DRAFT DISCUSSION PAPER

SWSLHD Older Persons and Rehabilitation Plan

Contents

1. Introduction

SWSLHD Older Persons and Rehabilitation Plan - Overview

The aim of the SWSLHD Older Persons and Rehabilitation Plan is to outline the service requirements, directions and priorities, required to meet future service demand due to the population growth and ageing in south western Sydney. The *Plan* provides a strategic platform for the Local Health District (LHD) to further develop aged care and rehabilitation services.

To develop a clear vision and direction for the Older Persons and Rehabilitation Services in South Western Sydney Local Health District (SWSLHD), the Plan will be considering:

- Aged care and rehabilitation services currently provided in the SWSLHD
- The role of each of the facilities and services in the provision of aged care and rehabilitation services in the LHD and how the facilities and services operate as an integrated network
- Equity of and access to services along the continuum of care
- Developing more community based services for the target consumer/patient groups
- Reducing the number and length of periods of ill health in older people through more focus on preventative and restorative care in order to reduce frailty risk
- Key service enablers to support service provision.

Older clients are defined in this Plan as those with either an acute or chronic illness, who have particular physical or cognitive disabilities, issues with care, accommodation and support, or with multiple medical or polypharmacy problems. The chronological age is not the main driver. Particular attention is given to frail older people including dementia which usually corresponds to the degree of frailty.

The Rehabilitation component focuses on adult rehabilitation only, giving particular attention to the needs of people who have had a stroke, have a chronic disease, an intellectual disability, brain injury and spinal cord injury. In addition, some clients of the Rehabilitation Service have unique physical or intellectual disabilities and are also often in need of assistance with care, accommodation and/or support.

For ease of reference in the document, clients have been divided into either older people with complex health and support needs or adult patients who need rehabilitation services. The boundary between the two primary target groups is arbitrary.

Carers are acknowledged as providing very valuable care to older and frail people, those with chronic health conditions, and people with disabilities. Given that both Older Persons and Rehabilitation clients usually have a strong reliance on carers, the needs of carers are also considered. In addition, the District has developed a combined document - *SWSLHD Disability and Carers Strategy 2017-2022,* which is considering the specific needs of people with disability and carers.

Equity is a core service consideration in the Plan. The Plan will ensure that the needs of vulnerable groups such as Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse (CALD) and people from a lower socioeconomic background are considered.

Development of the Plan is overseen by the Steering Committee and guided by the relevant District, State and Commonwealth Policies and guidelines (refer to the Appendix section of the document).

Since the plan was developed, the restructuring within NSW Health occurred with the establishment of LHDs which replaced previous entity of area health services.

The SWSLHD unprecedented population growth and ageing of the population and changing demographics, as well as significant facility planning and redevelopment projects have created the need for the new Older Persons and Rehabilitation Plan. It is envisaged that the Plan will provide direction for health services to maintain the quality of life of older people with complex needs and people requiring rehabilitation.

2. DRAFT Vision

The Draft Vision for the SWSLHD Older Persons and Rehabilitation Plan

DRAFT Vision
Leading care, healthier communities with a focus on quality and safety in health care

Principles

The principles informing this Plan and service development into the future are consistent with the *SWSLHD Strategic Plan 2018-2021 and the SWSLHD Planning Principles.*

1. Promote **proactive approach** to health and wellness in older age to support people to live meaningful and functional life, maintain independence and remain living in their own home.
2. **Rehabilitation services** are engaging with consumers/patients to establish their therapy goals which include physical, emotional and social domains.
3. Older people are **valued** and **listened to**, and treated with **compassion, dignity and respect** at all times.
4. All care including rehabilitation is provided in the **most appropriate environment** possible in accordance with the needs of the patient and in consultation with them, their family and carers. These environments include home, residential aged care facilities and other health care facilities and the **seamless transition** between these settings.
5. All patients receiving rehabilitation services will have timely and equitable access to the most appropriate services
6. **Care** is safe, effective, responsive, and appropriate and evidence based.
7. Health care will be **consumer, carer and family centred** and responsive to the values and cultural and other needs of individuals, families and communities.
8. Fostering **high quality research** within Aged Care and Rehabilitation to optimise care provided.
9. The **health workforce is responsive, trained and skilled** to recognise complexities of older people health needs and to provide high quality rehabilitation care focused on restoring function and support systems to deliver the best health outcomes.
10. Care is **holistic, integrated and coordinated** across primary and specialist health services and settings.
11. Care is **equitable**, with vulnerable populations and communities provided with additional support and assistance to access care.
12. **Embracing new technologies, innovations and evidence-based practice** for the benefit of patients and the efficiency of service provision.
13. **Collaboration and multidisciplinary care** will occur across all health settings and include patients/consumers, community members and other service partners.
14. Health **information and data** will be used to ensure quality health care is provided.

2.1 Purpose of the discussion paper

The purpose of this discussion paper is to provide the broad context and inform the consultation process in order to develop the SWSLHD Older Persons and Rehabilitation Plan.

The future planning will be done in partnerships with consumers, carers and families; with aged care and rehabilitation clinicians including medical, nursing and allied health; private services and practitioners and other government and non-government stakeholders.

Consultation is a key component of the planning process. The consultation process for this project is underpinned by principles of co-design and partnership.

Consultation and planning processes will be guided by expertise and advice from the steering committee members. Due to the varied nature of services provision, and a myriad of services and agencies involved, a multi-faceted approach to consultation will be taken to ensure involvement of a number of stakeholders.

Figure 1: Older Persons and Rehabilitation Plan-Consultation Components

The consultation process should be considered to be flexible and able to be adjusted to better suit the needs of stakeholders. If identified throughout the consultation process, additional stakeholders should be added to the relevant workshops.

The consultation seeks to obtain views about how services from the SWSLHD and the broader health

and support system respond to older people and rehabilitation patients with complex care needs and their families. It will encompass the patients and family's experience across all care settings, their changing health status, needs and wishes, and the processes involved in effective patient care and service integration.

2.2 Key questions for consideration

Integrated, networked services

- What are the strategies to promote healthy ageing and early intervention, including initiatives for identification of functional decline?
- What are the gaps and challenges in servicing your community?
- What are the gaps and needs for the complete episode of care, including acute, allied health and rehabilitation?
- What are the options for service development and realignment-within the LHD? External to it?
- Identify the role of each of the facilities and services in the provision of aged care and rehabilitation services?
- How can aged care and rehabilitation services be better integrated within health services and facilities across the LHD?
- What is the role of the private and not for profit sector in the older persons and rehabilitation service provision? What opportunities are there for collaboration and partnerships in the provision of services?
- How can services be better coordinated between SWSLHD and primary care providers including GPs?
- How can services be better coordinated between Health Services and ongoing community support providers?
- Are there any adequate level of support for people awaiting long-term care options instead of remaining in hospital long after they have completed their episode of acute or sub-acute care?

Evidence based Models of Care

- What service models of care are required to establish viable and sustainable older persons and rehabilitation service?
- Is adequate support available for aged care clients in non-aged care wards? What are the issues?
- Aged Care and Rehabilitation Services and interface with the NDIS: issues?
- Do we need disinvesting in services which have become outdated or lack evidence?
- Care of older Non Weight Bearing (NWB) patients after fractures such as ankle, tibial plateau and femur?
- What are the options for the shared care MoC?
- Geriatric outreach- is integration required between geriatric outreach MoC?
- Rehabilitation for patients who had amputations - MoC?
- What is the best management for deconditioned patients (such as those with extended ICU stays or cardiothoracic patients)?
- Community Services MoC?

Enablers

- What actions are required to address gaps in system-wide enablers such as health workforce and professional development; information and communication technology; business intelligence; collaboration and partnerships; interpreters and transport?

2.3 Older Persons and Rehabilitation Services Plan – DRAFT Focus Areas

Draft Focus Areas	Description
Better life for all (wellness approach for ageing) – best for each individual	Wellness approach for ageing needs to be considered as a process that takes place across the life course rather than as a state at a particular point in time, and is crucial to maintain optimum trajectories of functional ability and capacity across life and into the older age. It is important to extend the period in which older people are well and independent by increasing services and programs that keep people out of hospital.
Support significant growth in older and disabled population	As our population is ageing there is an increase in often multiple chronic health conditions, disability and frailty, which is placing significant pressure on services across the District. An introduction of evidence based models of care that shift the balance of care from hospital to community and home based settings is one of the service priorities.
Supports vulnerable communities and promotes cultural safety	Some people in our community experience increased patient vulnerability and complexity due to social and /or health circumstances. Populations experiencing inequities in health status include Aboriginal peoples, people from CALD and refugee backgrounds, people living with disability and other vulnerable groups such as people from lower socioeconomic background and people living in outer-metropolitan areas. To ensure services are effective and reach the people needing them, services need to be designed to create culturally safe environments, and to be delivered to promote cultural safety.
Networks, integration and community based services	The complexity of the Older persons and Rehabilitation service system highlights the need for excellent communication and cooperation across all providers, to ensure integrated service delivery for the client and family. Increasing the integration of aged care and rehabilitation services has the potential to increase access to care; streamline existing care; promote more

	efficient use of existing resources; and improve the patient experience without increasing total service costs.[1]
Evidence based models of care	The population growth and ageing and advances in surgical and medical care are driving demand for developing new evidence based models of care (MoC) which are better networked and person-centred, reflecting the preferences of our clients and their carers, and the latest research. New MoC need to demonstrate reduced hospital readmissions, improved health outcomes, increased patient satisfaction, decreased resource use and decreased cost.
Empowering consumers and carers in their care	It is of paramount importance to empower consumers, carers and family members to participate in care planning and decision-making at an individual, service and system level in order to deliver person-centred care that is respectful and responsive to the needs, preferences and personal circumstances of the patient, carer and family members.[2]

2.4 Engaging with consumers and carers and family members

Given the heavy reliance of older persons and rehabilitation services on consumers on carers, carer support is an essential component of the service provision. Early discharge and long term independence is often related to the availability and capability of a carer, and as such carers must be considered as an integral part of health care services.

SWSLHD is committed to consumer, carer and community involvement in the planning and operation of local health services and has a well-established structure to support this participation. Each hospital has a Community Participation Network of individuals from the local community working with clinical and nonclinical staff. Examples of how people participate include working with health staff in committees, working groups and projects; engaging with clinicians in care planning, conducting patient and carer interviews and surveys; attending forums to provide ideas and opinions; assisting in the training and orientation of health staff; sharing consumer stories to provide greater insight into the patient, carer and family member journey; joining an action group to work on specific issues and providing comments through social media or the formal feedback process.

SWSLHD also offers a comprehensive Carers Program which provides a range of information and support services by: raising awareness amongst SWSLHD staff and residents about carers and their role, promoting the contribution of carers in all their diversity, supporting the improvement of access and service delivery to carers; supporting the enhancement of carer wellbeing, promoting an environment that supports the caring role and; advocating for carers at an organisational level. (Note: more information on carers can be found in the Priority Population Section).

[1] Reed J, Cook G, Childs S, McCormack B. A literature review to explore integrated care for older people. International Journal of Integrated Care. 2005

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

3. Health and Wellbeing of the Older Persons and Rehabilitation Population in SWSLHD

Individuals and a population experience constant change, and these changes have important implications for their health and wellbeing. While some health and welfare concerns span all age groups, others tend to emerge at specific life stages. This section describes health conditions and issues which are more prominent in older age.

The older population is extremely diverse, ranging from fit, active, and healthy octogenarians to extremely frail, totally dependent people with chronic disease and severe disabilities. A range of factors influence older people's ability to remain healthy as they age; these include behavioural and biomedical risk factors and ongoing social and mental wellbeing. This section explores some of these factors. SWSLHD will promote healthy ageing, support older people to live independently for long as possible and provide access to appropriate, high quality, evidence-based health care that is provided in a safe, timely, equitable and coordinated manner, as close to home as possible. This includes working in partnership with primary care and the government, health and support sectors to promote healthy ageing.

Promote healthy ageing includes:

- Implement initiatives based on the population health approach where consumers, carers and their families are engaged and empowered in health promotion and self-management activities, including initiatives to increase health literacy
- Promote and support availability and affordability of fresh food and promote healthy diets
- Promote best practice smoking cessation programs
- Promote increased activity for older people to help them stay active, fit and strong
- Strengthen and expand falls prevention strategies
- Foster good urban design with accessible transport that contributes to liveability and population health and wellbeing
- Address social isolation and loneliness
- Adopt proactive approach to functional decline, including identification and early intervention to avoid potential hospital presentations and admissions.

3.1 Dementia and delirium

The prevalence of dementia increases dramatically after the age of 70 years, approximately doubling every five years. About (0.1%) of the population under 65 years of age has dementia, compared with about (5.2%) of the population aged between 65 and 70, and (28.8%) of the population aged 85 years or older. The prevalence increases to (41%) for those over 90 years of age. The prevalence of dementia in SWSLHD is expected to be on rise due to the growth in the cohorts of 80-84 age group (122%) and in the over 85 age group (102%).

Dementia can lead to difficulties with mobility, continence, nutrition and immune system function. These can lead to frailty, infections and difficulty breathing, with pneumonia the most common complication leading to deaths in Australia in 2015. People living with dementia are likely to receive care at home, in hospitals, post-acute or respite facilities and RACF.

In some cases there are early-onset, or young-onset, dementia which begin before age 65. It can start as early as age 30 but usually happens around age 50. Research shows that people with intellectual disability develop dementia at an earlier age than the general population and this also needs to be recognised when planning services. There is a need of developing specialist capacity to enable effective assistance of younger people with dementia and their families in South Western Sydney.

The hospitalisation rate for dementia as a principal diagnosis and as a comorbidity for people over 65 years of age in SWSLHD, between 2016 and 2018 was (1877.0 per 100, 000 hospitalisations) vs (1649.1 per 100,000 hospitalisations) for NSW. Hospitalisation rates were higher for Canterbury- Bankstown and Campbelltown LGAs residents compared to NSW residents.

Behavioural and psychological symptoms in people with dementia

It is estimated that 56% to 90% of people with dementia will experience Behavioural and Psychological Symptoms (BPS) at some stage, with the most common symptoms being apathy, depression and anxiety. About 50% of people with dementia will have at least four symptoms simultaneously. According to the Royal Australian and New Zealand College of Psychiatrists (RANZCP) estimated the prevalence of BPSD at:

- 61–88% among people with dementia in a community setting
- 29–90% in residents in Australian RACF
- 95% among hospitalised patients in long-term acute care

The incidence, treatment and manifestations of BPSD are often different between community and residential care for various reasons. The management of severe BPSD is predominantly a concern for residential care, as once people with dementia begin exhibiting severe BPSD it is difficult to provide care in the community and they are admitted into residential care. Over the course of the illness, people with dementia need access to a range of health care and social services including GPs, community services, allied health services, hospital, day and respite care, in - home care and residential care.

According to the Royal Australian College of General Practitioners (RACGP) the current Medicare funding model doesn't adequately support diagnoses of illnesses such as dementia in general practice.

The Royal Commission into Aged Care Quality and Safety's (Royal Commission's) *Interim report: Neglect* from November 2019, defines restrictive practices as 'activities or interventions, either physical or pharmacological, which have the effect of restricting a person's free movement or ability to make decisions.

From a clinical perspective, there can be significant and serious adverse effects on individuals who are prescribed medications that may be considered to be a pharmacotherapy for BPSD, especially to their physical and mental wellbeing. Importantly, there are fundamental issues around the effectiveness and success of pharmacotherapy for BPSD. The first-line management should include a person-

centred, multidisciplinary management plan of non-pharmacological approaches including an early identification and adoption of preventive and early intervention measures (e.g. environmental, psychosocial).

Delirium

Between 20-40% of older adults admitted acutely will experience delirium during their admission, with rates of 30-50% in older patients undergoing surgery.

In the Intensive Care Unit (ICU) setting, between 30% and 80% of patients experience delirium, with symptoms such as agitation, confusion, sleeping difficulties and memory loss. The condition often impedes recovery in patients, resulting in longer hospital stays, greater reliance on ventilators, and cognitive impairment after discharge. As a result of being in critical care, many returning patients who have experienced delirium during their first admission show symptoms of post-traumatic stress disorder and frailty, marked by a tendency to fall.

Delirium is common in patients with dementia, and about a third of cases of delirium are potentially avoidable. Delirium is often under-recognised and sub-optimally managed. Inadequacies in environment and staff knowledge and skill sets lead to increased incidence of and duration of delirium. Environmental modifications, increased awareness amongst patients, carers and staff, will improve care for patients at risk of/with delirium. Many of the infrastructural focusses for dementia-specific and dementia-friendly care will likewise benefit patients with/at risk of delirium.

3.2 Frailty

Frailty can affect up to 10% people aged 65+ years and over which equals to 12,233 people in SWS and around 25% to 50% of those 85+ which equals up to 7,470 people in SWS. Even higher rates of frailty are observed in older admitted patients. There is a clear evidence that frail older people are at increased risk of acute illness; medical instability, slow or incomplete recovery from diseases, surgery and hospitalisation; delirium; iatrogenic harm; falls, injuries; disability, dependency and institutionalisation. Frailty is complex and multifaceted and varies in onset, progression and recovery. Studies have shown that 48 % of people over 85 years of age die within one year of a hospital admission, and ten days in a hospital bed leads to the equivalent of ten years ageing in the muscles of people over 80 years of age. As a result, frailty is associated with high mortality and high healthcare utilisation.

The ACI Acute Care Taskforce developed a working definition of frailty*: A predominantly age-related state of patient fragility or increased vulnerability that results from a compromised ability to maintain homeostasis and limited functional reserves across multiple physiologic systems.* Appropriateness of care is of particular importance for frail elderly people.

The frail older person, who is not recognised as such, often presents in a non-specific way, late and in crisis with a geriatric syndrome. Their care is often hospital-based, episodic, disruptive, disjointed and associated with poor health outcomes, such as higher mortality, risk of requiring residential care, hospitalisation and increased length of hospital stays and poor patient/carer experience too.

It is of paramount importance to identify frailty earlier and respond proactively, as preventative and coordinated care can modify frailty severity, reduce stressors and improve outcomes.

There is proven benefit in performing a Comprehensive Geriatric Assessment and 75+ GP's health assessment with interventions such as exercise, nutrition support, vaccination, managing polypharmacy and falls risk.

Screening and assessment for frailty should consider a person's physical performance, nutritional status, cognition, mental health, health assets and a person's goals and cultural context. By recognising frailty and providing timely and coordinated interventions in the community will result in long term benefits for older people who can live well with frailty. There is a need for standardised validated tools to be in-built into routine care of older patients to enable healthcare providers to recognise and assess frailty.

3.3 Mental health

Differentiating mental disorders from 'normal' ageing has been one of the more important achievements of recent decades in the field of geriatric health. Depression, Alzheimer's disease, harmful alcohol use, anxiety, late-life schizophrenia, and other conditions can often go unrecognised, untreated or misdiagnosed, with severely impairing and sometimes fatal outcomes.

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

Some older people develop a mental illness as they age, while others grow older with a continuing experience of a mental illness that developed earlier in their lives. Better diagnosis of both mental and physical health conditions and greater awareness of mental illness symptoms among older people are priorities.

Mental health problems in older people can be complex in their presentation and management, and require specialist clinical knowledge and skills to manage issues across a range of service settings.

3.4 Chronic conditions

People living with a chronic condition in Australia account for up to 80% of the health care burden in 2020, and they are likely to have several co-morbidities.

Cardiovascular disease and cancer were the leading causes of burden for older Australians contributing (24%) of total the disability-adjusted life year (DALY), each followed by neurological conditions (11%), musculoskeletal conditions, and respiratory conditions (9%, each).

Among these top disease groups, the rate of burden per 1,000 people increased with age - except for cancer, where the rate was highest for 80–84 year olds.

Almost half (49%) of SWSLHD residents responding to the Australian Bureau of Statistics' (ABS) Patient Experience Survey (2016-17) reported having a long term health condition (cancer, cardiovascular disease, mental illness, chronic obstructive pulmonary disease, asthma or diabetes) and nearly 1 in 4 (23%) reported having two or more of these conditions.

Males and older people experience the highest rates of hospitalisation and death due to chronic conditions, although the difference between males and females is decreasing over time.

The leading causes of burden among older Australians, were the same for men and women with only the order differing between them.

Men: the leading cause was cancer and other neoplasms (28%), followed by cardiovascular disease (25%), respiratory diseases (9%), neurological conditions (8%) and musculoskeletal diseases (7%).	**Women:** Cardiovascular disease was the leading cause (23%), followed by cancer and other neoplasms (20%), neurological conditions (13%), musculoskeletal conditions (11%) and respiratory diseases (9%).[3]

Diabetes

Based on the ABS 2014–15 National Health Survey (NHS), around 1 in 6 people aged over 65 reported having diabetes—just over 574,000 people.

It is estimated that about 67,000 people in SWSLHD have been diagnosed with diabetes, at (6.9%) prevalence rate- the highest among LHDs in metropolitan Sydney.[4]

The health consequences of diabetes are significant, causing acute and chronic health conditions. Diabetes is a risk factor for the development of cardiovascular disease (CVD), with heart attacks and strokes up to four times more likely in people with diabetes.

