Health
South Western Sydney
Local Health District

SWSLHD Older Persons and Rehabilitation Plan

Scoping Paper

November 2019

PROJECT SUMMARY

Rationale of Project

The South Western Sydney Local Health District (SWSLHD) is going through a period of unprecedented growth. The population is expected to grow by a third between 2016 and 2031 from just under 1 million to around 1.3 million. The SWS's population is ageing rapidly, with a 74% increase in the number of people over 65 years of age by 2031. The highest growth of 92% will be in the age cohort 85 years and over.

The significant population growth, the ageing of the population and a trend of increasing burden of disease will have an impact on the SWSLHD's hospital and community services provision across the continuum of care including acute and subacute services as well as primary care, ambulatory care and other community based services into the future. Older person's and rehabilitation models of care can improve outcomes of recovery and minimize functional decline in vulnerable patients with chronic and complex care needs. The Older Persons and Rehabilitation Plan (the Plan) will inform development of evidence-based patient-focused models of care and future service directions for aged care and rehabilitation services within the SWSLHD.

Strategic Imperative

The SWSLHD provides health care services and supports to improve the health of people living in the local government areas (LGAs) of Fairfield, Liverpool, Camden, Campbelltown, Wollondilly, Wingecarribee and the former Bankstown LGA. These LGAs cover approximately 6,243 square kilometres, with urban, rural and semi-rural areas and sites identified for significant urban growth and environmental protection. It is estimated that currently around 966,450 people reside in the District.

The District is experiencing rapid population growth over the next 15 years, due to the high number of births and development of new housing estates. The SWSLHD population will grow by 33 % by 2031, with an additional 318,150 people, compared to 21% growth for the rest of NSW. The highest growth rate of 92% will be in the age cohort 85 years and over, followed by the 70 to 84 years age cohort with a growth of 81% between 2016 and 2031.[1] The significant population growth and the substantial development of growth centres within SWSLHD have meant that consideration of how and where health services will be provided in these areas as well as the more established areas is needed. There are about 61,000 people living with disability in the District. The number of people with disabilities will also increase with the ageing of the population.

The older persons and rehabilitation services system 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.

Reform of the mental health, aged care and disability systems has brought a significant change in an already complex system of care and support. 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.

The District is culturally and socioeconomically diverse with 43% of population born overseas and approximately 10% or 92,000 people reported speaking English 'not well or not at all' and 20% of people over 65 years of age. Majority of SWS population live in LGAs with higher than average levels of socioeconomic disadvantage compared to NSW.[2] Higher levels of disadvantage are linked to higher levels of disease risk factors and lower use of preventative health services.

Most people will remain healthy and active throughout their lives. However, some people particularly as they age, will find it increasingly difficult to manage due to chronic or persistent health problems, an injury or a disability, or a combination of these. Frailty is common in people requiring care and support at home, those who are housebound, long-term care residents, recipients of home care, and among older people admitted to hospital.
Researchers also have reported the negative effects of loneliness on health in old age. Loneliness, coupled with other physical and mental problems, gives rise to feelings of depression in the elderly persons.

With the significant growth of the older population and facing the challenge on how to deal with clearly increasing numbers of elderly frail clients with high levels of need, the development of comprehensive service plan for older persons and rehabilitation services in South West Sydney is vital.

People aged 65 years and older are extensive users of inpatient services with over 40% of all hospital admissions being for people over 65.[4] People over 80 years comprise only 3% of the population but represent 20% of all emergency admissions and 19% of acute bed days.[5] Older people presenting to the Emergency Department manifest high levels of acute morbidity, and are appropriately admitted. As cited in the Royal Melbourne Hospital's Evidence Based Guidelines: prevention of functional decline in elderly patients, between 34 and 50 per cent of older people experience functional decline in hospital, with as many as 30 per cent of people aged over 70 years returning home from a hospital stay with a reduced ability to perform the usual activities of daily living. 10 days in a hospital bed (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80.[6]

Given the increasing prevalence of chronic conditions in an aging population (e.g. cancer, diabetes, cardiovascular disease and respiratory problems) there is a high demand for the integrated, multidisciplinary rehabilitation services.
The provision of rehabilitation services for people with chronic conditions may result in greater health and improved psychosocial outcomes for the individual, reduced hospitalisations and length of stay (LOS), and reduced morbidity and mortality.

