Special Commission of Inquiry into Healthcare Funding

Submission Number: 172

Name: Central Coast Local Health District

Date Received: 21/11/2023

Central Coast
Local Health District

NSW Special Commission of Inquiry into Healthcare Funding

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11-17-2023

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Executive Summary

The Central Coast Local Health District (CCLHD) is situated between metropolitan Sydney 60-90 kilometres to the south, and the regional metropolitan Greater Newcastle area about 80 kilometres to the north. In 2020 there were 345,809 people residing in the Central Coast LGA. The region contributes to 4.2 per cent of NSW's total population while encompassing 0.2 per cent of NSW's geography. The projected population growth on the Central Coast is mostly driven by the ageing population. The age groups that are expected to experience the most growth in the Central Coast LGA is the 85 years and over and 70 84 years age groups (3.40 per cent and 1.58 per cent a year to 2041). The growing population on the Central Coast means there will be increasing demand for health services alongside a need to maintain or improve the quality and efficiency of health care.

CCLHD has established clear direction to manage service delivery over the next five years. Its newly released Clinical Services Plan has been codesigned to deliver exceptional care and achieve the vision of Caring for the Coast. The projected growth in the population, especially among the elderly, means there will be increasing demand for services of a complex nature. As a result, there may be increased pressure on an already stretched system. In the future it will be necessary to understand the complex needs of this growing cohort.

There are many opportunities to develop services and increase capacity to better meet the health needs of the community. The rapidly changing environment requires the LHD to be agile, fostering research, innovation and partnerships to inform both clinical and non-clinical practice and change. As an organisation, embracing learning and past experience is an integral part of ongoing development and improvement. This means learning from the past, innovating, learning from others and actively engaging with other providers and partners to explore better ways of operating and delivering care.

Key enablers include attracting, retaining and growing the capability of the workforce, identifying opportunities for digital transformations and implementation of new technology, partnering with external service and primary care providers, partnering with education providers to attract and develop workforce pipelines.

To ensure funding models support service provision to meet demand, consideration is required to reduce funding silos between acute and out of hospital (State and Commonwealth) services to support integrated chronic disease programs and incentivise care delivery closer to home for patients. The LHD is proactive in its approach to support healthcare in the community or the home and virtual settings. As future health needs evolve, technological advances and healthcare sustainability necessitate new models of care.

The LHD is working towards more people accessing care outside hospital settings and providing more options for care in the community and the home. A key linkage is facilitated through strong partnerships with general practitioners and non-government organisations. Active work is underway with these providers in conjunction with Ministry of Health to navigate clarity around funding mechanisms and support.

Central Coast Local Health District Context

The Central Coast Local Health District (CCLHD) provides public health services to the communities of Central Coast Council. Located between Sydney and the Hunter Valley, the Central Coast is a popular coastal region attracting young families and retirees. The region is served by two acute hospitals – Gosford and Wyong. With 484 beds, Gosford Hospital is the principal referral hospital and regional trauma centre for the Central Coast while Wyong Hospital is a 379-bed acute, level 4, major metropolitan Hospital providing inpatient, outpatient and emergency service for the northern sector of the Central Coast. Woy Woy Hospital provides sub-acute care and Long Jetty Healthcare Centre provides community health and Urgent Care services.

The Central Coast region faces a range of demographic challenges. Across the region there is growth in population, and an increasing ageing population with increasingly complex health and social needs. Additionally, the region is home to a large Aboriginal and Torres Strait Islander population. In 2020 there were 345,809 people residing in the Central Coast LGA.

The region's population is older when compared to the state average. The Central Coast LGA has fewer residents of working age, with a greater percentage of people aged over 65 when compared to the state average. A low working age population has the potential to further contribute to socioeconomic disadvantage, increasing the burden of disease and demand for health services. This, coupled with the ageing population, also indicates a risk of increased demand for health services from the elderly population.

The projected growth in population, especially among the elderly, means there will be increasing demand for services of a complex nature. As a result, there may be increased pressure on an already stretched system. In the future it will be necessary to understand the complex needs of this growing cohort, and where possible, seek to co-design accessible services across the region.

The region experiences poor health outcomes across the wide spectrum of health areas. There is higher burden of disease and increased prevalence of lifestyle risk factors. Understanding the health status of residents living in the Central Coast region is imperative to better understand the collective health needs of the region.

In New South Wales, local health districts are required to effectively plan the delivery of health care services to ensure they are responsive to the health needs of the population they serve. This includes the population residing in, or accessing services located within, the boundaries of the Local Health District (LHD). Historic and forecast activity across CCLHD indicates demand will exceed capacity. Through consultation, CCLHD have identified key Emergency Department, hospital substitution and non-admitted service models that may reduce demand on key clinical services. These include targeted Hospital in the Home services for priority patient cohorts, Urgent Care Services and specialised outpatient and outreach services. Further analysis will determine selection and implementation of service models through consideration of their ability to demonstrably reduce demand on, and maintain capacity of, key clinical services. The outcome of this analysis will also determine whether further service models need to be considered to maintain capacity.

Forecast demand is especially high at Gosford Hospital compared to Wyong Hospital, notably Emergency Department and acute inpatient services. Considering the service profile of both facilities will be important to determine how services could be networked across the two facilities, to better balance demand, and ensure timely and equitable access to the right level of clinical care.