[3] AIHW (Australian Institute of Health and Welfare) 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3. BOD 4. Canberra: AIHW.
[4] Diabetes Map www.diabetesmap.com.au

Diabetes and ageing also increase the risk of chronic kidney disease (CKD). Diabetic nephropathy may progress to end stage kidney disease, requiring dialysis to prevent or delay death. In SWSLHD, in the period between 2012 and 2017 about one third of patients on dialysis had diabetic nephropathy. Diabetes can cause vision loss, nerve damage (neuropathy) and delayed wound healing, which can lead also to the lower limb amputation which can also be a contributor to falls.

Over the past three years (2014 -2017), residents of SWSLHD had 507 diabetes-related lower limb amputations of some form (an average of 169 per year). More than three quarters were toe, foot or ankle amputations.

If the current trend continues, by 2031 the number of lower limb amputations per year will reach 300.

In 2017-18 there were 1,757 hospitalisations for diabetes as a primary diagnosis at a rate of (173 per 100,000 population) for SWSLHD residents, compared to (149 per 100,000 population) for the whole NSW, respectively. Hospitalisation rates for type 2 diabetes are increasing with age. The hospitalisation rate is highest in people 75–84 years of age.

Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD), which includes chronic bronchitis and emphysema, was responsible for 2,564 deaths in 2017 in NSW (91% or 2,332 in those aged 65 years and over) and more than 22,378 hospitalisations in 2018-19.

There were 2,455 hospitalisations for COPD in 2018-19 for the SWSLHD residents (78% or 1,906 for people aged 65 years and over). The hospitalisation rate for older males in SWSLHD tend to be higher (1638.6 per 100, 000 population) compared to the NSW rate (1497.8 per 100, 000 population). The hospitalisation rate for females was similar to NSW rate (1244.9 per 100,000 population) and (1242.8 per 100,000 population), respectively.

Co-morbidities

Older patients are more likely to have multiple acute and chronic co-morbidities and tend to require the coordination of range of community services before they can go home, including home modifications and support services. A lack of availability of services results in delays in discharging inpatients who are medically stable. This impacts on length of stay and may result in further deconditioning of patients. A lack of service availability may also result in an increase in avoidable hospital presentations. Ultimately, patient-centred multidisciplinary care, extending beyond the hospital setting, provides the best outcomes and measures healthcare effectiveness. Further development of health pathways across primary and secondary health providers will result in developing sustainable, clear, concise and localised pathways from a whole-of-system perspective (Refer to the Rehabilitation Section).

3.5 Last 1000 days

The Last 1000 Days[5] is a vehicle for drawing attention to patients' time. It is widely recognised that the older people, the chronically ill, and those with life limiting conditions are the same people who spend the most time in healthcare settings. These are the very people who have the least time to waste.

It is important to determine where and how an older person living with frailty would want to spend their last 1000 days. There is a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity. According to the research, the 10 days in a hospital bed (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80 years of age. [6]

It is often difficult to accurately predict prognosis for older adults living with frailty and they have different needs at the end of life to younger people. Traditional models of specialist palliative care do not always meet these needs or those of the carers and family supporting them.

What makes frailty different from other conditions at the end of life is that there can be prolonged periods of relative stability and then a potentially mild illness/injury can cause a significant or catastrophic deterioration. This acute deterioration often triggers the conventional response to crisis, ambulance to ED, investigations and the commencement of medical treatment, which can be invasive in nature. Understanding and identifying frailty is important because it helps explaining the burdens of conventional acute hospital care so that patients and their families can make more informed choices.

#EndPJparalysis is based on the original campaign from the United Kingdom that produced great patient outcomes by seeing a reduction in patient falls, pressure injuries and the length of time a patient was admitted to hospital. The End PJ Paralysis movement **(#endPJparalysis)** addresses the lack of movement that occurs when people remain in their pyjamas. Acknowledging that bed rest has an impact on musculoskeletal, cardiovascular, respiratory, skin and other systems and contributes to the functional decline*, PJ paralysis movement* is a new health care program which encourages patients to ditch their pyjamas and wear everyday clothes to get better and fitter quickly. The pilot on one ward per hospital has started in the SWSLHD and involves assistance by allied health staff to patients with walking, talking, moving and getting dressed.

3.6 Cancer

In 2014, people aged 65 and over were estimated to account for more than:

- half (58 %) of new cancer cases diagnosed
- three-quarters (77 %) of cancer related deaths

[5] Professor Brian Dolan: The Last 1,000 Days. Presentation to Nottingham University Hospitals NHS Trust (Nov 2016).

[6] Kortebein P, Symons TB, Ferrando A, et al. Functional impact of 10 days of bed rest in healthy older adults. J Gerontol A Biol Sci Med Sci. 2008;63: 1076–1081.

Overall, for older Australians, lung cancer is the most common cause of death from cancer, followed by prostate, colorectal, pancreatic, and breast cancer (women).[7]

South Western Sydney has the third lowest participation rate for breast cancer screening for women aged 50-74 compared with NSW (47.3% and52.8%, respectively). Participation in bowel cancer screening for people aged 50-74 is 36.4% compared to the NSW average of 39.5%.

Late diagnosis appears to be a major problem in older people. They are more likely to be diagnosed following an emergency admission, diminishing their chances of long term survival. They also experience poorer survival after diagnosis with a cancer that has already spread. Encouraging earlier diagnosis in older people should be a major priority.

Older patients are also less likely to receive active cancer treatment, such as surgery, radiotherapy or cancer drugs. In some cases, frailty and other issues can reduce a person's ability to withstand treatment and can result in an unacceptable impact on quality of life.

Within the field of oncology, there have been recommendations to advance the subspecialty of geriatric oncology, develop clinical care pathways for older cancer patients, offer speciality clinics and link in with age care and community services.[8]

Older people are less likely to have opportunities to participate in cancer research, meaning that opportunities to develop the evidence base on how best to treat older people are missed. [9]

Taking into account the increase in cancer occurrence and the quality of life among older population, a special approach is necessary for the diagnosis, treatment, and survival of older patients with cancer.

3.7 Nutrition

For older people, adequate food and hydration can help them recover from illness and surgery, remain independent, reduce their length of stay in hospital and help avoid readmission to hospital. There is general agreement that body fat mass increases up to about 75 years of age and then decreases or remains stable.

Malnutrition occurs when a person is not consuming enough calories or nutrients to meet their energy requirements and is common in older people and can be exacerbated by illness and hospitalisation. It can cause weight loss, health problems, muscle and skeletal loss and lead to serious conditions such as frailty and sarcopenia.[10]

People over 65 years of age at risk of malnutrition, need to be screened within 24 hours of admission and at regular intervals throughout their hospital stay. Although the provision of an adequate supply

[7] AIHW Report 2016
[8] Workshop. Clinical Oncological Society of Australia 2013
[9] Older people and cancer. National Cancer Intelligence Network. Public Health England 2014

[10] Visvanathan, R., Nutrition in the Frail Elderly. Editor 2014, Aged & Extended Care Services, The Queen Elizabeth Hospital And Adelaide Geriatrics and Research with Aged Care Centre

of energy and nutrients is obviously key to the treatment of malnutrition, used alone this intervention will not necessarily be successful. Other causative factors must also be considered and addressed.[11] Nutritional status predicts speed and degree of functional improvement and discharge outcomes in frail rehabilitation patients.

The functional independence measure (FIM) is routinely collected on admission and discharge for all patients attending inpatient rehabilitation in Australia. FIM score varies between minimum 18 and maximum 125, and a higher score means greater independence. Recognition of malnutrition on admission to inpatient rehabilitation predicts the speed and degree of rehabilitation gains and discharge outcomes. Small changes in nutritional status score can result in large improvements in function.[12]

3.8 Oral health

Although data on oral health-related quality of life is limited with respect to older Australians, research has identified oral conditions and diseases that have the greatest impact on older people's day-to-day lives. The average number of missing teeth for people aged 65 and over in 2013 was 10.8. On average, women had a slightly higher number of missing teeth than men (11, compared with 10.6), and the average number of missing teeth was also affected by a number of socio-demographic factors, particularly remoteness and income.[13]

Older people are at higher risk of periodontitis (gum disease or periodontal disease) and are more likely to experience advanced forms of the disease. This may be due to the accumulation of risk factors and longer-term exposure to periodontal bacteria—smoking, diabetes, obesity, osteoporosis, and heart disease –which all increase the risk of periodontitis, and the length of time a person is exposed to periodontal bacteria may increase the severity of the disease. Dementia is also associated with poorer oral health, and may impact on ability to manage oral care, as well as ability to communicate symptoms.[14]. Adverse outcomes associated with periodontal disease include pain, reduced oral intake, chewing/swallowing problems, infection (local and pneumonia), and poor self-image. In addition, difficulty with swallowing or speech and poor nutrition require coordinated care from speech pathologists and dieticians. Oral health needs of older people need to be addressed in acute, residential and primary care settings.

3.9 Falls and falls related injury

Falls are common among older people, with one in four people aged 65 years or over having at least one fall per year. Fall-related injury is a major cause of morbidity and mortality in older people.

[11] Hickson M. Malnutrition and Ageing, Postgrad Med J. 2006 Jan; 82(963): 2–8.
[12] ACI Frailty Forum 2020: Nutritional Status Predicts Speed and Degree of Functional Improvement and Discharge Outcomes in Frail Rehabilitation Patients by Dr Kelly Lambert, Academic Program Director Nutrition & Dietetics, University of Wollongong.
[13] Australian Institute of Health and Welfare (AIHW): Chrisopoulos S, Harford JE & Ellershaw A 2016. Oral health and dental care in Australia: key facts and figures 2015. Cat. no. DEN 229. Canberra: AIHW.
[14]Ní Chróinín D; Montalto A; Jahromi S; Ingham N; Beveridge A; Foltyn P, 2016, 'Oral Health Status Is Associated with Common Medical Comorbidities in Older Hospital Inpatients', Journal of the American Geriatrics Society, vol. 64, pp. 1696 – 1700.

Falls can result in serious injuries to patients of all ages such as fractures and head injuries. These lead to disability and fear potentially triggering a decline in physical function and loss of independence.

Osteoporosis is a major cause of pain, mobility impairment and loss of independence which result from fractures and related complications. For older people with osteoporosis, even a minor bump or fall can cause a life changing fracture.

Falls are the most commonly identified cause of injury-related hospitalisations. Males and females have similar rates of fall-related hospitalisations, except among older people where females have higher rates.

Hospitalisations that are related to falls may be attributed to injury from the fall itself, or may be due to conditions related to or exacerbated by a fall, such as subsequent rehabilitation.

In 2017-18, there were 3,343 fall-related injury hospitalisations in SWSLHD for people over 65 years of age, with a rate (2836.0 per 100,000 population) for females and (2126.4 per 100,000 population) for males, similar to NSW rate of (2835.4 per 100,000 population) and (2052.4 per 100,000 population), respectively.[15]

There has been an increase in the number of falls occurring in the SWSLHD patients between 50 and 70 years old, with patients over 65 years of age remained at the greatest risk of falling when admitted to hospital in 2019.

The SWSLHD Cardiology Department has recorded an increase of 53% in the number of falls in 2019 due to the comorbidities and challenging behaviours in their patients.[16]

The Aged Care and Rehabilitation Stream has demonstrated a (24%) reduction in the number of falls in 2019 compared with 2018.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) states that falls are a significant cause of potential harm in health care, and are a national safety and quality priority. Falls prevention and individualised harm minimisation plans based on best practice and evidence can improve patient outcomes.

There have been a number of strategies developed across SWSLHD in 2019 which are focussing on the falls reduction in the patients.

Specific initiatives under The Falls Prevention and Management Program such as *Stepping On*, are also being managed by the Health Promotion Service. The program provides information on how to reduce the risk of falling and maximise independence at home. In addition, the Falls Prevention Program provides free professional development for *Active Over 50* exercise leaders to assist them to integrate the latest evidence for falls prevention exercise into their classes.

[15] NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.

[16] SWSLHD Clinical Governance Annual Falls Report - Based on patient fall notifications in the Incident Information Management System (IIMS) 2019.

The NSW Falls Prevention Program is coordinated by the Clinical Excellence Commission, in collaboration with the Ministry of Health, the Agency for Clinical Innovation, Ambulance NSW and local health districts and seeks to promote a comprehensive, systemic approach to falls prevention and to reducing fall injury within NSW. As part of The *Leading Better Value Care* In-hospital falls initiative the SWSLHD pilot team has been successful in progressing falls prevention strategies in relation to risk assessment and completion of management plans.

3.10 Wound management

With our ageing population, chronic diseases that compromise skin integrity such as diabetes, peripheral vascular disease (venous hypertension, arterial insufficiency) are becoming increasingly common. Skin breakdown with ulcer and chronic wound formation is a frequent consequence of these diseases. Types of ulcers include pressure ulcers, vascular ulcers (arterial and venous hypertension), and neuropathic ulcers.

The incidence of complex and chronic wounds is high across the NSW health system, and continuing existence of a wound has a significant impact on the quality of life for patients, carers and families. Wound management can form a significant expense for patients and health services.

Patients who are admitted to hospital in NSW for chronic wounds have complex needs. More than two thirds of these patients are aged 65 years or over and 65% have two or more comorbidities. Patients living with chronic wounds often have multiple visits to hospital, with each patient having on average nearly three admissions to hospital with a wound. There is significant overall burden associated with treating chronic wound in admitted, emergency department and non-admitted acute settings, with total costs over the next ten years expected to reach $3 billion.

The Leading Better Value Care (LBVC) Chronic Wound Initiative aims to streamline the way care is provided for people living with chronic wounds to improve the experience of receiving and providing care, enhance outcomes for patients and optimise the use of resources.

SWSLHD has established a working group which aims to develop District approaches and discuss recommendations and the stages for implementation. The working group is currently in the process of stakeholder service mapping along in order to progress development of a Model of Care.

3.11 Incontinence

Older age does not cause incontinence, however, there are a number of changes that may happen when we age that can increase the risk of incontinence and other bladder and bowel health problems. In Australia, incontinence is the third highest reason for frail, elderly people to move from their homes into a nursing home. In other countries such as America and the United Kingdom, it is the second highest reason. In Australia, urinary incontinence affects over four million people, of which majority are women.[17] Following a diagnosis of incontinence, the risk of hospitalisation is 30% higher in women

[17] Incontinence facts and stats, Continence Matters South Australia, 2019.

and 50 % higher in men. Further, the risk of entry into RACF is two times higher for incontinent women and three times higher for incontinent men (Continence Foundation of Australia, 2000). Incontinence may also contribute to falls in older people who are in hospital especially when people are waking to go to the toilet 3 or more times a night .[18]

A person's clinical/medical status, medication, mobility, physical environment (for example, access to toilet facilities,) and cognitive status can have an effect on their continence. Older people need to receive appropriate assessment and interventions based on best evidence to prevent the onset of incontinence or to effectively manage existing continence issues.

The Centres Promoting Health Independence (CPHI) – Improving Care for Older Persons project identified ten domains of clinical practice imperative in the holistic care of the older person. This CPHI project was undertaken in response to the perceived need to improve identification and management of incontinence among subacute in-patients. It was proposed that through identifying gaps in clinical practice and education of ward staff – medical, nursing and allied Health – incontinence could be better diagnosed and treated.

Enable NSW – provides assistance for eligible consumers requiring aids and equipment in the home to ensure safety and promote functional independence. It includes Continence Aids Payment Scheme which provides assistance for people requiring aids for continence problems to access continence products at a reduced price.

3.12 Social isolation and loneliness

Social isolation and loneliness can be an issue for individuals of any age, however for older people it is often exacerbated by social circumstances such as living alone. Overall, 2 in 5 (45%) people live alone, and the likelihood is increasing with age—(39%) of people aged 65–74, (40%) of people aged 75–84, and (51%) of those 85 and over live alone. Women were also more likely to live alone (53%), compared with (34%) of men.

Physical problems such as impaired mobility, foot health, balance, osteoporosis, chronic pain, visual and hearing impairment, incontinence and malnutrition may also limit independence, wellbeing and social engagement. Inadequate access to transport can exacerbate this. Long periods of social isolation and/or loneliness can have a negative impact on physical and mental health and wellbeing.

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

[18] Vaughan, C.P., et al 2010. The association of nocturia with incident falls in an elderly community-dwelling cohort International Journal of Clinical Practice Apr 64(5) 577-583.

3.13 Elder abuse

Elder abuse includes physical, psychological, sexual, emotional, material or financial abuse, neglect or abandonment and may be intentional or unintentional. It violates basic legal and human rights. Older people need to be able to live with dignity and security and be free from abuse.

In that respect, carers need to receive adequate information, education and support at the time the person is registered for care to reduce the risk of elder abuse. Education and training programs on the recognition, intervention, and management of elder abuse should be available to all health professionals involved in the care of older people.

Medical practitioners, especially GPs, have a pivotal role in the recognition, assessment, understanding and management of elder abuse, with effective and available reporting mechanisms to allow action when required. [19]

3.14 Demand for rehabilitation services

Longer life expectancies and increasing survival rates for those with severe disability, coupled with the rising prevalence of chronic diseases means that there will be an increase in the health burden associated with limitations in functioning.

Rehabilitation is also an important aspect of aged care. The key principles of aged care rehabilitation include the restoration and preservation of functional status.

Older patients often become physically deconditioned following an acute illness, resulting in increased disability. Inpatient rehabilitation may be required for the more severely disabled patients. Important aspects of rehabilitation include mobility training, self-care training, and arranging appropriate services to support older patients at home.

People with complex discharge needs – many rehabilitation patients require coordination of range of community services before they can go home, including home modifications and support services. Reducing delays to the initiation of rehabilitation and to discharge once functional goals have been achieved, will further reduce length of stay and enhance patient's functioning.

Brain Injury Rehabilitation

In NSW, over 100,000 people currently have a brain injury. Over 1,000 people each year sustain a traumatic brain injury and experience long-term disability. Causes of traumatic brain injuries include external events such as motor vehicle accidents, falls, assaults, sporting accidents or blows to the head. Traumatic brain injury (TBI) commonly affects younger people and causes life-long impairments in physical, cognitive, behavioural and social function. The needs of people with a traumatic brain injury are unique, in terms of their length of stay and behaviours. In particular, the younger male with a brain injury may be aggressive and have other challenging behaviours which mean that they are unable to be catered for in a general ward.

[19] Australian Medical Association (AMA) Position Statement 2015.

People who have had stroke and transient ischemic attack (TIA)

Stroke as a principal diagnosis makes (11%) of CVD related hospitalisations after coronary heart disease (28%) and heart failure and cardiomyopathy (12%).

The stroke incidence increases with age, with rates for males and females highest in the 85 and over age group (3,000 and 2,600 per 100,000 population) —around 1.6 times as high as those in the 75–84 age group among males (1,900 per 100,000) and 2 times as high among females (1,300 per 100,000).[20]

Stroke is the leading cause of chronic disability in adults in Australia. Almost all patients require rehabilitation services after an acute episode of care for stroke. For at least a year after the stroke occurs, people will, to varying degrees, require assistance with activities of daily living, with mobility and with managing a speech impairment. Rehabilitation of these patients should commence in the acute setting, with continued multi-disciplinary rehabilitation provided in either a sub-acute, community or home based setting depending on individual circumstances.

People with spinal cord injury

Spinal cord injury (SCI) can occur as a result of a trauma such as a fall, car accident, medical condition such as spina bifida, stroke or Friedreich's Ataxia, or as a result of other back and spine conditions. Approximately (80%) of newly reported spinal cord injury cases are due to traumatic injury (i.e. accident related) and (21%) are non-traumatic. This group consists of medical conditions such as vascular disorders, degenerative spinal conditions, genetic disorders and cancerous lesions.

SCI were most frequent in 15-24 year old age group (accounting for 30%). There is also an increase in the 65-74 year age group sustaining a SCI. The extent of a spinal cord injury is relative to the extent of neurological damage, which is either 'complete' or 'incomplete' and to the level of the spinal cord that is affected. The extent of the neurological damage provides a predictor for recovery, but the vast majority of people with a spinal cord injury have long-term neurological loss.[21]

SCI injuries cause significant hardship and disability to victims and their families, resulting in life-long care and loss of productivity. Acute spinal cord injury (SCI) services are based at Prince of Wales and Royal North Shore Hospitals. These services also offer specialist SCI rehabilitation, predominantly for people with traumatic SCIs. SWSLHD manages patients with a non-traumatic SCI in general rehabilitation wards.

People with deconditioning rehabilitation and general/neurological rehabilitation needs

Rapid deconditioning resulting in disability is recognised serious complication with acute illness, with a cohort of patients requiring the intensity of a multi-disciplinary rehabilitation service. Patients with a diagnosis of Multiple Sclerosis, Parkinson's disease, Huntington's disease, Guillain-Barre Syndrome and other medical or neurological conditions that are complicated by acute illness may also benefit from a period of in-patient multidisciplinary rehabilitation. The expertise of Geriatricians and Rehabilitation Consultants is required for the care of these patients in conjunction with the other multidisciplinary team members.

[20] Australian Institute of Health and Welfare analysis of ABS 2019.
[21] Australian Spinal Injury Alliance: Facts and Statistics.2019.

People who had undergone an amputation

Amputation is an acquired condition that results in the loss of a limb, usually from injury, disease, or surgery. The causes for amputation may include any of the following:

- Congenital (present at birth): limb deficiency occurs when an infant is born without part or all of a limb.
- Diseases: such as blood vessel disease (called peripheral vascular disease or PVD), diabetes, blood clots, or osteomyelitis (an infection in the bones). People with diabetes are around 23 times as likely to have a leg, foot or toe amputation as those without diabetes and around 85% of diabetes related amputations are preventable if identified and treated early. Across NSW, Aboriginal people are more likely than other Australians to have a lower limb amputation.
- Injuries: especially of the arms. 75 % of upper extremity amputations are related to trauma.
- Surgery: to remove tumors from bones and muscles.

