scope and range of functions required to address the ongoing service model of the facility. Based on projections for minor injury and illness presentations and community health service projections, it is proposed that the Community Health Service includes:

- 12 bookable rooms, including, but not limited to:
    - Three treatment rooms for community nursing, wound management and palliative care clients.
    - Two interview rooms with minimum dual egress for Mental Health clients and Alcohol and Other Drugs clients. These rooms should be co-located near each other. Dual egress rooms may also be utilised for consumers with behavioural concerns, such as those with dementia and/or delirium.
    - Two large interview rooms (28m2), sized to accommodate familiies, set up with child and family equipment.
    - One large, culturally appropriate room, sized to accommodate sessions for large families.
    - One consult room with an ensuite bathroom, to support services like womens health clinics.

  - Child and family health room with immunization set up to be co-located with womens health room.
  - One large group room, with access to courtyard space
- One exercise gymnasium:
  - To support rehabilitation and therapy, including group rehabilitation classes
  - Option to open to interview rooms for space utilisation
  - To include therapy treatment area for 1:1 assessment and treatment. Could be a curtained area with plinths
  - The open area will accommodate a range of equipment, such as stairs, parallel bars and exercise bikes
  - Will have sufficient strorage area for equipment related to the gymnasium
  - Will have sufficient wall space for attaching equipment
  - Will contain an overhead or mobile lifter
  - Appropriate proximity and access to waiting area
  - Will require access to a resuscitation trolley and linen trolley
- Three space minor injury and illness zone to support the urgent care centre including:
  - Three bay urgent care centre treatment zone
  - One of these to be a single room, deterioration response capable, including piped gas
  - Resuscitation bay equipment
  - Point of care testing bay and equipment
  - Space to accommodate ophthalmology equipment, such a slit lamp. This could be located in the UCC or in a flexible space, such as in a CHC treatment room
  - Space to accommodate plaster application and removal
  - Minimum one basin plus one ensuite
  - Staff station
  - Secure storage for medicines

- Reception and waiting areas will include:
  - Community health, Pathology and UCC reception and waiting areas – these may be combined.
  - Appropriate seating for elderly clients, clients with a disability, clients with a mobility aid and bariatric clients
  - Community Health Centre to have separate waiting and safe play areas for children and families
- Space allocation for Needle Syringe Program shopping room
- Pathology:
  - 2 specimen collection rooms with prone chairs. One room may have a multipurpose setup, to ensure utilisation of the spaces when required.
  - Storage area for Pathology equipment and supplies
- Visitor amentities, which will include:
  - Toilets
  - Parent/breastfeeding room
  - Access to an outdoor courtyard/ rehabilitation space

  - Access to an adult change facility ('changing place')
  - Vending machine and water dispensers
  - Beverage bay, with tea and coffee facilities
  - Child play areas, which are appropriate and safe
- Culturally safe spaces for the Aboriginal community to drop in.
- Parking, which will include:
  - Spaces suited to children and their families including parking for Parents with Prams
  - Considering the needs of older people including drop off / pick up areas adjacent to the main entry
  - A pick up/drop off zone suitable for ambulance or other road transport to facilitate transfers to ERH
  - Bicycle parking and possibly parking for scooters
  - Safe pedestrian access from the car park to the entry
  - Sufficient onsite parking for clients, as well as parking for staff and an anticipated five fleet cars at any given time.
- Staffing infrastructure will include:
  - Bookable large (x2) and small (x2) meeting rooms and one education room
  - Soundproof shared office spaces to accommodate an estimated 18 clinical staff
  - Two single office spaces to accommodate Health Service Manager, visiting specialists
  - 40 activity based work stations to accommodate 53 District-wide clinical and non-clinical staff members, who are located within the Eurobodalla, with an average on-site non-clinical occupancy of 72%. These staff are not directly related to the community health centre or UCC, however require access to a workstation. These workstations must be separated into small groups/ pods and breakout spaces to allow for confidential work and to minimise noise disruption. Docking stations should be universal and allow for a variety of guest laptop configurations.
- Support spaces and staff-specific spaces will include:
  - Staff Station in the UCC
  - Linen bay – this could be a shared area, or may need a linen bay in both UCC and CHC.
  - Equipment storeroom, sized to meet the storage needs for all services
  - General storeroom for consumables
  - Height and weight bay – accessible by both UCC and CHC
  - Clean utility and medication room – accessible by bith UCC and CHC
  - Cleaner's room
  - Dirty utility room
  - Storage for maintenance equipment, both within and external to the facility.
  - Storage for an equipment loan pool, which will be available to TACP, occupational therapy and palliative care patients.
  - Staff toilets
  - Staff property bay to accommodate 58 staff.
  - Showers
  - Staff room, with access to outdoor areas (it is important to provide a positive work environment)
- Inbuilt and portable virtual care devices.

