

# Area Aged Care and Rehabilitation Services Plan

August 2006



**Aged Care and Rehabilitation Services Plan 2006-2010**

August 2006

**Further copies may be obtained:**

Via the Hunter New England Health Website

[http://intranet.hne.health.nsw.gov.au/strategic\\_\\_and\\_\\_service\\_planning\\_unit](http://intranet.hne.health.nsw.gov.au/strategic__and__service_planning_unit)

Hunter New England Health

Planning Unit

Locked Bag No 1

New Lambton 2305

Or phoning: HealthLink 1800063635

## TABLE OF CONTENTS

<b>1. EXECUTIVE SUMMARY</b>	<b>4</b>
<b>2. BACKGROUND</b>	<b>6</b>
2.1 Scope	6
2.2 Overview of Consultation Process and Feedback	7
2.3 Current Service Environment	8
2.4 Evidence to Support Plan Development	8
2.5 Current Service Provision	12
2.6 Community Services	12
2.7 Aged Care Assessment Teams	12
2.8 CAPAC, ComPacks and Back to Home Programs	13
2.9 Transitional Care and Residential Short-term Accommodation	13
2.10 Community Options, Carer Respite Services and CareLink	13
2.11 Residential Aged Care Facilities	14
2.12 Aged Care Emergency Teams	15
2.13 Acute Inpatient Services	16
2.14 Aged Care Services	17
2.15 Dementia Services	18
2.16 Rehabilitation Services	19
2.17 Carers	21
2.18 Strategic and Service Issues	22
2.19 Clinical Network	22
2.20 Building Capacity and Capability Across all HNE Health Settings	22
2.21 Models of Care	22
2.22 Dementia and Delirium	23
2.23 Younger People with Disabilities	23
2.24 Workforce	23
2.25 References	24
2.26 Service Triangles	25
2.27 Aboriginal Health Impact Statement	27
2.28 Ethnic Affairs Priority Statement	27
<b>3. STRATEGIC OBJECTIVES AND ACTION PLAN</b>	<b>28</b>
<b>4. APPENDICES</b>	<b>47</b>
Appendix 1 - NSW Health definition of an “aged care client”	47
Appendix 2 - Core Planning Group Members	48
Appendix 3 - Stakeholder Survey Letter	49
Appendix 4 - Stakeholder List	51
Appendix 5 - Stakeholder Engagement	52
Appendix 6 - Outline of Various Governments’ Responsibilities in Service Provision	56
Appendix 7 - Policy Documents and Background Papers	58
Appendix 8 - Diagram showing the distribution of disability and accommodation in groups over and under 60 years.	59
Appendix 9 - Aged Care Service Emergency Teams	60
Appendix 10 - Aboriginal Impact Statement	61

## 1. EXECUTIVE SUMMARY

The development of a Hunter New England Aged Care and Rehabilitation Services Plan has been identified as an Area priority. A core planning group comprising an Executive Sponsor, Planning Officer, clinicians, other relevant service representatives and a consumer commenced plan development in September 2005.

The Plan will guide the provision of services for older people and their carers and adults needing rehabilitation. It aims to improve opportunities for them to remain as independent and healthy as possible, and with the ability to participate in community life. Equity of access to quality services, effective and coordinated use of resources, and the development of partnerships and linkages across the geographical and cross cultural diversity of the Hunter New England area are challenges the plan seeks to address through the initiatives proposed, and, in particular, through the development of a Clinical Network.

The establishment of the Clinical Network for Aged Care and Rehabilitation Services will work across our area to provide strategic leadership and direction for our aged care and rehabilitation services. Its responsibilities will include service planning and development, clinical governance, information, workforce issues, professional development and support for staff.

Building on existing aged care and rehabilitation plans and structures, a range of additional consultation strategies to engage internal and external stakeholders were undertaken in the development of this plan. Key directions, endorsed by stakeholders and driven by demographic imperatives include:

- Developing area-wide workforce competence and capacity in the fields of aged care and rehabilitation.  
*The concept of the care of older people being the domain of some discrete aged care services is superseded by the clear fact that providing care that meets the needs of older people is core business for the Acute Hospital Networks as well the Primary and Community Clusters. Education, training and development of all staff working in adult services are essential. Timely access to rural allied health services and specialist aged care and rehabilitation services have also been identified as a matter of concern.*
- Developing new models in the provision of rehabilitation and aged care.  
*It is recognised that the patient, carer and the General Practitioner are the primary basis of health care, and that multi-disciplinary, home-based acute and post-acute care may be a safer and more effective approach to the provision of rehabilitation and aged care. The Plan proposes that significant resources be allocated to hospital diversion and early discharge programs.*
- Improving the recognition and management of delirium and dementia.  
*The allocation of additional resources aimed at improving diagnosis, carer support, education, community case management, and assessment and management of 'behaviours of concern' in all emergency departments, hospitals, community health centres and other Hunter New England Health facilities will be required.*

- Improving discharge outcomes for adults with severe post-trauma disabilities.  
*Working together with the Department of Ageing Disability and Home Care to improve services and accommodation options for younger adults, including both people with severe physical disabilities needing 'hands on' care and people whose post-acute deficits are more around the need for ongoing supervision of personal safety, was also identified as an area of significant concern.*

The plan is divided into four sections:

1. Part A - Executive Summary
2. Part B - Background, current service provision and projections and process requirements for the plan
3. Part C – Service's strategy map, objectives and strategic action plan, and an estimate of the resources required to implement proposed initiatives
4. Part D - Appendices

During the development of this plan, consideration has been given to the budgetary requirements of the strategies included, and an attempt has been made to be realistic and prudent in costing proposals. The authors understand that finances are limited and not all strategies may be able to be addressed without budget supplementation.

## 2. BACKGROUND

The Aged Care and Rehabilitation Services (ACARS) plan for Hunter New England (HNE) Health describes the provision of services for adults needing rehabilitation as well as older people and their carers. The Area's vision of *'Healthier Communities: Excellence in Health Care'* is focused, in this plan, on working with our communities to deliver quality aged care and rehabilitation services, and to improve opportunities for people to remain as independent and healthy as possible and able to participate in community life. HNE Health's Aged Care and Rehabilitation Services aim to complement and supplement services provided by General Practice, which is the central and primary basis of health care in Australia. Strategies included in this plan are based on NSW Health's Strategic Directions for the next twenty years (Planning for the Future NSW Health 2025) with the four overarching goals of: keeping people healthy, providing the health care that people need, delivering high quality services and effectively managing health services.

Specialised HNE Health's Aged Care and Rehabilitation Services (ACARS) include the following:

- Aged Care Assessment Teams
- Carer Education and Support Services
- Commonwealth Carer Respite Services
- CareLink
- Community Options Program
- Confused and Disturbed Elderly Units
- Dementia Services
- Geriatrician and Rehabilitation Staff Specialists
- HNE Health Residential Aged Care Facilities
- Inpatient, Outpatient and Community Rehabilitation Services
- Post-acute and Community Stroke Services
- Rehabilitation Day Hospitals
- Transitional Living Unit (Brain Injury Service)
- Resident Short-term Accommodation Service

Service provision addressed in this plan is not limited to services that are the usual domain of aged care and rehabilitation, such as the services provided by Geriatricians and Rehabilitation Specialists. The appropriate delivery of rehabilitation, aged care and dementia care services across all HNE Health care settings and clusters will be supported by the Aged Care and Rehabilitation Service Clinical Network in collaboration with the General Managers of the Acute Hospital and Primary and Community Networks. The development phase of the Aged Care and Rehabilitation Services Clinical Network (CN) has commenced. It is anticipated that the Network will be functioning by October 2006.

### 2.1 Scope

Across the HNE area aged care and rehabilitation services are needed by people residing in urban, rural and remote communities as well as people from culturally and linguistically diverse backgrounds including significant communities of Aboriginal and Torres Strait Islander People. While sixty-five years of age is traditionally used as the point where the term 'older aged' may be applied in the non-Aboriginal community, Aboriginal people would regard a person over 45 years as an older person requiring aged care services. Aboriginal people experience significantly greater morbidity and premature mortality due to, among other things, the increased prevalence of chronic conditions such as cardiovascular disease, diabetes, kidney disease, chronic respiratory disease and cancer compared with non-Aboriginal people.<sup>1</sup>

The 'NSW Health Framework for integrated support and management of older people in the NSW health care system 2004-2006' defines an 'aged care patient' not in terms of

being over 65 years, but rather in terms of whether they are likely to be consumers of health care services. The Framework definitions of an aged care patient are included as Appendix 1.

In summary the population groups that this plan addresses are:

- Older people, usually Aboriginal and Torres Straight Islanders 45 years and over and non-Aboriginal people 65 years and over
- People under 65 years who have 'age-related' conditions
- Adults (usually over 15 years) requiring rehabilitation services
- The carers of the above groups
- The wider community in terms of healthy living strategies

## **2.2 Overview of Consultation Process and Feedback**

Internal and external stakeholders were identified and consulted at various stages during the planning process. Members of the core planning group (Appendix 2) also ensured that the plan aligned with relevant state initiatives and frameworks.

A Communications Officer was assigned to the plan and provided assistance and advice on communication issues. An Aboriginal Health Worker and a Multicultural Health Worker also provided advice to the group and appropriate initiatives have been included in the strategic action plan.

In addition a recent assessment was conducted for NSW Health in relation to the "Framework for integrated support and management of older people in the NSW health care system". The Framework required reporting to NSW Health on the provision of care to older people and facilitated identification of some key issues in the provision of these services for HNE Health.

Stakeholder feedback was provided by the use of written and phone surveys, individual and group meetings at various sites and invitations to make comments on draft documents (copy of the stakeholder survey letter is included as Appendix 3). A wide range of stakeholders were invited to review and comment on the background paper and strategic action plan and included NGO's, GP's, allied health, Aboriginal Health, Multicultural Health, Population Health, private aged care providers, mental health, palliative care and University staff (refer to Appendix 4 for stakeholder list). A consumer representative on the core planning group ensured representation from consumer groups, and feedback was also provided by the HNE Community Forums on Health. Feedback identified key issues in the provision of Aged Care and Rehabilitation Services and how the issues could be best addressed over a five-year period. Responses to the surveys were received from both rural and urban areas of the Hunter New England Health Service.

Improved work-force planning (building capability and competence) followed by increasing capacity and flexibility in provision of rehabilitation services, and improving our approach to dementia and delirium were identified as the most important issues. Responses also indicated that there is currently a lack of coordinated service provision across the area. The implementation of this service plan and the establishment of the Clinical Network for Aged Care and Rehabilitation will begin to address these identified issues.

More specific details of stakeholder engagement and feedback are included as Appendix 5.

### 2.3 Current Service Environment

The service environment for the delivery of ACAR Services is complicated by the various levels of Commonwealth, State and Local government involved, as well as the challenges presented by the geography of the HNE area. An outline of the various government responsibilities is included as Appendix 6. A list of policy documents and background papers relevant to the development and context of this plan is included as Appendix 7.

Access is a major barrier to equity of service provision and is influenced by geographic, economic and socio-cultural factors. There are significant challenges posed in providing equitable health care services to urban, rural and remote communities. This is further exacerbated by the nature of ACARS patients who, by virtue of being aged and/or disabled are often less mobile than others. The challenges for rural and remote services are particularly apparent where resources are often limited.

The structures in place prior to the formation of HNE Health are summarised as follows:

- In the Lower Mid-North Coast an Aged Care and Rehabilitation (ACAR) Clinical Stream reported to the Primary Health and Extended Care Directorate. A Geriatrician Clinical Leader, a Senior Nurse Manager and Manager of Aged Care and Rehabilitation provided operational management. Every six months the entire ACAR Stream met for a day for education and staff development
- In the New England (NE) Area there were diverse aged care and rehabilitation groups managed by General Managers. Expert Working Groups (EWGs) in both "Aged and Dementia" and "Rehabilitation" met bi-monthly. These EWGs had wide representation from internal and external stakeholders, were forums for the developments of partnerships and policy, and feed up to the NE Clinical Council through the Northern Medical and Extended Care Clinical Stream
- In the Greater Newcastle Cluster the Aged Care, Community and Rehabilitation Service (renamed the CARE Network) was established in 2003. The management team of a General Manager, Clinical Director, Director of Allied Health and Business Manager reported to a member of the Area Executive. Monthly forums of managers and clinicians provided two-way communication to the services, facilities and management. Geriatrics and Rehabilitation Services provided regular consultation to the Lower Hunter, whereas the Upper Hunter had a visiting Geriatrician and limited Rehabilitation consultation service

### 2.4 Evidence to Support Plan Development

#### *Demographics*

The population of the HNE area is ageing. In relation to the proportion of the population aged 65 years and older, Table 1 shows that proportions will increase across all clusters and by 2011 four clusters will have significant older populations – Lower Mid North Coast 25%, Peel 18%, Tablelands 17% and Upper Hunter 16%. While ageing itself is not a disease, the burden that morbidity associated with ageing places on the health care system is well documented. It is estimated that by 2011 patients aged over 65 years will comprise 38% of NSW public hospital admissions and occupy 52% of beds days.

A snapshot of bed occupancy at the John Hunter Hospital taken on the 7<sup>th</sup> March 2006 showed that in the medical wards, 55% of the 130 beds were occupied by patients who were 65 years or over and, similarly in the surgical wards on the same day 55 % of the beds were occupied by persons 65 years and over. These results confirm that Aged Care is core business for the Acute Hospital Sector as well the designated Aged Care Services.

**Table 1: Population Changes by Cluster**

<b>Cluster</b>	<b>Number 2006</b>	<b>Number 2011</b>	<b>% Growth 2006- 2011</b>	<b>% 65+ yrs 2006</b>	<b>% 65+ yrs 2011</b>	<b>% ≤14 yrs 2006</b>	<b>% ≤14 yrs 2011</b>
Greater Newcastle	402,580	414,060	2.9	10.69	12.1	12.6	11.6
Lower Hunter	140,020	145,600	3.9	12.6	14.4	21.8	20.2
Lower Mid North Coast	85,930	89,230	3.8	22.6	24.8	18.3	16.6
Mehi	30,130	29,540	-1.9	11.4	12.9	22.9	21
McIntyre	20,710	20,180	-2.5	8.06	8.8	9.5	8.8
Peel	73,090	73,990	1.23	15.8	17.6	21.1	16.7
Tablelands	50,870	50,670	-0.39	15	17	10.5	9.5
Upper Hunter	34,340	33,690	-1.89	13.7	15.9	21.7	20.4
<b>HNE TOTALS</b>	<b>837,670</b>	<b>856,870</b>	<b>2.3</b>	<b>13</b>	<b>14.7</b>	<b>16</b>	<b>14.5</b>

Ref: DIPNR Dec 2004

Table 2 shows the estimated Aboriginal population ( $\geq 45$  years) by Local Government Area (LGA). The LGAs of Lake Macquarie, Moree, Newcastle and Tamworth have the largest number of Aboriginal people in the older age groups.

