Submission No 35

INQUIRY INTO IMPACT OF AMBULANCE RAMPING AND ACCESS BLOCK ON THE OPERATION OF HOSPITAL EMERGENCY DEPARTMENTS IN NEW SOUTH WALES

Organisation: NSW Health

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NSW Health Submission

Impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales

NSW GOVERNMENT | Health

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Acronyms

Phrase	Abbreviation
Aged Care Assessment Team	ACAT
Agency for Clinical Innovation	ACI
Australasian College for Emergency Medicine	ACEM
Bureau of Health Information	BHI
Chronic Heart Failure	CHF
Chronic Obstructive Pulmonary Disease	COPD
Clinical Excellence Commission	CEC
ComPacks Information Management System	CIMS
Criteria Led Discharge	CLD
Culturally and Linguistically Diverse	CALD
Emergency Department to Community	EDC
Elevating the Human Experience	ETHE
Emergency Care Institute	ECI
Emergency Department	ED
Emergency Protocols Initiating Care Project	EPIC
Emergency Treatment Performance	ETP
Estimated Date of Discharge	EDD
Fellow of the Australian College for Emergency Medicine Specialist	FACEM
Full-time equivalent	FTE
General Practitioner	GP
Health Administration Corporation	HAC
Hospital in the Home	HITH
Key Performance Indicators	KPIs
Leading Better Value Care	LVBC
Local Health Districts	LHD
Medicare Benefits Schedule	MBS
Mental Health Emergency Care Centre	MHEC
National Disability Insurance Scheme	NDIS
National Health Reform Agreement	NHRA
Out of Hospital Care	OHC
Patient Experience Officer	PEO
Patient Flow Collaborative	PFC
Patient Flow Portal	PFP
Patient Safety and Distribution Unit	PSDU
Planned Care for Better Health	PCBH
Primary Health Network	PHN
Priority 1A	P1A

Rapid Access Clinics	RACs
Residential Aged Care Facilities	RACFs
Respiratory Syncytial Virus	RSV
Secondary Triage for Residential Aged Care Facilities	ST-RACF
Short Term Escalation Plan	STEP
Specialty Health Networks	SHN
System Flow Centre	SFC
Transfer of Care	ToC
Transitional Aged Care Program	TACP
Urgent Care Clinics	UCC
Virtual Clinical Care Centre	VCCC
Waiting for What	W4W

Executive Summary

NSW Health welcomes the opportunity to make a submission to this inquiry.

As the largest public health system in Australia, NSW Health operates Emergency Departments (EDs) that attend to more than three million patient presentations each year.[1]

Despite the unprecedented challenges over recent years – with a series of natural disasters impacting large parts of the state, as well as the ongoing COVID-19 pandemic – the NSW health system continues to perform well. This is due in large part to the extraordinary dedication and commitment of staff from across the health system – from doctors, nurses, allied health professionals and paramedics, to pathologists, cleaners, booking clerks and everyone in between. Many – particularly those in regional NSW – were personally impacted by events such as floods and bushfires, but still showed up to work so their communities could continue to have access to health services.

Meeting growing demand for emergency care

The demand for health services, including emergency medical care, has grown exponentially over the past decade. Even in this environment, NSW has consistently been the better performing Australian jurisdiction for timely access to care in EDs. In 2020-21:

- 79% of patients in NSW EDs started clinical treatment within national benchmark times, compared to 71% nationally.
- NSW EDs had the shortest median wait time to treatment at 17 minutes, compared to 18 minutes nationally.
- NSW EDs achieved the Australasian College for Emergency Medicine (ACEM) benchmark targets in all categories for emergency presentations seen on time except for triage category 2 (emergency). NSW's triage category 2 performance of 79% was just under the benchmark of 80%, however, was the highest performer nationally.
- NSW was the only jurisdiction to achieve the ACEM target of 75% for triage category 3 (urgent).

In the transfer of care between ambulance patients to EDs, NSW is again the better performer for the time taken for patients to be transferred off an ambulance stretcher to a hospital ED. In 2020-21, 84.8% of NSW patients were transferred within 30 minutes, compared to 72.7% in Victoria, 65.2% in Queensland, 62.7% in Western Australia, 63.8% in South Australia, and 65.9% in Tasmania.[2]

This performance is despite a significant growth in presentations; the 2nd quarter of 2011 (April to June) witnessed 500,242 ED presentations in NSW[3]. By the 1st quarter

[1] The NSW Health Annual Report, 2020-21, available at: 'https://www.health.nsw.gov.au/annualreport/Publications/annual-report-2021.pdf', p. 3.
[2] Australian Medical Association, 'Ambulance Ramping Report Card', 2022, available at: 'https://www.ama.com.au/sites/default/files/2022-05/ambulance-ramping-report-card.pdf', Figure 1.
[3] Bureau of Health Information, Data Portal, available at: 'https://www.bhi.nsw.gov.au/data-portal'.

of 2022 (January to March), overall NSW ED presentations had increased 43% to 716,288[4].

NSW Health acknowledges that at times, despite our best efforts in these circumstances, the expectations of patients are not always met and their experience may be contrary to what the system and its staff strive to achieve.

The ability to treat patients in recommended timeframes can be impacted by a range of factors, reducing timeliness to care and increasing ED staff workload and workplace pressures.

The focus of NSW Health remains to keep people well, to reduce unnecessary ED attendances, better manage the flow of patients attending EDs, avoid unnecessary admissions and ensure appropriate early discharge.

Impact of natural disasters and the COVID-19 pandemic on the health system

The Black Summer bushfires of 2019-20, as well as widespread flooding in 2021 and 2022, have had a compounding effect on the NSW health system. In affected regions, EDs and acute care facilities remained open, with contingencies made for impacted facilities. A range of staff from other parts of the health system, including paramedics, doctors, nurses and mental health specialists, were redeployed to affected areas to support local teams.

Non-urgent elective surgery and other non-urgent health services were necessarily rescheduled to enable health staff to focus on immediate community and patient needs and ensure hospital capacity was maintained during these times. Typically with events of this nature, patients impacted would be seen as soon as possible as part of a 'catch-up' phase for the health system.

The continuous and widespread nature of these events over the past few years, however, has placed pressure on the health system to operate and respond as it would normally.