- Accommodating people with disabilities e.g. wheelchair access, signage for people with visual impairment, disabled parking.
- Accommodating the needs of bariatric patients including providing wider doorways, sufficient storage of bariatric seating and equipment.
- Providing a safe and healthy workplace including safe access and egress, appropriate barriers between public and private areas, break rooms, work stalls that provide visual and audio privacy.
- Loading dock or designated area for delivery and pick-up of linen, delivery of consumables, pick-up of waste.
- All rooms to be virtually enabled (consult rooms, treatment rooms, meeting rooms, group rooms and workspaces)

15.1. Support services

15.1.1 Pathology Service

NSW Health Pathology remains the preferred provider for public pathology services in NSW. A collection service exists within the Batemans Bay Hospital, providing collection and point of care testing. Pathology specimens collected at the Bateman's Bay Hospital are processed locally at the NSW Health Pathology Laboratory, Moruya Hospital, with more complex testing referred to networked NSW Health Pathology laboratories.

A point of care pathology service within the Community Health Centre may be nurse-led. NSWHP would assist with training and maintenance of the PoC device as currently provided. Visiting specialists may refer to the integrated collection point to reduce turnaround time for patients and ensure that care is provided within one appointment where possible. The use of NSW Health Pathology also ensures that pathology results can be accessed quickly on NSW Health eMR, rather than waiting for results from private Pathology services.

It is recommended that:

- Batemans Bay maintain a public pathology collection service.
- NSW Health Pathology maintain two collection rooms. One room can have a multipurpose setup, to ensure utilisation of the spaces when required, in addition to storage facilities. Current collection in Batemans Bay include a 1.5m x 1.5m storage area.
- Equipment will mirror the needs of the service, based on presentations to the urgent care centre and community and allied health services. These can be adapted over time and will assist in the identification of rapidly deteriorating patients.
- Collection spaces will be equipped with a prone chair or fully adjustable medical treatment chair.
- The PoC testing device be located in the UCC, which all appropriately trained staff will be able to access.
- A reception desk will be public facing and waiting spaces will be co-located with the existing infrastructure footprint. The Pathology service will be located front of house.
- Alternatively, NSW Health Pathology may maintain two curtain-shielded bays rather than rooms.

The collection service will be agile, maintaining workforce dependent on clinical needs. As per the current model of care in place in Batemans Bay, staff will rotate from the ERH in Moruya. It is anticipated that the collection service will run from 8am – 4pm, Monday to Friday. It is possible that collection may be available for extended hours, or on weekends; it is recommended that the collection centre be located adjacent to street front entry.

15.1.2 Maintenance and Engineering Service

Maintenance and engineering services for Batemans Bay Community Health Service will be provided on outreach basis from the ERH, as per the current arrangements in other community health facilities. Preventative maintenance schedules will be developed to support the team across the Eurobodalla, and reactive maintenance will be completed by staff or contractors as required. Workforce requirements will be determined as the master planning is completed.

It is recommended that:

- The facility includes storage space to keep maintenance and engineering equipment, including ladders and tools, etc.
- The facility grounds include on-site storage for gardening equipment, including mowers, blowers etc.
- Maintenance staff access activity-based workstations as required to complete desk-based work.

15.1.3 Cleaning Service

Cleaning services for the Batemans Bay Community Health Service will be provided on outreach basis from the ERH, as per the current arrangements in other community health facilities. There will be a scheduled service, as well as additional cleaning services provided when necessary. Workforce requirements will be determined as the master planning is completed.

It is recommended that:

- The facility includes a purpose-built room to keep cleaning equipment, as well as appropriate plumbing/sinks and chemicals.

15.1.4 Linen Service

Linen services will be required for both the Community Health Centre and the Urgent Care Centre. There will be a contract in place for the linen service to pick up and deliver linen.

It is recommended that both areas have:

- Linen trolleys to store clean linen.
- Linen skips, to house the dirty linen.

15.1.5 Waste Management Service

The Batemans Bay CHS will align with NSW Health's commitment to deliver an environmentally sustainable footprint, including transitioning to a low-waste system. As per other sites in the LHD, there will be a contract with a provider to collect waste, including:

- General waste
- Co-mingled recycling

- Clinical waste
- Confidential waste

15.1.6 Security Service

The Batemans Bay Community Health Service's security arrangements will be consistent with what is present in SNSWLHD's other community health centres. Crime Prevention Through Environmental Design (CPTED) strategies will be utilised in the planning and design phases.

15.1.7 Fleet Vehicle Service

The fleet service will operate from ERH, with a number of fleet cars housed at the Batemans Bay Community Health Service. Car spaces will allow for 5 fleet vehicles to be located there and if more vehicles are required, they can be picked up from ERH.