Age has also been cited as an independent risk factor for adverse events during surgical admissions. Surgical older patients are prone to numerous pathological insults over the course of their hospital admissions, all of which contribute to delayed recovery, longer (LOS), decreased chances of return to independent living and increased morbidity and mortality. Geriatricians remain well placed to guide and direct medical care of the older surgical patient. Orthogeriatric co-management that is an integrated model of care with shared responsibility improves time to surgery and reduces the length of hospital stay and mortality compared with orthopaedic care with geriatric consultation service and usual orthopaedic care, respectively.[7]

As the population ages, the number of older people with a diagnosable mental illness is projected to increase significantly. In particular, the number of older people with dementia and severe Behavioural & Psychological Symptoms of Dementia (BPSD) is expected to increase significantly, associated with the large growth in the number of people aged 85 years and over. People with dementia are known to have much longer length of stay in hospital and increased prevalence of adverse events (e.g. falls and pressure injury) than older people without dementia. In some circumstances, people with mental illness who are under 65 years can present with potential ageing-related problems causing significant functional disability and/or mental health problems in the context of dementia.
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.

Older people (over 75 years) are known to have a higher incidence of fall related injury than the rest of the population. Fall related injuries have a significant impact on the quality of life of older people and are a significant cost to the health system in terms of inpatient and residential aged care beds, medical and allied health staff, and pharmaceuticals.

The aged care patient requires multi-disciplinary support across the continuum of care, ranging from acute, post-acute, rehabilitation, maintenance and palliative care. This support is required in hospitals, the community and residential settings, depending on the unique needs of the client/carer at an individual point in time. This Plan strongly supports the need for both community support services and health services to actively work together by agreeing on protocols and processes to ensure that older people experience an integrated and effective transition from the health service's care settings back to the broader community.