**Table 2: HNE Estimated Aboriginal Resident Population: 45 years and Older (ABS 2004)**

<b>Cluster: Greater Newcastle</b>									
LGA	45-49	50-54	55-59	60-64	65-69	70-74	75+	Total by LGA)	Cluster Total
Lake Macquarie	205	118	90	95	50	29	19	606	
Newcastle	139	106	73	55	30	17	24	444	
Port Stephens	81	56	45	27	24	10	13	256	
Total by age group	425	280	208	177	104	56	56		<b>1,306</b>
<b>Cluster: Lower Hunter</b>									
Cessnock	67	52	38	24	9	7	10	207	
Dungog	14	8	4	3	3	1	1	34	
Maitland	64	51	35	13	9	11	9	192	
Singleton	33	16	18	8	6	1	0	82	
Total by age group	178	127	95	48	27	20	20		<b>515</b>
<b>Cluster: Lower Mid North Coast</b>									
Gloucester	8	4	4	3	4	1	2	26	
Great Lakes	57	45	35	24	18	15	9	203	
Greater Taree	80	57	46	34	29	16	6	268	
Total by age group	145	106	85	61	51	32	17		<b>497</b>
<b>Cluster: McIntyre</b>									
Bingara	2	1	3	0	0	0	0	6	
Inverell	41	30	24	11	12	5	6	129	
Yallaro	2	4	4	2	2	0	0	14	
Total by age group	45	35	31	13	14	5	6		<b>149</b>
<b>Cluster: Mehi</b>									
Moree	142	118	130	76	44	30	21	561	
Narrabri	62	40	34	25	27	14	5	207	
Total by age group	204	158	164	101	71	44	26		<b>768</b>
<b>Cluster: Peel</b>									
Barraba	4	4	6	4	1	0	1	20	
Gunnedah	66	59	48	41	34	11	13	272	
Manilla	10	11	11	5	1	1	0	39	
Nundle	7	2	1	1	2	1	2	16	
Parry	40	23	20	17	10	6	9	125	
Tamworth	102	97	62	39	21	16	18	355	
Walcha	12	10	6	2	2	5	4	41	
Total by age group	241	206	154	109	71	40	47		<b>868</b>
<b>Cluster: Tablelands</b>									
Armidale/Dumaresq	70	41	36	24	14	12	6	203	
Glen Innes	11	9	6	4	3	3	7	43	
Guyra	14	23	8	9	3	6	2	65	
Severn	9	3	5	1	1	0	0	19	
Tenterfield	16	10	11	6	5	0	5	53	
Uralla	19	18	15	8	8	2	5	75	
Total by age group	139	104	81	52	34	23	25		<b>458</b>
<b>Cluster: Upper Hunter</b>									
Merriwa	1	2	1	4	0	0	0	8	
Murrurundi	2	2	2	0	0	1	1	8	
Muswellbrook	19	13	23	4	1	1	0	61	
Quirindi	11	19	22	6	10	5	3	76	
Scone	10	3	7	5	2	2	3	32	
Total by age group	43	39	55	19	13	9	7		<b>185</b>

### *Disability and Accommodation*

The Australian Bureau of Statistics (ABS) provides reports on disability using 60 years as the age separation. In 2003, Australia-wide, 17% of the population were aged 60 years and over. Fifty one percent had a reported disability and 19% had a profound or severe core-activity limitation. Less than half (41%) reported needing assistance, because of disability or old age, to manage health conditions or cope with everyday activities. However, people aged 85 years and over reported a much higher need for assistance than those aged 60-69 years (84% compared with 26%). Only 5% of people 60 years and over live in 'cared accommodation' and 3.7% lived in 'other non-private dwellings', such as self-care units in retirement villages etc. A diagram showing the distribution of disability and accommodation in groups aged over and under 60 years is included in Appendix 2.

Whilst the demographics of the aged population have been discussed previously, there is also a need to consider younger adults with a disability. Table 3 highlights that there are still significant numbers of individuals (28%) who fall outside the 'aged care' system but present with disabilities requiring ongoing management and support, and in some instances life time care. For these younger adult patients, models of rehabilitation need to be explored and relationships with long-term community support agencies strengthened.

**Table 3: HNE Health Separations for Rehabilitation Service Groups 2001-05**

Rehabilitation Service Related Group Separations for HNE Health					
Sum of Separations	Financial year				% of grand total financial year 04/05
Age_Groups	fy 01/02	fy02/03	fy03/04	fy04/05	
0-4	1	3	0	0	0
5-9	4	0	0	2	0
10-14	4	3	2	8	0
<b>Sub total for 0-14yrs</b>	<b>9</b>	<b>6</b>	<b>1</b>	<b>10</b>	<b>0%</b>
15-19	18	27	19	30	1
20-24	20	17	29	21	1
25-29	17	24	21	23	1
30-34	42	44	33	26	1
35-39	37	36	38	59	3
40-44	52	46	46	47	2
45-49	60	47	34	66	3
50-54	31	67	38	65	3
55-59	65	71	78	147	7
60-64	99	85	104	121	6
<b>Sub-Total for 15-64yrs</b>	<b>441</b>	<b>464</b>	<b>440</b>	<b>605</b>	<b>28%</b>
65-69	135	175	167	176	8
70-74	209	250	261	252	12
75-79	219	288	364	314	15
80-84	270	345	351	355	17
85+	361	431	457	430	20
<b>Sub Total for 65+yrs</b>	<b>1194</b>	<b>1489</b>	<b>1600</b>	<b>1527</b>	<b>72%</b>
<b>Grand Total</b>	<b>1644</b>	<b>1959</b>	<b>2042</b>	<b>2142</b>	<b>100%</b>

## 2.5 Current Service Provision

Aged care and rehabilitation services are currently provided across the Hunter New England area by both generalist and specialist healthcare teams based in a variety of settings. Settings include community health centres, acute hospitals, residential aged care facilities and in the home.

## 2.6 Community Services

The role and service provision of HNE Health community health services extends beyond the provision of care to 'aged care and rehabilitation' patients. Wound-care, immunisation, screening and allied health services are examples of the diversity of community health services. However, a significant proportion of the community health service patients are older people.

Funding sources for community health services includes State funding through HNE Health, Commonwealth funding through Home and Community Care (HACC), and some DVA contracts. In some HNE Health community settings the same staff may target the same patients funded by a variety of sources because of the efficiencies gained. Whereas in other settings such as the Lower Mid North Coast (LMNC), the Aged Care Community Staff are in different locations and have separate management to the HACC and generalist community nurses.

The diversity and geography of HNE Health is evident in the models of service available to different areas. Remote community aged care and rehabilitation services are frequently delivered by a sole practitioner who also provides a generalist service to the community. Access to allied health and specialist medical services is either infrequent and/or involves traveling long distances, either for the patient and carer or for HNE Health staff.

## 2.7 Aged Care Assessment Teams

The rapidly ageing population profile is placing unprecedented demands on community-based aged care and rehabilitation services. Older people are frequently 'ageing in place' with multiple disabilities.

HNE Health Aged Care Assessment Teams (ACATs) have been effective in reducing waiting times for assessments of older people, but there are still some areas where waiting times for people needing ACAT assessments are outside acceptable benchmarks.

In the Northern region there are three ACAT teams, in Lower Mid North Coast there is one team based in Wingham and the Southern Region has three teams. The ACATs are usually co-located in Community Health Centres.

With more people being supported in the community, ACATs and community aged care teams have longer-term involvement with clients who have complex needs requiring ongoing review and management. A more coordinated approach is needed in relation to the roles performed by various healthcare providers. For example, ACAT and Community Health staff may both conduct client assessments. A community nurse may complete a Community Health Service assessment and then refers the client to an ACAT Occupational Therapist to conduct an ACAT assessment who then may refer to a dementia worker for a dementia assessment. This duplication highlights the need to develop efficiencies in multi-tasking and emphasises the usefulness of a shared common assessment tool.

Ninety percent of clients referred to ACAT have some degree of brain failure and the integration of dementia staff, ACAT teams and other Community Aged Care staff will progress the Australian Government's policy of "supporting healthy ageing for older

Australians and *quality, cost effective care* for frail older people and support for their carers".<sup>5</sup>

### **2.8 CAPAC, ComPacks and Back to Home Programs**

There are real risks associated with older people remaining in an acute hospital, such as deconditioning and exposure to pathogens. Older patients have benefited from provision of a range of person-centred early discharge options, such as Community And Post Acute Care (Southern), Back to Home (Northern), Aged Care Transitional Intervention Program (LMNC) and ComPacks (a NSW Health funded, case managed package of care for up to six weeks after discharge from some public hospitals). These services offer rapid access to multidisciplinary post-discharge community services. A sustained expansion of post-discharge services to align with the increasing demand older people will place on acute hospital beds will be necessary over the span of this service plan. The pilot Sub-Acute Fast Track Elderly (SAFTE) program is exploring the opportunities to prevent admission of older people with emerging health crises.

### **2.9 Transitional Care and Residential Short-term Accommodation**

Residential short-term beds are currently available in the Greater Newcastle and Lower Hunter Clusters. These programs provide an opportunity to consider the longer-term needs of patients in a stable sub-acute environment, and to facilitate, in consultation with the patient, carers, and long-term providers of Aged Care Services, a smooth and seamless transition from acute to long-term care and/or residential accommodation.

The target group for this service to date has been patients who are currently in acute care, are 65 years or older, (younger people are considered on a case by case basis), are medically stable and also have been identified as requiring long-term care and/or residential services, and, who have a delegated Aged Care Client Record which accurately reflects their current care needs.

A new Transitional Care Program is currently being implemented and will expand the availability of both community and residential transitional care beds in Greater Newcastle, Lower Mid North Coast and Tamworth.

### **2.10 Community Options, Carer Respite Services and CareLink**

Community Options services aim to reduce inappropriate admissions to institutional care among highly dependent people and those with complex care needs, but who could nonetheless remain at home with appropriate support. A range of support services is coordinated by Community Options. Actual service provision is usually brokered out.

Commonwealth Carer Respite Centre is a coordination service for short term or emergency respite to assist carers of:

- Young people with disabilities
- The frail elderly
- People with chronic illness or mental illness
- Those receiving palliative care

The service aims to enable people to remain in their own home as long as possible by giving carers a break and by supporting carers during periods of increased stress. Commonwealth Carelink Centres are information centres for older people, people with disabilities and those who provide care and services. Centres provide free and confidential information on community aged care, disability and other support services available locally, interstate or anywhere within Australia. These three services are funded from a variety of sources and are auspiced in different ways across the old boundaries of Area Health Services.

## 2.11 Residential Aged Care Facilities

HNE Health has residential aged care facilities at Wallsend, Gloucester, and Muswellbrook as well as having designated aged care beds in most Rural Hospital and Health Services, totalling around two hundred beds altogether. A review of the current status and future use of all NSW Health Residential Aged Care Facilities including those in HNE Health is currently underway.

Most residential aged care is provided by Non-Government Organisations and funded by the Commonwealth Government. HNE Health has a commitment to continue to develop linkages with the Residential Aged Care Sector that will optimise person-centred health care for older people. Table 4 lists all the residential care beds by cluster (including HNE Health aged care beds and non-Government beds) and identifies those areas where additional licences have been allocated.

**Table 4: All Residential Aged Care Beds in HNE (includes HNE and NGO beds)**

Cluster	LGA	Available Beds	Additional Licences Allocated (but beds unavailable)
Greater Newcastle	Lake Macquarie	1561	
Greater Newcastle	Newcastle	1793	110
Greater Newcastle	Port Stephens	493	384
Lower Hunter	Maitland	313	
Lower Hunter	Cessnock	559	
Lower Hunter	Singleton	461	
Lower Hunter	Dungog	63	
LMNC	Great Lakes	512	180
LMNC	Greater Taree	396	210
Peel	Tamworth	421	67
Peel	Walcha	43	
Peel	Gunnedah	118	30
Upper Hunter	Liverpool Plains	68	
McIntyre	Inverell	163	13
McIntyre	Gwydir	22	
Tablelands	Glen Innes	131	
Tablelands	Armidale Dumaresq	225	36
Tablelands	Tenterfield	65	
Tablelands	Uralla	32	3
Mehi	Narrabri	123	
Mehi	Moree Plains	122	
	<b>Total available beds</b>	<b>7684</b>	
	<b>*Extra licenses (but beds not available)</b>		<b>1033</b>
	<b>Total Licenses</b>		<b>8717</b>

\* licence has been allocated, but the actual bed or facility has not been "built"

The Commonwealth Government has a ratio for operational residential care places of 108 places for every 1000 people aged 70 years and over. Using this ratio, the HNE will need 11,514 operational places by 2011. Operational places include residential beds as well as community aged care packages (CACPs) and extended aged care in the home (EACH) packages, broken down as follows:

- For every 1000 people aged 70 years:
  - 40 high care
  - 48 low care
  - 20 community packages

According to the above ratio the HNE area will require 9,382 beds in residential aged care facilities by 2011 (an increase of 1698 available beds).

Having the optimum number of operational places available is important for the delivery of safe, effective and efficient health care for the Hunter New England region. The Clinical Network will be proactive in progressing this program.

## 2.12 Aged Care Emergency Teams

Large numbers of older people are presenting to HNE Health Emergency Departments (EDs). Alongside the imperative to respond rapidly to the acute needs of frail aged people is the need to ensure EDs are 'age-friendly' and prepared for the doubling in number of the 80+ years patients over the next decade. Aged Care Service Emergency Teams (ASET) have been effective in introducing 'aged care' to the larger EDs, and have become an integral part of the landscape in those EDs. The core elements of ASET services are described in Appendix 6. Table 5 shows the number of presentations to EDs (excluding MPSs), by patients over 65 years and 80 years. Availability of ASET services are also included.

