12. Strategies for Future Development / Change

12.1 Shifting Care into the Community

Care in the community provides models of care that wrap around patients/consumers within their own community and neighbourhood. In the LMNC these services span "community health" (including child and family health, community nursing, sexual health), health promotion, community mental health, community aged care, drug health services and oral health services.

Services in the community include: prevention, community development, early intervention, assessment, treatment, health maintenance and continuing care services designed to improve or maintain the health and wellbeing of individuals and communities. Care in the community has the capability of providing earlier intervention and care, strengthening the integration of care and intervening to avoid unnecessary hospital admissions and presentations. Community-based healthcare is founded on a strong platform of equity and providing care that is targeted to vulnerable populations.

Strengthening the existing services and building pathways between community and hospital-based services provides important opportunities for earlier hospital discharge, supporting the continuum of patient care. A continued focus for the LMNC health services on integrating care where possible to improve the patient experience, quality of care and outcomes of healthcare. The objective is to minimise fragmentation of care, to achieve greater efficiencies and improve access to healthcare.

12.2 Expanding Ambulatory Care

From the local consultations with clinicians, both hospital and community based, there is support to extending the number and scope of multidisciplinary and multispecialty teams and clinics in an Ambulatory Care setting to better coordinate the management of patients with complex, chronic and/or comorbidities can ensure a more patient-centred approach and can avoid admissions. In the future to build on, and avoid unnecessary rehospitalisation's the introduction of rapid review clinics after discharge from the ED and from select clinical services including cardiology, orthopaedics, plastics and reconstructive surgery (wound clinic) can also prevent unnecessary hospital readmissions could be considered. The review of operating theatre activity also highlighted a number of procedures are being undertaken in the theatres that should more appropriately be undertaken in a procedural suite. An Ambulatory Care expansion should include space for this procedural activity which could also incorporate endoscopy capacity.

12.3 Meeting the Needs of Forster Tuncurry Residents

Of the 6,000+ Forster Tuncurry residents that currently attend Manning Hospital ED approximately 35% (2,000+in number) are admitted to the hospital for continued care (see Table 13 - Presentations by Forster Tuncurry Residents to Manning ED 2014/15-2017/18 - in Forster Health assessment section). By triage category, around 40% triage 3 are admitted, 24% of triage 4 and 12% of triage 5 residents from Forster Tuncurry are admitted. These lower numbers of admission support a strategy to establish a satellite ED Urgent Care model in Forster. Based on previous trends it should be capable of catering for around 3,500 – 4,000 presentations annually, similar to the role delineation Level 2 ED that operates at Gloucester Hospital.

The Urgent Care Centre (UCC) at Forster will be a key point of entry to the HNE public health system in the Mid Coast LGA. Health services have a responsibility to ensure all services provided to patients are

safe, appropriate and within the capability and role of the service and its clinicians[46]. That is, the scope of practice of the small health service, its clinical resources and/or workforce are sufficient to enable safe clinical emergency care. As UCCs are typically staffed by nurses and on-call general practitioners, see fewer than 10,000 presentations annually and have a limited ability to perform diagnostic tests such as x-rays and pathology tests, the ability of urgent care centres to provide definitive care is limited.

People present to an urgent care centre when they believe they have an issue that requires immediate attention. Ideally as many people as possible will be able to obtain definitive care at the UCC. They can either be discharged directly from the UCC may need to be admitted to the inpatient ward at the appropriate hospital for their care level, which would be either manning, Gloucester or John Hunter Hospital. Research has found that UCCs see virtually all categories of emergency presentations, treat critically ill and injured patients and perform most procedures. Patient presentation types at UCCs therefore are very similar to those at EDs, with the most common presenting illnesses arriving at a UCC being single site injury, digestive system illness and respiratory illnesses.[47] An evaluation commissioned by ACI of five selected pilot sites of UCCs in metropolitan and regional locations was undertaken in 2014, with the findings being very general but indicating the UCC model is one of a suite of streamlining models for treating non-urgent, non-complex patients and no evidence that it is any better or any worse than any of those models in NSW public hospital EDs.[48]

The UCC is a model of care that delivers ambulatory medical care outside of a hospital ED without a scheduled appointment. The UCC gives the ED an alternative model, distinct from the After-Hour GP clinic, for non-emergency patients who may otherwise present to ED.