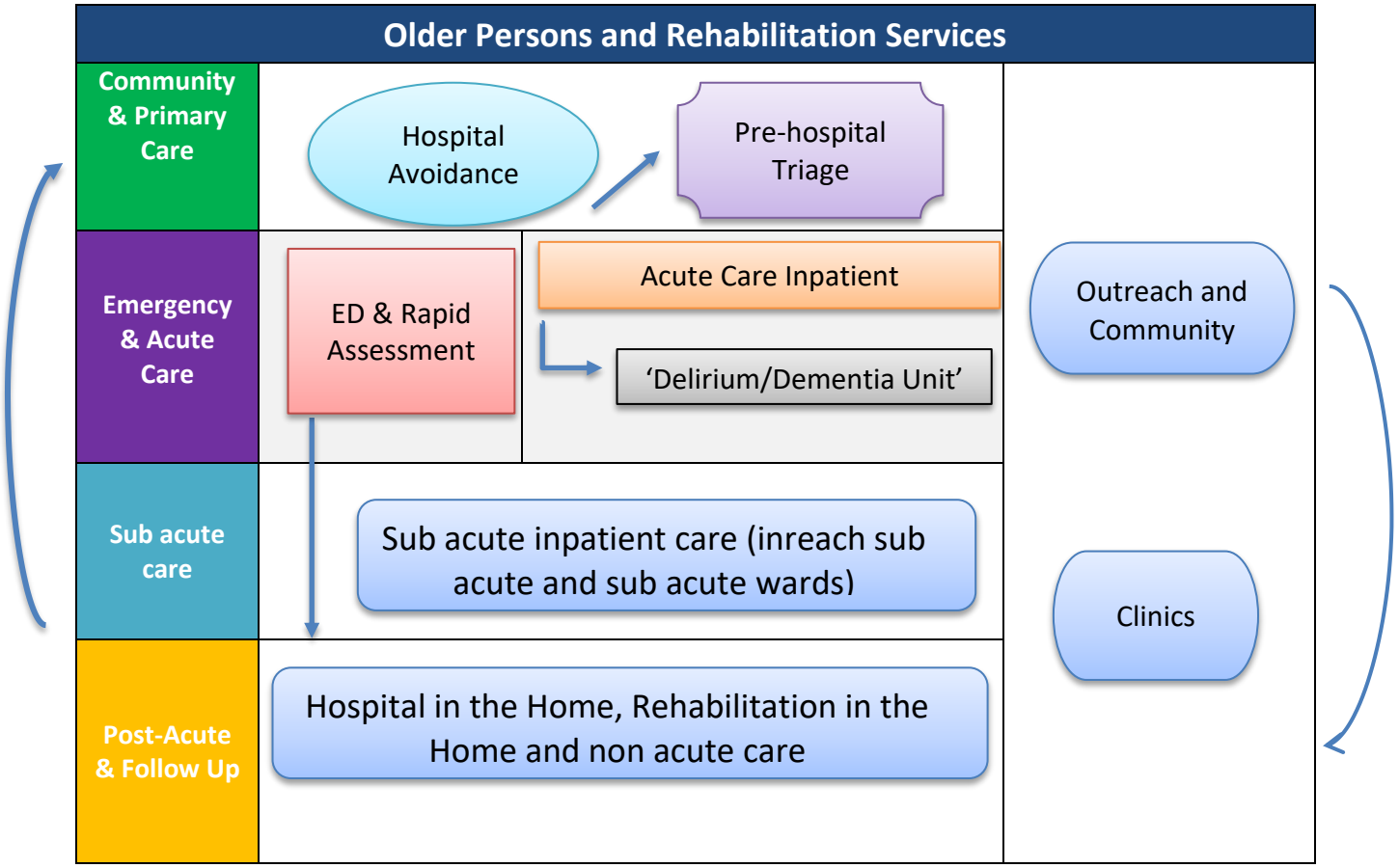

Figure 1. Schema of Older Persons and Rehabilitation Services within the SWSLHD

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. Refer to *Appendix 1* for definitions of each developed by the Agency of Clinical Innovation (ACI). 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.[8]

This Plan 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.

The *Older Persons* component of the Plan will address the health needs of all older people with either an acute or chronic condition, who have particular physical or mental disabilities, issues with care, accommodation and support, or with multiple medical or polypharmacy problems.

The *Rehabilitation* component of the Plan 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. Clients of the Rehabilitation Service have unique physical or mental disabilities and are also often in need of assistance with care, accommodation and/or support.

The purpose of the Older Person's and Rehabilitation Services Plan is to inform on:

- description and volume of current activity (inpatient/outpatient/ED) across the District
- service gaps- the type, level or location of older persons and rehabilitation services
- key drivers and future service demand new models of care based on community need and new technologies
- service and infrastructure requirements
- service and networking arrangements with key internal and external stakeholders
- affiliation with other older person's service providers

Policy Context

Clarity and direction for the complex system of older person's and rehabilitation services is provided through a range of national, state-wide and local policies and strategies.

- Commonwealth Plans and Guidelines including My Aged Care: central client record, regional assessment service for home support services, fee care estimator, web portal for clients and providers and Royal Commission into Aged Care Quality and Safety
- NSW Health Plans and Guidelines including the NSW State Health Plan: Towards 2021, NSW Aging Strategy 2016-2020, Agency for Clinical Innovations (ACI) Framework for Integrated Care for Older Persons with Complex Health Needs, NSW Service Plan for Older People's Mental Health Services 2017-2027, Integrated Surgical Care for Older People, Sub-Acute Care Type Policy Guidance
- SWSLHD Health Plans and Guidelines including SWSLHD Strategic Plan 2018-2021, SWSLHD Care in the Community Clinical Service Plan, SWSLHD Disability and Carers Strategy 2017-2022, Clinical Services Plan for Liverpool Hospital to 2031, Macarthur Clinical Services Plan to 2031, Addendum-Bowral and District Hospital CSP, the Draft SWSLHD Surgical and Procedural Services Plan to 2031 and the Draft Bankstown Clinical Services Framework.