**Table 5: ED Presentations 04-05 Financial Year by Age & Facility**

ED (excluding MPSs)	65 yrs and over	80 yrs and over	ASET Availability
Belmont	4160	1660	M-F 8-4.30
Armidale	1675	604	
Cessnock	2227	781	
Dungog	412	143	
Kurri Kurri	1070	389	
John Hunter	10,071	4212	7days 8-4.30
Maitland	4488	1659	M-Thur 8-4.30
Manning	4776	1739	4 shifts / week
Moree	603	153	
Tomaree	1512	558	
Mater	6293	2422	7 days 8-4.30
Scott Memorial	176	82	
Singleton	852	269	
Tamworth	5343	1780	5 days 8-4.30

Table 6 shows that for the 2004-05 financial year presentations to HNE Health EDs included:

- 44,459 presentations by 28,754 different people 65 years and over, which included
- 16,677 presentations by 10,785 different people 80 years and over. In other words, 30% of people 80 years and over in the HNE area present to ED at least once a year.

Table 6 also shows that a high percentage of the older patients presenting to EDs are admitted. Appropriate aged care assessment in the ED and the availability of community services such as CAPAC and ComPacks can increase opportunities for older people to avoid admission to hospital.

**Table 6: ED Presentations and Dispositions July 2004-June 2005**

<b>HNE ED (including MPSs) Presentations by Admission Status by Age Group</b>				
Admissions = Dispositions: 1, 2, 3, 10, 11 & 12				
Non-admissions = Dispositions: 4, 5, 6, 7, 8 & 9				
From: 1/07/2004 to: 30/6/2005				
Age Group	Admitted	Non-admitted	Total	Percent of grand total of presentations who are admitted to hospital
<b>Total 0- 64 yrs</b>	<b>31240</b>	<b>175959</b>	<b>208565</b>	<b>15</b>
65-69 yrs	3327	5562	8942	37
70-74 yrs	3908	4955	8894	44
75-79 yrs	4992	4932	9946	50
<b>Total 65 –79yrs</b>	<b>12227</b>	<b>15449</b>	<b>27782</b>	<b>44</b>
80-84 yrs	4660	3916	8592	54
85+ yrs	4746	3323	8085	59
<b>Total 80 + yrs</b>	<b>9406</b>	<b>7239</b>	<b>16677</b>	<b>56</b>
<b>Total 65 + yrs</b>	<b>21633</b>	<b>22688</b>	<b>44459</b>	<b>49</b>
<b>Grand Total all ages</b>	<b>52873</b>	<b>198647</b>	<b>253024</b>	<b>21</b>

Data from John Hunter Hospital ED for the calendar year 2005 shows that those patients seen by ASET were less likely to be admitted.

- There were 6666 presentations of patients 75+ years of whom 58% were admitted
- 1024 of those presentations 75+ years were seen by ASET and 48% were admitted

Enhancement of current service provision as well as the introduction of ASET type assessment in the remainder of the HNE Health EDs will be needed in order to improve discharge outcomes for the increasing numbers of older patients presenting. Improvement in the capacity and competence of all EDs with respect to aged care and rehabilitation assessment is essential.

### **2.13 Acute Inpatient Services**

Currently there are limited acute inpatient beds directly under the care of a Geriatrician. Most aged care and rehabilitation services in the acute inpatient sector are consultation services and response time from request to consultation varies across the area. The employment of two more staff specialists in the Northern area (one geriatrician and one rehabilitation physician) is proposed to improve equity of access to services across HNE Health.

As stated previously, in 2011, patients aged over 65 years will comprise 38% of NSW public hospital admissions and 52% of bed days. It is clear that the traditional method of treating the specific problem such as the heart or the gall bladder, while ignoring the complexities of caring for 'aged care or rehabilitation patients' until the need for a referral to rehabilitation or geriatrics arises is not sustainable long term.

As well as providing specialist services, the Aged Care and Rehabilitation Clinical Network will have as one of its key aims, facilitating education, training, policy and development guidelines to normalise the assessment and management of ACARS patients into the routine practice of the various disciplines. The prevention of secondary impairments and adverse events such as loss of mobility, prolonged delirium and pressure ulcers will reduce acute length of stay and facilitate the more appropriate referral of those patients who require either a multidisciplinary rehabilitation program or a period of 'enablement' in transitional care. The development of clinical nurse specialists in

aged care in those wards and facilities where the numbers of older people are increasing, and the recognition and support of clinical leaders in allied health, will provide a network for clinical education to reach the bedside and extend across the area in an equitable and consistent manner.

### **2.14 Aged Care Services**

At the centre of an effective age care service is a nexus of the patient, the carer and the general practitioner. The support of this structure is paramount in the delivery of person-centred aged care.

Aged care is best provided in a multidisciplinary environment. Older people who have disabling conditions and who require specialist clinical and personal support arrangements have these needs best met by comprehensive, multidisciplinary, aged care assessment and management.

Services providing this special care and support should adopt evidence-based practice models. Services at the local level need to be appropriately resourced to meet the challenges of changing demographics. A major challenge facing HNE Health is to develop ways of providing multidisciplinary consultation to remote areas utilising outreach (fly-in) service, videoconferencing and tele-health from specialist centres as well as finding innovative ways of encouraging staff to work in remote areas. HNE Health also needs to increase collaboration with NGOs, DADHC and other residential aged care providers to ensure that the ageing population will be able to access appropriate services now and in the future.

Acute care and rehabilitation should occur simultaneously. All disciplines involved with the care of older people should have special training in aged care. Managers should be aware that care of older people is increasingly becoming important core business.

When an older person presents to any HNE Health entry point such as a Community Health Service, ED or Rural Hospital and Health Service (MPS) the following steps should occur:

1. Identify and triage or prioritise the potential aged care client
2. Proceed with urgent treatment, support or intervention as appropriate
3. Offer the potential aged care client or their representative specialised multidisciplinary assessment and management
4. Commence multidisciplinary assessment and management
5. Develop and implement a multidisciplinary care plan for continuing management in partnership with the aged care client and families/ carers and relevant care and service providers<sup>3</sup>

The strategic directions in the care of older people for the next five years and beyond is to strengthen HNE Health's capacity to provide:

- Pre-acute care – rapid response and community services
- Acute care at home – providing acute care level services in the home and residential care facility – supporting GP management of acute cases
- Acute inpatient care
- Extended care – community services, self-management, chronic disease links, palliative care links
- Rehabilitation services
- Community aged care services
- ACAT services
- Residential care (HNE Health has several residential aged care facilities and MPSs with designated residential care beds)
- Prevention and healthy ageing strategies, and health promotion
- Assistance to increase capacity of other providers to deliver services required

## 2.15 Dementia Services

“Dementia is the second largest cause of disability burden in Australia after depression. It affects not only the person with the diagnosis but touches the lives of family, friends and whole communities.”<sup>6</sup>

Current HNE Health dementia services include 12 full-time equivalent community dementia support workers funded by a variety of sources including HNE Health, Commonwealth Government, DADHC and Alzheimer’s Australia NSW. This group comprises various disciplines (mostly nurses) with some team members having other roles eg as an ACAT worker. The Greater Newcastle Sector also has a Community Dementia Unit (CDU) that provides assessment, support and education. This service has six staff including a Neuro-psychologist, Social Worker, three Clinical Nurse Consultants (Education, Community and Acute Dementia) and an administration assistant. Memory Clinics are available through the CDU and the Rankin Park Centre Day Hospital Memory Clinic.

The Hunter New England area will experience larger increases in dementia prevalence and incidence than the average for NSW, with dementia affecting over 3% of the population by 2050.

Assuming there will be a linear increase in prevalence over the period 2002–2050 the projections show an increase of 479 cases each year for HNE Health. Over the five years of this plan we can expect the number of cases to increase from the current figure of 10,577 to 12,972.

The ‘New South Wales Action Plan on Dementia’<sup>7</sup> estimates that the living situation of people with moderate or severe dementia is: 51% at home; 37% in nursing homes; 9% in hostels and 4% in other institutions. Approximately half of all people with moderate to severe dementia will be living outside aged care facilities. The role of carers in maintaining a person with dementia in the community is complex and is expanded in the section on Carers. Whether living in the community or in residential aged care facilities, people with dementia are accessing, and need to access, the full range of health services across the community-acute care spectrum.

The demographic projections and prevalence statistics for dementia necessitate a significant increase in the provision of community dementia services as outlined in the Strategic Action Plan in Part C of this document.

Services provided by community dementia staff include:

- Initial assessment of people referred to ACAT with the predominant problem of dementia / cognitive impairment (within the limits of the case load capacity of the dementia nurse)
- Assessment of more complex dementia cases referred from aged care assessment team nurses or community nurses
- Working within the Commonwealth Guidelines for Aged Care Assessment Teams and within the established system of the aged care service
- Case management of people with complex dementia and their carers i.e. dementia with behavioural problems or carer stress
- Maintaining close relations and partnerships with general practitioners and geriatricians
- Acting as a resource in dementia for community nurses and other members of community aged care services
- Facilitating patient and relative education and referral to appropriate dementia related services
- Increasing community awareness about dementia

## 2.16 Rehabilitation Services

Rehabilitation is a managed process of active change by which a person who has become disabled acquires the knowledge and skills needed for optimal physical, psychological and social functioning.

For the purpose of this plan, HNE Health Rehabilitation Services have been identified as those providing for the care of adults with a disabling condition, and generally involve a range of staff including medical, nursing and allied health professionals. HNE Health Rehabilitation services are provided in line with the state guidelines in terms of the range of services. The key focus of service delivery involves the following:

- Goal directed restoration of function to individuals following acute illnesses or trauma
- Provision of secondary preventive strategies for people with stable disability and maintenance care (which may mean years of facilitation of participation in exercise and social activities)

Rehabilitation services are required to address the post-acute therapeutic needs of people following trauma or other disabling events. These services provide the necessary prescribed, prioritised interventions and case management for a range of complex associated issues including: self-care, communication, mobility, chronic pain, bladder and bowel function, interpersonal relationships and disease adjustment.

Rehabilitation services assist with community reintegration in relation to a person's accommodation, transport, educational, vocational and lifestyle needs and serve to improve a person's quality of life. Services are provided in inpatient, outpatient and domiciliary settings and aim to:

- Maximise the functional activities of patients
- Maximise the participation of the patient in his or her social setting
- Minimise the pain and distress experienced by the patient
- Minimise the distress of, and stress on, the patient's family and carers

Inpatient and outpatient rehabilitation programs in the HNE area are currently provided for the following clinical groups:

- Neurological rehabilitation (Stroke, Multiple Sclerosis, Parkinson's)
- Orthopaedics (joint replacements, fractures, fractured neck of femur)
- Brain injury rehabilitation
- Lower limb amputee rehabilitation
- Post acute spinal cord impairment
- Chronic non-cancer pain management
- Aged care enablement

Community Based Rehabilitation requires mobile staff, outreach teams, support services and improved co-ordination within and between specialist and generalist services. A case management approach to rehabilitation is often the key to facilitating appropriate service delivery for patients, and supporting their carers.

Access and equity in service delivery is related to the availability of resources and expertise, particularly in rural settings. This has considerable impact on outcomes that can be achieved. Access to transport and accommodation for patients, and their relatives, is a major barrier to accessing services. Improved infrastructure for enhancing access to services is required at larger centres while smaller centres require greater access to allied health staff such as occupational therapists and physiotherapists. Appropriate rehabilitation interventions also need to be developed for Aboriginal people to address access issues. Table 7 outlines rehabilitation separations as a proportion of total separations, while Table 8 compares length of stay data (by age) for each rehabilitation

service, to a national and benchmark group median. The median length of stay (LOS) in the major rehabilitation units of Rankin Park, Maitland, Tamworth and Wingham (for many of the age groups), are above the national median (though this is not reflected in the benchmark group median). These increased median levels could be due to several reasons including the need for supported accommodation on discharge, co-morbidities, the complexity of rehabilitation care required access to staff such as allied health and discharge planners and waiting times for community based services. While some of these issues have already had strategies implemented, additional initiatives are included in our strategic action plan.

**Table 7: Percentage of Rehabilitation Service Related Group Separations by HNE Health Facility**

(Units with rehabilitation services and/or beds are in bold)

<b>% Rehabilitation Separations HNE Health by Facility 2004-2005</b>	
<b>Q Number and Facility</b>	<b>% of Total Separations</b>
<b>J201-Armidale and New England Hospital</b>	<b>5.65</b>
J202-Barraba Multi-Purpose Service	0.00
J203-Bingara District Hospital	0.00
J205-Glen Innes District Hospital	0.70
J206-Gunnedah District Hospital	0.09
J207-Guyra and District War Memorial Hospital	0.05
<b>J208-Inverell District Hospital</b>	<b>3.27</b>
J211-Manilla District Hospital	0.28
J212-Moree District Hospital	0.79
J213-Narrabri District Hospital	0.89
J214-Prince Albert Memorial, Tenterfield	0.09
J215-Quirindi District Hospital	0.23
<b>J216-Tamworth Base Hospital</b>	<b>16.71</b>
J218-Vegetable Creek Multi-Purpose Service	0.09
J219-Walcha District Hospital	0.00
J220-Warialda District Hospital	0.14
J221-Wee Waa District Hospital	0.09
J224-Gloucester Soldier's Memorial Hospital - Hospital unit	0.19
<b>J225-Manning Base Hospital</b>	<b>6.58</b>
<b>J226-Wingham Memorial Hospital</b>	<b>10.46</b>
Q101-Morriset Hospital	0.05
<b>Q202-Cessnock District Hospital</b>	<b>3.92</b>
Q203-Dungog District Hospital	0.33
Q205-Kurri Kurri District Hospital	0.42
<b>Q206-Maitland Hospital</b>	<b>7.66</b>
Q208-Merriwa District Hospital	0.00
Q209-Muswellbrook District Hospital	0.09
Q210-Denman Multi-Purpose Service	0.09
Q211-Newcastle Mater Misericordiae Hospital	0.79
<b>Q213-Royal Newcastle Hospital</b>	<b>15.36</b>
Q214-Belmont Hospital	0.89
Q216-Scott Memorial Hospital, Scone	0.05
Q217-Singleton District Hospital	0.47
Q219-Wilson Memorial Hospital, Murrurundi	0.05
Q225-Nelson Bay and District Polyclinic	0.00
<b>Q230-John Hunter Hospital (Rankin Park Centre)</b>	<b>23.53</b>
<b>Total</b>	<b>100</b>
<b>Total number of separations</b>	<b>2,142</b>

**Table 8: Median Length of Stay for HNE Rehabilitation Units by Age**

Age	Rankin Park	Royal Newcastle Hospital	Maitland	Tamworth	Armidale	Manning	Wingham	National Median	Benchmark Group Median
<15								30	31.5
15-19	39	17						25	33
20-24	11		8				4	21	24
25-29	25	20	53			2		23	30
30-34	19	19	44					18	25
35-39	39	15		20		3	8	16	22
40-44	15	6	18	11			15	15	23
45-49	26	13	47	24	12	6	39	16	24
50-54	13	11	21	23	2	4	19	14	20
55-59	26	11	43	29	23	8	14	13	20
60-64	15	9	67	14	13	3	22	13	20
65-69	21	15	20	18	21	5	13	13	18
70-74	22	10	22	14	13	4	14	14	18
75-79	25	13	26	15	18	5	20	14	19
80-84	26	15	22	18	16	3	15	15	19
85-89	25	15	23	16	14	9	19	16	20
90-94	22	16	28	20	14	7	17	17	20
95+	22	16	9	8		4	33	18	20

Source: Australasian Rehabilitation Outcomes Centre AROC 2005 Reports

Note: The benchmark group is from participating public facilities in NSW, Victoria, Queensland, South Australia and Western Australia. The national data comprises all participating public and private facilities from the aforementioned states as well as Tasmania.