15.1.8 Food Service

Food services will be available to patients at the Batemans Bay CHS however will be a limited service. The model will be developed in consultation with Healthshare NSW and will include food services for patients in both the CHC and the UCC. Food preparation, if required, will take place at ERH, with a delivery arrangement to Batemans Bay CHS. The centre will also have a vending machine as well as tea/coffee facilities.

16. Implementation approach

The Batemans Bay Community Health Centre project will commence in partnership with the Ministry of Health, Health Infrastructure, staff, consumers and external consultancy groups. It is envisaged that.

- Services will transition through a phased approach at least 12 months prior to the opening of the new ERH. Model of care and service changes may be introduced prior to the move into the new building to support change management.
- Models of Care will continue to be refined throughout the development project.
- It is important that the Community Health Service project will progress in alignment with existing strategies, including the connecting with country program. This strategy is underpinned by principles of co-design and inclusion of local Aboriginal people.
- Investment in technology will enable teams to work across sites in a connected way. Virtual care investment will ensure connectivity between patients and service providers, keeping patients as close to home as possible, for as long as possible. SNSW LHD will investigate the use of scheduling tools, to maximise the efficient use of spaces.

To ensure successful transition from the Batemans Bay Hospital to the new Service, the District will commence change management processes in line with the ERH project. Work will be completed with current staff to familiarise them with the proposed model of care. An urgent care service model of care is new to the District; it will be clearly articulated that this clinic is not an ED, though will be networked and supported by the ED at ERH. Staff will be engaged early to understand the requirements around the assessment and treatment of presenting patients, and champions will be engaged from within the Batemans Bay Hospital to support this transition.

Community engagement around the new facility and model will commence early. It will be critical to the success of the new model of care to ensure that there is clarity around what conditions with which the community should present to the urgent care centre. Localised, consistent messaging to support the transition will ensure that community understand there is no loss of service but the implementation of a new model of care and facility to support care close to home for Batemans Bay residents.

16.1 Governance

Community Health Services in Batemans Bay have a range of stakeholders including the NSW Ministry of Health, General Practitioners, PHN, Local Government, non-government organisations and other service providers.

Governance over the Community Health Service Project will be achieved via internal committees and through participation in internal and external committees. A similar governance structure for existing community health services may be adopted with broader representation with health service partners. Current governance of the community health services will remain, as the service will operate under the established Eurobodalla Community Health team as part of the Coastal Network. Governance will consider both the clinical and the operational management of the service, in compliance with legislation, standards of practice, and policy, and to meet the needs of all service providers.

Models of care will be finalised in collaboration with staff and will include a robust clinical governance structure to support the safe assessment and treatment of presenting patients.

16.2 Evaluation and reporting

Regular progress reporting against an established project plan will be put in place for the life of the project and an evaluation framework will be developed to support service review and changes following commissioning as part of the intended flexible model of service delivery and commitment to ongoing service improvements to align services with the needs of the community.

Appendix

Appendix 1: Non-admitted patient OOS for Bateman's Bay and Eurobodalla health services, 2018-19 and projected OOS for 2031.

Service Streams	Base OOS 2018-19	Projected OOS 2031	Number of rooms required
Addiction Medicine	1441	1,636	0.54
Aged Care Assessment	246	405	0.09
Alcohol and Other Drugs	242	303	0.11
Audiology	47	64	0.02
Breast	301	401	0.10
Cardiac Rehabilitation	632	1,041	0.35
Continence	117	185	0.05
Endocrinology	945	1,268	0.36
Falls prevention	421	638	0.46
General medicine	np	5	0.00
Geriatric Evaluation and Management (GEM)	90	136	0.04
Geriatric Medicine	302	498	0.19
Hospital avoidance programs	995	1,346	0.55
Infectious diseases	308	411	0.11
Mental Health (2019-2020)	4,322	6,411	2.07
Midwifery and maternity	250	273	0.09
Nephrology	575	847	0.26
Nutrition/Dietetics	227	338	0.09
Occupational Therapy	323	501	0.15
Oncology	np	3	0.00
Paediatrics	622	694	0.21
Palliative Care	1,414	2,144	0.46
Physiotherapy	2,274	3,115	1.16
Post-acute care	2,039	2,858	0.89
Primary Health Care	6,044	8,163	2.60
Pulmonary Rehabilitation	336	432	0.16
Rehabilitation	900	1,365	0.46
Sexual Health	206	307	0.09
Social Work	1,096	1,634	0.44
Speech Pathology	231	315	0.08
Wound Management	1,094	1,803	0.52
Grand Total	**28,040**	**39,549**	**12.7**

Source: NAP 2018-19, resident postcode 2536, in-person and virtual contact modes. Excludes enteral nutrition and General practice and primary care. NAP 2019-20 for mental health OOS.