COVID-19, and in particular the newer strains of the virus that emerged from the middle of 2021, has also significantly affected health system performance. This was compounded by an early influenza season which began at the end of April 2022, and an increase in presentations for bronchiolitis (a common chest infection in infants and young children) as a result of the Respiratory Syncytial Virus (RSV).

EDs in NSW have been impacted by waves of acute respiratory infections which peaked in mid-January 2022 during the height of the initial Omicron COVID-19

[4] Bureau of Health Information, 'Healthcare Quarterly', Tracking public hospital and ambulance service activity and performance in NSW, January to March 2022, available at: 'https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0009/730197/BHI_HQ48_JAN-MAR-2022_REPORT.pdf', p.28.

outbreak, with up to 1,400 presentations each week. These rates have not yet returned to the low inter-wave levels seen in 2021.[5]

Ambulance volumes have been similarly impacted. The most recent results show that, in January to March 2022, there were 326,544 ambulance responses, up 17.8% compared with the same quarter in 2017.[6] Of these, 9,360 were responses to priority 1A cases[7] for patients with life-threatening conditions – the most since BHI began reporting in 2010.

Of patients presenting to EDs, 169,250 arrived by ambulance,[8] up 13.0% from 149,729 five years earlier.

The higher transmissibility of newer strains of COVID-19 has also meant large numbers of the health workforce have been impacted, affecting staffing in many areas of the health system, and compounding workforce fatigue. This has translated into disruptions to ward and ED staffing and an inability to readily open hospital surge beds when demand requires, especially during the peak winter months.

External factors impacting timeliness of transfer of care

Increased patient volumes, as well as workforce impacts as a result of illness and furloughing during the COVID-19 waves, has affected the timeliness of transfer of care between the ambulance service and EDs.

The natural disasters and the COVID-19 pandemic have also impacted NSW Heath partners in care in the primary care system, aged care sector and disability services which contribute significantly to hospital demand. Like the NSW health system, these sectors have faced significant pressures throughout the COVID-19 pandemic. Many of the issues faced, such as workforce furlough and fatigue, and added complexities of care, are shared.

NSW has also had a significant number of outbreaks of respiratory illness in aged care facilities, which has led to admissions to hospital of frail aged patients with influenza and COVID-19, and has reduced the ability of residential aged care facilities to take new or returning admissions from acute hospital beds.

Reduced capacity in the community for residents at aged care facilities and delays in accessing care under the NDIS, contributes to both the flow of patients into the hospital through ED, and subsequent discharge from hospital.

Patients may sometimes remain in hospital despite being medically ready for discharge as they are awaiting a place at a RACF or for NDIS services to be approved.

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[5] NSW COVID-19 Weekly Data Overview, 'Epidemiological week 31, ending 6 August 2022', available at: 'https://www.health.nsw.gov.au/Infectious/covid-19/Documents/weekly-covid-overview-20220806.pdf', Figure 13.
[6] Bureau of Health Information, Data Portal, available at: 'https://www.bhi.nsw.gov.au/data-portal'.
[7] Bureau of Health Information, Data Portal, available at: 'https://www.bhi.nsw.gov.au/data-portal'.
[8] Bureau of Health Information, 'Healthcare Quarterly', Tracking public hospital and ambulance service activity and performance in NSW, January to March 2022, available at: 'https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0009/730197/BHI_HQ48_JAN-MAR-2022_REPORT.pdf', p.28.

In recent months there have been on average 600 patients occupying acute hospital beds who were ready for discharge or transfer.

In NSW, the number of RACF places per 1,000 target population (people aged 70 and over) has declined from 85 per 1,000 in 2012 to 73 per 1,000 in 2021. The current Commonwealth Government target is 78 RACF places per 1,000 target population.[9]

The effectiveness of the primary care system, especially GP services, is also a key driver of public hospital demand. Some hospital emergency presentations would be more appropriately addressed by primary care prevention, early intervention, treatment and management.

Addressing demand on public hospital services

NSW Health is continually undertaking a range of initiatives to address the internal factors that impact on the transfer of care.

The Secondary Triage for Residential Aged Care Facilities (ST-RACF) initiative is a partnership with NSW Ambulance and was initiated in March 2020 as a way of reducing unnecessary transfers from residential aged care facilities to EDs and/or hospitals at the start of the pandemic. While it was initially developed to respond to residents experiencing COVID-19 symptoms, the ST-RACF has subsequently been expanded to support a broader range of non-critical Triple Zero (000) calls from aged care facilities.

Between June 2020 and June 2021, NSW Ambulance received 106,254 calls from residential aged care facilities - 47,833 (45%) were classified as low acuity calls. Of these calls, 12% (5,885) were managed by the Secondary Triage process with 57% (3,343) of residents receiving their care in residence, with no transfer to hospital required.[10]

Another initiative is the RPA Virtual Fracture Clinic, which has been running for 22 months and has enrolled 500 patients in virtual fracture, physiotherapy-led care. These patients have been drawn initially from the EDs but the clinic will be also accepting patients from general practice, eliminating need for presentation to an ED for minor fractures.

In 2020-21, NSW Health launched the state-wide initiative – Planned Care for Better Health (PCBH) which is one of the flagship programs for Integrated Care. PCBH aims to identify people at risk of hospitalisation early, strengthen the care provided to them and improve their experience of receiving care to keep them healthier over the longer term.

The target population is people with complex chronic disease and social care needs, identified through the risk of hospitalisation algorithm. Enrolment into the PCBH initiative enables proactive delivery of patient centred targeted interventions in the

[9] Australian Government, Australian Institute of Health and Welfare, 'Providers, services and places in aged care', available at: 'https://www.gen-agedcaredata.gov.au/Topics/Providers,-services-and-places-in-aged-care'

[10] New South Wales Health, 'Annual Report 2020-21', available at: 'https://www.health.nsw.gov.au/annualreport/Publications/annual-report-2021.pdf', p. 24.