### 2.17 Carers

In 2003, there were 2.6 million carers who provided some assistance to those who needed help because of disability or age. About one fifth of these (19%) were primary carers, that is people who provided the majority of the informal help needed by a person with a disability. Just over half (54%) of all carers were women. Women were also more likely (71%) to be primary carers. Of those providing care, one million (39%) were in the 35-54 year age range. This age group's caring responsibilities involved children, partners and/or ageing parents. Thirty-seven percent of primary carers spent on average 40 hours or more per week providing care and 18% spent 20 to 39 hours per week. Of those providing primary care for their partner, 48% were aged 65 years and older.

Those who provided care to people with a disability were more likely to be older and/or have a disability than those who did not provide care. Twenty-four per cent of primary carers were aged 65 years and over, compared to 13% of the total population. Of those living in households, the disability rates were 40% for primary carers, 35% for all carers and 20% for non-carers.<sup>1</sup>

Assuming that 2.4% of the population are primary carers, then there are over 20,160 primary carers currently in the HNE area with 4,800 of these aged 65 years and older. There are significant issues for the carers of younger people with disabilities, in particular the carers of patients with brain injury.

Carer support and education is provided by a variety of government and NGO organisations. The EduCare service has an important and expanding role in the Southern Region and provides education, training and referral to carers, as well as training to staff. There is one FTE Carer Support Liaison Officer in the Northern region and 0.6 Carer Support Liaison Officer in the Lower Mid North Coast region whose roles is more liaison than direct service provision. The further development of carer support services is essential.

The role of carers needs to be formally recognised and valued by ensuring that:

- Carers have significant input into assessment and care planning process
- The training and education process such as those provided by EduCare and the Carer Support Liaison Services are expanded to meet needs
- HNE Health takes steps to support carers' health and well-being

### **2.18 Strategic and Service Issues**

The ACARS plan brings together two main streams: Aged Care Services, (including Dementia Services) and Rehabilitation Services. Although they have a different patient focus, there are significant similarities in the multidisciplinary approach to person centred care. Frequently the same health care professionals and facilities are involved in the delivery of care across these streams, however the efficiencies in the size and composition of the multidisciplinary team is sometimes contrasted by the complexities of caring for a composite casemix (for example the co-location of younger people in a brain injury program in the same area as an older person receiving post-surgical rehabilitation). One of the challenges facing ACARS and HNE Health is to develop services which will meet the needs of the growing older demographic whilst ensuring at the same time that the healthcare needs of younger adults with a disability are met.

### **2.19 Clinical Network**

The establishment of an ACARS Clinical Network to coordinate the delivery of safe and evidenced-base health care across all HNE Health care settings will increase capacity and efficiency, and strengthen linkages between disciplines, facilities and care settings across the size and diversity of HNE Health.

### **2.20 Building Capacity and Capability Across all HNE Health Settings**

The foundation of HNE Health is 'Our People, Culture and Capability' and one of the most important key directions identified for ACARS is around this issue. The ability to attract and retain quality staff in aged care and rehabilitation and the development of competence in care of ACARS patients by all clinicians involved in adult care in the HNE area are paramount. Of particular concern is the lack of allied health staff in rural and remote areas. It is acknowledged that HNE Health needs to also work towards assisting other providers in building their capacity to meet future increased demand for ACAR services.

### **2.21 Models of Care**

A review of existing models of rehabilitation across HNE Health will ensure that the area is making best use of its current resources, is using best practice and will assist with understanding current service strengths, weaknesses and gaps. Increasing the capacity to provide rehabilitation services in day therapy centres and community-based and home rehabilitation, including models that meet the needs of clients residing in small or isolated communities has been identified as a key priority by stakeholders. The low rate of use of

some ACARS services by Aboriginal people is of concern and further evaluation of this issue is needed.

### **2.22 Dementia and Delirium**

The development of an integrated service for dementia should include: assessment and diagnosis, carer support, education, case management and assessment and management of behaviours of concern, in both the acute care and residential care settings. In addition there is the need to improve the acute care of confused older patients by improving the physical facilities in hospitals and educating staff to assess and manage delirium and dementia.

### **2.23 Younger People with Disabilities**

Working with DADHC to improve the availability of services and accommodation for younger people with severe physical disabilities as well as intellectual/cognitive and behavioural disabilities is identified as a high priority. For example there are people who are at significant risk but, because they are mobile, receive little or no service to support them in the community.

Stakeholders in ACARS are mindful of the inappropriate scenario of a young person spending their life in a residential aged care facility whilst the continued occupation of a post-acute bed by a person waiting for accommodation placement is also an inappropriate use of resources. Building on existing linkages between DADHC and HNE Health, improved mechanisms for escalating cases which are complex and likely to need high level management and clinical negotiations, and options for more suitable accommodation need to be developed.

### **2.24 Workforce**

Internal and external stakeholders and members of the core-planning group provided feedback about workforce issues and devised relevant strategies that have been incorporated in the strategic action plan. Key workforce issues relate to recruitment and retention of all aged care and rehabilitation staff (particularly in rural areas), the education and professional development of staff and the availability of allied health practitioners. The planning group were unable to estimate the numbers of staff currently providing an aged care and rehabilitation service across the area due to the blended workforce.

Strategies such as providing incentives for staff to undertake rotations to rural areas, developing Clinical Nurse Specialist roles in all adult wards, employing additional staff to be able to implement the aged care and rehabilitation clinical network and to be able to implement area wide programs (such as healthy living programs), have been included as initiatives for implementation in the action plan.

## 2.25 Rerences

<sup>1</sup> Information from Senior Aboriginal Health Education Officer HNE Health (Northern)

<sup>2</sup> NSW Aboriginal Chronic Conditions Area Health Service Standards (NSW Health 2005)  
[http://www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005\\_588.pdf](http://www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_588.pdf)

<sup>3</sup> NSW Health Framework for integrated support and management of older people in the NSW health care system 2004-2006

<sup>4</sup> Data from Older Persons Acute Care Model presentation 17<sup>th</sup> March 2006. C. Peek, Service Manager JHH Division of Medicine

<sup>5</sup> Aged Care in Australia Australian Government 2003  
<http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-about-agedaust-agedaus1.htm-copy2>

<sup>6</sup> John Hatzistergos NSW Minister for Health Sept 2005

<sup>7</sup> Office on Ageing, Social Policy Directorate, 1995, Being There, The NSW Government's Action Plan on Dementia 1995-1999, Sydney

## 2.26 Service Triangle

The following Service Triangle represent the major components of the Aged Care and Rehabilitation Service (ACARS).

The table below defines service level classifications and features:

No	Level*	Definition	Features
1	Universal- in all areas	Disease prevention and health promotion to maintain good health. Information and advice provided	Targeted at the whole population Involves primary prevention and promotion of healthy lifestyle Services will include screening/assessment programs and/or other approaches to early detection of risk factors Provided by GP's, community health services
2	Basic- in local areas	Services for people with disease/condition who require community – based care, care co ordination and/or self management support	Targeted at people with the disease/condition who are at mild to moderate risk of the disease progressing and requiring hospitalisation This group may comprise 70-80% of the total patient population Services will also include diagnosis, care planning, clinical management, care coordination, psychosocial support and residential care
3	Specialist- in regional centres	Specialist services for people with disease/condition who require acute inpatient, acute outpatient and acute community care, and specialised interventions	Targeted at people with the disease/condition who need support to increase disease stability and symptom control Their disease/condition is moderately complex plus/minus co-morbidities Moderate to high risk of the disease progressing or their condition deteriorating High risk of hospitalisation Services will also include specialist multidisciplinary consultation, assessment and therapy
4	Complex - at limited sites	Services for people with disease/condition who require specialist in-patient care	Targeted at people with diseases/conditions requiring specialist care Highest cost per intervention Services provided require very specialised skills, equipment and infrastructure that are only located at limited locations/sites

\*

If a service is provided at one level it is then automatically available in the level / levels above

Service Triangle  
Template in development

**2.27 Aboriginal Health Impact Statement**

“The health needs and interests of Aboriginal people have been considered, and where relevant, incorporated and appropriately addressed in the development of the Aged Care and Rehabilitation Plan”.

See Appendix 10 for the completed Aboriginal Health Impact Checklist.

**2.28 Ethnic Affairs Priority Statement**

“In the development of the Hunter New England Health Aged Care and Rehabilitation Services Plan, the health needs and interests of people from culturally and linguistically diverse groups have been considered and collaboration with the Multicultural Health Unit has occurred. HNE Health is committed to delivering services that best meet their needs and there are specific strategies included in the Strategic Action Plan demonstrating that commitment”.

### 3. STRATEGIC OBJECTIVES AND ACTION PLAN

The following pages present the ACARS Strategic Objectives and Strategic Action Plan. The plan details the strategic initiatives that will be implemented to ensure we achieve our Strategic Objectives.

#### **ACARS STRATEGIC OBJECTIVES**

Our Vision, Purpose, Key Focus Areas and Strategic Objectives are presented as a one-page summary.

Our Key Focus Areas are those areas that we consider are critical to achieving our Vision. For each Key Focus Area, Strategic Objectives are identified to ensure that ACARS remains focussed on the most important issues and needs.

#### **ACARS STRATEGIC ACTION PLAN**

Our Strategic Action Plan identifies performance measure/s for each of the key objectives and presents the strategic initiatives (the actions, activities or projects) that we will implement over the next five years to improve our performance, reach our targets and achieve our key objectives.

Each Objective is risk-rated using the HNE Health Risk Matrix, which is based on the NSW Health Severity Assessment Code (SAC). In rating the strategic objectives the consequences and likelihood of not achieving an objective and the impact on service provision and outcomes for the community were considered. The risk ratings identified for each strategic objective signify the priority placed on achieving each objective and where we want to be as an organisation in relation to the objective in five years time.

# Aged Care and Rehabilitation Services Strategic Objectives

- OUR VALUES**
- TEAMWORK
  - HONESTY
  - RESPECT
  - ETHICS
  - EXCELLENCE
  - CARING
  - COURAGE
  - COMMITMENT

**VISION:** Healthier communities: Excellence in healthcare  
**PURPOSE:** Working with our communities to deliver quality aged care and adult rehabilitation services

Focus Area: **Communities, Patients and Carers**  
 To achieve our vision, the key outcomes we must deliver are:

- ❖ Communities that feel empowered in relation to aged care services and rehabilitation services
- ❖ Improved health and well being for all
- ❖ Improved equity of access to services
- ❖ A quality health care experience

Focus Area:  
**External Partners**

To deliver the required community outcomes, we need to excel in:

- ❖ Engaging our external partners in improving the health of our communities

Focus Area:  
**Internal Networking and Processes**

To deliver the required community outcomes, we need to excel in:

- ❖ Person-centred care and continuous service review
- ❖ Effective integrated service delivery
- ❖ Improved communication between healthcare providers
- ❖ Safe and evidence-based healthcare
- ❖ Carer inclusion and support provision

Focus Area:  
**Resource Accountability**

To deliver the required community outcomes, we need to excel in:

- ❖ Prioritisation and advocacy for allocation of resources to best meet health needs

Focus Area: **Our People, Culture and Capability**  
 (Employees and Contracted)

To achieve the desired community outcomes and sustain our ability to change and improve, we need to excel in:

- ❖ Attracting and retaining high quality staff in aged care and rehabilitation
- ❖ Developing competence, capability, individual accountability and performance
- ❖ Demonstrating innovative healthcare

## ABBREVIATIONS

ACARS	Aged Care and Rehabilitation Services	Falls Coord	Area Falls Coordinator
ACARS Mans	Aged Care and Rehabilitation Services Managers	GM	General Manager
ACAT	Aged Care Assessment Team	GM ACUTE	General Managers, Acute Hospital Networks
ACAT Mans	Aged Care Assessment Team Managers	GM P&CN	General Managers, Primary & Community Network Clusters
Ac. Hos Mans	Acute Hospital Managers	GNC	Greater Newcastle Cluster
ACSA	Aged and Community Service Association	HACC Coord	Hunter Integrated Pain Service
AHS	Aboriginal Health Service	HIPS	Home and Community Care Coordinator
Area Qual Man	Area Quality Manager	Hlth Equip Man	Health Equipment Manager
ASET	Aged-Care Service Emergency Teams	HNE	Hunter New England
CADE	Confused and Disturbed Elderly	IIMS	Incident Information Management system
CAPAC	Community and Post Acute Care	Man MSR&P	Manager Medical Services Recruitment and Planning
CBS Mans	Community Based Service Managers	Man Org Dev Lng	Manager Organisational Development and Learning
CCRC Man	Commonwealth Carer Respite Centre Manager	MH Mans	Mental Health Managers
CDGNC	Clinical Director, Greater Newcastle Cluster	MHS	Multicultural Health Service
CHC	Community Health Centre	MHSOP Man	Mental Health Service for Older People Manager
CHID	Community Health Information Development	MPS Mans	Multi Purpose Services Managers
CHIME	Community Health Information Management Enterprise	Ortho Rehab Clin	Orthopaedic Rehabilitation Clinician
Chr Dis Coord	Chronic Disease Coordinator	Pharm Man	Pharmacy Manager
CHS	Community Health Service	PHPP	Population Health, Planning and Performance
CN	Clinical Network (= the ACARS Clinical Network)	Pod Man	Area Podiatry Manager
CN Coord	Clinical Network Coordinator	Pop Health	Population Health
CN Dev Gr	Clinical Network Development Group	PSOs	Patient Safety Officers
Cl. Mans	Cluster Managers	RHHS	Rural Hospital and Health Service (formerly MPS)
CNS	Clinical Nurse Specialist	RPC	Rankin Park Centre
Comms Off	ACARS Communications Officer	RPC Serv Man	Rankin Park Centre Service Manager
DADHC	Department Ageing, Disturbed and Home Care	RPCT	Respecting Patient Choices Team
Day Cen Mans	Day Centre Manages	SAFTE	Safe And Fast Track Elderly Care
DC&SE	Director, Communication and Stakeholder Engagement	SMJHDDOM	Service Manager, John Hunter Hospital Division of Medicine
Dir	Director	TAFE	Technical & Further Education institution
Dir AH	Director Allied Health	TBD	To Be Determined
Dir Ab Hlth	Director Aboriginal Health	Tele-Hlth Pro Man	Tele-Health Project Officer
Dir Brain Inj Serv	Director Brain Injury Service	TLU	Transitional Living Unit
Dir I & P	Director of Integration and Partnerships		
Dir N&MS	Director Nursing and Midwifery Services		
Dir Str Serv	Director Stroke Service		
Dir WFD	Director Workforce Development		
Dir WFP	Director Workforce Planning		