The CCLHD Clinical Services Plan 2023-2028 (CSP) seeks to articulate how the LHD will respond to the
85 increasing health needs and expectations of the community. As part of this, there are opportunities to embrace the development of new service models, technology and virtual care and partnerships with primary care and other service providers to develop a stronger more flexible, integrated patient-centred health service. The CSP outlines key strategic directions and actions required to drive their implementation over the coming 5 years.

90 Future focused strategic directions have been developed with consideration for the broader planning context for CCLHD. These have been determined through understanding of the policy environment, population and demographic drivers, historic and forecast activity as well as internal and external consultation with key clinical and non-clinical groups. The following key strategic directions were identified:

95 I. **Implement timely emergency care alternatives**: Provision of timely, urgent and emergency health care services

II. **Maximise the efficiency of acute service capacity**: Determining service profiles and networking to optimise activity

III. **Enhance out of hospital services**: Provision of services delivered outside of acute
100 hospital settings, expanding out-reach, community and home-based services

IV. **Promote prevention, education and self-management**: Health promotion and education to support improved health and wellbeing outcomes, and opportunities for self-management of care.

Enablers critical to all strategic directions include, workforce, data and technology (including the
105 Virtual Care Strategy), partnership and capital and infrastructure Plans. Strong executive sponsorship and change management will be critical to consider new approaches and achieve successful implementation of the CSP.

From a service perspective, within the Central Coast region, healthcare is delivered by a mix of state and Commonwealth public providers, private providers, residential aged care and community-based
110 providers. While the region is small, the geography and infrastructure within the Central Coast region creates challenges for patient access to CCLHD health services.

CCLHD delivers public acute and community-based services, however there are challenges with regard to accessibility of primary care services. The impact of accessibility challenges for GPs has a flow-on effect both to community and older people across the region. Future service planning will
115 need to consider how all service providers across the region can effectively collaborate to support the health needs of the population on the Central Coast.

NSW Health Planning Policy Context

The overarching directions for service planning are influenced by a number of key policy and direction setting documents from the NSW Health. These consider physical infrastructure,
120 workforce, capacity planning, accessibility to care both for the population as a whole and vulnerable cohorts, as well as setting expectations for the delivery of safe and quality care in NSW. Key NSW policies and considerations that guide locality planning are summarised below.

Table 0-1: Locality planning drivers: Policy context

Policy context	Key directions
NSW Health Future Health	Strategic outcome 2.1: Deliver safe, high-quality, reliable care for patients in hospital and other settings.

Policy context	Key directions
	Strategic outcome 6.1: Drive value-based healthcare that prioritises outcomes and collaboration. Strategic outcome 4.5: Attract and retain skilled people who put patients first. Strategic outcome 2.5: Align infrastructure and service planning around the future care needs.
NSW Integrated Care Strategy	The NSW Integrated Care Strategy (which forms part of the NSW State Health Plan) aims to transform the delivery of care to improve health outcomes for patients and reduce costs deriving from inappropriate and fragmented care, across hospital and primary care services, including by: Designing better connected models of healthcare to leverage available service providers to meet the needs of smaller rural communities. Providing greater access to out-of-hospital community-based care, to ensure patients receive care in the right place for them.
NSW Health 20-Year Health Infrastructure Strategy	Ensuring that assets, physical or digital, are fit-for-purpose and help to improve health outcomes and experiences for the people of NSW. Investment planning that considers trends in future healthcare delivery and a broader range of infrastructure assets. This includes a greater focus on virtual and digitally enabled care in non-hospital facilities, such as the home, to better suit future demand and patient and community expectations.
NSW Health Workforce Plan 2022-2032	Build positive work environments that bring out the best in everyone. Strengthen diversity in our workforce and decision-making. Empower staff to work to their full potential around the future care needs. Equip our people with the skills and capabilities to be an agile, responsive workforce. Attract and retain skilled people who put patients first. Unlock the ingenuity of our staff to build work practices for the future.
NSW Aboriginal Health Plan 2013-2023	Building trust through partnerships. Ensuring integrated planning and service delivery. Strengthening the Aboriginal workforce. Providing culturally safe work environments and health services.
NSW eHealth Strategy for NSW Health 2016-2026	Develop a digitally enabled and integrated health system. Deliver patient-centred health experiences and quality health outcomes.
NSW Ministry of Health Performance Agreement 2022-23	Sets out the service and performance expectations for funding and other support provided to the Clinical Excellence Commission to support the provision of equitable, safe, high-quality and human-centred healthcare services. Articulates direction, responsibility and accountability across the NSW Health system for the delivery of NSW Government and NSW Health priorities.

125

Workforce Snapshot

There has been significant investment in CCLHD staffing over the past five years to provide for future growth in service delivery. In FY2018-19, the CCLHD workforce was 6,700 staff. As at March in FY2022-23, the CCLHD workforce profile was more than 7,000 staff. This now makes up 5,831 full time equivalent (FTE) staff. The impact of COVID-19 resulted in an increase in staffing with additional
130 funding received from NSW Health for this specific purpose. Across key workforce categories the FY2022-23 CCLHD profile includes:

I. 48 per cent Nursing
II. 30 per cent Clinical and Corporate Support
III. 10 per cent Allied Health
135 IV. 12 per cent Medical

Nearly three-quarters (73 per cent) of the workforce are permanently employed with the remaining (27 per cent) employed by temporary or casual contractual arrangements.