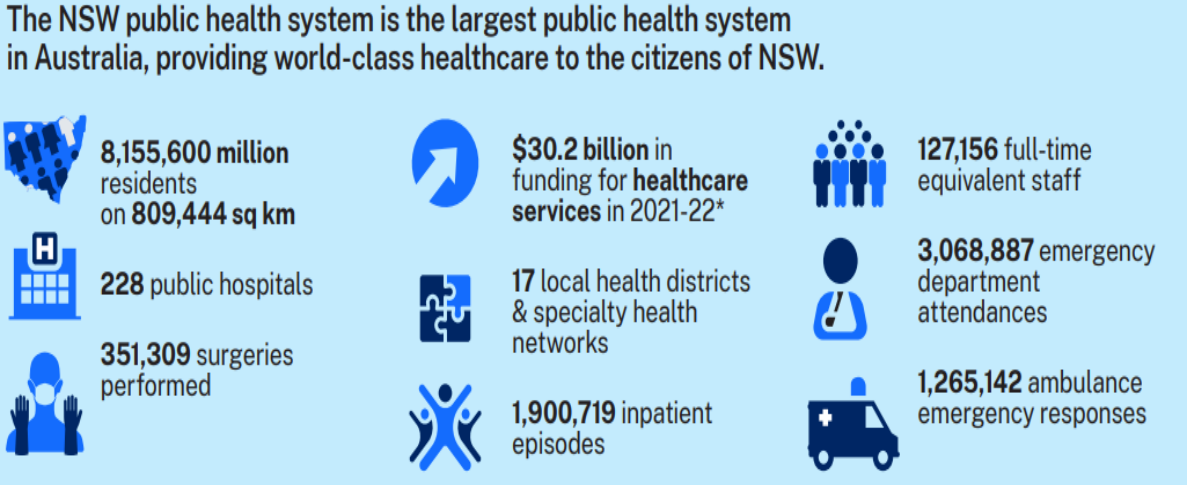
community that support patients to self-manage their illnesses and to reduce dependence on acute hospital resources. Through the PCBH program and other integrated care initiatives, patients receive appropriate care in the right setting for them. There have been over 640,000 instances of low acuity ED presentations and bed days avoided collectively by the NSW health system over the past three years.

Working with the Commonwealth and other partners in care

The health system is an intricately interlinked ecosystem; one dependent on many other sectors working well in tandem. Within Australia, one of the complexities affecting health care delivery is the split accountabilities between the Commonwealth, and the states and territories. The Commonwealth funds general practitioners and primary care through the Medicare Benefits Schedule (MBS) as well as the Pharmaceutical Benefits Scheme, while the states and territories provide public hospital services and some community-based services. The Commonwealth also funds the aged care sector as well oversees the NDIS.

NSW Health continues to work closely with our Commonwealth Government partners to enable greater access to aged care facilities, enhance NDIS placements, and support the primary care sector through a range of initiatives.

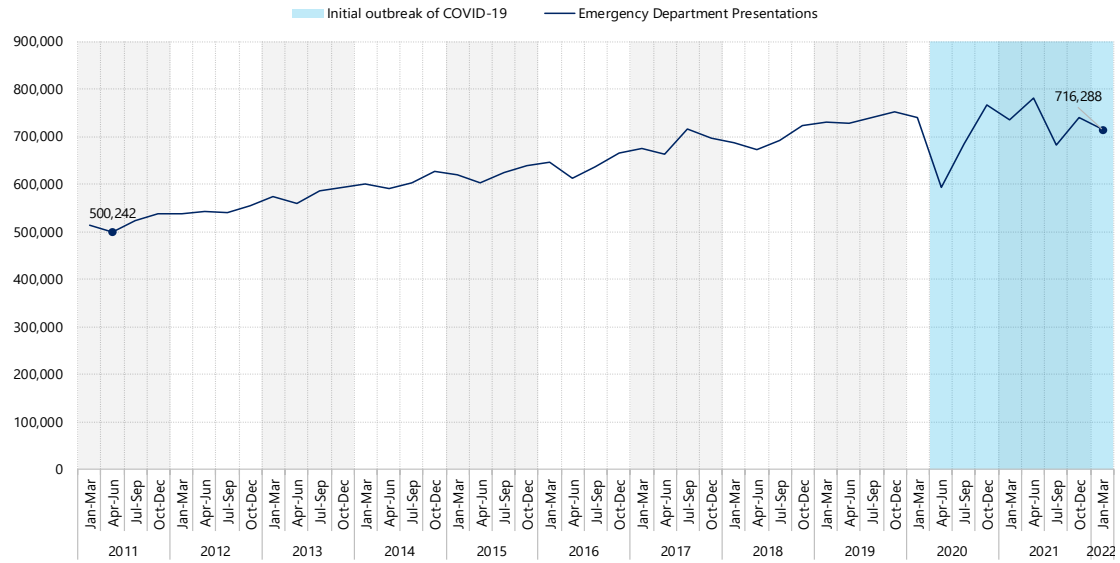
1. Increasing demand for emergency care



The NSW Health system is the largest public health system in Australia.[11] By 2061, NSW will be home to an additional 3.3 million people, representing growth of 40%. A quarter of the population will be 65 years of age or older.[12] The demographic projections for NSW point towards an ongoing growth in demand for health services in future.

1.1 Performance of NSW EDs

The demand for health services, including emergency medical care, has grown exponentially over the past decade. The 2nd quarter of 2011 (April to June) witnessed 500,242 ED presentations in NSW. By the 1st quarter of 2022 (January to March), ED presentations had increased 43% to 716,288.



[11] The NSW Health Annual Report, 2020-21, available at: 'https://www.health.nsw.gov.au/annualreport/Publications/annual-report-2021.pdf', p. 3.
[12] NSW Government, '2021-22 NSW Intergenerational Report', 2021-22, available at: 'https://www.treasury.nsw.gov.au/sites/default/files/2021-06/2021-22_nsw_intergenerational_report.pdf', p. 8.

Within the environment of rising demand and complex environmental factors, NSW has consistently been the better performing Australian jurisdiction for timely access to care in EDs.

In 2020-21, 79% of patients in NSW EDs started clinical treatment within national benchmark times, compared to 71% nationally. NSW EDs also had the shortest median wait time to treatment at 17 minutes, compared to 18 minutes nationally.[13]

In 2020-21 68.97% of all ED patients in NSW had a length of stay of 4 hours or less compared with 66.71% nationally. NSW performance ranked, slightly behind WA (70.77%) and Qld (69.11%). Additionally, NSW was the only jurisdiction to achieve the ACEM target of 75% for triage category 3 (urgent).

NSW EDs achieved the Australasian College for Emergency Medicine (ACEM) benchmark targets in all categories for emergency presentations seen on time except for triage category 2 (emergency). NSW's triage category 2 performance of 79% was just under the benchmark of 80%, however, was the highest performer nationally.