## Aged Care and Rehabilitation Services Strategic Action Plan

<b>FOCUS AREA:</b>	<b>Communities, Patients and Carers</b>						
<b>OBJECTIVE:</b>	To achieve our vision, a key outcome we must deliver is: <b>Communities that feel empowered in relation to aged care services and rehabilitation services</b>					<b>Risk Rating</b> Current    Target	
						K	L
<b>DESTINATION STATEMENT:</b>	<i>People in our communities have confidence in working with us on health service issues and in managing their own health</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>♦ Funding 1,2,3</b>	<b>★ Priority L, M, H</b>
Percent HNE Health Advisory Councils and Committees with representation of persons over 65 years/ persons with a disability/ persons caring for someone with a significant disability	90%	Annual	<ul style="list-style-type: none"> <li>Develop strategies to increase participation and representation of older people and/or those requiring rehabilitation services on communities such as Area Health Advisory Councils, Community Health Forums, Local Health Advisory Committees, and other relevant carer/consumer groups</li> </ul>	Clinical Network	June 2007	1	

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## Aged Care and Rehabilitation Services Strategic Action Plan

<b>FOCUS AREA:</b>	<b>Communities, Patients and Carers</b>						
<b>OBJECTIVE:</b>	To achieve our vision, a key outcome we must deliver is: <b>Improved health and well being for all</b>					<b>Risk Rating</b>	
						<b>Current</b>	<b>Target</b>
						<b>D</b>	<b>H</b>
<b>DESTINATION STATEMENT:</b>	<i>People in our communities are healthier and have fewer health risks</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>♦ Funding 1,2,3</b>	<b>★ Priority L, M, H</b>
Rate (per 100,000) of hospitalisation for patients with fractured neck of femur (65 years and older)	4.2	Monthly	<ul style="list-style-type: none"> <li>Implement and evaluate the Falls Injury Prevention Program Area wide</li> <li>Develop and promote an Area approach to improve physical activity, especially for people over 65 years</li> <li>Establish an Area-wide Healthy Living Program for all older people and adults living with a disability</li> </ul>	Area Falls Coordinator  Pop Health  Clinical Network	March 2007  March 2008  Sept 2008	2  2  3	   L
Rate of flu-vax immunisation for patients aged 65 years and over in HNE residential care facilities	90%	Annual	<ul style="list-style-type: none"> <li>Develop processes to manage immunisation of residents in HNE Residential Aged Care Facilities</li> <li>Promote uptake of flu-vax by ACARS staff</li> </ul>	Clinical Network/ Pop Health ACARS Mans	Feb 2008  Aug 2008	1  1	

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## Aged Care and Rehabilitation Services Strategic Action Plan

<b>FOCUS AREA:</b>	<b>Communities, Patients and Carers</b>						
<b>OBJECTIVE:</b>	To achieve our vision, a key outcome we must deliver is: <b>Improved equity of access to services</b>					<b>Risk Rating</b> Current Target <b>J L</b>	
<b>DESTINATION STATEMENT:</b>	<i>Within our Area, people with a clinical need have access to the appropriate services that meet their needs within a reasonable timeframe</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>♦ Funding 1,2,3</b>	<b>* Priority L, M, H</b>
Average non-urgent ACAT waiting times. (Measure only available from CHIME sites)	< 5 wks	Monthly	<ul style="list-style-type: none"> <li>Review ACAT and community aged care processes and staffing requirements</li> <li>Implement strategies to improve access to respite and placement of patient in aged care facilities</li> </ul>	Clinical Network/ ACAT Mans ACAT Mans, ACARS Mans	Feb 2007  Oct 2007	1  2	
Number of patients awaiting aged care placement in selected acute hospitals	50	Monthly	<ul style="list-style-type: none"> <li>Undertake regular reviews of patients awaiting aged care placement in acute hospital beds and engage the Commonwealth Government and NSW Department of Health in planning for the future needs for residential beds</li> <li>Develop a proposal to provide an inpatient facility in the Southern Region for the assessment and management of patients with behaviours of concern</li> <li>Reduce length of stay in CADE units in Lower Mid North Coast and Northern Region</li> </ul>	Clinical Network/ ACARS Mans  MHSOP Man  MHSOP Man	July 2007  Nov 2007  May 2007	1  2  1	
% Older people with acute decline referred to SAFTE seen within 48 working hours	90%	Quarterly	<ul style="list-style-type: none"> <li>Implement SAFTE and expand CAPAC and 'Back to Home' programs</li> </ul>	ACARS Mans, Ac. Hos Mans	Sept 2007	3	H
% of patients 70 years and over presenting to EDs seen by ASET	20%	Quarterly	<ul style="list-style-type: none"> <li>Provide comprehensive aged care assessments in major acute hospital EDs by expanding the ASET service</li> </ul>	ACARS Mans, Ac. Hos Mans	Oct 2007	3	H
Percent allied health patients first seen for assessment within benchmark (Measure only available from CHIME sites)	81%	Monthly	<ul style="list-style-type: none"> <li>Utilise a range of strategies including face to face assessment in the community, provision of transport to centres and tele-health where appropriate, to ensure timely access to allied health and community nursing consultation in remote areas</li> </ul>	Clinical Network	Nov 2007	2	

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding \* Priority: L = Low, M = Medium, H = High

## Aged Care and Rehabilitation Services Strategic Action Plan

FOCUS AREA:	Communities, Patients and Carers						
OBJECTIVE:	To achieve our vision, a key outcome we must deliver is: <b>Improved equity of access to services</b> <i>(continued)</i>						
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	♦ Funding 1,2,3	* Priority L, M, H
Waiting times for community rehabilitation. (Measure only available from CHIME sites)	80% within 28 days of referral	Monthly	<ul style="list-style-type: none"> <li>• Improve access to Geriatricians and Social Workers within Community Aged Care Services for secondary assessment</li> </ul>	Clinical Network/ GM P&CN	Nov 2007	3	H
			<ul style="list-style-type: none"> <li>• Appoint dementia workers to move towards a rate of 1 dementia worker per 5000 people 70 years and over to provide timely assessment, carer support and assist with management of patients with behaviours of concern in the community</li> <li>• Improve access to Mental Health Services for Older People and Neuropsychology services for ACARS patients</li> </ul>	Clinical Network/ GM P&CN, Cl. Mans	June 2010	3	M
			<ul style="list-style-type: none"> <li>• Explore engaging private workforce in relation to the provision of clinical services while longer term strategies are implemented</li> </ul>	MHSOP Man/ Clinical Network	Dec 2007	3	L
				Clinical Network/ GM P&CN Cl. Mans	Nov 2008	2	

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

\* Priority: L = Low, M = Medium, H = High

## Aged Care and Rehabilitation Services Strategic Action Plan

<b>FOCUS AREA:</b>	<b>Communities, Patients and Carers</b>						
<b>OBJECTIVE:</b>	To achieve our vision, a key outcome we must deliver is: <b>A quality health care experience</b>					<b>Risk Rating</b>	
						<b>Current</b>	<b>Target</b>
						<b>L</b>	<b>R</b>
<b>DESTINATION STATEMENT:</b>	<i>People who come into contact with us are confident that we consistently deliver safe, effective, appropriate services</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding 1,2,3</b>	<b>★ Priority L, M, H</b>
Percent initiatives implemented as a result of complaints management within ACARS specific services	90%	Annual	<ul style="list-style-type: none"> <li>Utilise IIMS to collect data concerning adverse events and complaints to ensure that ACARS interventions and initiatives improve patient safety and satisfaction</li> </ul>	Clinical Network/ PSOs	Nov 2006	2	
			<ul style="list-style-type: none"> <li>Incorporate questions for satisfaction of ACARS consumers in the HNE patient satisfaction survey tool</li> </ul>	Clinical Network/ Area Qual Man	Nov 2007	1	

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## Aged Care and Rehabilitation Services Strategic Action Plan

<b>FOCUS AREA:</b>	<b>External Partners</b>						
<b>OBJECTIVE:</b>	To deliver the required community outcomes, we need to excel in: <b>Engaging our external partners in improving the health of our communities</b>						<b>Risk Rating</b> Current Target <b>K N</b>
<b>DESTINATION STATEMENT:</b>	<i>Our partnerships deliver benefits to Hunter New England people through shared goals, clearly agreed responsibilities and effective outcomes</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>♦ Funding 1,2,3</b>	<b>* Priority L, M, H</b>
Percent initiatives implemented in partnership with identified external service providers	20	Annual	<ul style="list-style-type: none"> <li>• Establish an activation process for escalating 'difficult to resolve cases' to appropriate clinical and management decision makers</li> <li>• Develop a service agreement with DADHC for the joint assessment of people with intellectual disabilities (in line with "Stronger Together" principles) who are older or who have early onset of ageing (eg people with Down's Syndrome)</li> <li>• Advocate for the improved availability of long-term care, support services and accommodation for younger people with severe disabilities</li> <li>• Develop/continue partnerships with a range of non government organisations such as HACC and residential aged care providers to ensure continuum of care</li> <li>• Improve links with Universities and TAFEs to ensure ACARS is consulted on the development of undergraduate and postgraduate courses</li> <li>• Increase the representation of ACARS at a range of interagency forums/committees/meetings e.g. HACC Planning, ACSA Regional Branches, Transport meetings</li> <li>• Participate in the development of the HNE Health partnership agreement with AMSs</li> <li>• Continue to promote good working relationships with the Div. of General Practice to support the role of GPs and VMOs</li> </ul>	Clinical Network Clinical Network/ACARS Mans  GM P&CN,  Clinical Network/HACC Coord/CI Mans/GM P&CN Clinical Network/Dir WFD, ACARS Mans  Clinical Network//Dir AH CN, Dir I&P	Dec 2006 Dec 2006  Dec 2006 July 2007 Oct 2007 April 2007  April 2007 May 2007	1 1  1 1 1 2  2 1	

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding \* Priority: L = Low, M = Medium, H = High



## Aged Care and Rehabilitation Services Strategic Action Plan

FOCUS AREA:	Internal Networking and processes							
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: <b>Effective integrated service delivery</b>						<b>Risk Rating</b> Current Target <b>D H</b>	
DESTINATION STATEMENT:	Staff work together to deliver co-ordinated, consistent high quality healthcare							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	♦ Funding 1,2,3	* Priority L, M, H	
Percent initiatives implemented from ACARS Service Plan within designated timeframes	60%	6 Monthly	• Implement the Aged Care and Rehabilitation Clinical Network	Clinical Network	Oct 2006	TBD	M	
			• Develop 'HNE Equipment Services' to meet the growing and changing service demands	Coord/Dev Gp GM P&CN, Hlth Equip Man	Dec 2006	3		
			• Develop a partnership with Aboriginal Health Services for the joint assessment of older Aboriginal people, particularly in relation to patients with suspected cognitive impairment and dementia	Clinical Network/Dir AHS	May 2007	2		
			• Develop an integrated service for the provision of care to orthopaedic rehabilitation patients and those involved in multiple major traumas across HNE	Clinical Network/Ortho Rehab Clin	Apr 2008	2		
			• Develop an integrated approach to the management of Traumatic Brain Injury across HNE	Clinical Network/Dir Brain Inj Serv	May 2008	2		
			• Develop an integrated approach to the management of Spinal Cord Injury across HNE	Clinical Network/Dir Brain Inj Serv	Oct 2007	2		
			• Provide evidence-based rehabilitation services to patients with chronic non-cancer pain	Clinical Network/HIPS	Dec 2006	2		
			• Explore the potential for person-centred common assessment tool, discharge and referral processes that extend across the continuum of care from the community to acute, post-acute and back to community	Clinical Network	Sept 2007	2		
			• Develop a case management capacity for complex chronic care ACARS cases across HNE, while ensuring efficiencies by utilising linkages with other chronic disease programs	ACARS Mans, Chr Dis Coord	Oct 2008	2		
			• Advocate for the improved availability of both high and low care aged care facilities across HNE to manage people with behaviours of concern	Clinical Network/MH Mans GM P&CN	Dec 2007	1		

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

\* Priority: L = Low, M = Medium, H = High

## Aged Care and Rehabilitation Services Strategic Action Plan

FOCUS AREA:	Internal Networking and processes							
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: <b>Effective integrated service delivery</b> ( <i>continued</i> )							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	♦ Funding 1,2,3	* Priority L, M, H	
Percent initiatives implemented from ACARS Service Plan within designated timeframes ( <i>continued</i> )	60%	6 Monthly	• Rollout Older Persons Acute Care Model to other acute facilities	Clinical Network/ Ac. Hos Mans	Nov 2008	2	M	
			• Develop and implement plan for the provision of post-acute Stroke Services across HNE	Clinical Network/ Dir Stroke Serv	Dec 2007	2		
			• Implement the provision of podiatry services in conjunction with amputee clinics	Pod Man, GM P&N	June 2007	3		
			• Develop strategies for the provision of Neuro-Degenerative disease services while ensuring efficiencies by utilising linkages with other chronic disease programs	Clinical Network/ ACARS Mans/ Chr Dis Coord	Sept 2009	2		
			• Establish tone and function clinic at Rankin Park Centre Day Hospital	RPC Serv Man	Nov 2006	3		L
			• Facilitate the implementation of Advanced Care Planning, which may include the Area Respecting Patient Choices program, throughout HNE in consultation with the Program Coordinator and the Chronic Disease Strategic Plan	Clinical Network/ RPCT	Dec 2006	1		
			• Explore and develop alternative models of Medication Management Review in HNE Residential Aged Care Facilities	Clinical Network/ Pharm Man	May 2007	2		
			• Promote the use of 'My Health Record'	ACARS Mans, ACARS Staff	June 2007	1		
• Review the provision of transitional care services	ACARS Mans	June 2008	2					