The staffing profile is illustrated by the following key demographics:

I. 24 per cent are over 55 years of age
140 II. 3.2 per cent identify as Aboriginal and Torres Strait Islander
III. 1.5 per cent of staff have a disability.

A vacancy review was undertaken in 2023 and critical workforce shortages were identified at CCLHD across a range of skills sets, including junior medical officers, nurses, health informatics, occupational therapists, social workers, mental health teams, clinical psychologists, and
145 environmental service staff.

Shortages experienced over the past 12 to 18 months are likely to remain. Together with limitations in national and international workforce availability in 2023, these shortages will continue to affect CCLHD workforce supply in the short to medium term (one to three years). This suggests there is a critical need to ensure clinical service planning gives consideration to the changing workforce profile
150 and expectations to ensure a sustainable workforce into the future. CCLHD are developing a Workforce Plan. For CCLHD, the changing context and needs of the population and the workforce mean that services will need to evolve. Significant policy drivers impacting different parts of the system, from emergency care (e.g. UCCs and services) to aged care (e.g. impacts of residential aged care facilities (RACF) changes), will mean that the way the community as a whole interacts with the
155 health system will continue to change.

Improvement Journey

CCLHD has been on an improvement journey since 2018 with the implementation of lean six sigma programs to build capability and drive innovation. The LHD identified that building the capability, infrastructure and culture was needed to deliver sustained organisation- wide improvement as a
160 journey to be taken over several years.

CCLHD is now under growing pressure, with activity increasing at a significant rate and continued workforce challenges. Focussed effort has delivered an improvement in safety and quality and finance performance, following a deterioration in key performance metrics. The impact on emergency access is seen in performance against key indicators such as Emergency Treatment
165 Performance, Transfer of Care and Triage category compliance.

As a result, CCLHD has developed an approach to assist building and integrating the spread of internal capability to drive sustained performance improvement. A performance framework and problem solving process and tools have been developed that direct improvement initiatives to achieve organisational goals, including the use of metrics, business cases and learning from previous
170 activities. A centralised improvement and innovation processes has been developed and a Healthcare Improvement Team coordinates focussed improvement activities for high priority initiatives. This methodology has seen a significant lift in LHD performance and delivery of safe and timely care over the past 2. The organisational approach to improvement embeds a safety culture and continuous improvement and learning across the organisation, with the aim to deliver sustained
175 improvements in the quality and experience of care.

Partnerships and Governance

Partnerships have an important role in the health and social care landscape on the Central Coast. CCLHD partnerships include working with the Central Coast Health Alliance, the broader community sector to deliver new models of care, the Central Coast Research Institute with the University of
180 Newcastle, research and innovation opportunities, and collaboration with the age care sector.

Partnerships with other health service providers include NSW Ambulance, Health Pathology, eHealth and HealthShare. Aboriginal Community partnerships include Yerin Eleanor Duncan Aboriginal Health Service and Ngaimpe Aboriginal Corporation – The Glen.

Central Coast Alliance

CCLHD partner with HNECCPHN and have established a formal governance structure – The Central Coast Alliance. The purpose is to leverage shared priorities across health and social care to develop and implement collaborative healthcare solutions to improve health outcomes for the Central Coast population. It aims to provide increasingly integrated and co-ordinated health services by identifying opportunities for collaborative, clinically-led service development and working together to accelerate their implementation. Consideration is given to the impact on the whole of the system, the patient's outcome and experience, and the best value per resource spent. Since the Alliance first formed in 2017 and as a result of its maturity/development a number of activities that were focus activities are being managed as business as usual between the partners. The Alliance focuses on initiatives which are jointly identified as priorities for a fixed timeframe. These are captured in a shared operational plan and monitored in the Alliance Steering Committee.

The Alliance recognises the need to ensure the focus remains on priority work areas that will deliver the most impact to the Central Coast community at scale, by collaborating with various stakeholders and investing resources where they matter. In parallel to this there are some key limitations and challenges in the region –particularly for the LHD struggling to meet demand. The Alliance recognises that while it is well placed to support some of these challenges, the entity itself is not well defined or understood by stakeholders seeking support –and identifies the need to continue to work on their purpose, governance and communications. The four agreed priority work areas:

I. Aged Care
II. Chronic Pain Management
III. Diabetes Management
IV. Mental Health

GP Collaboration Panel

The GP Collaboration Panel has been running on the Central Coast for many years. The panel are funded by both the HNECCPHN and the CCLHD. GP consultation and input is a vital part of the Collaboration Panel. Initially there was one GP consultant, while it was invaluable it was felt that a larger representation of GPs would be more able to provide a wider perspective of ideas and options relating to issues identified. As a result, in 2020 recruitment took place and a panel of GPs from across the Central Coast was established. The Panel has been established to oversee the development and implementation of an annual program of priorities aimed at improving the operation the healthcare system for patients and community on the Central Coast by facilitating effective partnerships between hospital, general practice and the PHN that enables provision of high quality care that is comprehensive, person centred, population oriented, coordinated, accessible, safe and high quality.

The members of the GP Collaborative Panel provide active, genuine and meaningful input and feedback into planning service responses at both a practice and population health level, as well as in relation to other issues important to the GPs. The members will also contribute to decision making as to how programs and models of care can support the integration of primary, secondary and tertiary services to allow more streamlined continuum of care within the Central Coast Region.