Management of triage category 1, 2 and 3 patients commencing treatment on time in the emergency department remained stable in the first half of 2021- 22.

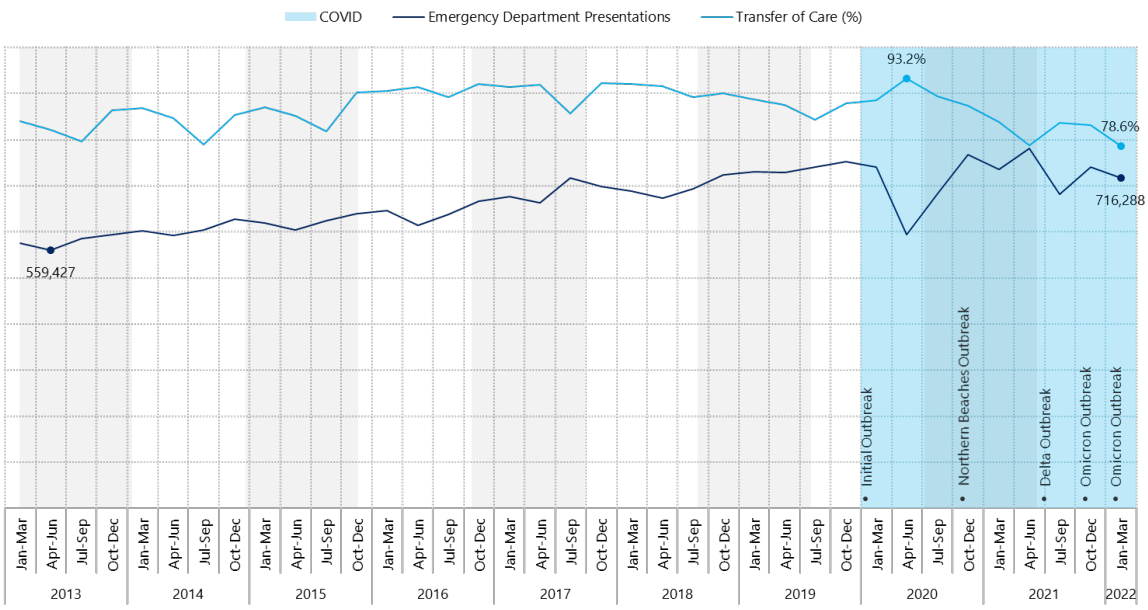
As the Omicron variant emerged in December 2021, the percentage of patients treated on time decreased slightly compared to 2019 levels, while the percentage of patients who left the emergency department within four hours remained stable.

Patients who present with COVID-19, or are suspected of having COVID-19, all take significantly more time to be assessed and treated. The treatment time is influenced by the requirement for enhanced infection control procedures which include the time for staff to put on and remove full Personal Protective Equipment, wait times for COVID-19 PCR testing and the requirement to separate out non COVID-19 patients from COVID-19 patients. The extended timeframes lead to decreased flow through the ED impacting on the ED's ability to achieve target timeframes or improve this measure. The safety of our patients and staff is paramount and this extra work is required.

1.2 Transfer of care performance

In the transfer of care between ambulances and EDs, NSW is the better performer for the time taken for patients to be transferred off an ambulance stretcher to a hospital ED.[14] In 2020-21, 84.8% of NSW patients were transferred within 30 minutes, compared to 72.7% in Victoria, 65.2% in Queensland, 62.7% in Western Australia, 63.8% in South Australia, and 65.9% in Tasmania.[15] These timeframes have been maintained despite a significant growth in volumes.

[13] Australian Government Australian Institute of Health and Welfare, 'Emergency department care access', available at: 'https://www.aihw.gov.au/reports-data/myhospitals/intersection/access/ed'.
[14] Australian Medical Association 'Ambulance Ramping Report Card' 2022, available at: 'https://www.ama.com.au/sites/default/files/2022-05/ambulance-ramping-report-card.pdf', p. 3.
[15] Australian Medical Association 'Ambulance Ramping Report Card' 2022, available at: 'https://www.ama.com.au/sites/default/files/2022-05/ambulance-ramping-report-card.pdf', p. 4-5.



Transfer of Care and Emergency Department Presentations.[16]

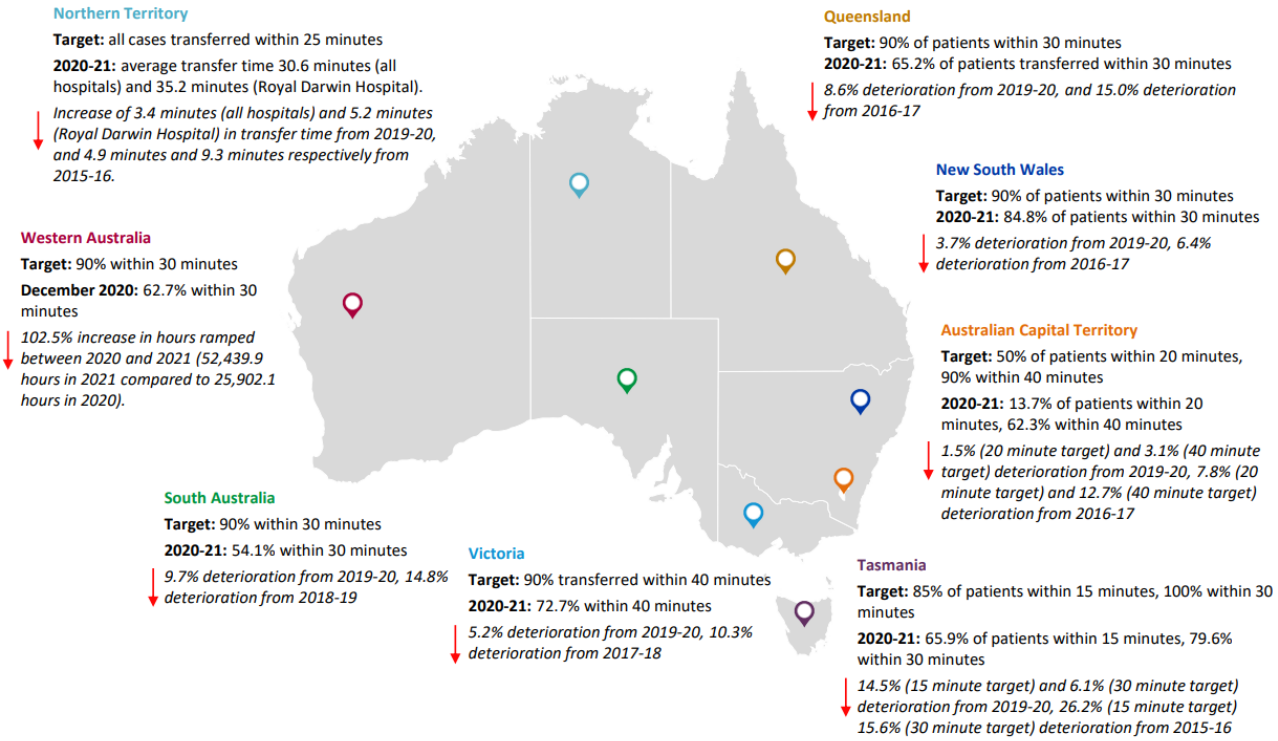
[16] Bureau of Health Information, Data Portal, available at: 'https://www.bhi.nsw.gov.au/data-portal'.

