Health & Aged Care Regional Action Initiative

Addressing bed block in the Illawarra and Shoalhaven

Improving outcomes for older people

community INDUSTRY GROUP

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THE ISSUE

The population of residents in the Illawarra region aged over 65 is already higher than the national average. The Illawarra's population is estimated to be **320,000** in **2023** with **20% (64,000) over 65, and 3% (8,100) over 85**.

Within 9 years it is expected that one in four people living in the region will be aged over 65.

The Illawarra Shoalhaven Local Health District (ISLHD) has hospitals at Bulli, Wollongong, Port Kembla and Shellharbour with **more than 700 beds at 4 locations across the Illawarra.** The Australian Institute of Health and Welfare (AIH&W) notes that **53% of all hospital stays are by people over 65** and **the most prevalent cause for admission is an actual or suspected injury from a fall.**

Aged Care services are privatised and diverse with **over 2000 aged care beds** across **more than 30 locations** in the broader region, as well as several thousand people receiving in-home care services. For **more than two years** it has been regularly reported that there are **between 100 and 200 older people** at any one time in the **northern Illawarra public hospitals that are ready for discharge.**

Half of people aged over 75 require help with activities of daily living after a hospitalisation.

THE CAUSES

Aged Care Provider

- Generational reform after decades of low funding, chronic ageism, and recent Royal Commission with many recommendations to improve the system
- Financial stress and years of financial losses causing paused expansion, reduced capacity or closures
- Chronic workforce shortages exacerbated by reforms including care minutes and 24/7 RNs
- Nearly 400 aged care beds closed, or not opened, in the Illawarra Region in the last 3 years
- No new beds planned and fears of more closures

Older People

- Lack of awareness of all the options available, including temporary respite in RACF with return to home supported through (HSP or HCP)
- Fear of the unknown, especially around RACF and HCP
- Challenging behaviours that may prevent entry to a non-acute or sub-acute setting
- Ongoing complex medical management issues that require regular direct GP or hospital support
- Lack of understanding by the patient and their family about the quality of aged care services
- Fear about the affordability and the financial assessments required to enter a full-time accommodation and care environment
- Financial barriers leading to fear of being discharged from a fully Medicare funded setting, and more

PROJECT OVERVIEW

Preparatory Phase

Review effective models and find possible research partners.
Engage key stakeholders and agree on a practical plan.

Baseline The Issue

Assess the detailed needs of the current and recent cohort of people approved for aged care but still in hospital especially the long-stay bed-block group.
Assess the current actual capacity of the regional supply of aged care services and find any opportunities to maximise or expand their services to better meet the needs.
Compare the patient needs and service supply baselines, and make recommendations for a regional service supply response plan.

Direct Assistance

Provide professional priority fast track transition assistance for those ready to relocate.
Develop and deliver a volunteer case management / advocacy scheme to offer to assist each person navigate the system towards the services they need with a trusted informed volunteer advisor.

Pilot

Lobby relevant decision makers to obtain the federal, state and local resources required to pilot these key essential service solutions.
Implement a continuous improvement program to ensure ongoing analysis, identification and implementation of strategies to finesse the proposed solutions.

Expand

Provide specialist project advisory assistance, based on the research from item 2 above, to services who want to:

- Implement fast track transition programs,
- Maximise their service offerings to better meet the current need,
- Expand their services to meet need growth targets, and/or
- Implement innovative services such as joint health & aged care services eg MPS, to meet special needs such as dementia, mental health and rehabilitation.

Sustainable Oversight

Establish an ongoing health and aged care collaborative taskforce comprising senior representatives from the key stakeholders including:

- ISLHD,
- Aged and Community Care Providers Association (ACCPA),
- Coordinare – the Primary Health Network,
- CI Group,
- To review and oversee improvement of strategies based on relevant research eg MARC, NARI etc. Thus ensuing they continue to meet emerging, changing and growing needs in a regional aged care response strategy.

The total cost is estimated to be $2,875,105 for the first three years

KEY INITIATIVES

1. Research Root Causes

While many of the causes are known or speculated upon, there has been no root-cause analysis completed to identify all causes and develop a wholistic program of initiatives to address each contributed factor.

Conduct the following research:

- Analysis of health data to identify trends in causes of hospitalisation and extended stays.
- Quantify current service system and supply issues.

2. Identifying Current Vacancies

Implementation of a regionally specific, real-time online register of current vacancies across the Illawarra/Shoalhaven.

Promotional activities to ensure key personnel e.g. social workers, discharge coordinators are aware of the register and how to use it.

3. Older Person Allies

Transition assistance by expert volunteers to assist vulnerable people to transition to a suitable place to live and receive suitable care – either in residential aged care or in the person's own home with support through CHSP or HCP.

Developed along the lines of the Hospital to Home service in the UK which utilises volunteers to support the return home for older people.

4. Addressing Workforce Constraints

Addressing workforce constraints will be key to the success of the collaborative project. The workforce shortage creates increased obstacles to expeditious transfer of people from hospital care to home, supported by CHSP or HCP services, or to a residential aged care setting.

By reinstating the successful CareForce project, we will address negative perceptions inhibiting job seekers from taking up opportunities in the care sector, and directly link job seekers with employers in the sector.

CAREFORCE