Central Coast Research Institute

The Central Coast Research (CCRI) Institute was established under an Affiliation Agreement between the CCLHD and the University of Newcastle and is located in the Gosford Health Precinct. The CCRI is overseen by a Board, chaired by Professor Mary Foley and undertakes translational research into the
230 development and delivery of new models of integrated care. By supporting the adoption of integrated care in policy and practice, the CCRI will bring tangible benefits to the health and wellbeing of the Central Coast community and beyond. Integrated care is a global strategy to improve the quality and cost-effectiveness of care by ensuring care and services are better coordinated around people's needs. The vision is to become a recognised international centre of
235 excellence in research and innovation in integrated care through the building of effective research partnerships across Australia and the Asia-Pacific. This vision is based on the belief that the health and wellbeing of all people can be maximised through the effective translation into policy and practice of high-quality research evidence on integrated care. The CCRI has four strategic priorities:

I. To support high-quality, priority-driven, collaborative research and education in the field
240 of integrated care
II. To enable the translation of evidence from research findings into policy and practice, and into the community
III. To drive innovation in health and wellbeing technologies that support integrated care through industry engagement and commercialisation
245 IV. To deliver economic, health and wellbeing benefits to the Central Coast community

Central Coast Living Lab

In November 2022, the CCLHD received a funding allocation of $1,500,000 from the Greater Cities Commission (Commission). The purpose of this funding is to support the Central Coast community by establishing an integrated care innovation hub and implementing a program of activities.

250 The Living Lab is focusing on the development of innovative integrated care solutions to support the ageing population of the Central Coast to manage their health conditions, live healthy and independent lives in the community, and in turn reduce the burden on acute healthcare resources through innovation and industry collaboration.

To support the project, CCLHD committed in-kind support of $400,000 consisting of access to
255 professional personnel e.g. clinical staff, research staff and students, access to expertise on clinical practices and workflows, management of data (including personal data, incidental consumables, use of spaces including collaborative workspaces, meeting rooms, teleconferencing facilities. The University (UoN) has committed $250,000 over 2 years and $400,000 in-kind contribution to the project, consisting of access to professional personnel e.g. Innovation Facilitators, Business
260 Development Manager, assistance in development and delivery of workshops, access to I2N resources including Venture Mentor Service, Pre-Accelerator and Accelerator, Researcher, PhD, and student matchmaking, access to IP and legal support where appropriate and access to Wi-Fi and printing. Central Coast Research Institute has committed $150,000 of in-kind support for the project, consisting of use of spaces including collaborative workspaces, meeting rooms, teleconferencing
265 facilities.

Central Coast Clinical Placement Agreement

CCLHD Partners with the University to facilitate clinical placements, workforce pipeline and innovation. Shared governance structures have been established to oversee these processes. The Clinical Placement & Education Agreement Management Committee (the Committee) has been

270 established to provide the governance framework for the Clinical Placement & Education Agreement between CCLHD and University of Newcastle. The committee focuses on the strategic arrangements between the parties with operational matters to be delegated to a working group. Key responsibilities include planning, monitoring and evaluating clinical placements and allocation across work areas, negotiating and agreeing any adjustments to the contributions or resources to be 275 provided by the parties under this agreement, and reviewing each year's Annual Base Number of Clinical Placements.

Primary Health Services

The HNECC PHN coordinates and delivers a range of primary health care services across the catchment. This includes general practitioner (GP) services, Allied Health Services, health promotion 280 and prevention initiatives, including diabetes support, and targeted support for Aboriginal health services. There are 394 general practitioners practising on the Central Coast, with a total of 92 general practices, and one Aboriginal Medical Service. For every full-time general practitioner on the Central Coast, there are 776 patients.

Access to GPs is a significant barrier to care for many people within CCLHD. Recent survey data of 285 adults in the Central Coast and Hunter New England region found that 31 per cent had been unable to access their preferred GP in the preceding 12 months as compared to 28 per cent in Australia. Nearly one-quarter of adults felt they waited longer than acceptable to get an appointment with a GP, compared to only one-fifth in Australia. Additionally, GPs are integral in caring for residents in Residential Aged Care Facilities and reducing presentations of older people to Gosford and Wyong 290 Emergency Departments.

In 2022, the Primary Health Network undertook a snap shot of Central Coast GP's. Across the Central Coast Region there are 112.9 FTE GP's, this is a decrease of 4 when compared to the 2019 snapshot. The snapshot also identified that 60% of practices were advertising/recruiting (excluding registrars), this is an increase of 34%. GP's per 100,000 people are 113 on the Central Coast, lower when 295 compared to NSW at 122.

Residential Aged Care Facilities

There are a large number of public and private Residential Aged Care Facilities (RACFs) located across the CCLHD catchment. RACFs employ medical staff, including registered nurses, GPs and 300 Allied Health Professionals, to provide health services to their residents. There are less residential aged care places on the Central Coast compared to NSW. In 2020 there were 70.3 residential aged care places per 1,000 people aged 70 years and over on the Central Coast compared to 75.7 in NSW. The LHD's community support programs provide in reach services to RACF's on the Central Coast.