Note: np = data suppressed as not reportable due to low numbers

*Note: * = repeat OOS data not available, all data entered as 'New OOS'*

Appendix 2: MoH ED Methodology for clinical bed spaces

Example:

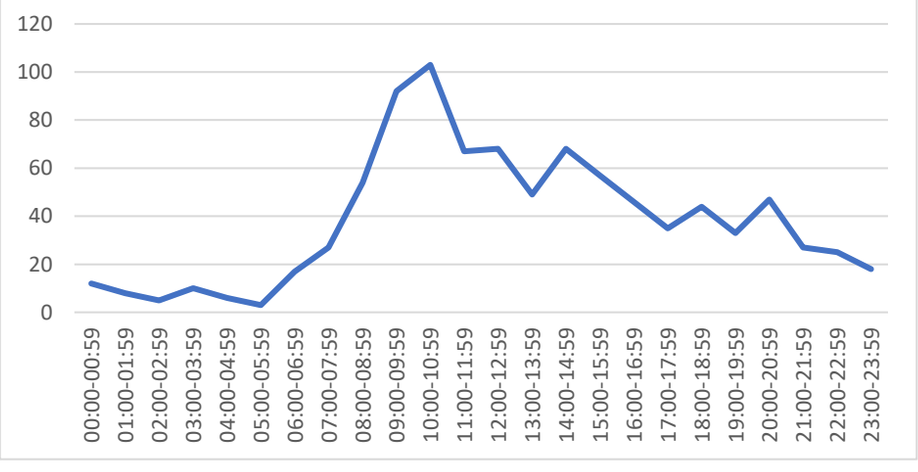
- Hospital A is projected to receive 50,000 presentations annually in 2021/22, with 25 per cent of these patients being admitted.
- The current arrival pattern is such that 90% of the patients present in the 18 hours between 6 am to 12 midnight
- The current length of stay is 5 hours for admitted patients and 2.5 hours for non-admitted patients.

Treatment spaces are calculated in the following method:

- Admitted patients
  - (((50,000*90% during 18hrs*25% admitted)/365 days)/(18 hours/5.0 hours LOS))/85% occupancy= 10 spaces for admitted patients, or
  - $\frac{(50{,}000*0.9*0.25/365)}{18/5} \Big/ 0.85$

- Non admitted patients
  - (((50,000*90% during 18hrs*75% non-admitted)/365 days)/(18 hours/2.5 hours LOS))/85% occupancy= 15 spaces for non-admitted patients; or
  - $\frac{(50{,}000*0.9*0.75/365)}{18/2.5} \Big/ 0.85$

Appendix 3: Time of arrival in December 2021 – showing a need to be able to flex up for seasonal peaks in activity



Source: FACT – filtered by: all triage categories, treatment completed and discharged, mode of arrival private and low acuity, source of referral low acuity sources.

Appendix 4: Benefits Realisation for Batemans Bay Community Health Service

Outcome / Objective	Key Benefits	Indicators
Better Client Experience	• Keeping clients out of hospital and supported by innovative models of integrated care within the community. • Improving client access to integrated community services for holistic care management • Seamless patient journey from acute to community based care • Improving engagement and relationships with the general community	• Avoidable hospital admissions as a % of total separations • Patient Experience Surveys • Clinical Services experience measures for the services provided at the centre
Better Value for Money	• Increased outcome efficiency • Increased output or cost efficiency through contemporary infrastructure • Increased output or cost efficiency through partnerships with private providers	• Avoidable hospital admissions as a % of total separations • Reduction in recurrent cost per unit of activity • Facility Maintenance Costs
Sustainability	• Meet the future growth in demand for community based services • Excellence in recruitment and retention of a skilled staff mix across all disciplines • Improved Financial Performance • Meet NSW Health performance targets, policy and guidelines.	• Service utilisation rates based on planning measures • Staff recruitment and retention rates • Financial activity based on budget performance
Accessible Services	• Greater availability of essential community health care services for the residents of the BB community • Increase accessibility of services for the Aboriginal community of BB	• Centre activity by postcode • Client experience survey on equitable experience disaggregated by : o Aboriginality, o Relative Socioeconomic Disadvantage Index o Age
Workforce	• Improved workforce culture / morale	• Staff surveys – satisfaction indicators

	• Improved staff recruitment and retention	• Recruitment time and staff retention rate
Safety	• Reduction in staff incidents at Community Health settings • Reduction in client incidents at Community Health settings	• Incident monitoring systems

Source: Adapted from ISLHD Ulladulla Community Health Centre Project Brief