Over the three years 2014/15 to 2016/17, residents of SWSLHD had 507 diabetes-related lower limb amputations of some form (an average of 169 per year). Of the lower limb amputations, more than three quarters were toe, foot or ankle amputations. The projections indicate by 2031 the number of lower limb amputations per year will reach 300 unless there is a significant investment in diabetes prevention and early intervention services. However, this may also be impacted by changes to vascular surgery treatments with the aim of preserving limbs.[22]

Loss of a limb produces a permanent disability that can impact a patient's self-image, self-care, and mobility (movement). Amputees NSW – provides a range of information and support services for people who become amputees, including peer support groups.

People on dialysis needing rehabilitation

Diabetic nephropathy may progress to end stage kidney disease, requiring dialysis to prevent or delay death. In SWSLHD, of the 696 patients who commenced dialysis in the period 2012 – 2017, 230 (33%) had diabetic nephropathy recorded as the primary cause for requiring dialysis. Of these people, 552 (79%) were aged between 25 and 74. Asian people and people from the Pacific Islands were overrepresented in the proportion of people undergoing dialysis. Projections indicate that by 2030/31, 380 SWS residents will require dialysis, an increase from 215 in 2017/18.

There is a need for special consideration of patients who are undergoing dialysis and simultaneously having underlying rehabilitation needs.

Renal rehabilitation was defined as “coordinated, multifaceted interventions designed to optimize a renal patient’s physical, psychological, and social functioning, in addition to stabilizing, slowing, or even reversing the progression of renal deterioration, thereby reducing morbidity and mortality.

[22] SWSLHD and SWSPHN 2020: Diabetes Framework to 2026.

Intellectual disability

Over half a million Australians have intellectual disability and a majority (61%) of those people have a severe or profound limitation in 'core' activities of daily living: self-care, mobility and communication. Speech problems were the most common problems reported by people with intellectual disability in 2003 (24%).[23]

People with intellectual disability are a major group of users of disability support services in Australia. There is an increasing number of people with a lifelong developmental and/or intellectual disability living longer than in previous decades. The demands for health and support services to assist people to live independently is increasing. Further, as people with an intellectual or developmental disability age, they also acquire age associated conditions (such as dementia) and experience other comorbidities.

Expertise is required to respond to the needs of this emerging group of clients, along with the needs of their carers (who are often parents and also ageing).

[23] Australian Institute of Health and Welfare 2008. Disability in Australia: intellectual disability. Bulletin no. 67. Cat. No. AUS 110. Canberra: AIHW.

4. Key drivers, issues and challenges

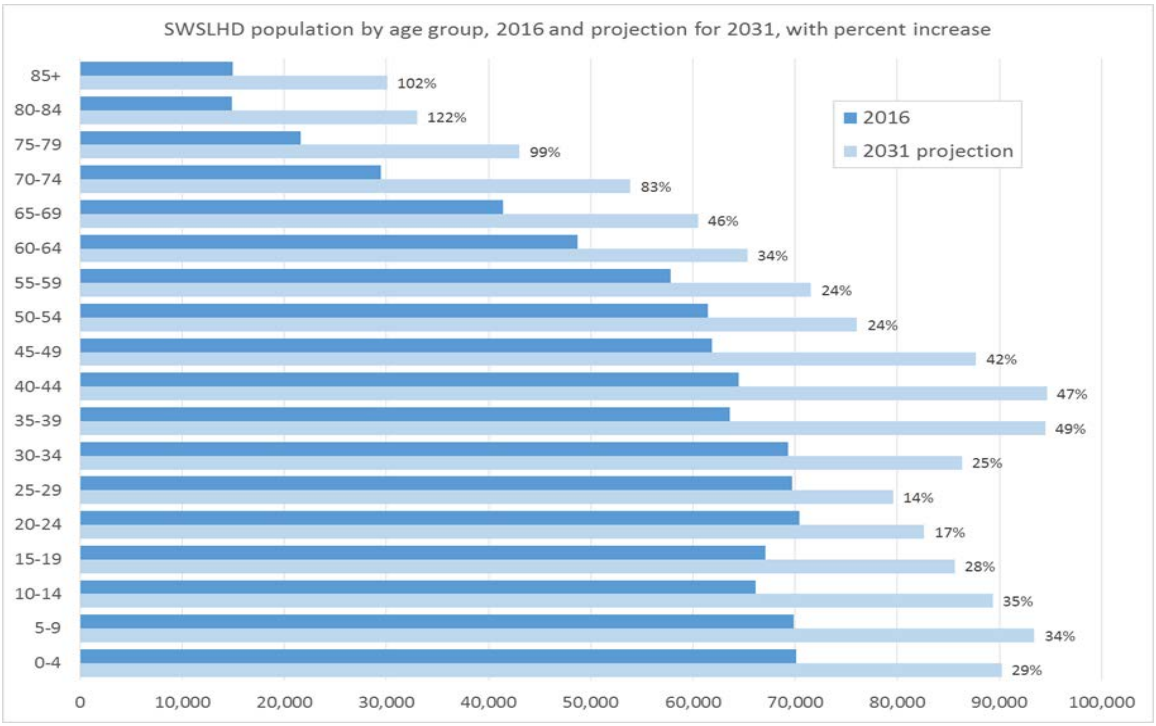
There are a number of key drivers shaping the planning for older persons and rehabilitation services in SWSLHD. While demographic and population trends and significant facility and service planning processes and evolving models of care have been identified as critical components, there are a number of other issues and challenges which require consideration during planning process.

4.1 Population growth and demographic information

The SWSLHD covers an area of 6,243 km across seven Local Government Areas (LGAs) of Bankstown (now part of Canterbury-Bankstown), Camden, Campbelltown, Fairfield, Liverpool, Wollondilly and Wingecarribee.

There are over a million people living in the South Western Sydney, making up 12% of the NSW population. Over the next fifteen years, population is projected to increase to over 1,317 million people mainly due to increasing number of births and decreasing number of deaths.

Figure 2: Population growth in SWSLHD by age groups, 2016 and 2031



Source: NSW Department of Planning, Infrastructure and Environment. NSW 2019 Population Projections

The SWSLHD population has experienced a 1.7 year gain in life expectancy in the latest decade. Between 2006 and 2016, life expectancy has increased the most in Fairfield and Liverpool and least in Wingecarribee and Campbelltown LGAs. The SWSLHD's mortality rate fell by 13% in the ten years to 2016.

In addition, the rapid population growth is also associated with new housing developments in the South West Growth Area and major infrastructure projects such as the Western Sydney Airport and associated aerotropolis.

Table 1: Population projections for 65 years and over, SWSLHD by LGA, 2016-2031				
LGA	No of older population 2016	% of LGA population 2016	% of SWSLHD older population 2016	No and % increase in older population by 2031
Bankstown	28,203	14	23	42,346 (38%)
Camden	8,151	10	7	23,012 (182%)
Campbelltown	18,356	11	15	34,137 (86%)
Fairfield	27,488	13	23	46,290 (68%)
Liverpool	14,056	10	18	46, 090 (114%)
Wingecarribee	12,189	25	10	16,535 (36%)
Wollondilly	6,360	13	5	12,161 (91%)
Total	122,326	100	100	220,571 (80%)

Source: NSW Department of Planning, Infrastructure and Environment. NSW 2019 Population Projections

All LGAs across SWSLHD will experience a substantial population growth. The most significant growth will be in Camden and Liverpool LGAs.

Growth in the proportion of older people in Australia is partly due to increasing life expectancy: in 2017, a 65-year-old man in SWSLHD could expect to live another 20 years and a 65-year-old woman another 22.6 years.

4.2 Ageing population

Older adults are those aged 65 years and over for non-Aboriginal and 50 years and over for Aboriginal population. This reflects the life expectancy gap between Aboriginal and non Aboriginal Australians. The proportion of the Aboriginal population aged 65 years and over (4.8%) is lower than the proportion of non-Aboriginal Australians (13.2%).

It is estimated that 122,326 people over 65 years of age were living in SWSLHD in 2016.

Proportionally, the largest distribution of older people across SWSLHD is in Bankstown and Fairfield LGAs, followed by Liverpool LGA, while proportionally about (25%) of Wingecarribee LGA population are people over 65 years of age. The District will experience a significant growth of (80%) in a number of older people, an additional 98,245 people. It is estimated that the fastest growing age groups are projected to be the 80-84 age group (122%) and the 85 years and older age group (102%), followed by 75-79 age group (99%) and 70-74 age group (83%). Geographically, the most significant increase will be in the Macarthur region: Camden (182%), Campbelltown (86%) and Wollondilly (91%) LGAs; followed by Liverpool LGA (114%).

4.3 Polypharmacy

Medicines are an essential component of clinical care for many older patients. On the basis of the analysis of a nationally representative sample of Pharmaceutical Benefits Scheme (PBS) prescribing data, it is estimated that about 935 000 Australians aged 70 years or more were using five or more

medicines during both of two 3-month periods of 2017. Rates of polypharmacy were highest among those aged 80–84 years (44%) and 85–89 years (46%), the researchers reported.

Polypharmacy can be appropriate, but there is substantial evidence for its potential harm and the importance of rationalising unnecessary medicines, particularly in older people.

Using several medicines concurrently – polypharmacy, places older people at risk of harm, including from adverse drug reactions, and is associated with poor clinical outcomes, including nutritional deficiencies, falls, frailty, impaired cognition, more frequent hospitalisation, and premature mortality. Adverse medication reactions account for around 3% of all hospital admissions, around 50% of which are preventable. Unplanned readmission to hospital following discharge is also a major problem in the elderly, with 29 to 35% of unplanned readmissions medication related.

Medical practitioners are increasingly aware of the high risk of harm for older people associated with polypharmacy, and the need for strategies for consolidating management of patients with chronic diseases and for deprescribing inappropriate medicines is recognised.

Clinicians often cited patient resistance as a barrier to deprescribing, but this was often not the case. Recent questionnaire *Patients' Attitudes towards Deprescribing* conducted by the University of Sydney had shown that nine in ten patients would be willing to stop one or more of their medicines if their doctor told them it was safe to do so. A lot of the clinician barriers seem to be around having time to prioritise a medication review within a routine consultation.[24]

Quality Use of Medicines is a focus of the *National Medicines Policy* and involves selecting treatment options wisely and improving medicine use, including prescription, non-prescription and complementary medicines, by health professionals and consumers. It also ensures that patients and carers and family members are afforded the knowledge and skills to use medicines safely and effectively. It is important to work with GPs and the primary care sector to ensure regular medication management reviews. *The National Strategic Action Plan to Reduce Inappropriate Polypharmacy (2018)* aims to reduce harmful or unnecessary medicines use by older Australians by 50% over 5 years.

Use of complementary and alternative medicines

Recent research suggests that the older people are more frequent users of complementary and alternative medicines (CAMs) than the general population—up to 80% have reported using at least one CAM on a regular basis in the past year. Use of CAMs in the older people represents significant challenge as this population is burdened by polypharmacy, decreased functional reserve and chronic disease. Preventing adverse reactions and drug interactions associated with CAM use is complicated by the fact that fewer than 50% of older patients disclose CAM use to their doctor or pharmacist.[25]

[24] Amy T Page, Michael O Falster, Melisa Litchfield, Sallie-Anne Pearson and Christopher Etherton-Beer. Polypharmacy among older Australians, 2006–2017: a population-based study. Med J Aust 2019; 211 (2): 71-75.
[25] Complementary and Alternative Medicine Use in the Elderly Geraldine Moses J Pharm Pract Res 2005; 35: 63-8.

Improved health literacy will enhance appropriate use of health services and ultimately enable older Australians to engage in taking an active role in their health and reducing the potential for adverse health outcomes.[26]

4.4 Immunisation

Immunisations for older adults are an important part of preventive care. Three common but potentially dangerous diseases that older people should be vaccinated against are influenza, pneumococcal disease and shingles (herpes zoster). Booster vaccinations against tetanus, diphtheria and whooping cough are also recommended for older people.

Influenza and pneumonia are acute respiratory diseases that can be very severe and, in persons at high risk, can lead to death. The great majority of deaths from influenza and pneumonia in Australia in 2018 were in persons aged 65 years and over (92%).

In 2018-19, about 75% of people aged 65 years and over in SWSLHD self- reported that have been immunised against influenza, similar to the whole NSW (76%).[27]
Increasing immunisation rates amongst older people may prevent deaths and reduce potentially avoidable hospitalisations, and improve overall health outcomes for older people. GPs are generally responsible for the delivery of these immunisations in the community and in residential care at no charge under the National Immunisation Program (NIP).

4.5 Demand for surgical and procedural services

The number of older people undergoing both elective and emergency surgical interventions in SWSLHD is increasing. In the last ten years to 2017, the demand for surgical services for people over 65 years of age has increased by 26% compared to 17% for adult population (15-64 years old). There is strong evidence that both frailty and cognitive impairment are important determinants of outcome in older people undergoing surgical intervention.

Orthogeriatric models of care are established locally within some variations between sites, on the basis of improving functional outcomes, and reducing complications, mortality and length of stay (LOS). There have been significant improvements in the care of the older hip fracture patient, resulting from joint working between geriatricians, orthopaedic surgeons and anaesthetists.
There is a need to standardise geriatric medicine input into the care of older surgical patients throughout the District.

Evidence to support the role of geriatricians in other surgical settings has been increasing recently.
Both Prince of Wales and Nepean Hospitals have established Care of Older People in Surgery (COPS) services in recent years, based on Orthogeriatric model, and with similarly positive results.

[26] Caroline A. Smith, Esther Chang, Suzanne Brownhill, and Kylie Barr. Complementary Medicine Health Literacy among a Population of Older Australians Living in Retirement Villages: A Mixed Methods Study. Volume 2016.
[27] NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health

4.6 Care integration

Clinical networks have been expanding across SWSLHD and the strengthening and enhancement of these networks is a prime focus of the Clinical Streams. As people age, there is an increase in chronic and complex conditions such as cancer, cardiovascular disease (heart, stroke and blood vessel disease), diabetes, respiratory diseases such as Chronic Obstructive Pulmonary Disease (COPD), arthritis and osteoporosis, dementia, and mental health issues. Ageing and long term and complex conditions are the key drivers for care integration.

An integrated primary and community care model has long been identified as a future direction for the District. This would provide comprehensive services across primary, community, hospital and other health related services, linked along the continuum to provide seamless patient care.

People with, or at risk of developing, one or more chronic conditions can benefit from access to rehabilitation to reduce the impact on, and rate of, functional decline. Access to rehabilitation for people that may not be eligible for disease-specific rehabilitation programs and services requires a committed workforce and system to engage people in their own care. Flexible delivery options and tailored interventions are at the core of rehabilitation for chronic conditions.

The Integrated Health Neighbourhood (IHN) approach involves a shift from inpatient models to ambulatory, primary (GP) and community models and non-hospital services to decrease admission rates and length of stay for some groups of patients as well as reduce reliance on hospitals as the major providers of health care.

A proposed feature of an IHN in the SWSLHD is the Integrated Health Hub (IHHub) which would deliver a comprehensive range of clinical services that can support 'stepped-up care' for local primary care providers and, where possible, outreach models of care for clinical services traditionally delivered from hospital sites. Partnerships are crucial to delivering better population health for older people and it is important that SWSLHD Aged Care and Rehabilitation Services keep working along an array of health and social care partners, including South Western Sydney PHN, GPs, Ambulance NSW, local Councils, other Government health and social care agencies, and non-government and community-managed organisations.

4.7 National Disability Insurance Scheme and younger people with disability

The introduction of the National Disability Insurance Scheme (NDIS) has created a number of challenges associated with the policy in relation to the eligibility and access to services for people with disability under 65 years of age. The number of people admitted to SWSLHD facilities identified as needing NDIS supports has grown significantly since introduction of the NDIS.

South Western Sydney has the second-highest number of NDIS participants in the country (12,982) as recorded in June 2019, second only to the Hunter New England.

To access appropriate NDIS supports for the client, coordinated multidisciplinary and multiagency planning is required at all stages of the process between the hospital-based multidisciplinary teams

and multiple private NDIS-registered providers including Allied Health, housing, attendant care and equipment providers.

The waiting times for the complex NDIS clients to be discharged put more pressure on the hospital system and is a resource intensive process for the staff – particularly for allied health professionals.

Since the introduction of the NDIS in 2013, the SWSLHD staff have become more literate in writing for the NDIS and enhanced their skills in providing evidenced-based and goal-directed interventions to clients within the NDIS. In addition, an introduction of the NDIS Project Officer role will support the delivery of initiatives to support both carers' and the person they care for transition to the NDIS.

Safe and Supported at Home (SASH) Financial Class Program is a new state government initiative that provides disability services to individuals whose needs are not addressed by the National Disability Insurance Scheme (NDIS). Each District has a nominated SASH Co-ordinator who can assist in the identification of SASH eligible client/patients and associated business practices.

4.8 Infrastructure and technology

Existing SWSLHD facilities will need continued improvement and uplift to adapt to projected population growth and ageing and to support evolving models of care and technological advancements. Infrastructure suitable for aged care must consider the needs of frail older people and those with dementia and delirium, and be able to support the latest clinician - led models of care to allow staff to deliver effective and efficient services across all settings. Good access to suitable rehabilitation services (inpatient, home-based and ambulatory services) is also a critical component of effective, patient centred care.

The technological requirements for aged care and rehabilitation into the future needs to be considered. This includes access to telemetry, falls prevention/detection equipment and digital monitoring of older patients in hospital and at home. Delivery of telehealth care in the outpatient and community settings, particularly when carers are present; inclusive of remote case management, care coordination and care navigation. Use of Robotics in aiding the provision of therapy, and increasing intensity and assistance for patients requiring rehabilitation.

4.9 Workforce

The older persons and rehabilitation workforce comprises a range of specialist and generalist medical, nursing, allied health and technical/support staff. Taking into the account complexity of the older persons and rehabilitation services some significant workforce issues include high workloads in inpatient settings for staff of all disciplines, the ageing of the workforce, and access to ongoing training and educational opportunities. Consistently with the population growth and ageing, and changes in service delivery models, enhancements to the medical, nursing and allied health workforce should be considered. Carers are the main providers of care in the community, and have been described as the 'invisible workforce' by the National Health and Hospital Reform Commission. It is estimated that carers provide 74% of the assistance required by older people and people with disabilities.

4.10 Physical environment

In order to support healthy ageing, building supportive and enabling environments is crucial. These can help people build and maintain capacity, for example, a walkable environment may foster physical activity. But they can also provide a range of resources or barriers that determine whether people with a given level of capacity can do the things they feel are important. Thus, although older people may have limited capacity, they may still be able to get where they want and need to go if they have access to an assistive device (such as a walking stick, wheelchair, or scooter) and live close to affordable and accessible transport. This will require a coordinated response from many sectors and multiple levels of government to create age-friendly environments (housing, employment, transport, and social protection) to facilitate the ability of older people to age in a place that is best for them and to do what they value.

The unfamiliar hospital environment and disruption of normal routines and habits are significant sources of stress to older people admitted to hospital. Suitably designed aged care precincts enhance patient care and reduce potential harm. Mobility and balance difficulties as well as vision and hearing impairment are common characteristics of older patients that should be catered for in facility design e.g. ensuring enough space for walking with mobility aids as well as rest areas, providing parking and drop-off areas with limited distance to major entrances and seating.

Special consideration to be given to the needs of CALD patients, carers and families, including appropriate multilingual signage and inclusion of communication devices such as three way phones in patient areas to facilitate use of professional health care interpreters.

An increasing number of people with dementia are cared for in hospitals. A poorly designed or inappropriately set-up physical environment increases confusion and problem behaviours, slows or negates rehabilitation and contributes to the stress experienced by staff and families involved in providing care to these patients with complex needs. On the other hand, a well-designed environment can reduce confusion and agitation, improve orientation, encourage social interaction, reduce depression and speed healing.[28]

Further information regarding appropriate environments to care for people with dementia is available from Alzheimer's Westerns Australia and Key Principles for Improving Healthcare Environments for People with Dementia.

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

4.11 Advance care planning and end of life care

With an ageing population and growth in chronic health conditions, there is an increasing demand for end of life and palliative care services.

[28] ACI Aged Health Network. Key Principles for Improving Healthcare Environments for People with Dementia.2014

Advance Care Planning (ACP) provides the opportunity for people to plan ahead for health care related decisions for a time when they may not have capacity to make decisions for themselves. Ideally, advance care planning should begin when a person is still well, such as during the assessment phase, and when there is a change in prognosis. This process has benefits for the individuals and families, clinicians and the broader health service system, including ensuring patient's wishes are known and respected, assisting clinicians to provide person-centred care and optimising the use of health resources.

Increasingly, Advance Care Planning and the use of Advance Care Directives is recognised as a fundamental component of health service delivery, particularly for frail, older people who often have progressive and ultimately, terminal, conditions. Multidisciplinary teamwork and partnerships with GPs/PHN, Telehealth, pathology/imaging, ED, ACT, HITH, Older Persons Mental Health, NSW Ambulance, SLHD Palliative Care services, PHU (outbreak management) and regular RACF DONs meetings - all have a potential role in increasing the uptake of ACP. Service providers, such as GPs, should include advance care planning as early as possible in the rehabilitation for chronic conditions process for all diagnostic groups and acuities.