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

\* Priority: L = Low, M = Medium, H = High

## Aged Care and Rehabilitation Services Strategic Action Plan

<b>FOCUS AREA:</b>	<b>Internal Networking and processes</b>						
<b>OBJECTIVE:</b>	To deliver the required community outcomes, we need to excel in: <b>Improved communication between healthcare providers</b>						<b>Risk Rating</b> Current Target <b>D H</b>
<b>DESTINATION STATEMENT:</b>	<i>We have communication systems that effectively involve clinical and non-clinical staff in decision making and ensure that knowledge is shared</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>♦ Funding 1,2,3</b>	<b>★ Priority L, M, H</b>
Percent Community Health Services utilising CHIME	90%	Annual	<ul style="list-style-type: none"> <li>• Improve information management across ACARS</li> <li>• Utilise electronic information transfer to improve information flow between ACARS services and GPs</li> <li>• Roll out CHIME to all HNE Community Health Services</li> <li>• Develop an integrated approach for the development of promotions for designated weeks such as:               <ul style="list-style-type: none"> <li>- Rehabilitation and Injury Prevention Week</li> <li>- Carers Week</li> <li>- Seniors Week</li> <li>- Dementia Awareness Week</li> <li>- Stroke Awareness</li> <li>- Brain Injury Awareness Week</li> </ul> </li> </ul>	ACARS Mans  Clinical Network CHID, CBS Mans ACARS Comms Officer	Dec 2008  Nov 2007 June 2010 Feb 2007	2  2 2 2	

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding  
 ★ Priority: L = Low, M = Medium, H = High

## Aged Care and Rehabilitation Services Strategic Action Plan

<b>FOCUS AREA:</b>	<b>Internal Networking and processes</b>						
<b>OBJECTIVE:</b>	To deliver the required community outcomes, we need to excel in: <b>Safe and evidence-based healthcare</b>					<b>Risk Rating</b> Current    Target <b>H            N</b>	
<b>DESTINATION STATEMENT:</b>	<i>We ensure our care is based on best practice and minimises harm</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>♦ Funding 1,2,3</b>	<b>★ Priority L, M, H</b>
Nosocomial pressure wound rate	0.8%	Quarterly	<ul style="list-style-type: none"> <li>Introduce programs for all clinical staff involved in the care of aged care and rehabilitation patients, to develop competencies in the assessment, management and documentation of pressure ulcers</li> <li>Establish mechanisms to monitor compliance with HNE Pressure Ulcer Prevention Policy across HNE, including mattress replacement</li> <li>Utilise Telehealth Wound Care project to provide support to remote areas</li> <li>Develop mechanisms for identifying current evidence-based best practice and establish processes for incorporation of those practices across all relevant care settings</li> </ul>	Clinical Network  Clinical Network/ Ac. Hos Mans MPS Mans Tele-Hlth Proj Man Clinical Network	Oct 2007  Dec 2007  Dec 2007 Dec 2008	2  2  1 2	

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## Aged Care and Rehabilitation Services Strategic Action Plan

<b>FOCUS AREA:</b>	<b>Internal Networking and processes</b>						
<b>OBJECTIVE:</b>	To deliver the required community outcomes, we need to excel in: <b>Carer inclusion and support provision</b>					<b>Risk Rating</b> Current    Target	
						<b>K</b>	<b>N</b>
<b>DESTINATION STATEMENT:</b>	<i>Carers are acknowledged and integrated in all care delivery</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>♦ Funding 1,2,3</b>	<b>★ Priority L, M, H</b>
Number of carers who complete a support/education program	> 10% Increase pa (from baseline of 350) from 2007	6 Monthly	<ul style="list-style-type: none"> <li>Work with DADHC to enable carer respite, and opportunities for social interaction for patients, by facilitating day centre attendance in major centres</li> <li>Develop training programs for staff about carers and strategies for effective inclusion of carers, noting the importance of addressing the needs of Aboriginal communities and multicultural communities</li> <li>Develop an integrated model for carer education and support across HNE for carers and families of ACARS patients</li> <li>Develop service and/or facility information and orientation packages for carers and patients</li> <li>Incorporate carer input into assessment, care planning, and discharge documentation</li> </ul>	Day Centre Mans/CCRC Manager CCRC Man EDuCARE Man  EDuCARE Man Clinical Network Clinical Network/ ACARS Mans	July 2008  Mar 2007  Nov 2006 May 2007 Apr 2010	1  2  3 2 1	L

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## Aged Care and Rehabilitation Services Strategic Action Plan

<b>FOCUS AREA:</b>	<b>Resource Accountability</b>						
<b>OBJECTIVE:</b>	To deliver the required community outcomes, we need to excel in: <b>Prioritisation and allocation of resources to best meet health needs</b>						<b>Risk Rating</b> Current Target <b>D L</b>
<b>DESTINATION STATEMENT:</b>	<i>Staff and communities are confident that resources are allocated to meet identified health needs according to agreed priorities</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>♦ Funding 1,2,3</b>	<b>★ Priority L, M, H</b>
Percent facilities with a completed ACARS physical environment access audit	90%	2 <sup>nd</sup> Yearly	<ul style="list-style-type: none"> <li>• Monitor the physical capacity of HNE hospitals, buildings and site to meet the needs of ACARS patients and carers</li> <li>• Ensure that HNE Health infrastructure planning for high growth areas is cognisant of the needs of ACARS patients</li> <li>• Identify and utilise current resources allocated for improved IT infrastructure and staff training</li> </ul>	ACARS Mans, Hosp and Comm. Based SMs Cap Works ACARS Mans	Aug 2008  Mar 2010 June 2007	2  2 1	

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## Aged Care and Rehabilitation Services Strategic Action Plan

<b>FOCUS AREA:</b>	<b>Our people, culture and capability</b>						
<b>OBJECTIVE:</b>	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in: <b>Attracting and retaining high quality staff in aged care and rehabilitation</b>						<b>Risk Rating</b> Current Target <b>C H</b>
<b>DESTINATION STATEMENT:</b>	<i>We have the right people with the right skills, in the right place, at the right time</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>♦ Funding 1,2,3</b>	<b>★ Priority L, M, H</b>
Number vacancies for clinical positions (Medical, Allied Health, Nursing)	20%	Monthly	<ul style="list-style-type: none"> <li>• In coordination with Workforce Development, explore ways of attracting and retaining high quality Allied Health, Pharmacy, Medical and Nursing staff (including overseas trained staff)</li> <li>• Identify vacancy rates for ACARS clinical staff across HNE</li> <li>• Provide support and incentives for staff undertaking rotation in remote/rural areas</li> <li>• Develop reasonable workload tool and measure ACARS services across HNE</li> <li>• Conduct exit interviews and use information to inform staff retention strategies for aged care and rehabilitation services</li> <li>• Encourage and support access to scholarships targeting areas relating to the delivery of aged care and rehabilitation services</li> <li>• Implement a specific orientation program to meet the needs of all ACARS staff (to include cultural awareness)</li> <li>• Determine the training and support needs of GPs providing VMO services to rural facilities</li> <li>• Ensure budgetary provision for relief cover of clinical staff over periods of leave</li> <li>• Review workforce redesign initiatives to support service provision (eg mobility assistants, footcare nurses etc)</li> </ul>	Dir N&MS Man MSR & P Dir AH Dir WFP Dir N&MS Man MSR & P Dir AH Dir WFP GM P&CN Gm Acute Dir N&MS Man MSR & P Dir AH Dir WFP ACARS Mans  Clinical Network Clinical Network/Man Org Dev Lng Dir I&P  CI Mans  Clinical Network/ ACARS Mans	April 2008  Feb 2007  Oct 2007 Aug 2007  Nov 2007 Dec 2006 May 2007 July 2007 May 2010 Dec 2007	2  1  2 2  2 1 2 2 2 2	

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## Aged Care and Rehabilitation Services Strategic Action Plan

<b>FOCUS AREA:</b>	<b>Our people, culture and capability</b>						
<b>OBJECTIVE:</b>	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in: <b>Developing competence, capability, individual accountability and performance</b>						<b>Risk Rating</b> Current Target <b>K R</b>
<b>DESTINATION STATEMENT:</b>	<i>Our staff develop their skills, accept responsibility for their decisions and actions, and are supported to optimise their performance</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>♦ Funding 1,2,3</b>	<b>★ Priority L, M, H</b>
Number Clinical Nurse specialist roles	50	Annual	<ul style="list-style-type: none"> <li>Develop and implement specific training targeting aged care and rehabilitation issues for staff working in all areas of HNE accessed by ACARS patients and carers</li> <li>Develop Clinical Nurse Specialist roles in Aged Care in all adult wards in all facilities across HNE</li> <li>Advocate for staff personal performance and development plans to reflect service needs with respect to best practice in aged care and rehabilitation across all care settings</li> <li>Develop strategies that increase access to education (including the role of IT)</li> </ul>	Clinical Network ACARS Mans	Sept 2007	3	M
Proportion facilities with at least one CNS	50%	Annual		Dir N&MS	Dec 2006	3	H
				Clinical Network	Dec 2007	1	
				Clinical Network ACARS Mans	June 2007	2	

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## Aged Care and Rehabilitation Services Strategic Action Plan

<b>FOCUS AREA:</b>	<b>Our people, culture and capability</b>							
<b>OBJECTIVE:</b>	<b>Demonstrating innovative healthcare</b>						<b>Risk Rating</b>	
							<b>Current</b>	<b>Target</b>
	<b>N</b>		<b>N</b>					
<b>DESTINATION STATEMENT:</b>	<i>We are recognised nationally and internationally for innovation in aged care and rehabilitation healthcare</i>							
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>♦ Funding 1,2,3</b>	<b>★ Priority L, M, H</b>	
Number ACARS research projects completed	10	Annual	<ul style="list-style-type: none"> <li>Audit ACARS staff to ascertain what current research and audits are being undertaken or contributed to by HNE ACARS staff and publish list of current activities</li> <li>Encourage and support staff to apply for grants and funding opportunities for further research in aged care and rehabilitation</li> <li>Encourage presentation of research across HNE</li> </ul>	Clinical Network	Sept 2007	1		
				Clinical Network	Oct 2007	2		
				Clinical Network	Nov 2007	1		

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## 4. APPENDICES

### Appendix 1 - NSW Health definition of an “aged care client”

“The target population for this Framework comprises older people and their families /carers who will most benefit from access to multidisciplinary aged care assessment and management.

The term ‘aged care client’ refers to those older people and their families/carers who use aged care services. It does not include everyone older than 65 years of age; that is, the definition is not age-specific. Its interpretation may vary according to whether the older person is a potential consumer of services, a patient in an acute or sub-acute setting, a resident in a residential aged care facility or a client of community health services. As older people use a diverse range of health services, an individual may fit any one of these descriptors at different times. The definition recognises the critical importance of families and carers.

Clients to be offered aged care services are usually older people and their families/carers who present with high level needs due to one or more of the following problems. These problems may be acute or chronic.

#### *Physical*

Immobility

Falls

Incontinence

Chronic pain

Malnutrition

Pressure ulcers

Inability to perform activities of daily living (bathing, dressing, grooming, eating, toileting)

#### *Mental*

Cognitive impairment \*

Behaviour disturbance \*

Other psychiatric illness

Lifelong psychiatric illness in old age

\*The descriptors ‘cognitive impairment’ and ‘behaviour disturbance’ include dementia and delirium.

#### *Disability*

Sensory disability eg sight, hearing, touch and smell

Developmental disability in old age

Care, accommodation and support

Bereavement and loss

Loss of carer or carer stress

Social isolation (as distinct from living alone)

Living in residential care

Guardianship and other legal aged care issues

Multiple referrals to services especially hospital readmissions

#### *Other problems*

Multiple medical problems

Polypharmacy

Alcohol and drugs

Elder abuse

Safety concerns resulting from change or decline in function

Aged care services may also be able to assist some younger adults with disability and high level needs.”

**Appendix 2 - Core Planning Group Members**

Scott McLachlan

Jo Varley

Ian O'Dea

Viki Brummell

Louise Evans

David Rhodes

Chris Perfrement

John Ward

Carmel Peek

Peter Harradine

Janine Briginshaw

Derene Anderson

Delys Brady

Del Heuke

**Appendix 3 - Stakeholder Survey Letter**

**HUNTER NEW ENGLAND  
AGED CARE & REHABILITATION SERVICES PLAN**

The completion of a HNE ACARS Plan has been identified as an area priority with completion due in early 2006. The Aged Care & Rehabilitation Core Planning Group is seeking your feedback about what you consider to be the key issues for aged care & rehabilitation services and how to address them over the next five years. You may wish to complete the survey either as an individual or collectively as part of a team or service. Responses will be collated and a report will be provided to all survey participants. The survey can be completed anonymously, though if any comments require clarification, we would like to be able to contact you to discuss further.

**Please return the survey to:**

Ian O’Dea, Clinical Nurse Consultant  
By 18 November, 2005 via email to [Ian.O’Dea@hnehealth.nsw.gov.au](mailto:Ian.O’Dea@hnehealth.nsw.gov.au) or return by post to:  
Rankin Park Centre, Locked Bag 1, Hunter Region Mail Centre. 2310

Service Name: \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

Completed by: Name (optional) \_\_\_\_\_

If a collective response, how many staff were consulted: \_\_\_\_\_

**Key Directions**

1. Of the 15 key directions identified on the accompanying page, what do you consider to be the three most significant issues (in order of importance) for ACAR Services?

- a).....
- b).....
- c).....

**How to Address Issues**

What strategies do you think HNE could use to progress these three most significant issues? (i) by utilising existing resources and (ii) with enhancements – please specify resources needed

- a)
  - i).....
  - ii).....
- b)
  - i).....
  - ii).....
- c)
  - i).....
  - ii).....