New Models of Care:

305 The Central Coast is home to the largest and fastest growing number of elderly and frail patients in New South Wales. By 2031, more than 22% of older people on the Coast will be aged 70 or over (some 80,000 people). Such older Australians, on average, live for 11 years in chronic ill health – the worst of any OECD country.

The elderly and frail cohort (>70yrs or >50yrs Aboriginal and Torres Strait Islander people) are at the 310 highest risk of adverse outcomes such as falls, disability, unscheduled hospital admissions, longer stays in hospital, uncontrolled polypharmacy, and greater difficulty recovering from illness and surgery.

To address such problems, the elderly and frail cohort requires multimodal care due that enable them to better engage in prevention and health promotion activities that support them to live as well as possible with their multiple and long-term conditions in the home environment and address key issues related to declining functional capacity and mental health.

However, the lack of coordinated access to primary and community-based services (some 35% of people do not have access to a GP on the Coast) as well as community aged care support, combined with increasing numbers of older people living in social isolation and disconnected from the communities in which they live, means that care outcomes for older people are not as good as they should be. For the Central Coast, the downstream impact of this situation is manifest in impacts observed in the emergency departments (ED) that delaying patient care.

CCLHD identified the need for stronger partnership to work across system boundaries to enhance the management of Elderly and Frail people at risk of unplanned hospital admissions by providing care at a place and time appropriate for the patient and where appropriate avoid ED presentation.

Elderly and Frail Model

CCLHD Emergency Departments (ED) are under immense pressure with mounting impacts observed on access and flow, performance metrics and risks to safe and high-quality patient care. The Elderly and Frail cohort are a significant contributing factor to the CCLHD overburdened acute care system, with an average ED Length of Stay (LOS) of 7.4 hours and an Emergency Treatment performance (ETP) rate 27%. Furthermore, 50% of Elderly and Frail ED presentations require an admission to CCLHD hospitals, with an Average Length of Stay (Also) of 7.1 days. This problem required a coordinated whole-of-system approach to proactively and strategically manage demand and prevent unnecessary presentations through strengthened and integrated pathways alternative to hospital care.

In June 2022, system partners CCLHD, Hunter New England Central Coast Primary Health Network (PHN) and Ambulance NSW collectively undertook a codesign process to identify gaps and enablers to critically provide connected care for Elderly and Frail Patients across the continuum to prevent unnecessary ED presentations.

Four initiatives were developed in partnership, aiming to critically close the gaps in the Elderly and Frail health pathway. Initiatives build on and leverage existing models to achieve economies of scale, centralise access and risk stratification and foster meaningful partnerships across PHN, NSW Ambulance and LHD to ensure proactive management of Elderly and Frail patients. Initiatives leverage CCLHD's virtual care service offering to optimise use of scarce resources and ensure more care can be delivered in the community.

Implementation of these initiatives have measurable benefits for CCLHD on TOC and Admitted Emergency Treatment Performance (AETP) through a 25% annual reduction in Elderly and Frail ED presentations for those in triage categories 3 to 5. A 42% reduction in Elderly and Frail inpatient admissions may be realised, which would support significant capacity release in the CCLHD acute care setting. Importantly, given the widely recognised risk of health decline associated with hospital stays for this cohort, managing patients in their place of residence will improve both patient experience and health outcomes.

The Elderly and Frail cohort can be defined as the group (>70yrs or >50yrs Aboriginal and Torres Strait Islander people) who are at highest risk of adverse outcomes such as falls, disability, admission and longer stays in hospital, difficulty recovering from illness and surgery and the need for complex multimodal care. Frailty increases with age; however, may affect younger individuals with early onset of geriatric conditions.

The response to increased acute care problems requires a coordinated approach to proactively and strategically manage demand and prevent unnecessary presentations through pathways alternative to hospital care. CCLHD, PHN and Ambulance NSW have collectively undertaken a codesign process (June 2022) to identify gaps and enablers to critically provide connected care across the continuum with the objective to:

I. **Proactively implement ED avoidance strategies** in order to prevent presentations by providing timely interventions in the community;
II. **Scale acute hospital substitution strategies** Aged care response Team (ACRT); Hospital in The Home (HiTH) to deliver care and services in the home or Residential Aged Care Facility (RACF); and,
III. **Improve the patient and carer experiences** through the provision of high quality, safe care at home or in place of residence.

These initiatives leverage tried and tested models, seen to be successful and provide measurable benefits across CCLHD and/or other LHDs. By building on existing models including Central Coast Health @ Home (CCH@H), CCLHD has the opportunity to achieve economies of scale, leverage multidisciplinary teams across organisational and system boundaries to realise significant efficiencies.

Through a collaborative process, system stakeholders identified four primary initiatives, underpinned by a set of care principles which form the basis of Central Coast response to Frail & Elderly connected care pathway.