Advance care planning can include the following:

- Conversations between a person and their family, carer and/or the health professionals who care for the person about the person's wishes for future care. These conversations can be documented in an advance care plan.
- Appointing an enduring guardian who can legally make decisions on a person's behalf about medical and dental care, if the person loses the capacity to make the decision.
- Making an advance care directive involves documenting a person's specific wishes and preferences for future care including treatments they would accept or refuse if they were reaching the end of life. It is to be used where the person does not have capacity to make or communicate the decision.
- In SWSLHD, the electronic medical record (eMR) and admission and discharge forms will be modified to enable clinicians to recognise and respond to patient's decisions for end of life care and to inform patient decision making - currently have advance care tab – cover sheet and directive get uploaded in that tab.

End of life care is the responsibility of all clinicians who are treating and caring for people with progressive life limiting disease with a focus on optimal care.

NSW Health has developed *End of Life and Palliative Care Framework 2019-2024*. A model for end of life care has been developed by the NSW Agency for Clinical Innovation, which supports clinicians to deliver care in the last year of life.

The Palliative Extended and Care Home (PEACH) program provides care packages to palliative care clients in selected LHDs within NSW, including SWSLHD. This program aims to support palliative care clients in the last days of their life in their own home.

The Program targets individuals of all ages who are known or referred to local Palliative Care Services; who are in the terminal phase of their illness and who reside within one of the five participating LHDs.

The *SWSLHD Advance Care Planning, End of Life and Palliative Care Strategic Plan 2016 - 2021* recognises that most patients can be successfully cared for by their treating doctor with adequate training, the right tools and when required, access to a palliative care consultative service. The Plan provides guidance around the systems, processes and education that all clinicians require to build their capacity to meet patient needs.

5. Priority Population Groups

This Plan recognises that some individuals and communities are experiencing disadvantage and are requiring additional support, include the following groups. The provision of care to priority population groups is supported by the District specific plans and policies.

5.1 Aboriginal and Torres Strait Islander peoples

This Plan will recognise the exceptional needs of Aboriginal and Torres Strait Islander peoples (herein referred to as Aboriginal people). As per an estimated population count in 2016, there are 20,000 Aboriginal peoples residing in SWSLHD. (See Section 12. Data and Activity, Figure 2: Aboriginal and non-Aboriginal population in SWSLHD by age group and gender, 2016).

Aboriginal people across NSW, and in SWSLHD experience higher rates of physical and mental ill health than other residents. Long term health conditions affect almost 9 in 10 (88%) of Aboriginal people over the age of 55, with higher risks of certain conditions including diabetes, cardiovascular disease and respiratory disease.

The proportions of the Aboriginal population that are aged 65 and over, and 85 and over, are considerably smaller than equivalents for the non-Aboriginal population, reflecting the higher mortality rate and lower life expectancy of Aboriginal population.

Older Aboriginal people tend to have higher rates of disability than other Australians. In the 2016 Census, just over 1 in 4 (27%) older Aboriginal people reported a need for assistance with core activities (self-care, mobility or communication tasks), compared with (19%) of other Australians aged 65 years and over.

Older Aboriginal peoples and Elders hold a unique position of respect, leadership and status within their families and communities. The connectedness of older Aboriginal people to family, community and Country are important considerations for service provision.

Developing and maintaining partnerships and collaboration with Aboriginal Elders and Elders groups, is fundamental to providing culturally appropriate services to older Aboriginal people that are responsive to their needs. Aboriginal peoples tend to need aged care services earlier than many other Australians.

Nationally, older Aboriginal and Torres Strait Islander peoples have proportionally higher representation in home care services and proportionally lower representation in residential care services relative to the total aged care target population due to issues with institutional care for some people .[29] The age profile of Aboriginal Australians in permanent residential aged care was

[29] Australian Department of Health, *2017–18 Report on the Operation of the Aged Care Act 1997*. Canberra: Australian Department of Health, 2018, p. 63.

substantially younger than that of their non-Aboriginal counterparts: 1 in 4 (26%) Aboriginal Australians in care were aged under 65, compared with (3%) of non-Aboriginal Australians.[30]

5.2 People from culturally and linguistically diverse backgrounds

South Western Sydney communities are culturally and linguistically diverse with 43% of residents born overseas compared with 34.5% for NSW. It encompasses residents from more than 120 countries of birth who speak over 80 languages and span all ages. Arabic is the most commonly spoken language other than English (LOTE); spoken by over 86,751 people from 25 different countries, followed by Vietnamese (spoken by 71,000 people) and Mandarin/ Cantonese (spoken by 39,500 people). South Western Sydney is also home to the large proportion of newly arrived refugees settling to NSW. The research paper on *Accessing disability services by people from culturally and linguistically diverse backgrounds in Australia,* finds that the rate of access of specialist disability services by people with disability from CALD backgrounds is highly disproportionate to their presence in the community and that as a whole, people from CALD backgrounds have a similar level of disability as Australia-born people but have a greater rate of profound and severe disability and a higher level of need for assistance in undertaking core activities. Rehabilitation is a large component of disability services. Therefore, understanding the gap, promoting the awareness of the services, developing appropriate and effective services to respond the need of people with disability from CALD backgrounds, are critically important to rehabilitation services. [31]

Table 2: SWSLHD residents over 65 years of age speaking a language other than English at home who speaks English 'not well' or 'not at all: number and proportion, 2016

Language	n	%
Vietnamese	4243	17.9
Arabic	3090	13.0
Cantonese	2100	8.8
Italian	1780	7.5
Spanish	1518	6.4
Mandarin	1460	6.1
Greek	1233	5.2
Assyrian Neo-Aramaic	1110	4.7
Serbian	926	3.9
Khmer	736	3.1

Source: ABS Census 2016

Of SWS residents with a primary language other than English, (10%) or 92,461 people have limited English proficiency (self-reported of speaking English 'not well or not at all') compared to (4.5%) for NSW. Among people over 65 years of age, (19.6%) self-reported of speaking English 'not well or not at all'. English language proficiency varies across language groups in SWS with around 18% of Vietnamese speaking and 13% Arabic speaking residents reporting they "speak English not well or not at all", as per side table.

Previous studies have reported that individuals with limited English language proficiency have more difficulty in gaining access to health care compared to English proficient individuals.

Many overseas-born Australians face substantial barriers in accessing and engaging with the essential supports and services that contribute to good outcomes.

[30] Australian Institute of Health and Welfare (AIHW) 2018. National Aged Care Data Clearinghouse: AIHW analysis of unpublished data.

[31] Qingsheng Zhou. Accessing disability services by people from culturally and linguistically diverse backgrounds in Australia. Disability and Rehabilitation International Multidisciplinary Journal. 2015

In general, older people from CALD backgrounds:

- have poorer socioeconomic status, compared with the older Anglo-Australian population
- may face substantial language barriers in accessing services (including reverting to language of birth as a result of dementia)
- might be having differing cultural/religious practices and norms, leading to lack of understanding of and barriers to service use
- lack of social supports and/or family networks
- former or current refugee status and potentially unrecognised accumulative trauma across the lifespan can have a profound impact on their health, the way they will access services and the way aged care services are provided.

As a result of age-related memory loss, older refugees may also lose English language skills and revert to their first or other language. If bilingual staff or interpreters are not made available from the earliest assessment time, the patient's confusion is likely to be heightened. Language is a crucial factor in determining a client's needs and abilities - a reliable aged care assessment of a non-English speaker cannot be made without a professional interpreter. Interpreter and translational services provided by SWSLHD Health Language Services are key support services for clinical care and are located in major hospitals. In addition to a phone and video call services, interpreters work in inpatient, outpatient and community settings.

Understandings of dementia vary immensely across different CALD communities. Poor dementia awareness can create stigma, and this can lead to greater social isolation and delayed help-seeking.

Understanding cultural differences in approaches to dementia, the role of ethnicity or migration experience in disease risk, and attitudes towards care are important elements of Australia's research program to address the challenges that dementia presents for Australia's ageing population.[32]

5.3 People living with disability

Disability can be acquired at birth or early in life, or as the result of accident, illness or injury throughout life. Almost 62,000 people in SWSLHD reported that they had a profound or severe disability which required them to have assistance with at least three core activities. The proportion of the SWSLHD population with a profound disability (6.5%) was (22%) higher than in NSW (5.4%) and (13%) higher than in Australia (5.8%). There is a variation across SWSLHD in the proportion of people living with disability.

The proportion of people living with disability is the highest in Fairfield and Bankstown LGAs (8.5% and 7.0%, respectively) and the lowest in Camden and Wollondilly LGAs (4.3% and 4.6%, respectively).

Compared to people without disability, people of working age with a severe or profound disability are more likely to rate their health as poor or fair (50% compared to 6%); three times more likely to report

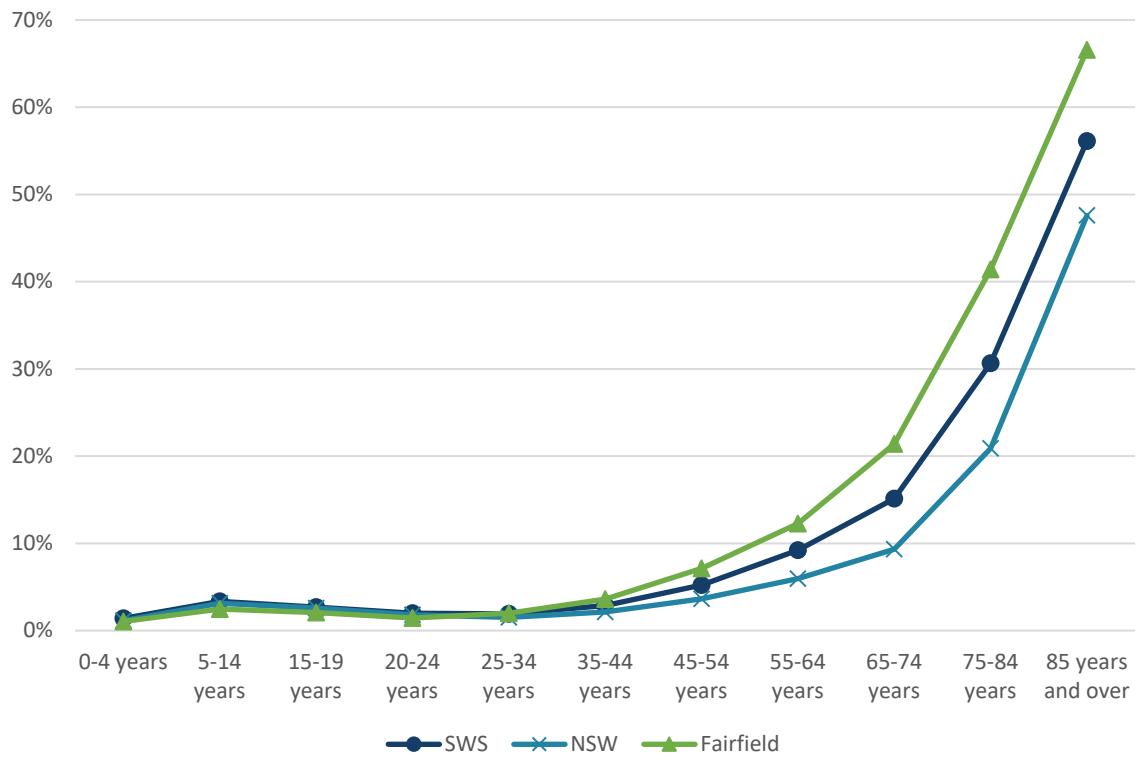
[32] The NHMRC National Institute of Dementia Research (NNIDR) Culturally and Linguistically Diverse (CALD) Dementia Research Action Plan.

three or more long term health conditions; more likely to report a mental health condition (50% compared to 8%); four times as likely to have arthritis; twice as likely to smoke; and much more likely to experience high psychological distress (22% compared to 1%).[33]

The proportion of the population living with disability increases considerable with age. The *2015 ABS Survey of Disability, Ageing and Carers* reported that 50% of men and 52% of women aged 65 and over had some form of disability. This proportion was higher for those aged 85 and over, with four in five experiencing disability. About half of people living with profound or severe disability in SWSLHD were aged 65 years and older and a further (38.5%) were aged 20-64 years.

- Fairfield LGA has significantly higher proportion of people with disability over 55 years of age compared to other LGAs in SWSLHD.
- It is estimated that about 1,559 Aboriginal people or (9.4%) of Aboriginal population in SWSLHD are living with disability.

Figure 3: Proportion of population reporting a profound or severe disability by age group in SWSLHD, NSW and Fairfield LGA, 2016



Source: Australian Bureau of Statistics (ABS), Census of Population and Housing 2016.

Some clinical streams and services have a stronger focus on people with disability or carers providing assessment, treatment, case management and/or referral to general practitioners and community services including:

[33] Australian Institute of Health and Welfare, Health status and risk factors of Australians with disability 2007–08 and 2011–12 Cat. No. DIS 65. AIHW: Canberra 2016.

- SWSLHD Aged Care Services and Rehabilitation Services
- SWSLHD Mental Health Services
- SWSLHD Paediatrics and Neonatology
- SWSLHD Carers Program
- Liverpool Brain Injury Unit
- SWSLHD Palliative Care[34]

5.4 People who identify as lesbian, gay, bisexual, transgender or intersex

Collectively, Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people are recognised as a specific minority population group. Individually, they come from all walks of life and are part of all other population groups. How LGBTI people identify themselves is influenced by many factors, including their age, ethnicity, socioeconomic position and their lived experiences and relationships with others. Data on LGBTI communities are not generally collected.

Health and access to health care services are adversely affected by social marginalisation, with up to 30% of LGBTI adults not seeking health care services or lacking a regular health service provider, compared with 10% of the non-LGBTI population. [35]Older Australians who identify as LGBTI have lived through a period of social and cultural transition. Many have likely suffered first hand stigma, discrimination, criminalisation, family rejection and social isolation. The rights of people who identify as LGBTI have substantially improved over the last 50 years; however, accessing appropriate services remains difficult for many older LGBTI Australians.

The National LGBTI Ageing and Aged Care Strategy addresses the need for change in aged care services, to promote equitable access to high-quality aged care for all people who identify as LGBTI. This includes initiatives such as a full inclusion, empowerment, and consultation.[36] Over time, it may be more possible to measure access and quality of services for older Australians who identify as LGBTI and their families and carers.

5.5 People who are homeless

Lack of affordable housing is the major cause of homelessness. People who are homeless include those sleeping rough, living in caravan parks and boarding houses, staying with family and friends as their only housing option, and those accessing the Specialist Homelessness Services (SHS) program. It is estimated that about 5,700 people are homeless or living in insecure housing across the SWSLHD and 912 people are aged 55 or over. Homelessness and particularly the disadvantages associated with it—can contribute to premature ageing through earlier onset of health problems more commonly associated with later life. In the context of people who are homeless, the population of 'older people' is commonly defined as those aged 55 and over.

[34] SWSLHD Disability and Carers Strategy 2017-2022.Sydney 2017.
[35] Pitts, M., Smith, A., Mitchell, A., & Patel, S., Private Lives: A Report on the Health and Wellbeing of GLBTI Australians. Australian Research Centre in Sex, Health and Society, La Trobe Melbourne. 2006.
[36] Department of Social Services (DSS) 2012. National lesbian, gay, bisexual, transgender and intersex (LGBTI) ageing and aged care strategy. Canberra: DSS.

Homelessness is a growing problem for older Australians, and will likely continue to increase over time due to an ageing population and declining rates of home ownership among older people. Over the last decade, the number of older homeless people increased by (49%), with the largest changes measured in people aged 65–74 and 55–64.[37] Although older women don't account for the majority of homeless people, they represent a rapidly growing demographic in the homeless population— increasing by (31%) from 2011. Factors such as domestic violence, relationship breakdown, financial difficulty and limited superannuation can put older women at risk of homelessness.

5.6 People who are living in outer metropolitan and regional areas

Approximately (9%) of residents live in metropolitan fringe of Wingecarribee and Wollondilly LGAs, many in smaller towns and rural properties experience geographic isolation and transport disadvantage. Due to geographical disparities, many people with profound or severe disabilities experience considerable delays in rehabilitation treatment, resulting in threats to quality of life. Compared to the rest of SWS population, Wingecarribee residents tend to be older with (17%) of the population over 70 years of age. Wingecarribee LGA has the highest proportion of lone person households in SWS (26%) which is higher than the rest of NSW (23.8%). As people age, their use of health services increases and the "rurality" of these residents will become increasingly important.
Car ownership (at least one car) in Wingecarribee (88.5%), Wollondilly (90.4%) and Camden (91.9%) is above the state level (82.6%) and Regional NSW (84.7%).

The Index of Relative Socioeconomic Disadvantage (IRSD) ranks geographic areas across Australia according to their socio-economic characteristics, such as low income, high unemployment and low levels of education. Although the Index indicates that both Wingecarribee and Wollondilly LGAs are comparatively advantaged (1022 and 1030, compared to Australian average of 1000), there are areas which experience greater disadvantage, in part associated with their rurality. Towns which fall below the 1000 reference point include Welby (933), New Berrima (943), Tahmoor (968), Menangle Park (986), Hilltop (988) and Moss Vale (998).

5.7 People experiencing socioeconomic disadvantage

Socioeconomic status of South Western Sydney residents based on Socioeconomic Indexes for Areas (SEIFA) indicated that following LGAs: Fairfield (856), Campbelltown (948), Canterbury-Bankstown (961) and Liverpool (972) have lower than average (1000) score.

Fairfield LGA is the most disadvantaged LGA in Sydney metropolitan region and the 4th most disadvantaged in NSW. In Australia, rates of chronic conditions are generally higher in areas of socioeconomic disadvantage. For example, people living in areas of highest disadvantage are more than twice as likely to have diabetes compared to those with the least disadvantage.

[37] Australian Bureau of Statistics (ABS) 2018. Census of Population and Housing: Estimating homelessness, 2016. ABS cat.no. 2049.0. Canberra: ABS.

People experiencing socioeconomic disadvantage are further impacted by difficulties in meeting the costs associated with chronic disease management, including access to rehabilitation and the cost of equipment and consumables, access to private allied health providers and medical services.

In 2014-15, only 44% of SWS residents had private health insurance cover, compared with 52% for NSW. Private health insurance rates were significantly lower in Fairfield (26%) and Campbelltown (35%) LGAs compared to NSW. The proportion of people with private health insurance cover among people over 65 is much lower and almost negligible for 85 years old.

5.8 Carers

A carer is usually a family member or friend who provides ongoing support to children or adults who have a disability, mental illness, chronic condition or who are frail aged. They may care for a few hours a week or all day, every day. Carers are not paid but may be eligible for government income support. The person providing the most care is often called the primary carer.

Carers are often one of the greatest advocates for people with disabilities, providing practical and emotional support to help them live their best life. Carers may help their family members or friends in diverse areas, including: mobility, communicating, medication management, caring for wounds, reading, writing, meals and household chores, property maintenance and transport, as well as promote social interaction and psychological wellbeing. Carers often have to learn about the health conditions of the person they provide care for, support decision-making, and navigate aged and health care systems.

Carers play a vital role in supporting their family members to join the NDIS, set their goals and use their NDIS plan effectively. In addition to the government-funded programs available to support carers, NDIS funding can support respite by giving carers short breaks from their caring responsibilities.

The SWSLHD Disability and Carers Strategy 2017-2022 captures the LHD's commitment to improving access to services and facilities and provides a broad set of strategies to better meet the needs of patients, community and staff with a disability as well as carers and staff members who also have carer responsibilities.

According to the Carers NSW: Carers from culturally and linguistically diverse backgrounds experience similar impacts of caring with "mainstream" carers including isolation, stress, burnout and the need for support. They don't not necessarily identify themselves as carers perceiving their role as "a duty" not as a choice. Cultural and language issues serve as additional challenges in their already difficult role.

Aboriginal peoples are more likely to be caring for another person with a disability, long-term illness or ageing related problem than non-Aboriginal Australians. The median age of Aboriginal carers is 37 years, 12 years younger than the median age for non-Indigenous carers.

Many Aboriginal carers accept caring as a normal part of family and community life and may not think of themselves as carers. As a result, some carers may not be aware of the resources and support programs available for Aboriginal carers.

Carers often experience health and wellbeing and financial difficulties. Some carers may also need help themselves, with ageing carers being more likely to have such needs. In addition, as carers of older people are ageing themselves they need more supports in their caring role.

Formal services and supports available to carers of older people in Australia are largely delivered by home care and respite services, subsidised through aged care programs, and complemented by resources such as education and counselling. Given the large number of family members and friends providing care to people over the age of 65 years, it is clear that the value of these services is significant and critical from the perspectives of the both client and services.

Carer Gateway is a national online and phone service that provides practical information and resources to support carers. The interactive service finder helps carers connect to local support services.

6. Older Persons Services

The goals of aged care services are to help older patients to have good quality of life, to support them to live in their own environment (sometimes through rehabilitation or with the aid of services), and when living at home becomes difficult or impossible, to assess them whether they need nursing home level of care. Where appropriate, end-of-life care is also part of the services provided to older people.

The provision of services is complex from both a service design and delivery perspective, with funding and guidance for the delivery of programs coming from multiple sources at the Commonwealth and State government level, as well as direct from the District and through other partnership arrangements.