Aim

The Plan outlines the purpose, scope, target group and key elements of older persons and rehabilitation services, the context in which they operate and current and future developments in the service environment. It identifies evidence-based models of care and key strategic priorities for the improving outcomes of aged care and rehabilitation clients.

Auspice of the Planning Framework

A Steering Committee will be convened to oversight the planning process and to make recommendations to the Board. Proposed membership of the Steering Committee is provided in Appendix 2.

The role of the Steering Committee will include but not be limited to:

- Identifying core stakeholders to be involved in the planning process
- Confirming objectives and priority strategies to be included in the Plan
- Reviewing and providing feedback on the draft Plan prior to circulation to core stakeholders for final comment
- Providing provisional endorsement of the final Plan prior to formal endorsement by SWSLHD Executive and SWSLHD Clinical and Quality Council

The Planning Unit will provide secretariat support.

Scope

The SWSLHD Older Person's and Rehabilitation Plan will provide a framework for older persons and rehabilitation service provision and infrastructure development required 2031. The potential structure for the Plan is outlined as follows:

- Policy and organisational context at a national, state and local level
- Identify the current health care needs of the different population groups and vulnerable groups (Aboriginal, Culturally and Linguistically Diverse (CALD), Lesbian, Gay, Bisexual, Transgender or Intersex (LGBTI), live in rural or remote areas, have a disability, dementia or chronic disease) and identify the significant population and demographic changes and its impact on demand for sub-acute care, including the diversity of the community,

access and equity
- Analysis of activity around Benchmarking with other LHDs – does the care we provide address the patient's need
- Document and review the older person/rehab patient journey with the LHD
- Review literature on evidence-based patient-focused models of care

- Explore current models of older persons and rehabilitation service provision, including strengths, limitations and opportunities for innovation
- Articulate how the Clinical Services Plans for Liverpool and Macarthur and the Draft Clinical Service Plan for Bankstown and Bowral allocate future activity in facilities such as Camden, Fairfield and Bankstown – Lidcombe Hospitals and Bowral and District Hospital and how these models of care will be used to further refine the development of future older persons and rehabilitation services across the LHD.
- Identify models to support early identification of frailty and intervention to promote enablement and prevent functional decline
- Identify enablers and barriers to the implementation and enhancement of older persons and rehabilitation service provision e.g. limited availability of private geriatric/rehabilitation practitioners in SWS
- Identify opportunities for virtual care including telehealth and telerehab
- Identify linkages and networking arrangements between all aspects of health service delivery including arrangements with non-government and private providers for the provision of required services.
- Identify what services would be appropriate to be provided within a hospital based setting as well as those that should be provided in alternative settings e.g. residential aged care facilities (RACFs) and community based
- Identify current service activity across SWSLHD and project activity to inform future service needs to 2031
- Investigate synergies with other service providers to identify opportunities for optimising delivery of appropriate health services to the growing population centres
- Determine governance and reporting responsibilities and accountabilities

A summary of the proposed planning process and timeframes for consultation is outlined in Appendix 2.

Key Questions to be addressed

- What is the current matrix of older persons and rehabilitation service provision across each facility of SWSLHD and those delivered by other internal and external stakeholders?
- What is the current and future demand for services with a view of population growth and ageing of population?
- What are the gaps and needs for the complete episode of care, including acute, allied health and rehabilitation?
- How can services be better integrated within health services across the LHD?
- What are the options for service development and realignment? Within the LHD? External to it?
- 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?
- What service models of care, networking arrangement and infrastructure are required to establish viable and sustainable older persons and rehabilitation service and where should they be located to facilitate access, equity and optimal cost efficiencies?
- What are implications of policy parameters such as ABF and targets in the National Partnership Agreement on the provision of sub-acute care in SWSLHD?
- What action is required to address gaps in system-wide enablers such as information technology, virtual care, business intelligence, workforce, professional development, teaching and research?

Conduct Planning

The majority of this process would be progressed within the in-house resources of the SWSLHD Planning Unit.

A Steering Committee is proposed to oversight and to direct the planning process. The major steps in planning are as follows.