Central to this connected care pathway, is the optimisation and delineation of roles and responsibilities across the PHN and LHD. The four CCLHD initiatives are:

I. **Central Coast Health @ Home Centralised Virtual Triage expansion to focus on Elderly and Frail patient cohort:** An access and intake model which expands on the Covid Community Support Team (CCST) as a nurse led integrated model of care that provides triage, consultancy, clinical support and advice for: General practitioners, NSW Ambulance (VCCC), Home care providers and Residential Aged Care Facility (RACF) staff. The purpose of this model is to enable timely and appropriate risk stratification and appropriate intervention utilising virtual care. Enabled by a virtual triage and intake, the model builds on the CCST standardised, protocol-driven approach for the provision and escalation of short-term care. Where clinically appropriate, CCH@H cares for patients in their own home using remote monitoring and virtual care modalities to monitor for signs of clinical deterioration. CCH@H virtual triage is enabled by Aged Care Emergency (ACE) framework and manual and supported by PHN partnership. The model is enabled by medical escalation points (GP-VMO) and has facilitated links and referrals to Emergency Department alternatives including Aged Care Response Team, HiTH, MAU, and HOPE-ED model. This model incorporates senior medical governance and access to daily medical support, currently the greatest barrier to timely decision making and access to care which could avoid deterioration or presentation.
II. **Aged Care Response Team (ACRT) expansion to increase capacity and hours of operation:** The ACRT is as a non-admitted outreach service to assess and intervene with Elderly and Frail people experiencing a health decline, at risk of requiring hospitalisation from; or, where a specialist review will help prevent an ED presentation (e.g., BPSD, falls with soft tissue injuries, cellulitis, chest conditions, acutely deteriorating wounds,

chronic and complex indwelling catheters). The proposed model supplements the existing ACRT priority response team with additional nursing and medical coverage to provide an additional 50% service capacity across the LHD as a care pathway for Elderly and Frail living in RACF.

III. **Establishment of Healthcare for Older Persons Earlier Emergency Department (HOPE-ED**) HOPE-ED is a geriatric led streamed ED model, established as a fundamental strategy to facilitate timelier specialist assessment, management and appropriate discharge of Elderly and Frail patients presenting to hospital. HOPE has an 8 bed unit co-located beside 8 bed Short stay unit (SSU) and facilitates rapid geriatric specialist assessments and multidisciplinary team expertise, partnered with a supported discharge program (RACE). HOPE operates as the frontline entry for patients who are likely to require care under the geriatric medicine team. Older patients requiring care from a different specialist team e.g. cardiac or respiratory will receive assessment and care through ED. After the initial assessment in HOPE, patients may remain for a stay <24 hours in HOPE or be admitted to the Medical Assessment Unit (MAU) or may be admitted to another specialist ward. They may also be assessed as suitable to go home with routine GP follow up or with follow up from RACE or other community-based services. This is a functional multi-disciplinary assessment model with the intention of rapidly addressing functional and social issues and a clear management plan to be supported in the community. HOPE complements the MAU which will continue to function as an undifferentiated admission model at Gosford Hospital. CCLHD is monitoring and evaluating the HOPE model and based on performance will determine at the end of FY23 the plan for expansion of HOPE to both hospitals.

IV. **Establishment of Rapid Access to Care and Evaluation (RACE) leveraging CCLHD's Hospital in the Home (HiTH) service:** RACE is a hybrid non-admitted/admitted multidisciplinary model at the interface between inpatients and community to facilitate early and supported discharge (5-day follow-up) for Elderly and Frail patients accessing HOPE-ED or other patients assessed and treated in ED and not requiring inpatient admission. For CCLHD, acute care capacity is proposed under bed type 25 for up to 10 patients, under HiTH governance. The service provides linkage to ongoing care and support, complex care coordination partnership GP. Additional phasing may include scalability to pull patients from inpatient wards to facilitate accelerated discharge within a multidisciplinary team.

Rapid Access Clinics

Outpatient specialist clinics have long waiting lists and are currently overbooked. A need was identified for implementation of an outpatient service aimed at reducing demand on Emergency Departments and inpatient hospital services, as well as increasing community-based support for patients. Examples of these clinics include:

i) Respiratory:

There have been different rapid access models of care for respiratory illnesses used globally. Even prior to the COVID-19 pandemic, a Respiratory rapid review service in Northwest UK demonstrated its ability to reduce length of stay through early discharge with prompt follow up and preventing readmissions. The John Hunter Hospital runs an effective Respiratory Rapid Access Clinic providing a service which supports patients in the community, allowing for early specialist review, early intervention, avoidance of presentation to the Emergency Department and ultimately hospital admission. In the financial year of 2021 – 2022, there were 182 readmissions under Respiratory

Medicine, of which 24% were due to chronic obstructive airways disease (COPD) and 18% were due to respiratory infection or inflammation.

450 The RAC provides a source of referral and identifies patients appropriate for management through HITH or APAC programs. Ultimately avoiding ED presentations and hospital admissions. The service includes a Respiratory nurse who provides Respiratory Clinical Liaison support in the clinic and certain inpatients on the ward who may require increased community support on discharge.

The implementation of this clinic:

455 I. Avoids presentations to ED through early intervention and treatment
II. Reduces hospital admissions allowing for discharge from ED
III. Prevents readmissions – particularly those due to COPD
IV. Reduces ED LOS due to ability for early referral to Respiratory for possible RAC
V. Facilitates early discharge with early Specialist follow up in outpatient clinic for patients
460 discharged from Emergency Department and hospital wards
VI. Reduces hospital length of stay

ii) Cancer Service – Gosford Rapid Assessment Unit

Cancer Service currently supports approximately 1000 outpatients per month on active treatment across Gosford and Wyong Cancer Day Units and the Central Coast Cancer Centre. There is an
465 average of 2600 occasions of service in our clinics, 2000 at Gosford and 600 at Wyong and 1800 medical consultations for non-inpatients each month. With the increase in activity and complexity of patients, there is a corresponding increase in patients requiring supporting treatment, assessment and potentially admission during their treatment trajectory.