Clinical leadership is provided through the Aged Care and Rehabilitation Clinical Stream for hospital-based and residential aged care outreach services and through the Director of Allied Health and Community Services for many of the hospital and community based services, including those funded through the Commonwealth and other programs including the Aged Care Assessment Team (ACAT), Regional Assessment Service (RAS) and Transitional Care Program (TCP).

The aged care services are multidisciplinary and comprehensive, covering both hospital and community, with the connection between the two to achieve continuity of care.

Coordinated care is essential for older people, who may experience an adverse event if care is not well-coordinated. This is particularly true when older people are experiencing transitions of care, from home to hospital, hospital to home, and in particular for those older people with multiple comorbidities and reduced capacity to engage in their own care and care decisions. Evidence is available on the risks associated with poor transitions of care, particularly in relation to rapid readmission and/or medication error and adverse events. In addition, the complexity of the service system highlights the need for excellent communication and cooperation across all providers reflected in local pathways and clinical protocols, to ensure integrated service delivery for the client and family.

The aged care client requires multi-disciplinary support across the continuum of care, ranging from acute, post acute, rehabilitation, maintenance and palliative care.

Most acute services concentrate on the care of the acutely ill older patients presenting with geriatric syndromes such as falls, delirium, or functional decline. However, acute care services may also manage general acute medical illnesses (may include conditions such as stroke) sometimes with psychiatric manifestations (such as depression).

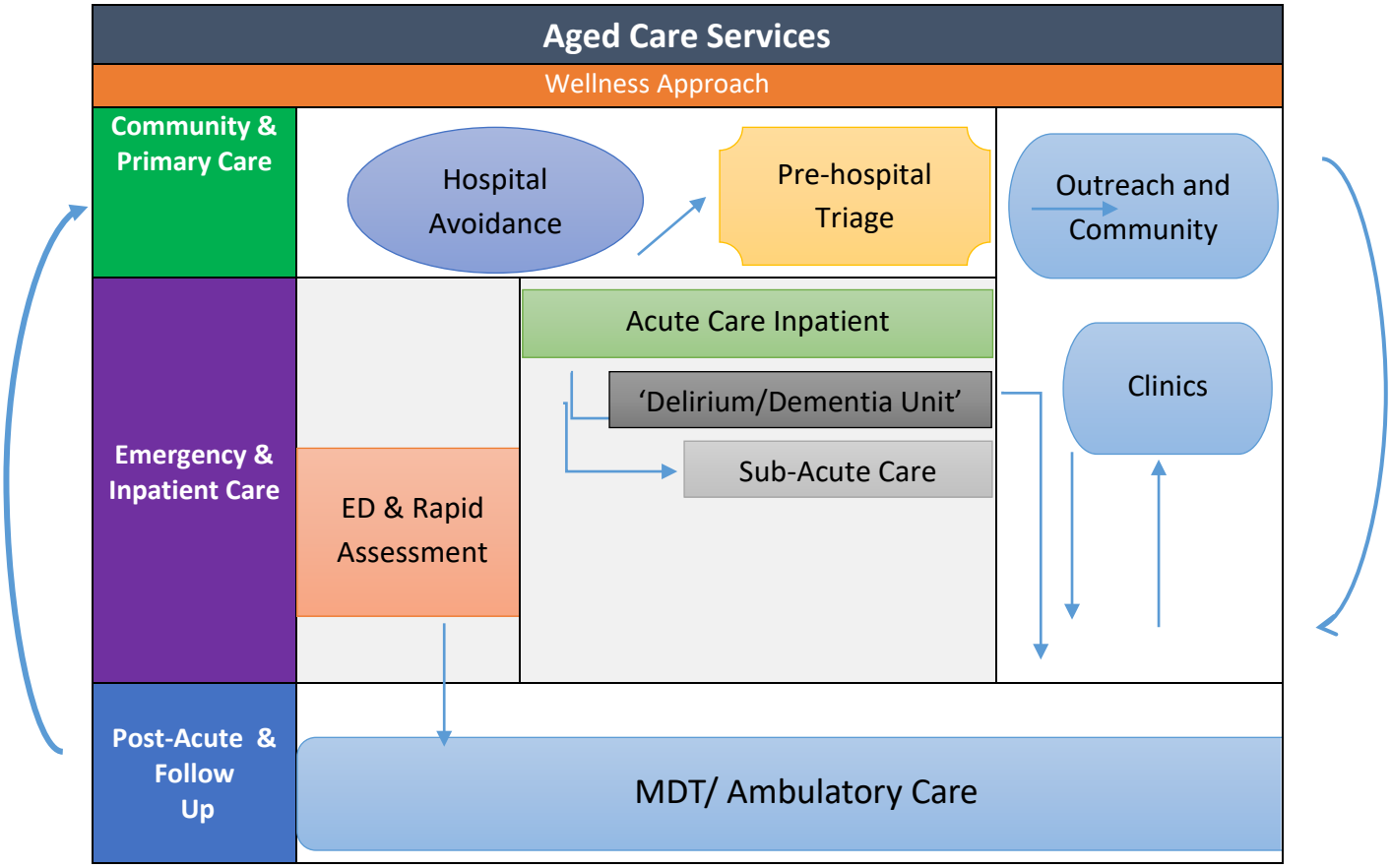
The types of services offered by the Aged Care and Rehabilitation Clinical Stream within the SWSLHD include:

- **Inpatient hospital care** at Bankstown, Fairfield, Braeside, Liverpool, Campbelltown/Camden and Bowral
- **Respite services**, including day centres and in-home respite

Hospitals. This might be in specialist aged care or rehabilitation wards or in one of the general wards

- A wide range of **outpatient clinics**, including geriatric medicine, memory clinics and specialised rehabilitation clinics
- Various **home-based support and rehabilitation programs**, including for people coming out of hospital and people who have not been in hospital
- **Assessment and referral services**, including the Aged Care Assessment Teams
- **Information and support services**, such as the Dementia Advisory Services, specialist nurse advisors and information officers in some community teams

Service Delivery Model



Key service partners include:

- Health Promotion
- Mental Health
- Other Sub-specialty Medicine and Surgery
- Allied Health
- Community and Primary Health
- Palliative Care
- Carer Support Services
- General Practitioners
- Residential Aged Care

- Community Care Providers
- Aboriginal Health Services
- Health Language Services

Apart from these services conducted by LHD, there are many other services available to older persons, persons with disability and carers. These may be run by community organisations, faith-based organisations or private businesses and could include support through things like personal care, domestic cleaning, shopping and meal preparation, transport and social support.

Table 3: DRAFT Description of SWSLHD Aged Care Services
***(Note: scope, criteria for eligibility and separate processes for referral& assessment differ across SWSLHD).**

Care in the admitted hospital settings	Description
Acute Geriatric Service	• Provides specialist inpatient care for the 70 years and older and those with co-morbidities and complex needs and medical conditions. • The ward provides comprehensive geriatric assessments and the formulation of management plans by Geriatricians working collaboratively with multidisciplinary teams.
Inpatient Consultation Service	• Specialist geriatric input to non – geriatric inpatients of any age • The consults are for and not limited to medical clearance / appropriateness for ACAT assessment or neuropsychiatric assessment, cognition and capacity, geriatric syndromes, complex discharge planning for patients that require comprehensive geriatric reviews.
Orthogeriatric Service	• Shared care model between orthopaedic surgeons and geriatricians utilizing a multidisciplinary approach for any patient aged 70 years and over with the fractured neck of femur. • The service ensures that pre, peri and post-operative needs of an older person are addressed. • It recognizes that traditional orthopaedic care may not be optimal for older people, who often have medical and psychosocial issues that may complicate their presentation, treatment and recovery including secondary fracture prevention.
Aged Care Services Emergency Team (ASET)	• A seven day - RN based service that provides a comprehensive assessment and management of patients 70 years and over and 50 years and over for Aboriginal population, and younger persons with aged related illnesses, presenting to the ED. • It includes referral of patients to the most appropriate in-patient and community services and provides ongoing follow-up care. • Limited access to allied health service including physiotherapy, speech therapy, occupational therapy, social work and pharmacy.
Aged Care Rapid Investigation and Assessment Service (ARIA) / Medical Assessment Units (MAUs)	• A seven day medical team led service located in the Medical Assessment Unit and is part of the Department of Geriatric Medicine. • Identifies patients in the Emergency Department who would benefit from rapid upfront multidisciplinary comprehensive geriatric assessment and management. • It facilitates discharge home with appropriate follow up or admit those that require in-patient management in ARIA or geriatric home wards.

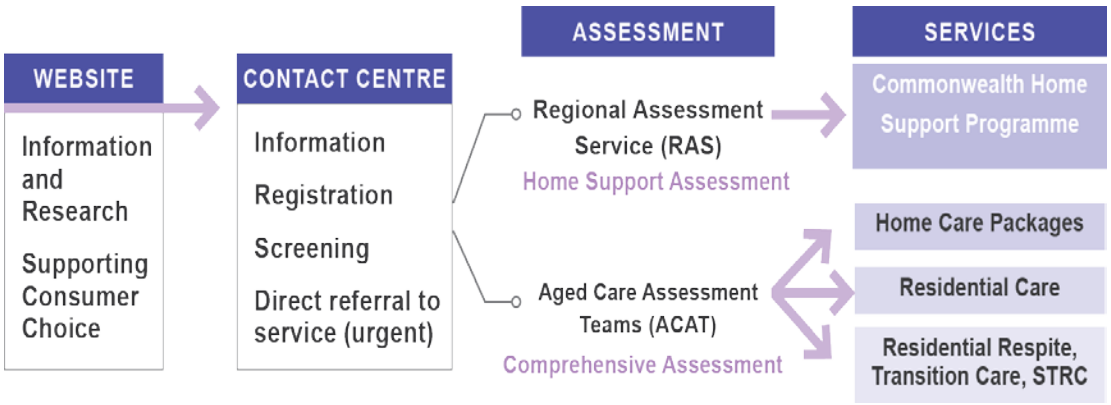
	• It provides outpatient clinic services and medical support to ASET. • The aim of MAUs is to provide suitable patients who have a shorter expected length of stay in the hospital (usually 5 days, implying less ill) with rapid assessment by a multidisciplinary team. If patients have a longer stay, they are usually transferred to proper wards as the unit has less nursing staff. The unit also caters for patients requiring further investigation or evaluation to differentiate diagnoses
Behavioural and Psychological Symptoms of Dementia (BPSD) Liaison Service	• Management of BPSD on the medical ward through both pharmacological and non-pharmacological methods, with reduced distress to patients and less need for sedating medication and restrictive practices. • Reduce length of stay and the need for psychogeriatric beds. • Once weekly multidisciplinary ward rounds with Aged Care Psychiatry encompassing Aged Care Psychiatrist, Aged Care CNC, Psychiatry Registrar, Geriatric Advanced trainee.
Non admitted services	• Outpatient clinics may be medical, multidisciplinary, nursing, or allied health. The range of clinics available varies according to site, and includes general and specialist clinics. Geriatric clinics include clinics for geriatric assessment, falls risk assessment and management, memory (for assessment for dementia) and continence.
Subacute services	• Subacute aged care/geriatric rehabilitation inpatient units provide post-acute and restorative care for geriatric patients. These patients are more frailed, have multiple co-morbidities and are therefore less medically stable than those who receive rehabilitation in a general unit. • A maintenance level of care is provided in all hospitals where a patient is awaiting residential aged care placement, while a significant proportion of rehabilitation admissions are for “restorative” care.
Rehabilitation services	• Rehabilitation is an important aspect of aged care. The key principles of aged care rehabilitation include the restoration and preservation of functional status. The elderly often become physically deconditioned following an acute illness, resulting in increased disability. Inpatient rehabilitation may be required for the more severely disabled patients. While some rehabilitation may be carried out in an acute care setting, many facilities have separate rehabilitation wards located either at the same hospital or at another subacute hospital. • Sometimes rehabilitation is also carried out in outpatient setting. Important aspects of rehabilitation include mobility training, self-care training, and arranging appropriate services to support elderly patients at home. In this process, realistic functional goal-setting is essential. Placement in residential aged care facilities may be required if patients are unable to return home.
Palliative Care Services	• Palliative Care services in SWSLHD are part of either Cancer Services or Community Health. There is a strong partnerships developed between aged care and palliative care services including on issues associated with end of life decision making and Advanced Care directives.
Care in the non-hospital settings	**Description**
Tharawal Aboriginal Geriatric Clinic	• Provides consultation on the management of chronic and complex medical conditions including cognitive decline in the ageing Aboriginal population.

Community Geriatrics Services (CGS) to Residential Aged Care Facilities	• There is a specialist geriatric outreach service to residential aged care in each sector: the Community Outreach Geriatric Service (COGS) delivered as a partnership between SWSLHD Aged Care services and Primary and Community Health aims to maintain the health and independence of older people living in residential care. The COGS provides rapid access to medical and nursing care for older people experience rapid decline or acute changes in their condition whilst remaining in their RACF. • Provides comprehensive geriatric assessment, palliative care, advanced care planning, management of geriatric syndromes and management of behavioural and psychological symptoms of dementia. • Facilitate management (e.g. IV Antibiotics) with *Hospital in the Home* for the residents whilst remaining in their familiar environment at the RACF. • Collaborate with the NSW ambulance to help further reduce unnecessary presentations to the ED. Collaboration with the PHN to provide resources to the RACF.
Community Outreach Geriatric Service (COGS) to Residential Care	• Aims to maintain the health and independence of older people living in residential care. • Provides a seven day rapid access to medical and nursing care for older people experiencing rapid decline or acute changes in their condition whilst remaining in their Residential Aged Care Facility. • Utilises virtual care technologies including – virtual consultation, virtual acute admission and electronic medical record documentation and assessment. And NSW Ambulance board monitoring. • Secure space within a RACF to accommodate a rapid assessment geriatric field clinic. • One COGS model of care will be used across SWSLHD with limited local adaptation.
Aboriginal Chronic Care Program (ACCP)	• Provides culturally appropriate care to Aboriginal people living with chronic diseases. • Holistic and collaborative service model from the prevention through to management.
Continence Management and Education	• Provided by Community Health Nursing Service by CNC. • Referrals through *MyAged Care*, following RAS assessment. • Conducts home visits and outpatient clinics in Community Health Centre setting. • Provides advice on continence management to hospital nursing, medical and allied health staff and to private practitioners including GPs.
Hospital – linked services provided in the community	**Description**
Aged Care Assessment Team (ACAT)	• Determines eligibility for Permanent Residential Care, Respite, Home Care Packages, Transitional Aged Care Program (TACP) and Short Term Restorative Care (STRC). • Referrals are generated electronically from the My Aged Care. • Includes a comprehensive assessment of a person's physical, medical, psychological and social needs, and any activity limitations. • Comprises multidisciplinary team of geriatricians, nurses, social workers, physiotherapists, occupational therapists and psychologists.

Transitional Aged Care Program (TACP)	• Transition Care services provide care either in the home or in a residential setting in an aged care facility. Transitional aged care program (TACP) aims to provide short-term goal - oriented rehabilitation and support consisting of multidisciplinary services to help patients transit back to home environment after acute hospital stay. • Aims to support older clients at discharge from hospital to achieve identifiable short term goals. • Provides up to 12 weeks packaged multidisciplinary services in a community based or residential setting immediately following discharge from hospital. • Includes mix of services: low intensity therapy, nursing, personal care, case management and medical support/oversight.
Specialist Aged Care Team (SpACT)	• Provides outpatient and home based therapy services as alternatives to inpatient care • Comprehensive, integrated and multidisciplinary model provide post-acute and subacute care, in order to improve functioning and independence.
Community Packages (ComPacks)	• Available for people assessed as having a short term need for case management and community services when they leave hospital. • Services available through the ComPacks program may include: case management, personal care, e.g. assistance with showering, dressing, domestic assistance e.g. house cleaning, meal preparation / assistance with eating and transport.
Community Dementia Clinical Nurse Consultant (CNC)	• Improves outcomes for people with dementia, their families and carers through clinical advice, consultation, education and support of other health professionals who are providing dementia care.
Specialist Mental Health Service for Older Persons	• Provides a range of services including assessment, treatment and management for older people affected by mental health disorders and/or severe behavioural disturbance. The services also assist families and carers of people experiencing these problems.
Care in the non-admitted hospital settings	**Models of care**
Specialist Geriatric Clinics	• Post discharge management and follow up. • Review of geriatric syndromes, falls and cognition. • Comprehensive geriatric reviews.

The Commonwealth funded services are delivered through a range of provider and care types within community-based and residential settings. My aged care has expanded and includes: central client record, regional assessment service for home support services, aged care assessment teams, fee care estimator and web portal for clients and providers.

Figure 4: Commonwealth funded aged care services via the current single-entry point



Source: D Tune, Legislated Review of Aged Care 2017, 2017, p 124.

The ACAT provides inpatient and community-based assessment to determine eligibility to receive Commonwealth funded aged care services, including residential and community-based care packages. There can be waiting lists for ACAT assessments in both hospital and the community which impact on the timeliness of care and/or need for hospitalisation. The Australian Government Department of Health has announced significant reform of the ACAT service. Impacts of the reform are not yet known. The current contract for ACAT is to June 2022.

The ACAT, RAS, TCP and SpACT services are provided by SWSLHD under the contract. This funding is non-recurrent. Each of these contracts have clear guidelines in relation to service eligibility, access, service provision and performance. If in the future these contracts are not continued, it is anticipated services will be transitioned to another provider within South Western Sydney.
The SWSLHD Director Allied Health and Community Services is responsible across the District for ACAT, RAS and TCP. Governance is provided through Local Team Leaders reporting to the SWSLHD Senior Service Manager(s) for Aged Care and Rehabilitation and ultimately to the Director Allied Health and Community Services.

6.1 GPs and SWSPHN Older Persons Services and Programs

The ageing population will have an impact on general practice, with previous research showing that older patients use more of GPs time than younger age groups due to the increase in number of chronic conditions managed as patients grow older. (Refer to Section 13: Access to Health Care for Older People: Medicare -subsidised GP care: (Tables:8-12)).

General practitioners provide essential care for the older people in the community and in the residential care. They manage common chronic medical problems and minor acute illnesses. They have an important role in primary disease prevention programs such as administering influenza vaccinations.

For more complex problems, patients are often referred to geriatricians or other medical specialists. Some GPs do home visits for older people who are not able to come to GP clinics. GPs, as the coordinators of care, could prevent visits to emergency departments and hospital admissions.

People over 75 years of age are able to access an annual Medicare funded comprehensive health assessment which provides a structured way of identifying health issues and conditions that are potentially preventable or amenable to interventions in order to improve health and/or quality of life. The purpose of this health assessment is to help identify any risk factors that may require further health management. In addition to assessing a person's health status, a health assessment is used to identify a broad range of factors that influence a person's physical, psychological and social functioning.

In addition, there are Chronic Disease Management Medicare items for GPs to manage the healthcare of people with chronic or terminal medical conditions, including those requiring multidisciplinary, team-based care from a GP and at least two other health or care providers. These Medicare items can be used to provide elements of rehabilitation for chronic conditions.

A number of referral pathways has been developed to support GPs in South western Sydney to appropriately refer to specialist services including section on Older Persons' Health. (*SWS HealthPathways* portal https://sws.communityhealthpathways.org/14452.htm).

It is important for GPs to further understand the impact of frailty on patients and how early identification and targeted intervention can reduce frailty, avoid inappropriate hospital admissions, keep people well and at home for longer and reduce need for RACF and hospital admissions.

The Northern Sydney Frailty Initiative helps GPs to recognise the condition of frailty and its complications, use of a frailty screening tool and identify treatment options/referral pathways for frailty which can assist with reducing further decline and supporting an older person to live at home independently.

Clarification and early diagnosis of dementia in primary care may facilitates access to services and increase support available to patients and their carers.

An early diagnosis of dementia in patients, gives their families time to plan ahead and to allow supports to be put in place. Patients and carers can be educated about what lies ahead and make plans to ensure as smooth a pathway into the future as possible.[38]

Examples of SWSPHN funded programs include:

Community CriSTAL Toolkit

SWSPHN is working in collaboration with SWSLHD to trial the Community CriSTAL Toolkit. The Criteria for Screening and Triaging to Appropriate Alternative Care (CriSTAL) tool is a validated prognostic tool that can assist in identifying older clients who are at risk of deteriorating health and flagging that discussions about those implications could be sensitively conducted. It is used within the acute hospitals and has been modified for use within the General Practice setting. The tool is easy to complete and suitable for use by GPs and nurses.

The toolkit being trialed contains the CriSTAL tool, in electronic or paper form, and documentation for discussing and recording goals of care and Advance Care Directives. The toolkit can be incorporated into everyday practice through linkage with the 75+ Health Check or chronic disease management such as GP Management Plan and Team Care Arrangements preparation or review with eligibility to claim Medicare Benefits Scheme (MBS) Level C and D consultations with GP sign off on Advance Care Planning documents.

The Toolkit has been trialed in two practices and a third trial is underway. There is capacity remaining for one more practice to be involved in the trial.