1.3 Comparison to other jurisdictions

NSW Health is considered to be a leader in the management of transfer of care in Australia. In April 2022, at the request of South Australia, Tasmania, and Western Australia, NSW Health hosted an interjurisdictional meeting to showcase the approach of NSW Health to the management of transfer of care. The meeting was attended by senior health executives from the three states including Ambulance Service Chief Executives.

The figure below provides a summary of the performance targets and reported performance for each state and territory. The measures used to report on this metric differ between states and territories, making it challenging to perform national comparisons and determine the scale of the problem at a national level. It is however evident that states and territories are falling short of their performance targets, and longitudinal data demonstrates that the time it takes to transfer a patient from the ambulance to the care of the hospital ED has been overall increasing year on year.

Figure 1: Patient transfer from ambulance to emergency department performance for each state and territory



NSW has a target of 90% of cases to be transferred from the ambulance to the ED within 30 minutes. In 2020-21, 84.8% of patients were transferred within 30 minutes. This represents a 3.7% deterioration in performance from the previous year (88.5%). The time taken to transfer patients to the ED has been gradually deteriorating since 2016-17, where 91.2% of patients were transferred within 30 minutes, a 6.4% deterioration in performance compared to 2020-21.[17]

[17] Australian Medical Association, 'Ambulance Ramping Report Card', 2022, available at: 'https://www.ama.com.au/sites/default/files/2022-05/ambulance-ramping-report-card.pdf'.

1.4 Insights into ED Patient Experience

A range of measures are monitored to understand patient experience within the hospital system.

Emergency Department Patient Experience Program

The Emergency Department Patient Experience Program was piloted in four EDs in early 2019 and has subsequently been rolled out to 52 EDs across NSW. The aim of the NSW Health ED Patient Experience Program is to improve the safety, comfort and quality of waiting areas for patients, their families and carers. The program involves four key strategies – patient experience officers, information technology, waiting room enhancements, and staff support and development.

More than 100 patient experience officers are now working in 52 NSW EDs across the state, providing expert, non-clinical advice and assistance to navigate the system, providing reassurance and addressing potential issues early to help people while they are waiting.

An analysis of patient feedback has showed that the PEO role was viewed by patients, families and carers, as having a positive impact on being shown compassion, respect, and kindness, receiving clear and effective communication, and receiving care in a comfortable environment. Given the challenges of the past three years the experiences of people attending NSW public hospital EDs were largely unchanged from 2019-20 to 2020-21, with approval levels remaining high.[18]

Patients and their families give feedback via kiosks that are placed in EDs or by a text message that is sent shortly after the patient leaves. The rapid results allow staff to plan and implement actions to address issues raised, thereby improving patients' overall experience of emergency care.

NSW Health acknowledges that these results reflect the exceptional work of our healthcare staff, both clinical and non-clinical, as well as consumer representatives who work with staff to improve care and experiences.

ED Patient Survey 2020-21

The Bureau of Health Information (BHI) results from the ED Patient Survey 2020-21 provides insight into the experience of 20,728 people who attended one of 77 of NSW's largest EDs for care from July 2020 to June 2021.[19]

- Almost all patients (89%) said that overall, the care they received was 'very good' or 'good' during a year with significant pressure placed on the health system and its staff due to COVID-19. Those rating their care as 'very good' was unchanged from the prior survey in 2019-20.

[18] Bureau of Health Information, 'Emergency Department Results from 2020-21 Patient Survey', available at: 'https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0004/723181/BHI_EDPS_2020-21_Snapshot.pdf',

[19] Bureau of Health Information, 'Emergency Department Results from 2020-21 Patient Survey', available at: 'https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0004/723181/BHI_EDPS_2020-21_Snapshot.pdf', p. 3.

- Almost eight in 10 patients (79%) said that, while they were waiting to be treated, ED staff checked on their condition, an improvement of 4% from 2019-20.
- Most patients (87%) said they were 'always' treated with respect and dignity while in the hospital, improved from 86% the previous year.
- More than 8 in 10 patients (81%) said ED health professionals 'always' explained things in a way they could understand.

32 questions were compared on patient experiences of rural and urban EDs with urban areas including those in metropolitan and major cities such as Maitland and Tweed Heads.

- Responses to 10 questions were more positive for patients attending rural EDs. This included questions about being involved in decisions about their care and treatment (67% rural compared to 64% urban) and decisions about their discharge (71% rural compared with 67% urban).
- Responses to 2 questions were more positive for urban ED patients. These questions were about being provided with a document summarising the care they received (75% urban compared with 45% rural) and whether ED staff introduced themselves (78% urban compared with 76% rural).

The patient survey results demonstrate the ongoing effectiveness of measures established by NSW Health to improve patient experiences in EDs across the state, and identifies those areas where improvement is needed.