Implementing a rapid assessment unit (RAU) located in the Gosford Cancer Day Unit provides an
470 alternative pathway to an ED presentation for sufficiently stable patients, to assess patient needs, provide treatment and facilitate admission if required. The RAU enables:

- ED and admission avoidance
- Direct admissions for eligible patients
- The saving of bed days and reduce LOS for planned admissions
475 • Improvement of patient flow and reduce exit block
- Patients to receive timely care from the treating team.

RAU has been established with 4 chairs in the Gosford Cancer Day Unit and with medical and nursing workforce targeting a reduction in avoidable admissions with the potential for significant acute bed day savings and length of stay reductions. The RAU will operates Monday to Friday between the
480 hours of 0730am and 1700pm. The benefits of this model includes:

I. ED avoidance – patients are directly referred to the RAU for assessment/treatment during RAU operational hours.
II. Admission Avoidance - Stable patients remain in the community after intervention with scheduled follow up. Admission is often avoided by early appropriate intervention.
485 III. Direct admissions - Patients assessed as needing admission begin treatment within the RAU transferring to an IPU bed as a direct admission once bed is available.
IV. Inpatient Direct admissions (scheduled RFA's) are admitted to the RAU to begin treatment at the beginning of shift, transferring to inpatient unit once bed available. This saves approximately 25 bed days per month. (300 bed days per year)

490 iii) NSW Health Collaborative Commissioning Framework

The Collaborative Commissioning Framework provides further opportunity for CCLHD and PHN to deliver innovative models of care. CCLHD and the HNEPHN have a strong commitment to delivering integrated and value based care through a partnership Alliance. The partners are committed to working on the collaborative commissioning opportunity and will continue to explore how this
495 activity could improve delivery of integrated services across both the Central Coast.

Activity Based Funding

In October 2022 CCLHD commissioned an external review on the use of Activity Based Funding and identify opportunities to improve Activity Based Funding (ABF) and Activity Based Management (ABM) within the LHD. CCLHD aims to improve the understanding of the NSW ABF system within the
500 LHD so that the system is effectively utilised to help deliver high quality effective and efficient clinical services. CCLHD also aims to strengthen its standing with NSW Health by more effectively meeting the requirements of the Ministry and improving the quality of the information available to both CCLHD and NSW Health at budget negotiations.

The LHD is funded to provide 146,505 National Weighted Activity Units (NWAUs) of health service
505 activity in the 2023-24 year as required by NSW Health under the annual Service Agreement at the State Efficient Price (SEP) of $5207 per NWAU23. The budget allocation is now slightly over $1billion with $814 million funded by activity based funding.

The review identified the LHD has the foundations for success in maximising the benefits provided by the use of ABF and ABM utilising the sound foundations in classification, counting, and costing of
510 patients to provide a platform to take the use of ABF and ABM to another level and to generate considerable improvements in transparency of funding, better use of clinical data for quality improvement purposes and greater clarity around identification of efficiency improvement opportunities.

The commitment of the Chief Executive, senior executive and Board was widely supported and there
515 is a broad understanding of the need to improve the use of both ABF and ABM. There were a number of important issues to be considered and managed as an improvement journey. These included:

I. Aligning internal commissioning, budgeting processes and performance management systems to the NSW Health ABF and ABM Compendium over a two year period while
520 adjusting the internal LHD cross charging arrangements to support the implementation of best practice ABF and ABM.
II. Determining a single LHD-wide price per NWAU with transparent variations expressed as transition grants where allocated for individual services.
III. Implement a cascade of budget allocations of NWAU to the activity based funded
525 constituent elements of CCLHD beyond the current distribution of NWAU so that the cascade extends to clinical department level. This process should be conducted on a shadow basis in the second half of 2022-23 with full implementation of activity based funding throughout CCLHD in the 2023-24 financial year. When NSW Health budgeting and accounting rules permit, performance against NWAU targets so established by this
530 budgeting process should be reported as a revenue source for each clinical service entity.
IV. Enhancing the integration of ABM into the performance management framework of the LHD by adding to the current reporting against NWAU activity volume targets with the additional reporting of cost per NWAU and coding accuracy targets

V. Regularly benchmarking the LHD's performance in terms of cost per NWAU, length of stay, coding accuracy with Illawarra Shoalhaven LHD, Sunshine Coast HHS and Barwon Health Service as peer organisations.

A Project Lead has been recruited to design and implement these recommendations across a two year period. A governance committee has been established to provide governance over the program and will oversee the ABF and ABM projects and change management within the program including program resourcing, key risks and issues.

Recent changes to the LHD Service Level Agreements place a greater emphasis on delivering activity with a tangible linkage to in-year funding from 2023-24. Commonwealth contributions for National Health Reform Agreement (NHRA) activity-based and block-funded services will be considered as own source revenue. This transition necessitates a tighter financial focus to ensure funding allocations are maximised and poor timely and effective recording practices or inefficient operating does not impact or penalise the LHD.