1. Clinical and Quality Council and Steering Committee endorse the scope. Steering committee membership is confirmed
2. Prepare and revise background data and review current literature to inform discussions with significant stakeholders

3. Develop and undertake a broadly based consultation process with clinicians (specialists, nurses and allied health) and, General Practitioners (GPs) and other internal and external service providers which will identify strengths and gaps/deficiencies in older persons and rehabilitation services provision and support, and areas for future development
4. Undertake a data analysis exercise to determine current and projected older persons and rehabilitation service activity to 2031 – addressing flow reversals and levels of self sufficiency

5. Review and update models of care and network arrangements to guide future service and infrastructure enhancements
6. Steering Committee considers the information from stakeholders, and identifies key priority areas for action and elements of older persons and rehabilitation service models of care
7. Planning Unit summarises priorities and prepares a draft Plan which outlines challenges and proposed directions
8. Stakeholder consultations on the draft Plan undertaken
9. Finalisation and endorsement of the Plan through governing structures
10. Release of finalised Plan including publically through the SWSLHD Web page.

Refer Appendix 3 for Indicative Process and Timeframes

Preliminary List of Stakeholders

- Consumers, carers and family members
- Community groups
- SWSLHD Clinical Governance
- SWSLHD Medical Services
- SWSLHD Allied Health
- SWSLHD Primary and Community Health
- SWSLHD clinical stream directors including Cardiovascular Services, Aged Care and Rehabilitation, and Complex Care and Internal Medicine and Critical Care
- SWSLHD Oral Health Services
- SWSLHD Aboriginal Health,
- SWSLHD Population Health and Health Promotion
- SWSLHD Multicultural Health Service
- SWSLHD Mental Health Service
- SWSLHD Facility Executive including third schedule facilities
- SWSLHD Consumer/Community Council, networks, groups and community members
- SWSLHD Enabling Services e.g. Centre for Education and Workforce Development (CEWD),
- Information Management and Technology Division (IM&TD)
- SWSLHD Sustainable Access Manager
- Aboriginal Health Services e.g. SWSLHD Aboriginal health staff, Tharawal Aboriginal Medical Service and Gandangara Health Services (N.B. Process to be confirmed within an Aboriginal Health Impact Assessment)
- South Western Sydney PHN and GP groups
- NDIS representatives
- Government and non-government organisations (NGO) funded service providers
- Private providers
- Educational institutions e.g. Western Sydney University, University NSW Australia, University of Sydney and research institutes – Ingham Institute
- The Australasian Faculty of Rehabilitation Medicine
- The Australian and New Zealand Society for Geriatric Medicine
- Residential Aged Care Facilities, Community services
- ACI The Aged Health Network, MoH
- Council on the Ageing NSW
- Age and Ageing CAG of SPHERE
- Engage with other LHDs (such as Opera model from WSLHD)
- Silver Rainbow Ageing and Aged Care-LGBTI

Appendix 1

The five sub-acute care types have been defined within the context of patient care service provision by the Agency of Clinical Innovation[3] as:

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.

Palliative Care

Palliative care is care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.

Palliative care is always:

- delivered under the management of, or informed by a clinician with specialised expertise in palliative care, and
- evidenced by an individualised multidisciplinary assessment and management plan, which is documented in the patient's medical record, which covers the physical, psychological, emotional, social and spiritual needs of the patient and negotiated goals.

Appendix 2: Steering Committee Membership

Associate Professor Friedbert Kohler	Co-Chair, SWSLHD Clinical Stream Director, Aged Care and Rehabilitation
Sue Colley	Co-Chair, SWSLHD Director, Allied Health and Community
Susan Hair Katrina Stott Regina McDonald	SWSLHD Director of Nursing Representatives (Dementia/Delirium CNC)
Dr Tuan-Anh Nguyen Dr Milan Simic Dr Fintan O'Rourke	Head of Department Representative (Rehabilitation and Geriatrics)
Peter Rophail	GM Bankstown-Lidcombe Hospital, Facility General Manager Representative
Rosemary Fraser	Manager, Community Aged Care SWSLHD
Mick Rowls	DoN, P&CH, Community Nursing Representative
TBC	Representative of Aged Care Services Emergency Team (ASET) or Aged Care Rapid Investigation and Assessment (ARIA)
Dr Carmelo Aquilina	SWSLHD Older People's Mental Health
Bradley Warner	SWSLHD Clinical Manager, Aged Care and Rehabilitation
Matt Jennings	SWSLHD Senior Allied Health representative
TBC	Community Consumer Representative
TBC	SWSPHN Representative
TBC	SWSLHD Older People's Mental Health
Simone Proft	SWSLHD Manager, Planning
	SWSLHD Senior Planner, Planning