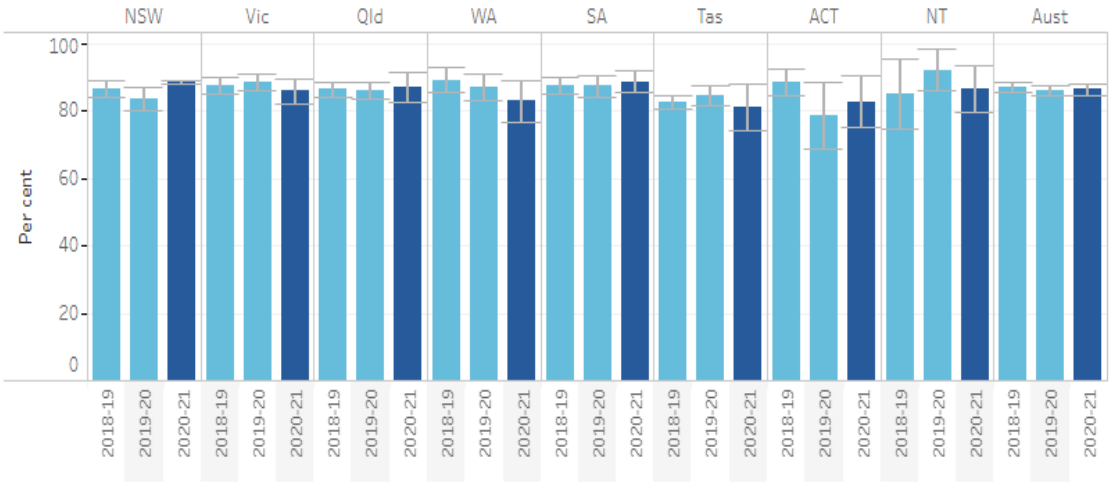
NSW Health's Elevating the Human Experience program is being implemented to improve the experiences of patients, carers and staff across rural and metropolitan health services in NSW. Following engagement of more than 500 consumers, carers, clinical and non-clinical staff, academics and other experts, the year one workplan is now underway to drive human experience improvement across NSW.

National Comparator for Patient Experience in EDs

In 2020-21, nationally for all measures, the rate of respondents reporting that hospital and emergency department doctors, specialists and nurses listened carefully, showed respect and spent enough time with them was above 82%.[20] As the figures on the next page show, the results are consistent across timeframes and jurisdictions.

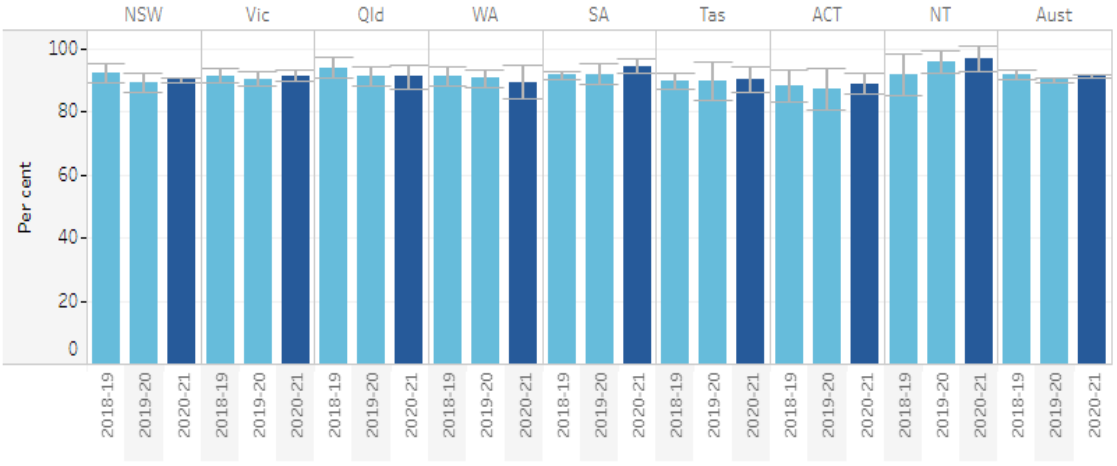
[20] Australian Government Productivity Commission, 'Report on Government Services', available at: 'https://public.tableau.com/views/2022_e_12_publichospitals/9_Patientsatisfaction?%3AshowVizHome=no'.

Figure 12.7a Measure 1: **Patient satisfaction with ED doctors or specialists — always or often listened carefully to them** by jurisdiction, by year



Source: table 12A.40

Figure 12.7a Measure 1: **Patient satisfaction with ED nurses — always or often listened carefully to them** by jurisdiction, by year



Source: table 12A.41

Source: Australian Government Productivity Commission, 'Report on Government Services', available at: 'https://public.tableau.com/views/2022_e_12_publichospitals/9_Patientsatisfaction?%3AshowVizHome=no'.

2. Impact of natural disasters and the COVID-19 pandemic on the health system

The Black Summer bushfires of 2019-20, as well as significant flooding events in 2021 and earlier this year, have had a compounding effect on the NSW health system.

In affected regions, emergency departments and acute care facilities remained open, with contingencies made for impacted facilities. However, the continuous and widespread nature of these events over the past few years has placed pressure on the ability of the system to operate as it would normally. COVID-19, and in particular the newer strains of the virus that emerged from the middle of 2021, have also affected health system performance. This was compounded by an early influenza season, which began at the end of April 2022, and an increase in presentations for bronchiolitis (a common chest infection in infants and young children) as a result of the Respiratory Syncytial Virus (RSV).

2.1 Model of Care impacts

During the COVID-19 response there has been an ongoing requirement to be agile in the review, revision, and augmentation of different models of care. This was evident across all areas of the system.

EDs established 'hot' zones to deal with increases in cases with COVID-19 or those with the potential to have acquired the disease. This resulted in clinical and non-clinical staff having to wear Personal Protective Equipment for long and sustained periods. These elements contributed to surge scenarios and impacted on flow through the ED as well as to inpatient units. Domestic staff worked closely with clinical staff to create and maintain the patient spaces for care which, when combined with the above factors and furloughing, affected patient flow. Enhanced infection control requirements necessitated changes to practice. Paramedic and patient transport crew practices changed, and these crews were required to wear Personal Protective Equipment and modify cleaning procedures to align with changing protocols.

The Adaptive Model for Adult ICUs was developed to guide intensive care staff, using planned models, to meet the needs and demands of ICU care at each stage of the pandemic response. LHDs and SHNs prepared and trained workforce groups in alternative models of care, which were operationalised in surge periods or times of ICU staff shortages.