## Appendix 4 - Stakeholder List

The following groups reviewed the plan and provided feedback:

JHH Emergency Department  
Stroke Service  
Central Dementia Service  
Allied Health:  
- Occupational Therapy  
- Dietetics  
- Speech Pathology  
- Audiometry  
- Social Work  
- Physiotherapy  
Pharmacy  
NGO's  
GP's  
Brain Injury Rehabilitation Service  
Brain Injury Association  
Carer Support  
Community Forums on Health  
Alzheimers Australia  
Aboriginal Health  
Aboriginal Community Controlled Health Services  
Multicultural Health  
Aged Care Assessment Team  
Mental Health  
Private Residential Aged Care Facilities  
Aged Care Day Centres  
Gloucester Activities Centre  
Dementia Day Centres  
Geriatricians  
Psycho-geriatricians  
Psychologists  
Rehabilitation Medicine  
Rehabilitation Units  
District Health Services  
Tertiary Referral Hospitals  
Rural Referral Hospitals  
Transitional Care  
Community Health  
Palliative Care  
ASET Nurses  
University of Newcastle  
University of New England  
Population Health  
Quality Improvement (Manning)  
Workforce Development

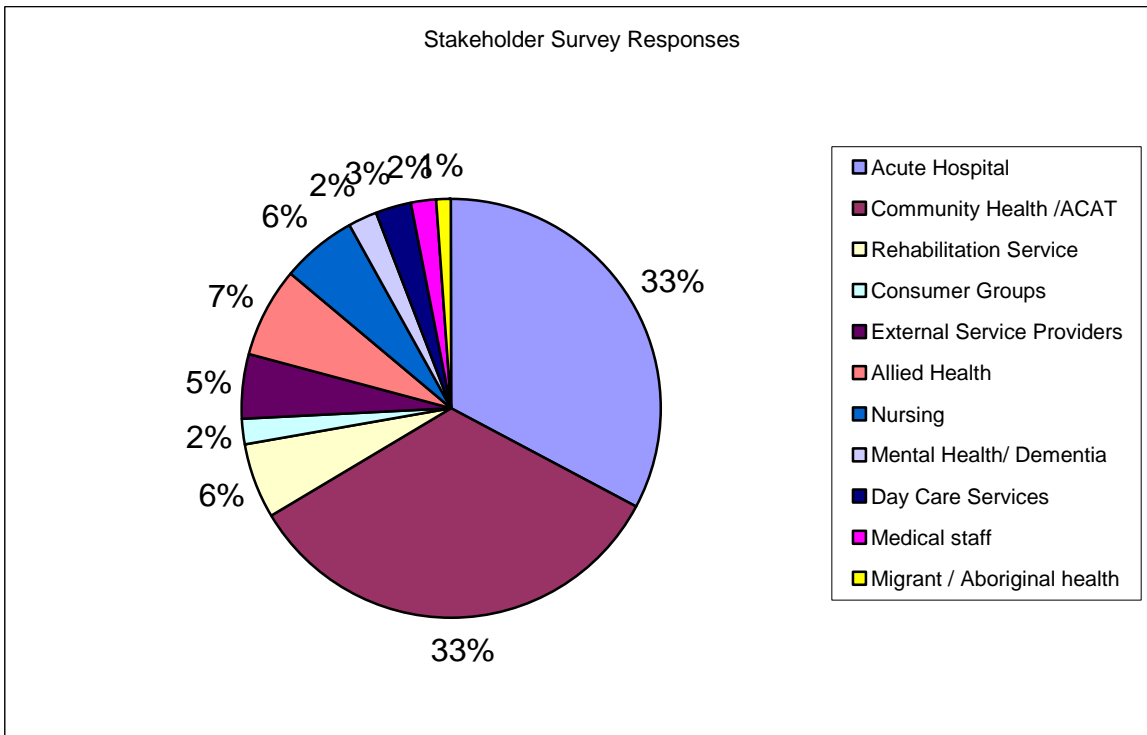
## Appendix 5 - Stakeholder Engagement

The consultation process with stakeholders of the Hunter New England Aged Care and Rehabilitation Services Plan was conducted under the guidance of the Aged Care & Rehabilitation Core Planning Group and included written and telephone surveys.

The survey process sought feedback from internal and external service providers and other key stakeholders (including consumers). Feedback identified the key issues in the provision of Aged Care and Rehabilitation Services and how the issues could be best addressed over a five-year period.

### Summary of Responses:

One hundred and fifty three (153) responses were received and collated. There were 96 (63%) telephone responses and 57 (37%) written responses. The figure below shows the groups who responded to the survey.



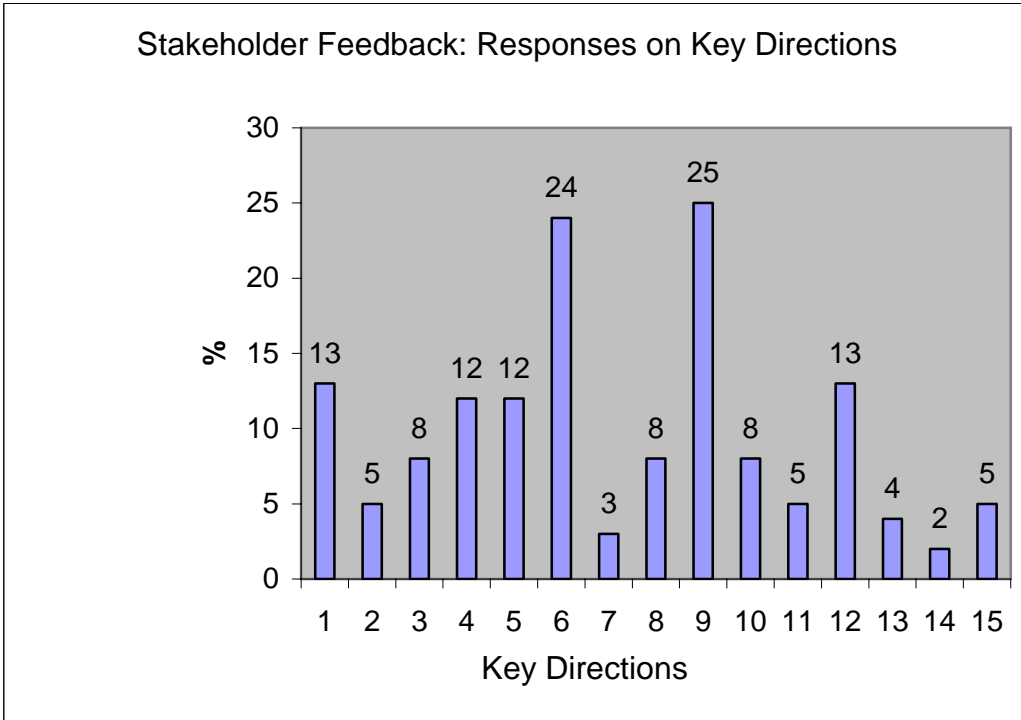
*Key Directions:*

Fifteen key directions were used as the basis for the consultation process. The key directions have been developed over the past twelve months through the self-assessment associated with the "Framework for the integrated support and management of older people in the NSW health care system", previous stakeholder consultation and existing Aged Care and Rehabilitation Plans.

Respondents to the survey were asked to indicate what they considered to be the three most important points from the following list:

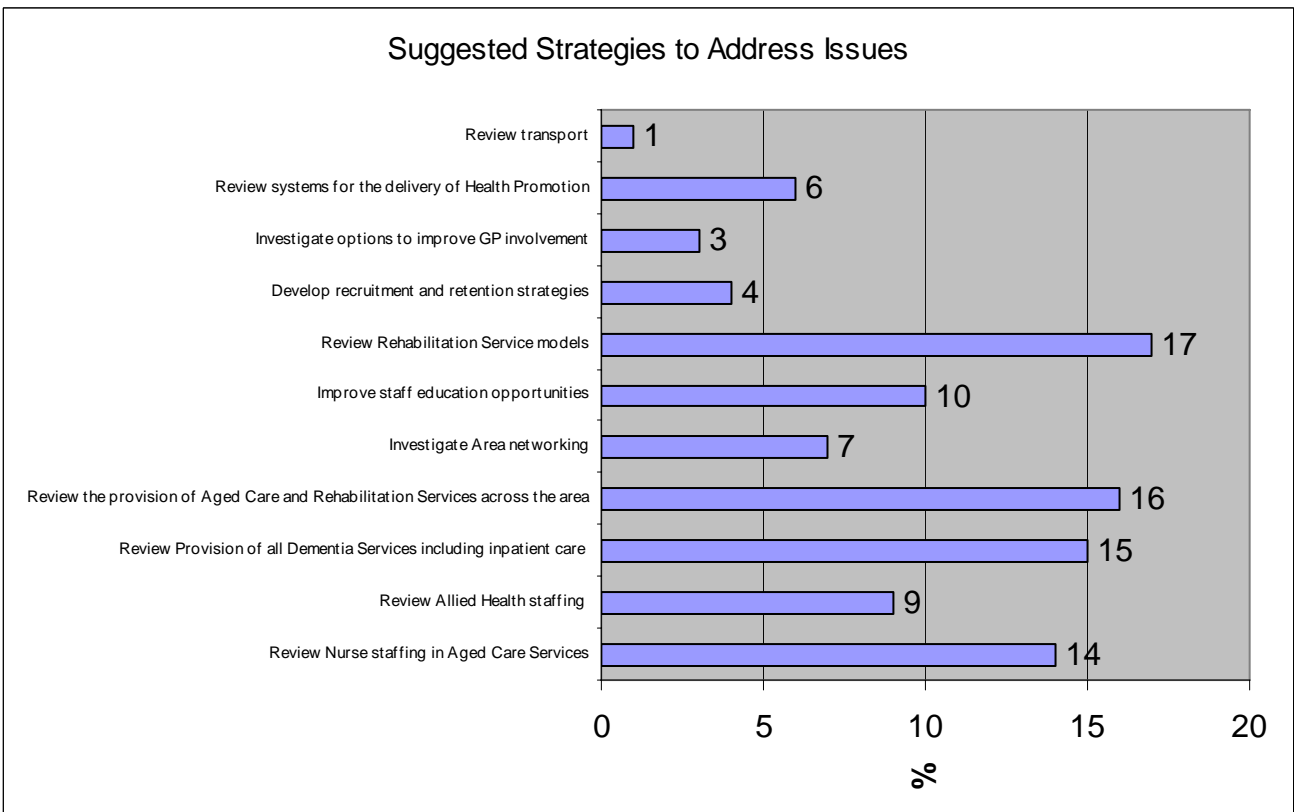
- 1 The development of an integrated service for dementia to include: assessment and diagnosis, carer support, education, case management, assessment and management of difficult behaviours, acute care and residential care.
- 2 The development of community aged care services to include the current ACAT roles, with dementia services, and supported by a geriatrician.
- 3 The expansion of hospital diversion programs, including rapid response services, ED assessment, ambulatory assessment clinics, flexible transitional care and community acute and post-acute services.
- 4 Improvement in the acute care of confused older patients by improving the physical facilities in hospitals and educating staff to assess and manage delirium and dementia.
- 5 Encouraging all services (hospital and community), to develop a person-centred approach to the care of older people, which is inclusive of carers and families.
- 6 Increasing the capacity to provide rehabilitation services in day therapy centres and community-based and home rehabilitation, including models that meet the needs of clients residing in small or isolated communities.
- 7 Developing shared care services with GPs for chronic diseases and especially dementia.
- 8 Increased involvement in health promotion, including falls injury prevention, healthy ageing programs and exercise promotion.
- 9 Workforce planning – the recruitment, retention & training of staff, including nursing, allied health and medical, to meet the increasing demands of the ageing population.
- 10 Improving the efficiency of care of older people in hospitals by improved assessment, person-centred care and improved discharge planning.
- 11 Infrastructure planning, particularly for high growth areas, such as Hawks Nest, Tea Gardens, Port Stephens, Forster, and particularly in the community.
- 12 Working with DADHC to improve the availability of services and accommodation for younger people with severe physical disabilities.
- 13 Working with residential aged care providers to improve the facilities and services available for older people, particularly in the area of dementia with challenging behaviours.
- 14 The development of IT and communication infrastructure to facilitate comprehensive and timely exchange of clinical information between care providers.
- 15 The development of user-friendly education programs for staff, patients and carers including information about accessing services across HNE Health.

The results indicated that points 9 and 6 were the most frequently identified.



*How to Address the Issues*

Respondents were also asked what strategies could be used to progress the issues outlined above. There were two hundred and ten (210) responses, which are outlined below.



*Summary:*

Responses to the surveys were received from both rural and urban areas of the Hunter New England Health Service, with Community Health and Acute Hospitals providing over 60% of the responses. The Rehabilitation Services responses were all received from the services based in the larger urban and rural centres areas. The allied health and nursing responses were separated where the respondents did not identify their workplaces.

Work force planning (key direction 9) followed closely by increasing the capacity to provide rehabilitation services (key direction 6) were the primary key directions highlighted in the survey. Integrating dementia service provision, encouraging a client person centred approach to aged care and working with DADHC to improve services for younger people with a disability were also issues that scored highly.

Responses indicate that there is a lack of coordinated Aged Care, Dementia and Rehabilitation service provision across the area highlighting the need to investigate and recommend improved service models. The implementation of this service plan under the guidance of the Clinical Network for aged care and rehabilitation will facilitate the effective management of these identified issues.

## **Appendix 6 - Outline of Various Governments' Responsibilities in Service Provision**

The Australian Government is responsible for the funding, regulation, planning and monitoring of residential and community aged care services. In addition, the Australian Government is responsible for funding of medical services through fee-for-service arrangements under Medicare. This includes the Medicare Plus initiative whereby general practitioners are funded to provide routine care in residential facilities (including urgent and after hours care) and to undertake comprehensive medical checks on residents. Provision is also made in Medicare for allied health services delivered 'for and on behalf of' general practitioners under a Multidisciplinary Care Plan.

NSW Health is responsible for acute care facilities, specifically public hospitals and community health services. In addition, it directly operates some residential and community care services. NSW Health shares responsibility with the Australian Government for the operation of Aged Care Assessment Teams (ACATs). NSW Health administers the health component of the Home and Community Care (HACC) program. This predominantly comprises community nursing together with community allied health and some day care services.