Advantages for participating practices:

- An opportunity to work in collaboration with a specialist nurse and receive coaching in how to identify patients at risk of deteriorating health
- Receiving training in how to use the Community CriSTAL toolkit to initiate discussions with patients around goals of care
- Upskilling in the use and implementation of Advance Care Planning documents
- Receiving additional support for practice staff to identify the care needs of elderly patients
- Initiation of Advance Care Planning conversations, a process that is acknowledged as difficult for patients, families and health care providers
- Collaborating with colleagues to advocate for patients wishes as they progress to End of Life
- Eligibility to claim MBS Level C and D consultations with GP sign off on Advance Care Planning documents.

Primary health care in residential aged care

The project involves collaborative development of Communication Manual to enhance quality healthcare. A manual has been successfully trialed in the Wingecarribee LGA. The manual contains

[38] Pond D, Brodaty H. Diagnosis and management of dementia in general practice. Aust Fam Physician 2004; 33:789–93.

useful information, clinical flowcharts for aged care nurses and locally developed communication tools which can be downloaded below. SWSPHN is currently working with representatives from aged care, NSW Ambulance and SWSLHD to adapt the manual for use in Campbelltown, Camden and Wollondilly LGAs.

Palliative care for people with dementia

Peace of Mind Project (POMP) is focussing on increasing palliative care for people with dementia and recognises impacts of losing decision making capacity. It includes the following initiatives:

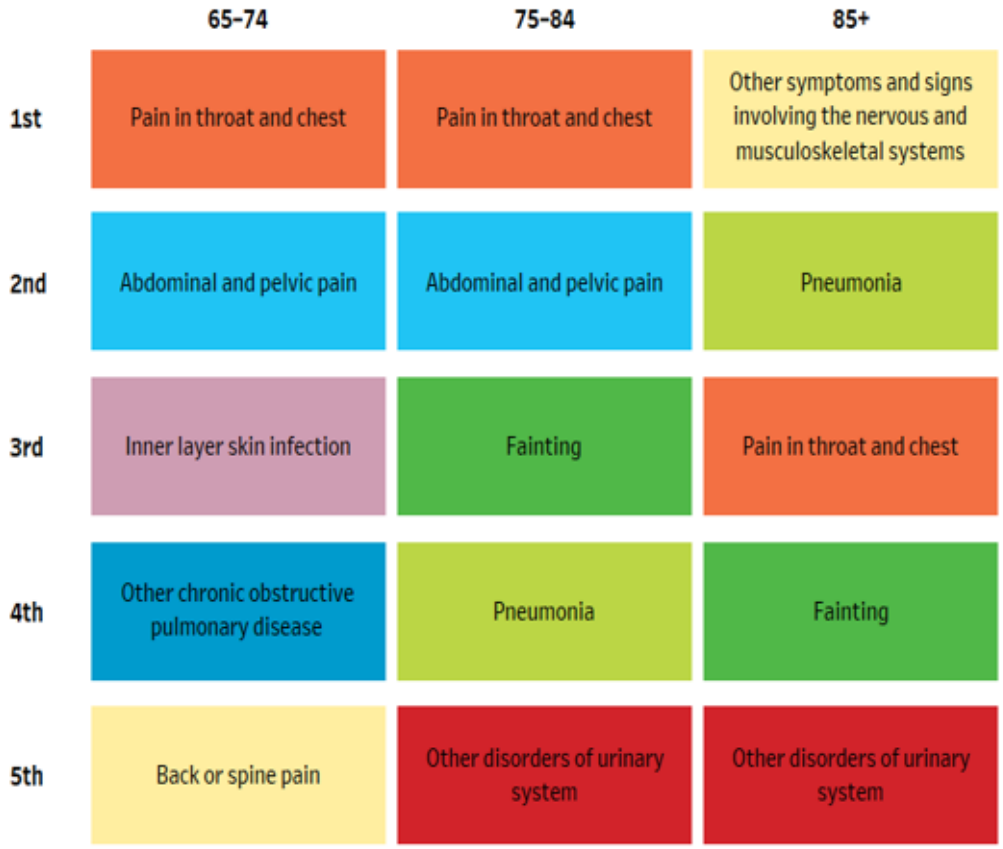
- Raising community awareness of advance care planning – community education events – in Camden, Campbelltown and Liverpool
- CPD events for GPs – every year as part of program re: ACP to increase skills and have conversations in primary care
- Developing a MoC for palliative care and dementia – matching HealthPathways.

7. Access to Health Care for Older People

7.1 Use of emergency departments

As per Australian Institute of Health and Welfare (AIHW) Report, in 2016–17, there were 1.6 million emergency department (ED) presentations in Australia among people aged 65 and over—around one-fifth of the total 7.8 million presentations. People aged 85 and over accounted for almost 1 in 4 (23%) of all presentations for people aged 65 and over. There were differences in presented diagnosis among age groups. The top three diagnoses recorded for ED presentations varied by age group and are presented in the figure below. For presentations among people aged 65–84 years, 'Pain in throat and chest' were the most common diagnoses recorded and for presentations among people over 85, 'Other symptoms and signs involving the nervous and musculoskeletal systems' was the most common diagnosis.

Figure 6: Five most common diagnoses for people aged 65 and over presenting at emergency departments, by age group, 2016-17



Source: AIHW National Non-admitted Patient Emergency Department Care Database (unpublished)

SWSLHD Emergency Department Presentations from Aged Care Facilities

Initial scanning of the SWSLHD ED presentations for people from the aged care facilities in 2019 demonstrates following:

- 6,802 patients from nursing homes presented to SWSLHD EDs
- 25% of presentations are related to falls
- 73% are patients over 80 years old

- 6,640 (98%) arrived by state ambulance
- 4,637 (68%) admitted patients stayed 4.7 days on average and accounted for 21,624 bed days (i.e. 62 beds at 95% occupancy)
- Gender: 56% females and 44% males
- Source nursing home: Frank Whiddon Masonic Nursing Home has significantly more patients presenting than any other nursing homes

Table 5: Number of Residents of the Residential Aged Care Facilities presented to the SWSLHD Emergency Departments, 2019

Bankstown - Lidcombe	1,659
Bowral	336
Camden	1
Campbelltown	1,868
Liverpool	1,702
Fairfield	1,236
Total	6,802

Table 6: Number of Residents of the Residential Aged Care Facilities presented to the SWSLHD Emergency Departments by Triage Category, 2019

Triage category 1	178
Triage category 2	1,413
Triage category 3	3,927
Triage Category 4	1,208
Triage category 5	76

7.2 Hospitalisations for older people

According to the AIHW, in 2016–17, people aged 65 and over accounted for 2.8 million **same-day** hospitalisations (42% of the total 6.6 million) and 1.8 million **overnight** hospitalisations (41% of the total 4.4 million).

The 'Care involving dialysis' was the main reason that older people experienced a same-day hospitalisation in 2016- 17 and for overnight hospitalisations, the diagnosis -'Other chronic obstructive pulmonary disease' was the most common principal diagnoses.

In 2016–17, acute care (medical, surgical and other acute care) was the most common broad type of care older people received in hospital (90%), followed by rehabilitation (7%).

The great majority of older people are discharged to their place of usual residence on leaving hospital. However, sometimes older people enter residential aged care after a period of hospitalisation. Excluding those whose usual place of residence was residential aged care, less than 2% of hospital separations in 2016–17 for older people were to residential aged care.

Hospitalisations in SWSLHD

In the SWSLHD, people aged 65 and over for four consecutive years (2014-2018) accounted for 40% and 39% of all ages hospitalisations, respectively as per table below.

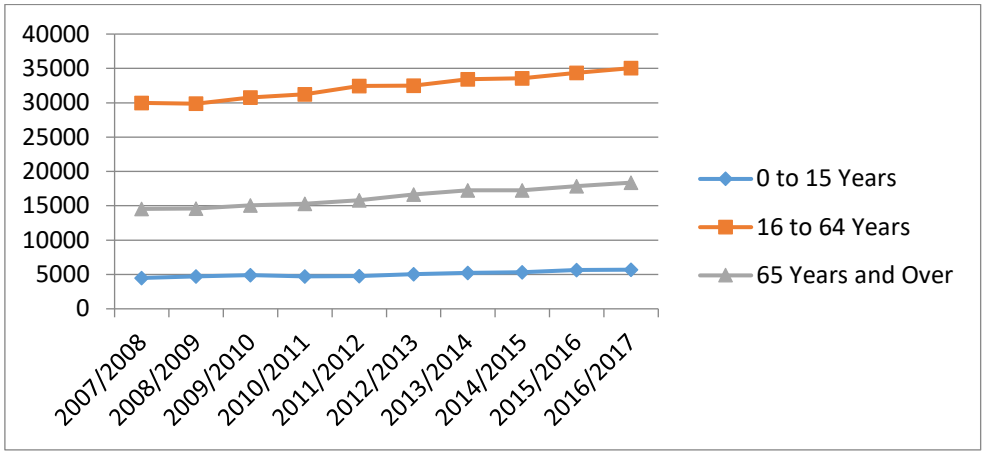
Table 7: Hospitalisations for SWSLHD residents by age group 3 categories, 2014-2018				
Age	**Total Separations**			
Age Group 3 Categories	**2014/2015**	**2015/2016**	**2016/2017**	**2017/2018**
Not Recorded				1
0 to 15 Years	16,560	17,486	17,455	17,115
16 to 64 Years	112,208	118,958	126,205	123,132
65 Years and Over	83,786	89,244	91,937	89,470
All ages	**212,554**	**225,688**	**235,597**	**229,718**
65 years and over as % of all ages	**39%**	**40%**	**39%**	**39%**

Source: CaSPA Portal – FlowInfo. Excluding Unqualified Neonates.

SWSLHD Surgical Demand by Age Trends

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

Figure 7: Demand for surgical and procedural services by 3 age groups for SWSLHD residents, 2007/08- 2016/17



	Increase in Demand (2007/08 to 2016/17)
0 – 15	26.8%
16 – 64	16.9%
65+	26.3%

Source: SWSLHD Surgical and Procedural Services Plan to 2031

7.3 Access to GPs & specialists

In 2016-17, there were more than twice as many Medicare claims for non-referred general practitioner (GP) attendances per person for those aged 65 and over than for those aged under 65 (10.0 compared with 4.4 claims). The oldest age group over 85 years of age accounted for (5%) of all non-referred GP attendances.

Specialist attendances claimed through Medicare in 2016–17 for people aged 65 and over represented (45%) of all specialist attendance claims. On average, people aged 65 and over made 4 times as many claims for specialist services as people aged under 65 (3.7 compared with 0.8 claims).

Access to GP care in South Western Sydney

In South Western Sydney, about 28% of people over 80 years of age have received GP health assessment compared to 3% for all ages.

There is a greater proportion of people over 65 years of age who have received chronic disease management by GPs (45% in the 65-79 age group) and (53% in the over 80 age group).

Medicare-subsidised GP care by SWSPHN, 2017–18

Table 8: SWSPHN GP Health Assessment by age groups, 2017-18

Service	Demographic group	Percent of people who had the service	Services per 100 people	Number of people	Number of services
GP Health Assessment	65-79	6.75	6.90	6,499	6,642
GP Health Assessment	80+	28.37	29.08	8,760	8,979
GP Health Assessment	All persons	3.04	3.11	30,043	30,720

Table 9: SWSPHN GP Multidisciplinary Case Conference and Chronic Disease Management Plan by age groups, 2017-18

Chronic Disease Management Services	Demographic group	Percent of people who had the service	Services per 100 people	Number of people	Number of services
GP Multidisciplinary Case Conference	65-79	0.40	0.69	386	669
GP Multidisciplinary Case Conference	80+	2.23	4.05	688	1,249
GP Multidisciplinary Case Conference	All persons	0.16	0.29	1,591	2,906
GP Chronic Disease Management Plan	65-79	44.50	116.97	42,838	112,606
GP Chronic Disease Management Plan	80+	53.15	134.18	16,411	41,431
GP Chronic Disease Management Plan	All persons	16.82	41.02	166,032	404,959

There is a difference between home and residential care in the uptake of medication review services for people over 80 years of age. About 5% of people over 80 years of age in residential care have received medication review services compared to only 2% in the home care.

Table 10: SWSPHN GP Medication Management Review- home and residential care by age groups, 2017-18

Medication Review Services	Demographic group	Percent of people who had the service	Services per 100 people	Number of people	Number of services
Medication Management Review (home)	65-79	1.24	1.24	1,193	1,194
Medication Management Review (home)	80+	2.17	2.19	670	675
Medication Management Review (home)	All persons	0.28	0.28	2,805	2,813
Medication Management Review (residential aged care)	65-79	0.53	0.53	511	512
Medication Management Review (residential aged care)	80+	5.11	5.13	1,579	1,584
Medication Management Review (residential aged care)	All persons	0.22	0.22	2,187	2,193

Table 11: SWSPHN GP After-hours – (non-urgent and urgent) attendances by age groups, 2017-18

After-hours Services	Demographic group	Percent of people who had the service	Services per 100 people	Number of people	Number of services
GP After-hours (non-urgent)	65-79	27.23	70.95	26,211	68,309
GP After-hours (non-urgent)	80+	33.42	131.31	10,319	40,543
GP After-hours (non-urgent)	All persons	32.76	70.44	323,417	695,442
GP After-hours (urgent)	65-79	2.74	4.39	2,635	4,222
GP After-hours (urgent)	80+	12.07	22.70	3,727	7,009
GP After-hours (urgent)	All persons	3.53	5.43	34,809	53,629

There are no great variations in the non-urgent after-hours GP attendances between age groups in the period 2017-18. However, 12% of people over 80 years of age have attended general practice after -hours for urgent care compared to 3% and 4% for 65-79 age group and for all ages, retrospectively.

Table 12: SWSPHN GP attendances in residential aged-care facilities per patient who received at least one GP attendance in a facility, 2017–18

GP attendances per residential aged-care patient	GP attendances per residential aged-care patient	No. of GP residential aged-care attendances	No. of GP residential aged-care patients
19.4	19.4	163,148	8,409

Source: Department of Health 2018. Medicare Benefits Schedule book, operating 01 May 2018. Canberra: Department of Health.

7.4 Aged Care: Aged Care Planning Regions

Drawing on data from the AIHW National Aged Care data Clearinghouse, in 2017, there were 9,216 residential aged care places and 175 transitional care places in the South Western Sydney and Southern Highlands Aged Care Planning Regions (ACPRs).

Table 13: Aged Care Planning Region and residential and transitional care, 2017

ACPR	Residential Care	Transition Care
SWS	6,946 (98.3%)	112 (1.6%)
Southern Highlands	2,270 (94.6%)	63 (2.6%)
NSW	68,967 (96.2%)	1,378 (1.9%)
Australia	95.7%	1.9%

Source: AIHW National Aged Care Data Clearinghouse, 2017

The South Western Sydney ACPR has a higher proportion of aged care recipients over 50 years of age who need assistance with core activity (15.8%) and significantly higher proportion of recipients born overseas (55.7%) and who preferred other language than English (40.9%) compared with Southern Highlands ACPR and NSW and Australia. The Southern Highlands ACPR has higher proportion of Aboriginal older peoples compared to SWS and Australia.

Table 14: Characteristics of aged care recipients, by ACPR in SWS, NSW and Australia, 2017

ACPR	Indigenous	Core activity need for assistance (50+)	Lives alone (65+)	Born overseas (65+)	Preferred other language than English (65+)
SWS	1%	15.8%	19.9%	55.7%	40.9%
Southern Highlands	2%	10.3%	25.9%	24%	6.4%
NSW	1.7%	12%	24.9%	34.9	19%
Australia	1.5%	11.5%	25.5%	35.8%	16.6%

Source: AIHW National Aged Care Data Clearinghouse, 2017

Most people want to stay at home for as long as possible as they get older. The Home Care Packages Program supports older people with complex care needs to live independently in their own homes. There are 4 levels of Home Care Packages — from level 1 for basic care needs to level 4 for high care needs. Level 4 supports people with high care needs (formerly Extended Aged Care at Home and Extended Aged Care at Home Dementia packages).

In SWS and Southern Highlands regions, there is an increasing demand for level 2 and 3 packages which are for lower level to intermediate level care needs as per table below. Lack of availability of services results in delays in discharging inpatients who are medically stable resulting in longer hospital stay and further deconditioning of patients.

In 2018, about half of people in SWS region have received level 2 packages, followed by level 4 packages (about 22%), and in the Southern Highlands region 43% have received level 2 packages and 29% level 4 packages.

Table 15: Number of people awaiting a home care package at their approved level at 31 March 2019, who have yet to be offered a lower level package, by ACPR

Package Level	Level 1	Level 2	Level 3	Level 4	Total
SWS	122	723	561	179	1,585
Southern Highlands	24	407	340	105	876

Source: Department of Health (the department) and the Department of Human Services (DHS).

Table 16: Number of people in a home care package at 31 December 2018, by ACPR

Package Level	Level 1	Level 2	Level 3	Level 4	Total
SWS	284	1,258	421	557	**2,520**
Southern Highlands	52	538	290	359	**1,239**

Source: Department of Health (the department) and the Department of Human Services (DHS).

8. Future Opportunities in Improving Older Persons Services

The Older Persons and Rehabilitation Plan will inform future service directions for aged care and rehabilitation services within the SWSLHD based on patient-focused models of care and an increasing shift in the balance of care to be home and community based. It is focused on ensuring equity of access and outcomes for the elderly patient with multiple system medical, functional and psychosocial problems and for all adults who require rehabilitation services. This Plan will outline the key focus areas and priority actions to achieve this:

- Plan our health services and infrastructure considering our rapidly growing and ageing population and meeting community expectations
- Provide 'person-centred' care that meets the individuals' immediate physical, spiritual, psychosocial and emotional needs along their journey
- Have a proactive approach designed to promote health and wellbeing, health literacy and self-management
- Continue to explore greater integration across the health and community sectors, and support a partnership approach with primary care and other stakeholders to prevent and manage chronic disease
- Investigate new approaches and technologies to reach older people and support their health and wellbeing
- Be integrated based on partnerships and seamless, coordinated care which allows streamed access to services from prevention to end of life
- Have consumers and their families as active participants in all decisions about their care
- Focus our own efforts on people who may need further or more targeted support – such as those on low incomes, carers, people from Aboriginal and CALD backgrounds, and people with mental health issues and dementia.

The NSW Agency for Clinical Innovation (ACI) has outlined the components of an ideal older patient's health journey in the diagram below.

Source: NSW ACI Building Partnerships: A Framework for Integrating Care for Older People with Complex Health Needs[39]

8.1 Evidence based Models of Care

- The Community Outreach Geriatric Service (COGS) is a District wide model of care delivered in the RACF setting. Further development of this model should be considered within the context of the SWSLHD Older Persons and Rehabilitation Plan. Priorities for expansion of the COGS service are outlined in the Geriatric Extended Aged Care Home (GEACH) Model of Care developed by the Aged Care and Rehabilitation Clinical Stream. Key considerations for the future development of these models are listed below:
    - Provision of care in, and alternatives to ED presentations. Relationship with ED, particularly provision of services overnight
    - Expansion of collaborative care with other medical services
    - Relationship with HITH, Palliative Care and Community Nursing
    - Expansion of service to include patients accessing Community Care Packages who are living in the community with the support of specialist services and/or all people living in the community
    - Shared care: Care in the orthopaedic settings to facilitate improved care for older people who have experienced a fall resulting in orthopaedic trauma.
    - Geriatric medicine input to a range of surgical specialties including general, vascular, cardiothoracic and urology.
    - The Agency for Clinical Innovation has released a Guide for the Surgical Care of Older People which provides direction on the way aged care and surgical services (including perioperative services) can collaborate to deliver improved care.

- Care of older people experiencing confusion or behavioural disturbance, primarily associated with a diagnosis of dementia or delirium. Physical, psychological and social issues associated with dementia require a bio-psychosocial holistic approach in providing appropriate care and treatment for the individuals.

- Review of access to rehabilitation for aged care clients across the District

- Further consider service requirements for younger onset dementia patients

- Further explore the role of Ambulatory Care in supporting rapid assessment of patients referred by GPs and other health services with strong links to Hospital in the Home and other community based services to facilitate access to appropriate out of hospital care and community based assistance.

[39] NSW ACI Building Partnerships: A Framework for Integrating Care for Older People with Complex Health Needs https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0003/249483/Building_Partnerships_Framework.pdf

8.2 Networks, Integrated and community based services

- The integrated service delivery model for aged care will shift the balance of care towards supporting frail, older people to be managed at home for as long as possible, with community focused services for hospital avoidance and home based care.
- When emergency and/or inpatient care is required, timely support for early intervention and management and support aiming for early discharge is provided.
- The Kings Fund[40] outlined the components of integrated care that contribute to an overall goal of high-quality, person-centred co-ordinated care for older people, as seen in the diagram below.

40

Oliver D, Foot C, Humphries R. The Kings Fund 2014. Making our health and care systems fit for an ageing Population. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf

Frail elderly future journey: Services & Experience

Clinical services and capabilities

The figure below sets out the key digitally enabled services and capabilities that should be available to frail elderly consumers at each stage of their future journey, in order to achieve the outcomes defined on the previous page.

Wellness

Services / experience

- Falls prevention sensors & wearables.
- Automated pill dispensers to support caregivers and those with dementia to ensure medication is taken.
- Virtual and F2F programs to support maintenance of existing function including virtual reality.
- Augmented and alternative communication to decipher and translate speech of people with speech impairment e.g. people with dementia or disability.
- Companion robots to provide emotional engagement.