To facilitate patient flow through EDs and support ICU capacity during COVID-19 outbreaks, the NSW ICU Patient Flow Coordinator service was developed. The NSW ICU Patient Flow Coordinator provides an ICU bed finding service to facilitate the transfer of critically ill patients across the system to support flow and capacity during COVID-19 outbreaks. The service assisted the timely flow of critically ill patients from EDs to intensive care. During the Delta and Omicron outbreaks, NSW Ambulance's Aeromedical Retrieval Service transferred over 200 critically ill patients to distribute the ICU patient load across NSW. The ICU Flow Coordinator service assisted in finding beds to facilitate transfer of over 150 of these patients.

A number of hospitals implemented targeted patient flow strategies to facilitate the movement of COVID-19 admissions from the ED. Respiratory specialty wards were

remodelled, and in some cases established, to manage higher acuity COVID-19 patients in need of increased respiratory support such as non-invasive ventilation and high flow oxygen therapy. Additional equipment was purchased and alternative workforce models were implemented to manage these patients which then freed intensive care beds for the most critically unwell.

The NSW Vaccination Program commenced in February 2021, and within eight months NSW reached 80% double dose vaccination rates for people aged 16 years and over. Through tailored strategies and considered forward planning, the Program was able to put in place vaccination clinics and support targeted campaigns to increase vaccination uptake, preventing serious illness and death from COVID-19 and helping to mitigate the economic impact of strict lockdowns. Between February and mid-March 2021, NSW progressively expanded its vaccination footprint from five major clinics to more than 100 vaccination clinics, including regional satellite sites and outreach.

The workforce redistribution, particularly of nursing and allied health workforce, was initiated to support the various vaccination programs across NSW. As these initiatives scaled down the workforce could then be returned to business as usual.

The temporary suspension of non-urgent elective surgery and other non-urgent health services at public and private hospitals during the pandemic have been a necessary step to enable health staff to be reallocated across the system to focus on immediate community and patient needs, and ensure hospital capacity and resources required for the COVID-19 response were maintained during the Alpha, Delta and Omicron COVID-19 outbreak. Patients impacted by these suspensions would be rescheduled and seen as soon as possible as part of a ‘catch-up’ phase for the health system.

2.2 Impact of COVID-19 on NSW Health Workforce

The NSW Health workforce has been at the forefront of the COVID-19 response for over two years. Cumulative impacts on the workforce include ongoing requirements for workforce surge during COVID-19 and its variants, as well as requirements to manage and maintain COVID-19 clinics and wards, testing, screening and mass vaccination centres.

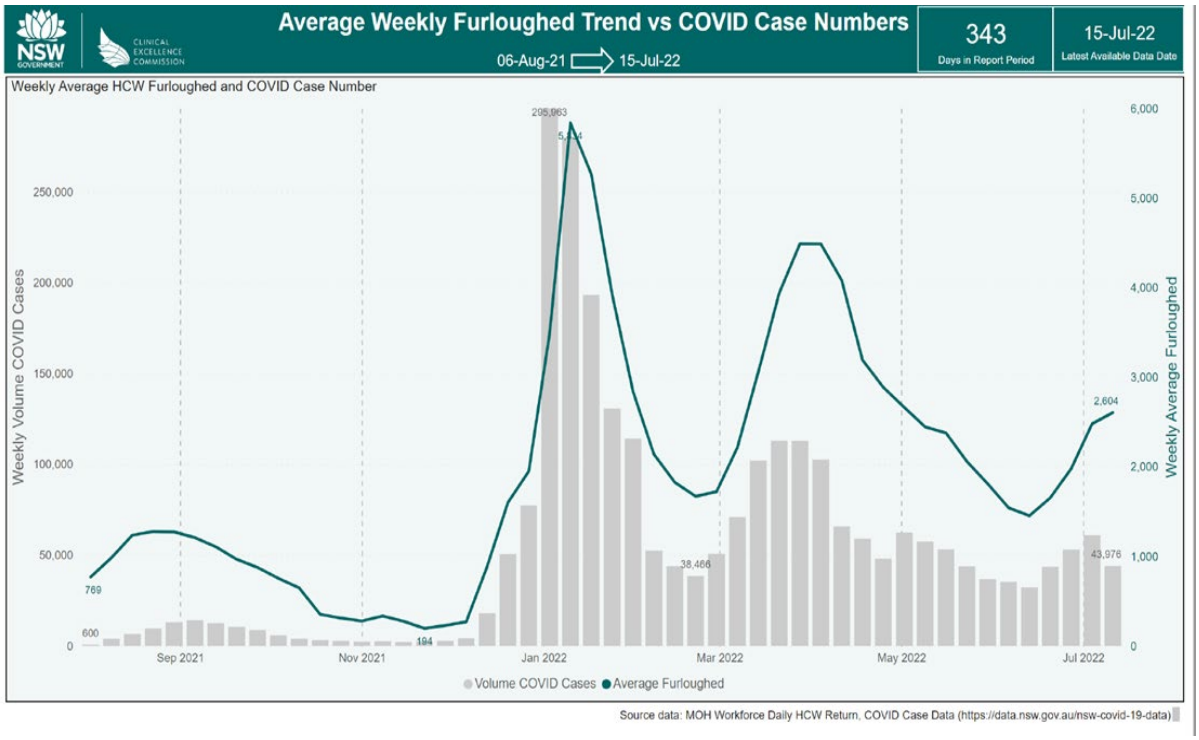
Workforce supply was impacted by border closures, and as the pandemic progressed, additional staff sourced from agencies and organisations that closed down at the start of the pandemic were no longer available as industry reopened.

The recommencement and ongoing delivery of elective surgery through subsequent COVID-19 and variant spikes also had an impact on workforce supply.

The impact of staff furlough through ill health or caring responsibilities and the inability to take planned leave due to the commitment to support COVID-19 demand has also put pressure on the delivery of health services, which is now increasingly visible in attrition rates.

Staff furlough impacting staff availability

Staff availability to support increased demand for healthcare services has been significantly impacted by the number of staff furloughed due to a positive COVID-19 diagnosis or as close contacts to a positive COVID-19 case. The number of staff furloughed peaked in mid-January 2022, at over 6000 staff, in line with the peak of community cases and hospitalisations, with the vast majority of staff in isolation due to community exposure as opposed to workplace exposure.