The NSW Department of Ageing, Disability and Home Care (DADHC) has an agreement with the Australian Government for the administration of the HACC program. It is responsible for the delivery of supports and services (particularly home-based services) for older people, people with a disability and their carers in NSW. Home Care is a key service provider in the community. DADHC also administers the Guardianship Tribunal and the Disability Council of NSW that reports directly to the Minister for Disability Services.

Local governments provide some hostel and community care services, as well as having a regulatory role. They may also provide funding and coordinate service provision, for example in the HNE Health Northern Region local councils auspice the Community Options programs.

The non-government sector is the major provider of residential and community care services and comprises private (for profit) operators, and not-for-profit (religious, charitable and community) organisations.

The links between each level of government and the non-government sector are through formal agreements, joint setting of strategic directions and joint planning processes, and/or consultative mechanisms. Service providers are subject to legally enforceable conditions of grant.

HNE Health provides a range of population-based aged care, mental health and rehabilitation services that complement general practice and other health services available for older people and adults needing rehabilitation services.

These services are geographically based, have varying degrees of integration between hospital and community-based services and are provided at several levels:

- Primary Health Care

Frequently the first point of entry into the health care system for patients of all ages and with all diseases. Most frequently care is provided by general practitioners, and sometimes by community health services

- Secondary Care

Basic specialist care usually carried out as an inpatient service of a general hospital but may be practiced in outpatient settings (i.e. at a health care centre, local hospital or in patients' homes)

- Tertiary Care

Specialised care requiring specially trained staff, equipment and/or other special physical facilities. Provides expertise and care for the more complex and rare conditions. Includes a teamwork approach and requires sophisticated in-house medical support and technology. Has a strong relationship with research and education.

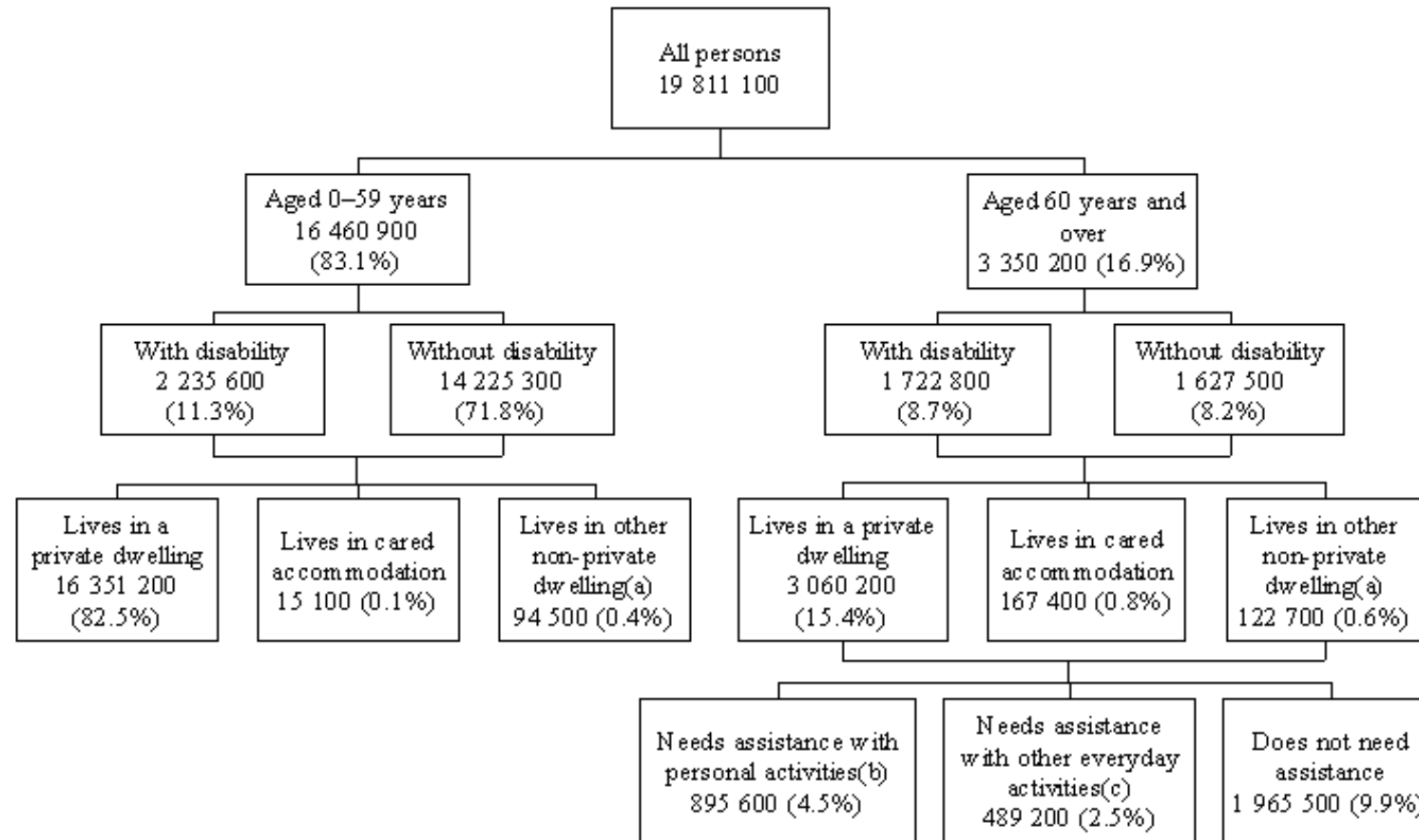
The roles of each level of government need to be complementary and delineated to avoid duplication of effort and resources, and the relationship with, and role of, the non-government sector is clearly established.<sup>3</sup>

## Appendix 7 - Policy Documents and Background Papers

- Background Paper prepared for current ACARS plan October 2005 (22 pages)
- Brief Summary of HNE Health's Strategic Plan for Aged Care / Rehabilitation Services. Prepared Area Planning Service August 2005 (2 pages)
- Summary of current programs relating to aged care across the HNE region. Prepared for HNE Planning Unit Feb 2005 (57 pages)
- New England Aged Care Strategic Plan 2002 (31 pages)
- Lower Mid North Coast 2003/04 review of their Age Care & Rehabilitation Service Plan. (28 pages)
- Summary of Ministerial Media Release re Dementia Estimates. Sep 2005 (3 pages). Full estimates paper available at [http://www.health.nsw.gov.au/pubs/2005/dementia\\_est.html](http://www.health.nsw.gov.au/pubs/2005/dementia_est.html) (46 pages)
- Summary of Aged Care Standards Gap Analysis for Northern Region Multi- Purpose Centres, utilising Commonwealth Aged Care Standards linked with Equip and Numerical Profile Plans, July 2005 (4 pages).
- Letter to CE re 'The Way Forward' A New Strategy for Community Care, August 2004. The Australian Government through the Department of Health and Ageing (3 pages) Link to PDF of document: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-research-commcare-wayf.htm/\\$FILE/wayforward.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-research-commcare-wayf.htm/$FILE/wayforward.pdf) (60 pages)
- Paper on Dementia Care in NSW  
Prepared July 2004 by Dr John Ward and a group of NSW Geriatricians and Psycho-geriatricians. (7 pages)
- Former HAHS response to the NSW Health Framework for Integrated Support and Management of Older People in the NSW Health Care System prepared Dec 2004 (30 pages)
- Former NEAHS response to the NSW Health Framework for Integrated Support and Management of Older People in the NSW Health Care System Prepared Dec 2004 (30 pages)
- AET Brief re Age Care & Rehab Plan Prepared Sep 05
- Draft HAHS Rehab Services Plan 2002-06 (45 pages)
- Stronger Together, a New Direction for Disability Services in NSW 2006-2016

**Appendix 8 - Diagram showing the distribution of disability and accommodation in groups over and under 60 years.**

(Source ABS 4430.0.55.003)



- (a) Other non-private dwellings comprise non-private dwellings apart from cared-accommodation.
- (b) Personal activities comprise self care, mobility, communication, cognition or emotion and health care.
- (c) Other everyday activities comprise paperwork, transport, housework and property maintenance.

## Appendix 9 - Aged Care Service Emergency Teams

Located in Belmont, JHH, Maitland, Manning, Newcastle Mater, and Tamworth EDs

Primary role is to see older people presenting to ED and to screen for 'Aged Care' Clients. Referrals are identified by the ASET staff, by screening tools, from the ED whiteboards and by direct referral from ED staff.

### CORE ELEMENTS OF ASET ROLE IN THE EMERGENCY DEPARTMENT

Core elements of ASET role in the Emergency Department (ED)		Desired / expected outcome
<i>The primary role of the ASET is in the ED. The core elements of the role of an ASET define the functions which should be carried out regardless of location of ED or extent of ASET coverage in ED. They provide the basis for determining measures of performance.</i>		
Advocacy	<ul style="list-style-type: none"> <li>• Individual older person in ED</li> <li>• Collective (advocate for aged care)</li> </ul>	Culture change
Coordinating relevant information about patients/clients		Continuity of care
Education	<ul style="list-style-type: none"> <li>• Formal sessions</li> <li>• Informal</li> </ul>	Improved case referral Culture change
Consultative aged care specialist role in the ED		Improved care and management of the older person
Quality care of complex issues	<ul style="list-style-type: none"> <li>• Identification / assessment               <ul style="list-style-type: none"> <li>○ Cognitive</li> <li>○ Functional</li> <li>○ Mobility</li> <li>○ Medication</li> </ul> </li> <li>• Planning</li> </ul>	Improved care and management of the older person
Facilitating access to other relevant services	<ul style="list-style-type: none"> <li>• Specialist services within the hospital</li> <li>• Links with GPs, RACFs</li> <li>• Community care services</li> </ul>	Smooth transition between services
Risk assessment and management in the ED		Safe management of older person in ED

**Appendix 10 - Aboriginal Impact Statement**

Have all items of the checklist been reviewed and answered?

Yes      No

Will this policy, program or strategy significantly affect the health of Aboriginal people? (the checklist may assist you to answer this question)

Yes       No

Is this policy, program or strategy likely to lead to a change in the nature or level of resources or health services available for Aboriginal Health?

Yes      No

If so, specify:

Strategies have been included to enhance consumer/carer input, to improve access to services (eg by providing transport, enhanced use of IT/telehealth), increased carer support/education and increased “acute care at home” services.

**Statement**

*The health needs and interests of Aboriginal people have been considered, and where relevant, incorporated and appropriately addressed in the development of the Aged care and Rehabilitation Plan.*

**Head of Unit Name:**

Scott McLachlan

**Unit Name:** Executive Sponsor, Director of Primary and Community Networks, Hunter New England Health.

**Development of the Policy, Program or Strategy**

1. Has there been appropriate representation of Aboriginal stakeholders in the development of the policy, program or strategy?

Yes      No      N/A

2. Have Aboriginal stakeholders been involved from the early stages of policy, program or strategy development?

Yes      No      N/A

Please provide a brief description

On December 12, 2005 the Planning Officer and Plan Leader (Southern) travelled to Tamworth to meet with the Aboriginal Health Worker nominated by the Area Director of Aboriginal Health. One of the meeting outcomes was an agreed process for facilitating appropriate feedback. Prior to this meeting in Tamworth, the Planning Unit Director and Planning Officer met with the Area Director of Aboriginal Health, to discuss how to appropriately and effectively consult on plan development

3. Have consultation/negotiation processes occurred with Aboriginal stakeholders:

✓Yes                      No                      N/A

4. Have these processes been effective?

✓Yes                      No                      N/A

A process was agreed and this has occurred with ease. Regular communication has occurred either through face-to-face meetings, by phone or by email. Information has been shared and effective working relationships have been formed. The Planning Officer has travelled twice to Tamworth to meet with Aboriginal Health Workers and has also made use of existing meeting schedules for this interaction to occur

5. Have links been made with relevant existing mainstream and/or Aboriginal-specific policies, programs and/or strategies?

✓ Yes                      No                      N/A

The Plan Development Team have been guided by the nominated Aboriginal Health Worker on appropriate strategies to facilitate these linkages

6. Has the policy, program or strategy been endorsed by the NSW Aboriginal Health Partnership/Local Aboriginal Health Partnership where required?

Yes                      No                      ✓ N/A

### **Contents of the Policy, Program or Strategy**

7. Does the policy, program or strategy clearly identify the effects it will have on Aboriginal health outcomes and health services?

Yes                      ✓No                      N/A

Evaluation of this plan will be under the auspices of the Clinical Network. As this plan is a “living” document, measures and initiatives may be amended to gain more specific data in relation to access, service utilisation and health outcomes. Also more specific measures re Aboriginal health outcomes will be included in the area Aboriginal Health Plan. The difference in age for an ‘older person’ between Aboriginal and non-Aboriginal people is documented in this plan.

8. Have these effects been adequately addressed in the policy, program or strategy?

Yes                      ✓No                      N/A

As above.

9. Are the identified effects on Aboriginal health outcomes and health services sufficiently different for Aboriginal people (compared to the general population) to warrant the development of a separate policy, program or strategy?

✓Yes                      No                      N/A

An area Aboriginal Health Plan is to be developed in 2006. In addition, planning processes ensure that there is appropriate input in all plans (in relation to the health needs of Aboriginal people).

**Implementation and Evaluation of the Policy, Program or Strategy**

10. Will implementation of the policy, program or strategy be supported by an adequate allocation of resources specifically for its Aboriginal health aspects?

✓Yes                      No                      N/A

Any initiatives in the Aged Care and Rehabilitation plan that require additional funds will be prioritised, costed and provided to the Area Executive Team for consideration. This same process will also occur for the area Aboriginal Health Plan.

11. Will the policy, program or strategy be implemented in partnership with Aboriginal stakeholders?

✓Yes                      No                      N/A

Ongoing consultation and collaboration will occur with relevant Aboriginal Health representatives and stakeholders to ensure effective implementation

12. Does an evaluation plan exist for this policy, program or strategy?

✓ Yes                      No                      N/A  
 (via the balanced scorecard reporting processes, monitored by the CN)

13. Has it been developed in conjunction with Aboriginal stakeholders?

Yes                      ✓No                      N/A

Briefly describe Aboriginal stakeholder involvement in the evaluation plan  
 During the life of this strategic plan, there are specific initiatives (eg relating to the joint assessment of older Aboriginal people in relation to suspected cognitive impairment and dementia) that will include Aboriginal stakeholder involvement in evaluation of the implemented action. Therefore, Aboriginal stakeholder involvement will occur during the life of the plan, but has not occurred in the initial stage of planning. However, Aboriginal stakeholders will be involved from the outset in the evaluation of the area Aboriginal Health Plan.