Appendix 3: Indicative Process and Timeframes

Objectives	Strategies	Indicative Timeframes
1. Scope planning	▪ Scoping Paper developed ▪ Scoping Paper considered by the SWSLHD Clinical and Quality Council	September-October 2019
2. Consolidate planning process	▪ Establish Steering Committee ▪ Engage with ACI and Ministry of Health on the project as relevant ▪ Consult with the Manager Community Participation and key CCC members and Director Aboriginal Health about preferred consultation processes ▪ Complete an Aboriginal Health Impact Assessment ▪ Consolidate and confirm detailed planning process and consultation approaches	February 2020
3. Identify current situation	▪ Identify the current health care needs of the different population age cohorts and groups ▪ Map existing services, networks and relationships ▪ Identify current planning for sub-acute services within existing CSPs or other planning documents/processes ▪ Literature review on the sub-acute models of care ▪ Identify and review current and projected activity ▪ Hold the first meeting of the Steering Committee ▪ In consultation with the Steering Committee, determine/finalise current consultation process i.e. in depth interviews, surveys, focus groups and consultation questions and key stakeholders	March -April 2020
4. Gain Stakeholder view	▪ Undertake consultation process – enablers and barriers, issues and strategies ▪ Progress consultations with consumers, carers and family members, internal and external service providers ▪ Establish working groups to identify and describe models/approaches ▪ Conduct peak workshop of LHD and external key stakeholders. Engage facilitator to assist with workshop. ▪ Conduct targeted meetings and discussions ▪ Ensure that needs of CALD communities and Aboriginal people are considered ▪ Summarise outcomes from consultations with communities and service providers	May-June 2020
5. Draft Plan	▪ Steering Committee to review feedback and identify priority areas for action ▪ Models of care delivery further refined ▪ Areas of strategic action drafted and consolidated ▪ Hold the second meeting of the Steering Committee	July 2020
6. Consultation on draft	▪ Draft document circulated for comment and meetings with targeted groups to confirm direction ▪ Discussion with CCC and via support and other groups with consumers ▪ Hold the third meeting of the Steering Committee	October 2020
7. Finalisation of the Draft Plan	▪ Steering Committee considers feedback and confirms implications for draft strategies including governance arrangements ▪ Draft CSP reviewed and finalised and strategies costed ▪ Hold the fourth meeting of the Steering Committee	December 2020

8. Approval	▪ Endorsement by SWSLHD Clinical and Quality Council and the Board ▪ CSP finalised, and sent to printers for publication ▪ CSP forwarded to key partners, facilities and streams ▪ Implement governance arrangements for the implementation	February 2021

References

1. NSW Department Planning and Environment, New South Wales State and Local Government Area Population Projections: 2016 Final.
2. Australian Bureau of Statistics (ABS) Census of Population and Housing 2016
3. Innovation, N. A. f. C., Subacute Care Type Policy Guidance - Aged Health, Palliative Care and Rehabilitation Networks. February 2017.
4. Australian Institute of Health and Welfare, and AIHW 2016. Australia's health 2016. Australia's health series no. 15. Cat No. AUS 199. Canberra: AIHW.
5. NSW Health Annual Report 2018.
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.
7. Baroni, M., Serra, R., Boccardi, V. et al. The orthogeriatric comanagement improves clinical outcomes of hip fracture in older adults. Osteoporos Int (2019) 30: 907. https://doi.org/10.1007/s00198-019-04858-2
8. Ken Hillman, Good life to the end. June 2017. 9781760294816.