Primary Care

Services / experience

- Geriatrician led 24/7 virtual health and outreach service providing remote diagnosis and support to RACFs, and outreach to GPs.
- Agreed criteria to detect and quantify frailty, captured in the shared care record.
- Routine screening and detection for frailty and dementia (i.e. amyloid/tau biomarkers) for people aged 70+ years[8].
- Automated medication review each time shared health record is updated with new information / data.

Acute

Services / experience

- Prioritised care needs and fast tracked through the ED.
- Sensors and wearable devices that detect movement, track location and sense heightened levels of distress, to minimize falls risk and support patients with cognitive impairment.
- ACAT assessment and transition plan commence at admission.
- Smart brain prosthetics and neural engineering for neurological diseases that present with age.

Ambulatory

Services / experience

- RACF access to the shared care record.
- Memory assessment specialists and services providing virtual and face-to-face assessments.

Care in the community

Services / experience

- Community nurse follow-up within 24-72 hours post discharge for patients identified as frail elderly on admission[6].
- Automated monitoring of changes to frailty status to support clinical decision making and align support package with need.
- Case management particular for people with dementia and their carers – at least once weekly interactions to monitor health status and care needs.

9. Rehabilitation

A dramatic increase in the absolute number of years lived with disability (YLDs) combined with a rising prevalence of severely disabling conditions have led to an increased demand for rehabilitation services.

Rehabilitation services focuse on adult patients with decreased functioning, activity limitations and participation restrictions related to the ageing process or health conditions amenable to rehabilitation/enablement interventions such as neurology/ stroke, amputees, post-surgical, brain injury, and trauma.

Clients of the Rehabilitation Service have unique developmental or intellectual disabilities and are also often in need of assistance with care, accommodation and/or support.

Rehabilitation is part of universal health coverage and should be incorporated into the package of essential services, along with prevention, promotion, treatment and palliation. In February 2017, World Health Organisations (WHO), Member States, international and professional organisations, non -governmental organisations and rehabilitation experts issued Rehabilitation 2030: a call for action, a commitment to key actions to strengthen rehabilitation services in Member States. These actions include: improving rehabilitation governance and investment; expanding a high-quality rehabilitation workforce; and enhancing rehabilitation data collection. The commitment to strengthen health systems to provide rehabilitation services should make it possible for millions of people not only to live longer, but to live well.[41]

Rehabilitation is part of all patient care, including acute care, and involves the prevention, assessment, management and supervision of a person with a disability until that person has attained an adequate and appropriate level of performance.

The provision of rehabilitation in acute care is critical to facilitate early intervention and effective, efficient flow of patients through the health system. Rehabilitation provided in acute care is ideally for a short length of stay with a focus on straight forward programs prior to discharge home or transfer to a specialist rehabilitation unit for ongoing input to facilitate independence and attainment of goals.

The term specialist rehabilitation refers to those episodes of care where a formal multidisciplinary program is provided.

The effectiveness of rehabilitation is highly dependent on the nature of the relationship between inpatient, outpatient and community services. Rehabilitation services are particularly sensitive to difficulties at service interfaces and hence organisational arrangements can either enhance integration and the quality of service delivery or exacerbate problems.

[41] World Health Organisation 2017. Rehabilitation 2030: A Call for Action Concept Note.

Research evidence suggests that increasing access to inpatient, home-based and centre-based rehabilitation services will improve patient flow through the acute system, reduce re-admissions and improve patient outcomes.
The majority (68%) of Australians receiving rehabilitation are aged over 65, peaking in the 75–84 age group.

A range of conditions will benefit from rehabilitation, including spinal cord injury, orthopaedic conditions, neurological conditions, amputations, multi-trauma, age-related illnesses and developmental delay.

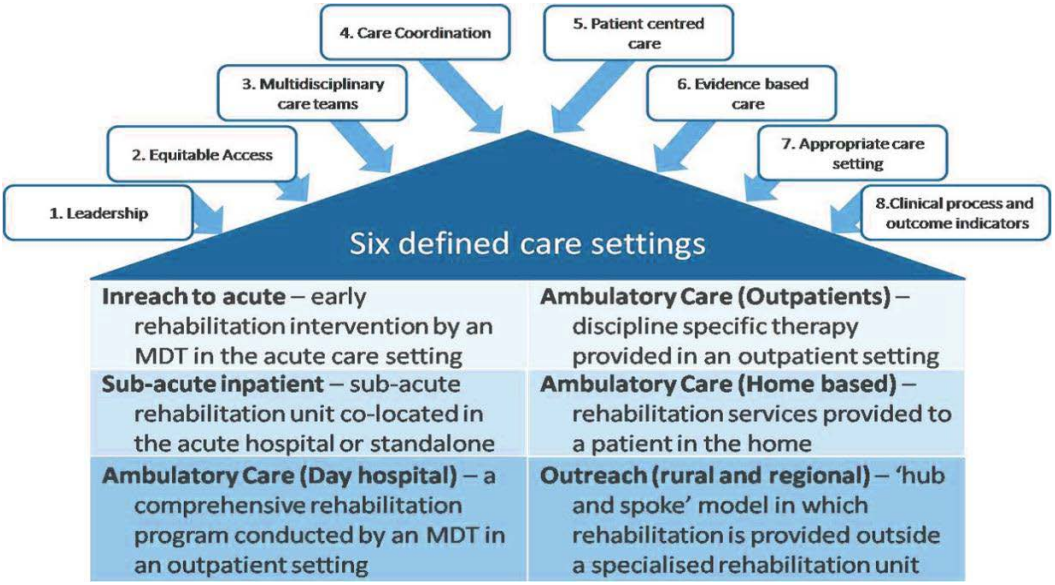
Rehabilitation Medicine is a specialty that aims to:

- restore functional ability for a person who has experienced an illness or injury
- enable regaining function and self-sufficiency to the level prior to that illness or injury within the constraints of the medical prognosis for improvement
- develop functional ability to compensate for deficits that cannot be medically reversed.

For the purpose of the NSW Rehabilitation Model of Care a principle has been defined as *statement of intent* of what is to be achieved. Principles apply to every aspect of a rehabilitation service.

Eight principles underpin the NSW Rehabilitation Model of Care

1. Leadership – Leadership is displayed at all levels providing a strategic and operational direction, a sense of team and a commitment to the principles of rehabilitation care.
2. Equitable access – Patients receive equitable access to rehabilitation services in the most appropriate setting and in a timely manner.
3. Multidisciplinary care teams – Patients have access to a 'core' multidisciplinary team who work collaboratively within an interdisciplinary framework. Access to non-core team specialist services is available as required.
4. Care coordination – Patient care is communicated and coordinated between the multidisciplinary team and other care providers across the continuum of care. Patients and their carers are encouraged to participate in goal setting and care planning.
5. Patient centred care – Rehabilitation services are patient centred and delivered to promote an enablement model of care. Patient centred care ensures an ongoing understanding of an individual's needs and expectations.
6. Evidence based care – Processes to promote the implementation of evidence and best practice are in place to support safe and effective care. Evidence based practice is supported through professional development, teaching, quality research and quality assurance activities.
7. Appropriate care setting – Patients receive rehabilitation services in the most appropriate setting based on individual patient's fit with the admission and discharge criteria for the relevant care setting and the potential to achieve rehabilitation goals.
8. Clinical process and outcome indicators – Consistent measurement processes across rehabilitation services are in place to monitor and demonstrate patient outcomes that contribute to enhanced functional independence.



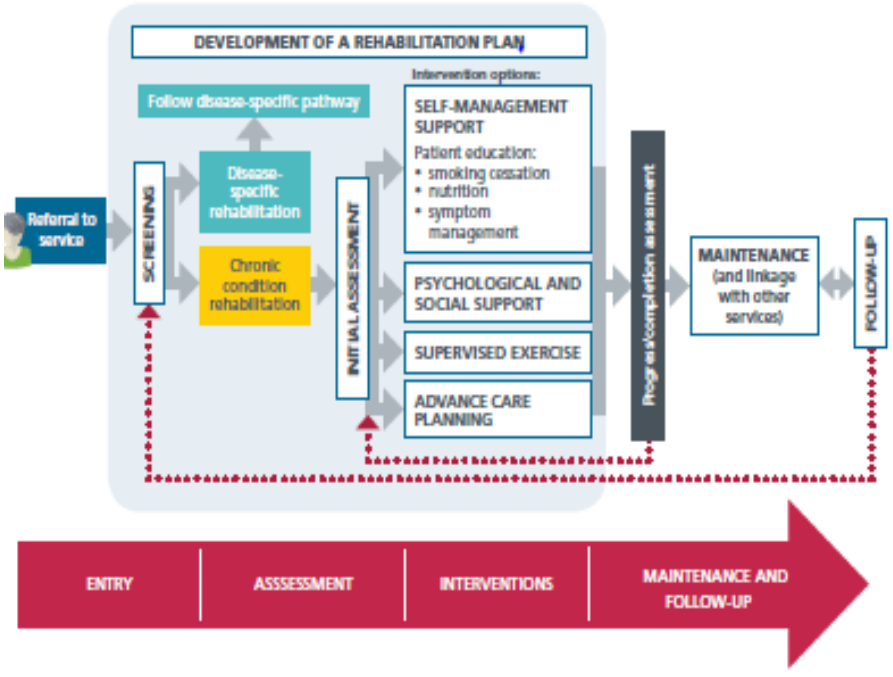
Source: Version from the NSW Rehabilitation Model of Care NSW Health Rehabilitation Redesign Project. Final Report – Model of Care 2015.

https://www.aci.health.nsw.gov.au/resources/rehabilitation/rehabilitation-model-of-care/rehabilitation-moc/NSW-Rehabilitation-MOC.pdf

ACI Rehabilitation for Chronic Conditions Framework

Evidence demonstrates that rehabilitation is successful in supporting the management of a number of chronic conditions including: pulmonary disease, cardiac disease, diabetes (type 2), peripheral vascular disease, cancer, chronic pain and musculoskeletal conditions. Rehabilitation programs for chronic conditions have been shown to improve quality of life, functional exercise capacity, self-management skills, reduce harm from risk factors and decrease the need for the use of acute healthcare facilities.

Figure 5: Rehabilitation for Chronic Conditions Framework



Source: ACI Rehabilitation for Chronic Conditions Working Group – Rehabilitation for Chronic Conditions Framework

The ACI has been developed to support the adoption of a uniform approach to rehabilitation in the context of chronic conditions specifically where a person is ageing with multimorbidity, or where access to disease-specific programs and/or services is limited. It aligns with and supports the principles of the National Strategic Framework for Chronic Conditions.

This Framework also encourages rehabilitation services to include people with a broad range of chronic conditions (such as neurodegenerative and neuromuscular conditions) so they too could benefit from improved functional exercise capacity and quality of life, as well as reduced hospital admissions.[42]

Components of chronic disease rehabilitation

1. Screening
2. Development of a rehabilitation plan
3. Assessment (initial, progress and discharge)
4. Self-management support (including health education, smoking cessation and nutrition)
5. Psychological and social support
6. Supervised exercise training
7. Advance care planning
8. Maintenance and follow up

9.1 SWSLHD Rehabilitation Services

Rehabilitation clients require different levels of care at different points in their rehabilitation journey. Patient flow considerations include those from the acute care setting to the sub-acute care setting and patient flow from the sub-acute care setting into an ambulatory care setting and ultimately the patient's return to the community and home.

The current service delivery across the SWSLHD includes inpatient, outpatient and ambulatory service types and vary in their volume and capacity; referral criteria and operational hours; staffing profile and support; and the level of networking within SWSLHD and with the community.

Table 4: Draft Description of Current SWSLHD Rehabilitation Services (*Note: scope, criteria for eligibility and separate processes for referral& assessment differ across SWSLHD).

In-reach to Acute Care	Services
Rehabilitation Unit (RU)	• Patients admitted to RU will generally have a higher degree of complexity in terms of diagnosis, therapy needs, discharge planning, accommodation and community supports due to the complex diagnoses and resultant level of disability. • Patients are accepted into RU following assessment by the Rehabilitation medical team during their acute admission.

[42] Rehabilitation for Chronic Conditions Framework. ACI Rehabilitation for Chronic Conditions Working Group. ACI 2017.

Acute Rehabilitation Consultation Service	• Provides rehabilitation advice for inpatients who have been in acute care (medical and surgical wards) for prolonged time with complex care needs/ multiple comorbidities and require significant time and resources for discharge planning as part of their rehabilitation process due to changes in function. • The Rehabilitation Medicine Service is often involved with family conferences for these patients to assist with discharge planning, even though they are not admitted under the rehabilitation service.
Rehabilitation Acceleration Program (RAP)	• In-reach to acute service which utilises additional physiotherapy and occupational therapy interventions to increase therapy intensity for patients whilst in acute care who may eventually require an inpatient rehabilitation care and thereby reducing overall length of stay and earlier discharge by improving function earlier and faster in the acute admission.
Medical Transit Unit (MTU)	• For patients who are not yet ready to progress into rehabilitation and have one of the following e.g. geriatric syndromes, intellectual disability, reduced weight-bearing due to recent orthopaedic fractures or procedures, significant pain requiring ongoing titration of analgesia or who can only tolerate low intensity therapy and who are awaiting accommodation such as RACF or group homes, home modifications or services planning such as NDIS.
Brain Injury Rehabilitation Unit (BIRU)-State-wide service	• Inpatient rehabilitation to people between 16 and 65 years of age who have sustained a moderate to extremely severe brain injury - usually traumatic, who have realistic rehabilitation goals and who live in the area served by the BIRU • The Liverpool Brain Injury Rehabilitation Unit (LBIRU) has supra-regional responsibility and accepts referrals from rural brain injury services located in Southern and South Western New South Wales. LBIRU has six service components including the Inpatient Unit, Community Outreach Services, Head2Work (vocational program), Transitional Living Unit, Community Living Unit (respite and short term accommodation service) and the Spasticity Management Service. Clients are referred from these areas for specialist inpatient rehabilitation and then referred back to their local brain injury service. • The LBIRU Community Team receives referrals from LBIRU inpatients when they are discharged to community and referrals post injury from health facilities, community agencies, medical practitioners, family members and self-referrals. • The Unit has established a national and international reputation for outstanding research in the rehabilitation of people with traumatic brain injury and was a key resource in the consultations that formed the basis for the New South Wales (NSW) Brain Injury Rehabilitation Program.

Ambulatory Care	Services
Rehabilitation in The Home (RITH)	• RITH is a community-based rehabilitation service based on the Hospital in the Home (HITH) model. This is considered an "inpatient admitted" service. • For patients who are medically suitable for discharge from hospital and willing/able to participate in a rehabilitation program at home. • After discharge from RITH, there is a need for many of these patients to continue specialist rehabilitation follow-up due to chronic nature of their conditions affecting their function.
Brain Injury Rehabilitation Unit - Community Outreach Service	• Rehabilitation, community re-integration and long term support to assist people who have had a brain injury to maximize their potential, facilitate personal and family adjustment and develop a network of support appropriate to individual needs. • Multidisciplinary approach to provide the assistance required by a particular client.
Brain Injury - Transitional Living Unit	• Assessment and training of skills to enable individuals to improve their outcomes before moving to the community after injury. • Re-assessment of living skills to enable individuals to improve their independence or change their support arrangements.
Specialist Intellectual Disability Team	• Specialist Intellectual Disability Health Team (SIDHT) is a multidisciplinary health assessment team providing support to people with an intellectual disability and significant functional impairment with complex health care needs. The SIDHT will work in partnership with rehabilitation services to support clients across the community and inpatient setting.
	Services
Outpatient Rehabilitation Medicine Clinics include	• General rehabilitation clinics o follow-up for patients recently discharged from RU, MTU, and RITH o review for patients currently on RITH o general rehabilitation referrals from GPs and other specialists o conducted by each staff specialist on a weekly basis • Amputee clinic • Orthotics Clinic • Spasticity Clinic • Spina bifida clinic
Group outpatient rehabilitation clinics	• Outpatient rehabilitation activities and therapies have been a widely accepted remedy for cardiac and pulmonary disease. • Multidisciplinary care

10. Future Opportunities for Improving Rehabilitation Services

Rehabilitation services are fundamental in enhancing patients' functional independence and play an integral role in patient flow across the health care continuum. The provision of effective rehabilitation services requires a diverse range of health professionals, services and external agencies to work together and overcome system challenges such as separate funding, administration and reporting structures.

The setting in which rehabilitation takes places is principally defined by the patient's changing needs over time and the availability of rehabilitation services in particular areas. Research evidence suggests that increasing access to inpatient, home-based and centre-based rehabilitation services will improve patient flow through the acute system, reduce re-admissions and improve patient outcomes.

Many older patients will have complex medical requirements during their rehabilitation in - hospital. Their rehabilitation needs need to be addressed in parallel with management of these medical issues.

10.1 Evidence based models of care

Rehabilitation services have the opportunity to reshape service delivery, embrace robotic technology, improve patient outcomes in both inpatient and ambulatory settings, and improve efficiencies and collaboration with health care providers across the health system through the implementation of the NSW Rehabilitation Model of Care founded on good practice principles and innovation.

Innovative models and multidisciplinary approaches to service delivery across the patient journey pathway will be explored. Increased ambulatory and community service setting options and the introduction of new technologies such as robotics and telemedicine will challenge the current thinking and appropriate workforce needs.

There is an increasing demand on inpatient and community care capacity due to the growth and ageing of the population and the great advances in medical treatment in surgical and medical specialties which result in people living longer with more complex physical and psychosocial needs.
In order to respond to an increasing demand and provide more comprehensive Rehabilitation Services across the care continuum and informed by the MoC Project, this Plan will consider the following models of care:

- Inpatient rehabilitation services focusing on supporting those people with the most complex physical and psychosocial needs and restoring an individual's function following a disabling injury, illness or surgical intervention.

- Rehabilitation in the home (RITH) service which is offering a more flexible care option for people who have support at home to undertake their rehabilitation program. Adequate social supports, suitable and safe environment and availability of required equipment are essential

elements that must be considered if an individual is to receive rehabilitation at home. Home based therapy services should be provided to clients unable to access outpatient or day therapy services, due to limited mobility and access. These services should be available to suit the needs of clients, for example carers who are working.

- A Mobile Rehabilitation Team (MRT) can provide in-reach rehabilitation in the acute care setting, with a view to providing earlier access to intensive therapy, improving function, reducing deconditioning and length of stay.

- Outpatient clinics provide access to specialist medical assessment, and review and therapy interventions to improve and maintain independence and function. Further development of outpatient clinics that are interdisciplinary including medical, nursing and allied health that focus on specific areas requiring rehabilitation post injury or illness is needed.

- Community-based rehabilitation programs and functional maintenance programs. Benefits are that rehabilitation services can be offered in an environment (the community setting) which provides the best context for the provision of therapies, and enables training of family and carers in the continued provision of therapeutic interventions.

- Transition services which provide accommodation and/or support services to patients requiring complex planning and organisation or 'phased' discharge options from rehabilitation services into the community.
    - Rehabilitation Services will focus on the needs of the following groups:
    - People experiencing stroke and those with degenerative neurological conditions
    - People undergoing elective and emergency orthopaedic and spinal surgery, or amputation
    - People requiring access to in-centre dialysis and rehabilitation
    - Older people at risk of deconditioning
    - People with a pre-existing disability
    - People with complex post-acute care needs.

- People with non-weight bearing (NWB) lower limb fractures - discharge planning concerns especially in older patients as they are not eligible/accepted at Inpatient rehabilitation during the NWB period due to rehabilitation criteria and they can't be discharged home.

10.2 Networks, Integration and community based services

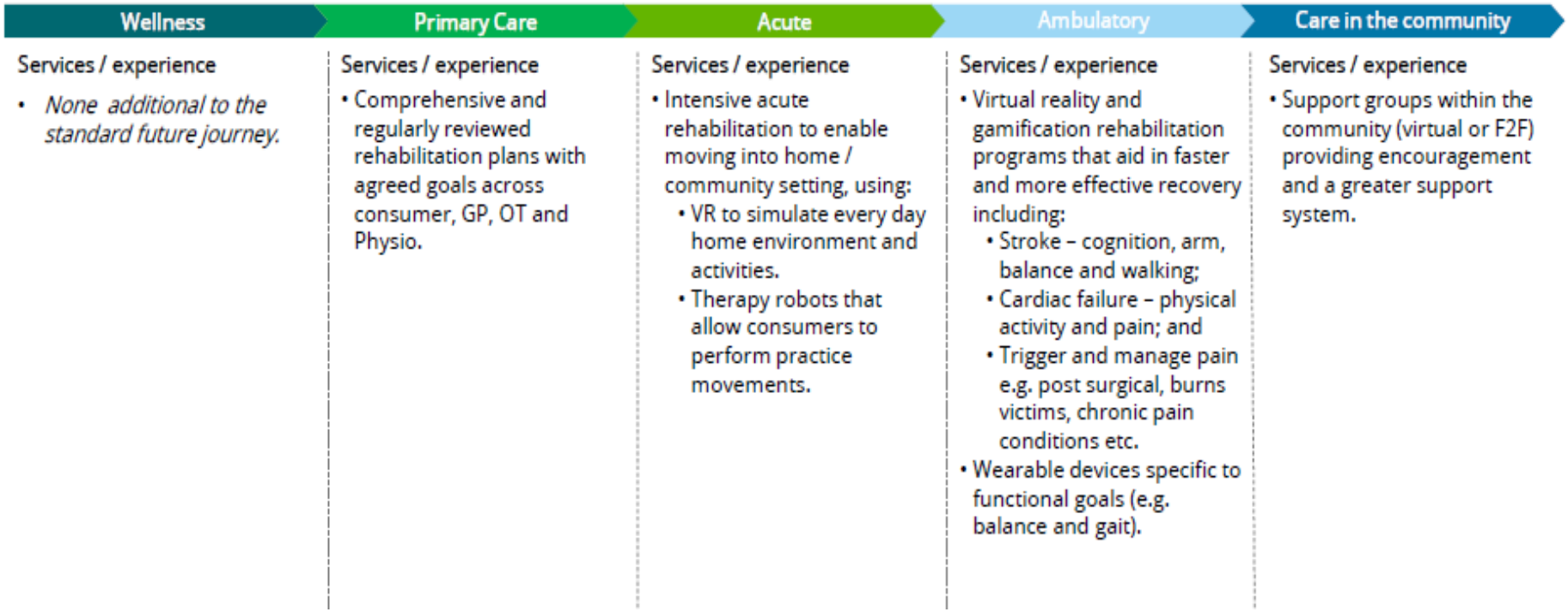
Residents of South Western Sydney require an integrated, modern rehabilitation service system to ensure people of all ages who require rehabilitation have access to appropriate services in a timely manner with the aim of moving them rapidly back into their communities. It is common for rehabilitation patients to make a number of transitions between facilities and providers. The frequency of these transitions makes it critical that systems and processes are in place to promote the integration and coordination of rehabilitation services to optimise patient experiences and outcomes. Strengthening integration between community based rehabilitation services with acute and subacute inpatient rehabilitation services will be essential for the patient's journey and improving patient's outcomes. Improving rehabilitation service connections with the wider health and social services

system is crucial, so that people can access the right care provider, at the right time and in the right place.