Due to the decreases of GPs in the area, the proposal to establish a UCC at Forster would be a Nurse Practitioner (NP) led model with close collaboration with local GPs. This would include the NP assessing and managing patients, prescribing medications, ordering diagnostic investigations and directly referring patients to other healthcare professionals. Although NPs working in UCCs have proven particularly effective at managing minor illness and injury, their scope of practice is flexible and not limited to particular groups of patients, or types of illness. Nurse practitioners are highly trained and are responsible and accountable for making professional judgements about when a patient's condition is beyond their scope of practice and for initiating consultation with other health professionals. Nurse practitioners who provide an approved service can also bill Medicare, which would contribute to the cost of delivering the service.

Key principles of the model[49] are to expedite the patient journey for patients with minor injury or illness that are urgent but not life threatening, by:

- using a quarantined space outside of the ED
- commencing treatment early
- supporting patients to be treated in a dedicated area by dedicated staff
- adhering to strict inclusion and exclusion criteria
- using clinical protocols that promote early initiation of nursing care

[46] Australian Commission on Safety and Quality in Healthcare, 2015, Credentialing health practitioners and defining their scope of clinical practice
[47] Baker T, Dawson SL 2014, 'Small rural emergency services still manage acutely unwell patients: A cross-sectional study', Emergency Medicine Australasia, no. 2, pp. 131–138.
[48] NSW Agency for Clinical Innovation, Evaluation of Urgent Care Centres Pilot, Final report April 2014 (by Aspex consulting)
[49] Emergency Care Institute NSW, Emergency Department Models of Care, July 2012

- having rapid access to appropriate imaging and pathology
- having easy access to specialty outpatient, GP and community care referral.

The decision to transfer a patient to another health service demands clear communication and coordination between the health services and the ambulance service. Telehealth helps extend specialty assessment and advice out to where patients are, and to better inform transfer decisions and the formation of patient management plans. This can reduce unnecessary patient transport and decrease demands on an already busy ambulance service.

There are a number of benefits and challenges that should be considered with this model and the inputs to describe and define the model of care and patient criteria can be informed by work already undertaken in Victoria, who have developed a toolkit for implementation, other hospitals in NSW including Mona Vale and Wauchope who use a GP led model, the Primacy Care Walk In Centres in the ACT who use a nurse led model and an ED toolkit developed by ECI.

Noting the high proportion of older residents in local population, the model should also consider an aged care model such as an ASET or ACE team based at Forster which provides outreach service to residential aged care facilities to maintain a focus on hospital avoidance. Importantly, communication and linkages with medical support are key, and the service should also be working collaboratively with the Forster Community Health service which already has a presence in Forster and the Private Hospital in Forster.

12.4 Wingham Community Hospital

Wingham Community Hospital will continue to deliver day rehabilitation services and sub acute outpatient services from its current location. Demand for inpatient rehabilitation is expected to continue to grow over the next 10 years to 2031, just over a two percent per annum. The facility has the physical infrastructure and service components required to support a rehabilitation service and is easily accessed from Taree, around 12 kilometers west of Manning Hospital. There were some issues raised during the consultation about the barriers to being able to transfer and admit patients from Manning Hospital to Wingham Community Hospital that should be addressed immediately. The advantage of having a sub acute hospital on a stand alone site means that patients are able to be managed and followed up in an appropriate rehabilitative environment. The disadvantage is that if a patient deteriorates, they will be transferred to Manning Hospital for their care, and/or the ability for an acute patient at Manning Hospital to commence rehabilitation care is limited to the access to allied health staff and appropriate gym space. Some consideration might be given in the future to investigate the feasibility of relocating the service onto Manning Hospital campus. This should be an option considered in any future master planning of the Manning Hospital site, when capital funding is identified to support the relocation. This would also require extensive community consultation around the advantages and disadvantages of such a proposal, as understandably Wingham Community Hospital is considered very important building and service to the Wingham and Taree communities.

12.5 Bushfire and Climate Change Health Impacts

Smoke pollution from bushfires is associated with respiratory effects and the toxicity of particulate matter sourced from bushfires is similar to that originating from urban sources.[50] An increase in the frequency of

[50] Naeher LP, Brauer M, Lipsett M, Zelikoff JT, Simpson CD, Koenig JQ et al. Woodsmoke Health Effects: A Review. Inhal Toxicol 2007; 19: 67–106. doi:10.1080/08958370600985875