To support this transition, the LHD has recently invested in and supported clinical documentation improvement (CDI) initiatives. CDI engages clinicians to improve the clinical documentation in the medical record, allowing for better reporting, analysis, and reimbursement. The LHD has partnered with an external provider to initiate and train staff in the CDI methodology, with the intention of becoming self-sufficient in the future. This modest investment is expected to yield significant benefits for both patient quality and safety and financial sustainability.

CCLHD is proactive in its approach to support healthcare in the community or the home and virtual settings. As future health needs, technological advances and healthcare sustainability necessitate new models of care. The LHD is working towards more people accessing care outside hospital settings and providing more options for care in the community and the home. A key linkage is facilitated through strong partnerships with general practitioners and non-government organisations. The LHD is actively working with these providers in conjunction with Ministry of Health to navigate clarity around funding mechanisms and support.

ABF Innovation – SCRAWL

SCRAWL software was developed by CCLHD Neurologists Dr Bill O'Brien and Dr Stephen Winters to improve communication between the clinical coding team and the treating medical teams. It aims to do this by providing structured clinical documentation in the patient's record that not only provides continuity in the progress notes and an ongoing management plan for the patient but, it's also in a format and language that improves the coders ability to code the medical record in accordance with Australian Coding Standards. SCRAWL provides benefits for the patient, the treating medical team and the clinical coding team.

SCRAWL has been implemented and is being used in Neurology and Orthopaedics at Gosford Hospital. SCRAWL aligns to the CCLHD culture that promotes and encourages innovation, collaboration and teamwork. In addition to this, SCRAWL aligns to the 2023-24 Annual Priorities for ***timely access to care*** by managing length of stay and has demonstrated a decrease in length of stay of stoke patients to date. ***High quality safe patient care*** is supported by good clinical documentation and well documented patient management plans and discharge summaries, and SCRAWL also aligns to ***Financial and Environmental Sustainability*** by ensuring that patient complexity is accurately recorded, and that funding reflects the resource utilisation. In terms of ABM, accuracy in the data allows for better benchmarking of activity with other health services and provides quality data to support evidence based decision making.

Originating in the Gosford Hospital Neurology department, SCRAWL has been successfully implemented over time and is used by the entire Neurology team for all types of neurology patients, 580 predominantly but not limited strokes. Junior medical officers reportedly like SCRAWL for the structure to the documentation it provides and the feedback opportunities provided by the senior consultants who review their documentation and management plans.

In 2022, SCRAWL was expanded into the specialty of Orthopaedics and while the engagement levels are different compared with Neurology resulting in SCRAWL not being used to its full potential, 585 orthopaedic junior medical officers reportedly like using SCRAWL for clinical documentation and management plans. SCRAWL has been implemented by the NSW Health Tele-Stroke Network and is endorsed by the Agency of Clinical Innovation (ACI). This is exciting from the research and innovation perspective of exploring new and better ways of delivering care and achieving better patient outcomes. In the rapidly changing environment of health, SCRAWL being used for tele-stroke means 590 that the capability of the system for use in virtual care and other innovative models of care is already being tested.

SCRAWL is more than a clinical documentation tool, it is activity based management (ABM) for clinicians and includes many benefits such as good clinical documentation that meets the needs of the treating medical team and the clinical coding team and indicative complexity can be entered by 595 the clinician and used to compare the coded record to the predicted complexity. This provides a coding auditing structure with any NWAU uplift made within the current financial year, and, is measurable. As part of the ABF Implementation plan, CCLHD is planning to trial SCRAWL within other medical specialities with potential to scale across the organisation.

Organisational Sustainability Strategy

600 The Organisational Sustainability Plan (OSP) is a key strategy in place to ensure the LHD continues to be a high performing and accountable organisation, delivering exceptional care, enhancing the health and wellbeing of our community. Underpinning this objective we believe the approach of delivering value based healthcare and integrated care will improve health outcomes that matter to patients.

605 The primary goals the OSP aims to ensure the LHD is delivering improved patient outcomes and performing at/or better than peers across all specialties and any unfavourable variance to budget is managed and eliminated. The objectives of the OSP are intended to achieve these goals by aligning with the LHD's primary objectives as set out in the Caring for the Coast Strategy 2019-2024

The delivery of the program and achievement of its objectives throughout the organisation has been 610 mandated by the LHD Board to be implemented. The Chief Executive provides leadership to the program and is responsible to ensure sound governance, management and communication.

To ensure the delivery of this program, governance has been established to ensure oversight at all operational levels. The OSP provides the foundations to

I. Ensure that there are plans in place to enable the LHD to stay within its allocated budget;
615 II. Establishment of an effective program, targets and monitoring framework for sustainability plans that will position the organisation as a leader and achieve service agreement targets;
III. Provide advice and make recommendations on operational decisions with regard to sustainability, cost and safety;
IV. Identify and facilitate opportunities to create greater value and deliver safe, reliable care;
620 V. Ensure risks and opportunities associated with quality, safety and finances are being identified, assessed and treated to an acceptable level.

A key LHD accountability tool is the regular Performance Review meetings held with the Executive and each of their Operations Directorates and services. To ensure the integration of the OSP within 625 the LHD, opportunities and performance against the strategy will be included as a standard item in these meetings. If performance against allocated OSP initiatives is unsatisfactory, frequency of these meetings will be increased. If Directorate or service performance is well-performing against the allocated initiatives then these meetings may become less frequent.