Rehabilitation future journey: Services & Experience

Clinical services and capabilities

The figure below sets out the key digitally enabled services and capabilities that should be available to consumers requiring rehabilitation services at each stage of their future journey, in order to achieve the outcomes defined on the previous page.



Source: Bankstown Health Neighbourhood Digital Transformation Strategy

11. Enablers

Areas which support and enable transformation in healthcare delivery are listed below,

ENABLERS	
Health workforce and professional development	Population growth and ageing as well as advances in technology and changes in MoC will be driving a demand for the training and professional development of medical, nursing and allied health workforce. There is a need for creating more opportunities for inter-professional learning across health workforce disciplines that are well suited to the provision of comprehensive multidisciplinary approaches to aged care and rehabilitation.
Information and communication technology	Consistent with the SWSLHD Virtual Care Strategy and the Bankstown Health Neighbourhood Digital Transformation Strategy, the future directions in information and communication technology will consider trialling innovative models of service delivery via telemedicine such as monitoring of home rehabilitation programs, group telemedicine therapy and virtual rehabilitation therapy.
Business intelligence	Due to the complex funding arrangements within Aged Care and Rehabilitation, there are multiple mandatory data collection and reporting requirements. Data analysis can be challenging due to inconsistent admitting or coding practices, a wide variety of data sources and in some cases minimal or no data availability. An electronic record will have significant efficiencies and improvements in the delivery of aged care and rehabilitation services, especially as the patient moves across the continuum of care.
Teaching and research	Our research is guided by the SWSLHD Research Strategy to 2023 which focuses on applied and translational research that is directly relevant to improving health care system performance and the wellbeing of patients and the community. SWSLHD is a member of SPHERE - the Sydney Partnership for Health, Education, Research and Enterprise which enable collaborative research. Age and Ageing, Musculoskeletal Health and Palliative Care are among the Clinical Academic Groups (CAG) of SPHERE. The Stroke and Neurology Research Unit is one of SWSLHD Academic Units. Continuing and further developing teaching and research partnerships across SWSLHD with universities and other institutions to support and lead innovations in the aged care and rehabilitation.
Collaboration and partnerships	The AC&R service delivery model could not comprehensively be provided without close collaboration and partnerships. Partnership/associated services include other SWSLHD streams and services such as Chronic Care and Internal Medicine – Neurology, Orthopaedics, Vascular Surgery, District Mental Health Services, Emergency Departments (EDs), Community and Primary Care and Allied Health Services, as well as external partners such as general practitioners, residential aged care facilities and community care providers.
Interpreters	A large proportion of older people from culturally and linguistically diverse (CALD) communities residing in South Western Sydney don't speak English well or not at all and they need an interpreter support in accessing AC&R services.

	As population ageing there will be an increase in demand for interpreter services, particularly for some language groups such as Arabic and Vietnamese. In addition, there is an increase in refugee arrivals who need an interpreter assistance.
Transport	People accessing AC&R services and their carers are those most likely to have mobility limitations and difficulty accessing public transport. Transport is critical to the wellbeing and connectedness of carers and the people they care for. Appropriate parking, including disabled parking and safe drop-off spots are required for clients using private transport. Emergency patient transport is provided by the Ambulance Service of NSW. Non-emergency health related transport is provided by various agencies including SWSLHD Patient Transport Services, Community Transport services, Aboriginal health services and the Department of Veterans' Affairs.

12. Glossary

Term	Definition
Aged Care and Rehabilitation Stream	The SWSLHD Aged Care and Rehabilitation (AC&R) Clinical Stream provides care for those health care consumers who are more likely to have multiple acute and chronic co-morbidities and who are most likely to have frequent interactions with the health and services provided outside of health sector.
Aged Care Assessment Teams (ACAT)	ACATs are teams of medical and allied health professionals who assess the physical, psychological, medical, restorative, cultural and social needs of older people and help them and their carers to access appropriate levels of support.
Aged Care Planning Region (ACPR)	The areas marked out in the ACPR maps which can be found on the department's website.
Approved provider	An organisation that has been approved to provide home care under the *Aged Care Act 1997*.
Commonwealth Home Support Programme (CHSP)	Entry-level support at home – Ongoing or short-term care and support services including help with housework, personal care, meals and food preparation, transport, shopping, allied health, social support and planned respite.
Home Care Packages Program	A program that supports senior Australians with complex needs to remain living at home through a coordinated package of care and services to meet the individual needs of people.
Interim package	A package at a lower level than a person's approved level, through which they are able to access some home care services while waiting for a higher level package.
My Aged Care	The main entry point to the aged care system in Australia.
National Prioritisation System	The nationally consistent process for allocating home care packages based on peoples' needs and circumstances.
The department	The Department of Health.

13. Appendix 1: Policy Context

Clarity and direction for the complex system is provided through a range of national, state-wide and local policies and strategies.

13.1 National Policy

Commonwealth Plans and Guidelines including My Aged Care: central client record	*My aged care* aims to help navigate aged care system. It provides regional assessment service for home support services, fee care estimator, and web portal for clients and providers. It encompasses a national intake, referral and assessment system providing access to Commonwealth subsidised aged care services.
Royal Commission into Aged Care Quality and Safety Report	The Royal Commission is required to examine: • The quality of aged care services • How best to deliver aged care services • The future challenges and opportunities for delivering accessible, affordable and high quality aged care services • What is required to strengthen the system to ensure that the services provided are of high quality and safe, and are person centred • How best to deliver services in a sustainable way. The Royal Commission into Aged Care Quality and Safety's Interim Report (October 2019) has found the aged care system fails to meet the needs of its older, vulnerable, citizens. It does not deliver uniformly safe and quality care, is unkind and uncaring towards older people and, in too many instances, it neglects them.
Disability Royal Commission	The Disability Royal Commission was established in April 2019 in response to community concern about widespread reports of violence against, and the neglect, abuse and exploitation of, people with disability. The Disability Royal Commission gathers information through research, public hearings, the personal experiences people tell us about and submissions, private sessions, and other forums.
National Framework for Action on Dementia 2015-2019	This framework guides the development and implementation of actions, plans and policies to reduce the risk of dementia and improve outcomes for people with dementia and their carers.
National Disability Insurance Scheme	The National Disability Insurance Scheme (NDIS) is the Commonwealth government's Scheme for supporting people with a "permanent and significant disability" and are under the age of 65. The NDIS is the new way of providing support to Australians with disability, and their families and carers. The NDIS is a move from a 'one-size-fits-all' approach to a system where people with disability have direct control over the funding they receive.
National Disability Strategy 2010-2020	This Strategy sets out a ten year national plan for improving life for Australians with disability, their families and carers. It draws on the findings of extensive consultation conducted in 2008-09 by the National People with Disabilities and Carer Council and reported in *Shut Out: The Experience of People with Disabilities and their Families in Australia (2009*).

13.2 NSW Policy

NSW State Plan - NSW 2021: A Plan to Make NSW Number One	The *NSW State Plan* guides the development of infrastructure and services in NSW to 2021. In relation to Health, the plan aims to keep people healthy and out of hospital and provide world class clinical services with timely access and effective infrastructure. The plan identifies the need for person centred care delivery, improved communication and collaboration.
NSW State Health Plan: Towards 2021	The *NSW State Health Plan* was released in 2014 and aims to meet the goals for health outlined in the *NSW 2021* Plan. The plan describes the CORE values which underpin the provision of health services across NSW: - Collaboration, Openness, Respect and Empowerment and aims to ensure '*the right care, in the right place at the right time*.' Three key directions to deliver innovation are identified: - Keeping People Healthy; Providing World-Class Clinical Care; and Delivering Truly Integrated Care. Key focus areas within the plan include reducing health risk behaviours, helping people manage their own health, improving connections within the health system, developing new models of care, strengthening partnerships internally and externally, maintaining a focus on quality and safety, listening to and empowering consumers, building infrastructure, workforce and research capacity and capability.
NSW Ageing Strategy 2016-2020	The Strategy provides a whole of government approach that is responsible for enhancing opportunities for older people across the state and region.
Agency for Clinical Innovations (ACI) Framework for Integrated Care for Older Persons with Complex Health Needs	The ACI under the auspices of the NSW Ministry of Health (MoH), has led the development of a framework for older people with complex health needs, their carers and families, to receive proactive, person-centred and evidence-based care, regardless of how or where they access it. The Framework aligns with the MoH Integrated Care Strategy to implement innovative, locally-led models of integrated care across the State.
Agency for Clinical Innovations (ACI) Integrated Surgical Care for Older People	The Guide to Integrated Surgical Care for Older People has been a joint effort between several ACI networks. In particular, the Guide addresses priority topics for the Surgical Services Taskforce, Anaesthesia and Perioperative Care and Aged Health networks. The Guide supports clinical teams to deliver appropriate, efficient and timely surgical care for complex and co-morbid patients, focusing on early and effective communication, proactive approaches to managing clinical risk and regular review of processes for ongoing improvement.
NSW Service Plan for Older People's Mental Health Services 2017-2027	The NSW Older People's Mental Health Services (OPMHS) Plan 2017-2027 guides the purpose, scope, target group and key elements of OPMHS, the context in which they operate and current developments in the service environment. They identify evidence-based service models and key strategic priorities for the development, delivery and improvement of OPMHS.
Draft NSW Wellness and Reablement in Aged Care Policy Directive	A state-wide NSW Health approach to wellness and reablement will help ensure Districts have consistency in implementation and monitoring in aged care services. The Policy Directive outlines roles and responsibilities, definitions, reporting and contractual obligations, outcome measurement in wellness and reablement, and an implementation plan guide to support assessment services and aged care programs.

Leading Better Value Care (LBVC)	The identification of initiatives to create better value health, aims to address healthcare challenges by enhancing the use of resources within the way we work while maintaining the safety and quality of patient care. LBVC has become a key driver in a system wide approach to value based healthcare which means delivering services that improve: • the health outcomes that matter to patients • the experience of receiving care • the experience of providing care • the effectiveness and efficiency of care. LBVC initiatives (relevant to the Plan) and their implementation in SWSLHD: • ACI Models of Care for the Osteoarthritis Chronic Care Program (OACCP) and Osteoporotic Re-fracture Prevention (ORP) program. The SWSLHD OACCP MoC has been implemented in Bowral OACCP with staffing and process enhancements to provide for an extended service. • ACI Model of Care for Osteoporotic Refracture Prevention (ORP) to address improvements post-acute management of fractures. The SWSLHD ORP MoC was implemented at Liverpool Hospital to deliver medical and allied health management to patients with osteoporosis post MTF within SWSLHD. • The LBVC Hip Fracture initiative aims to improve the alignment of care practices and pathways in NSW to the Australian Commission on Safety and Quality in Health Care (ACSQHC) Hip Fracture Clinical Care Standard (2016), WSLHD has established a working group and an SWSLHD Model of Care is currently being developed for the District through the SWSLHD Hip Fracture Working Group. • The LBVC In-hospital falls initiative has been selected in alignment with the NSW system's aim to provide safe high quality care for every patient. The SWSLHD pilot team has been successful in progressing falls prevention strategies in relation to risk assessment and completion of management plans. The LBVC inpatient falls management strategies are to be considered for implementation by the SWSLHD Falls Coordinator and Falls Committee across SWSLHD facilities as deemed appropriate. Other LBVC initiatives include: • Renal Supportive Care (RSC) - End Stage Kidney Disease-Palliative and End of Life Care • Management of Chronic Obstructive Pulmonary Disease (COPD) • Inpatient Management of Diabetes Mellitus • High Risk Foot Services (HRFS) • Management of Chronic Heart Failure • Wound Management • Direct Access Colonoscopy (DAC) for Positive Faecal Occult Blood Test • Hypo fractionated Radiotherapy - Breast Cancer • Bronchiolitis.

13.3 SWSLHD Planning

SWSLHD Strategic Plan 2018- 2021	This plan provides the overall plan for healthcare services development for SWSLHD to 2021. It describes how services will be implemented consistent with the CORE values of NSW Health and articulates a vision for SWSLHD of **Leading care, healthier communities**. Key principles underpinning the plan are delivering high quality health care, evidence based practice, consumer centred care, equity, learning and reflection, continuous quality improvement, innovation, sustainability, excellence and accountability, valuing and supporting the workforce, leadership and teamwork.
Clinical Services Planning and Redevelopments	Revised Clinical Services Plan for Liverpool Hospital to 2031 The Revised Clinical Services Plan for Liverpool Hospital to 2031 outlines detailed planning to a 2031 horizon for health services in Liverpool including ambulatory and hospital services. The Revised Clinical Service Plan (CSP) builds on the previous CSP document and provides further, in-depth detail on the clinical service requirements of Liverpool Hospital to support the redevelopment process. As part of the Liverpool Redevelopment there will be addition Complex Rehabilitation, Palliative Care and expansion of medical/surgical capacity.
	Macarthur Health Neighbourhood Clinical Services Plan to 2031 As part of 2017-2018 State Budget, the NSW Government announced $632 million for the redevelopment of Campbelltown Hospital. Planning has already commenced and the redevelopment will be delivered in stages over the next five years. The Clinical Services Plan for Macarthur to 2031 outlines detailed planning to a 2031 horizon for health services in Macarthur including ambulatory, community based and hospital services. It will inform the next stage of the redevelopment of Campbelltown Hospital and future planning for Camden Hospital and the proposed Integrated Health Hubs to be located at Oran Park and Wilton New Town. As part of the Campbelltown Redevelopment there will be addition Older Persons Mental Health, increased sub specialisation of older person medical services and additional medical/surgical capacity.
	Bankstown Clinical Services Framework to 2031 As part of 2019-20 State Budget, the NSW Government announced future funding for a new integrated health precinct in Bankstown. Leveraging the previous planning work, the Bankstown Clinical Services Framework to 2031 was commenced in late 2018 in collaboration with Bankstown - Lidcombe Hospital and SWSLHD stakeholders. Integrated Models of Care that outline services across the spectrum of care and including consideration of virtual care and other developing technologies will be established as part of this Clinical Services Plan. The Bankstown Clinical Services Framework to 2031 incorporates aged care and rehabilitation service developments and older person's mental health including specialist BPSD unit.

	South Highlands and District Health Neighbourhood Clinical Services Plan to 2031 To meet the challenges of the future, new and innovative ways of providing health services are required, the 2031 vision for the Southern Highlands Health Neighbourhood has been designed to meet these challenges. In addition, the Bowral & District Hospital's Model of Care document broadly defines the way the hospital delivers health services. It outlines best practice care and services options for the hospital's patients on all stages of their patient journey
SWSLHD Care in the Community (CITC) Clinical Services Plan to 2031	The Care in the Community Clinical Services Plan provides a direction for the future of primary care, ambulatory care and other community based services to meet the needs of the south west Sydney population. This work builds on existing partnerships between SWSLHD and other organisations such as SWSPHN, General Practitioners, local council and other community groups and non-government organisations.
SWSLHD Surgical and Procedural Services Plan to 2031	The SWSLHD Surgical and Procedural Services Plan to 2031 identifies the future models of care and service directions and priorities, including clinical networks and infrastructure required to meet projected demand across all forms of surgery and procedural work. The document aims to inform the development and enhancement of surgical and procedural services across SWSLHD by providing clear timeframes and plans for each facility.
SWSLHD Models of Care	SWSLHD Planning Unit in conjunction with a range of SWSLHD clinical and non-clinical stakeholders have developed a SWSLHD Model of Care (MoC) template and a guide to provide guidance to facilities and services with the development and documentation of the MoC particularly in relation to mapping of current and future services and support for service alignment with SWSLHD and facility Clinical Service Plans and Clinical Stream Plans. As part of the Bankstown Clinical Services Planning the following MoCs will be developed: Aged Care (Inpatient including Neurology and Stroke), Aged Care (Community / ASET), Rehabilitation and General Medicine and Medical Assessment Unit and Ambulatory Care / HITH. As part of the Macarthur Health Neighbourhood, Aged Care and Rehabilitation Services MoCs will be developed.
SWSLHD Virtual Care Strategy	The *SWSLHD Virtual Care Strategy* includes a 10 year vision for the adoption of Virtual Care in SWSLHD and identifies a set of integrated and coordinated capabilities that will shape the design and delivery of virtually enabled models of care in current and future infrastructure.
SWSLHD Advance Care Planning, End of Life and Palliative Care Strategic Plan 2016 - 2021	The *SWSLHD Advance Care Planning, End of Life and Palliative Care Strategic Plan 2016-2021* addresses three aspects of end of life: the need for an earlier focus on advance care planning; providing optimal end of life health care and access to specialist palliative care for people with complex palliative needs and their families.

SWSLHD Disability and Carers Strategy 2017-2022	The District understands that people with a disability have additional challenges in accessing the care that they need. SWSLHD recognises that carers are an integral partner in the provision of safe, quality healthcare. This Strategy aims to guide the District and all staff in ensuring that carers are valued and recognised, and that services and workplaces provide them with support.
Transforming Your Experience	*Transforming Your Experience* is SWSLHD's five year road map to positively transform how our patients, consumers, staff and communities experience our organisation and services. The Strategy provides us with a clear direction for working together to deliver safe and quality health services and build the health of our communities - now and into the future. ***Transforming Your Experience* is underpinned by four focus areas:** ◆ Consistent delivery, quality and safe care ◆ Personalised, individual care ◆ Respectful communication and genuine engagement ◆ Effective leadership and empowered staff. These areas combined will drive compassionate, personalised and quality care for our patients, carers and communities.
Consumer and Community Participation Framework 2016-2019	The Framework identifies a range of commitments to the implementation of participation partnerships between SWSLHD, its services and the communities. The flexible yet formal structure provides guidance to all health services and consumer/community representatives within the SWSLHD in undertaking consumer and community particpation. The current CCP Framework is under evaluation and review and new revised version will be soon endored.

14. Appendix 2: Subacute care definitions

Subacute care is defined as comprehensive goal-oriented inpatient care designed for a patient who has had an acute illness, injury, or exacerbation of a disease process; it is rendered either immediately after or instead of acute care hospitalisation, to treat specific active or complex medical conditions or to administer any necessary technically complex medical treatments in the context of the person's underlying long-term condition.

There are five recognised sub-acute care types: Rehabilitation, Palliative Care, Geriatric Evaluation and Management, and Psychogeriatric Care.

Palliative care is deemed out of the scope for this plan as it has been considered in greater detail in the SWSLHD Advance Care Planning, End of Life and Palliative Care Strategic Plan 2016 – 2021. However, it is important to acknowledge that the trajectory for ageing with declining psychological and physical function is prolonged and difficult to predict or manage. Therefore, this Plan will consider an importance of an early acknowledgment of progressive decline and advanced care planning and end of life discussions to allow for individual preferences to be addressed and managed.

Rehabilitation Care

Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating.

Rehabilitation is always:

- delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that includes negotiated goals within specified timeframes and formal assessment of functional ability.

Maintenance Care

Maintenance (or non-acute) care is care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition.

Following assessment or treatment, the patient does not require further complex assessment or stabilisation. Patients with a care type of 'maintenance care' often require care over an indefinite period.

Geriatric Evaluation and Management (GEM)

Geriatric Evaluation and Management care is care in which the primary clinical purpose or

treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions related to ageing, such as a tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems.

Geriatric Evaluation and Management is always:

- delivered under the management of, or informed by a clinician with specialised expertise in geriatric evaluation and management, and
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative timeframes and formal assessment of functional ability.

Psycho-geriatric

Psycho-geriatric care is care in which the primary clinical purpose or treatment goal is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance, caused by mental illness, age-related brain impairment or a physical condition.

Psycho-geriatric care is:

- delivered under the management of or informed by a clinician with specialised expertise in psychogeriatric care, and evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.