Source: Clinical Excellence Commission, 'Average Weekly Furloughed Trend vs COVID Case Numbers', 6 August 2021 – 15 July 2022 - internal NSW Health data

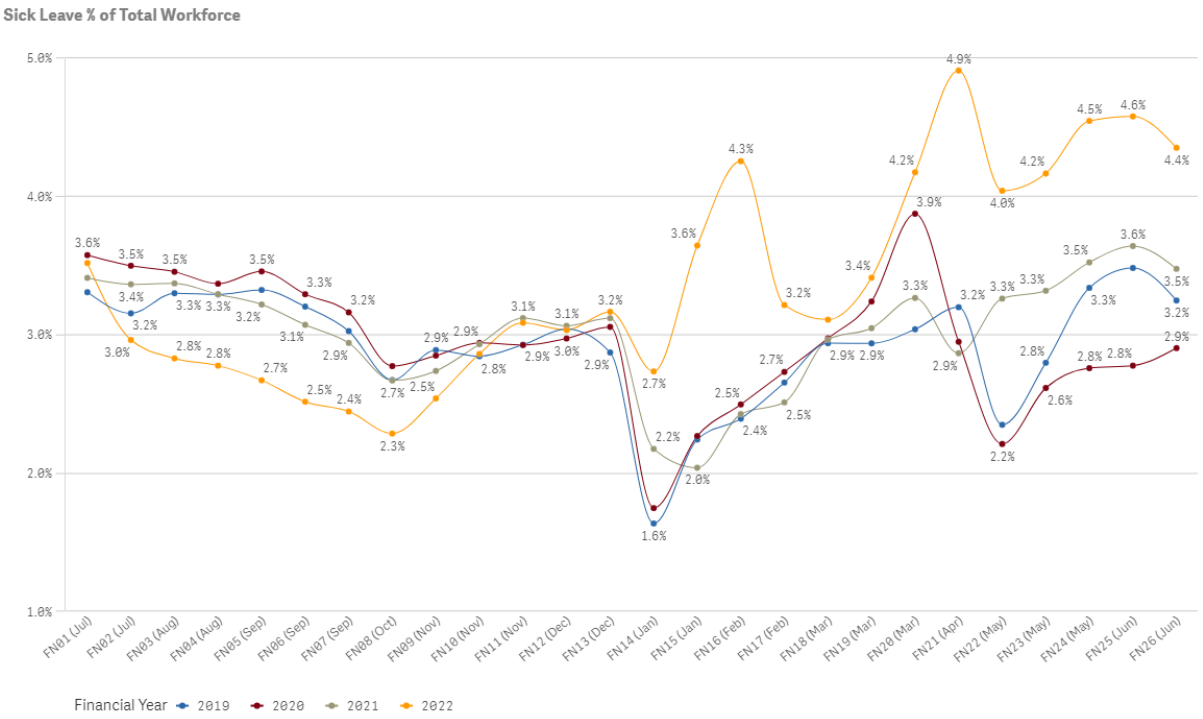
Staff furlough increased again in March 2022, again reflecting an increase in the community cases, supporting the case for increased capacity to mitigate the impacts of continued shifts in case numbers and the subsequent impact of healthcare workforce availability. This impact on staff availability put significant pressure on LHDs/SHNs at a time when service demand was heightened and put pressure on other individuals who were required to work additional shifts and extended hours to 'fill the gap'.

While the number of staff furloughed reduces post variant surge in line with community cases, the experience to date is that each surge is becoming more challenging as a result of cumulative workforce fatigue. This has a significant impact across the system but particularly in rural and regional areas where access to alternative workforce supply is limited and small workforce numbers means the loss of just one or two workers adversely impacts workforce availability.

Sick leave

Until the start of 2021-22, sick leave had trended similarly to previous years. However, through the Delta outbreak sick leave (as well as all other types of leave) reduced below seasonal norms, likely reflecting the commitment of the workforce to support heightened COVID-19 demand.

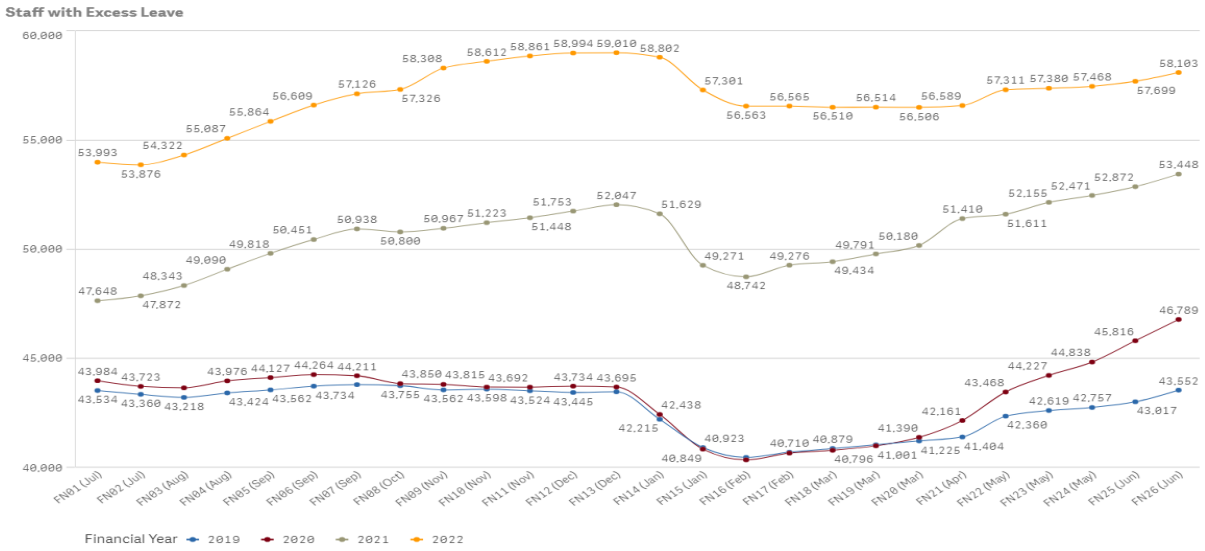
As shown in the chart below, this trend of reduced sick leave abruptly reverses in October 2021 following the Delta outbreak illustrating a 'rebound' effect reflective of staff fatigue. This increase in sick leave in the latter months of 2021 is further exacerbated by the Omicron outbreak with a sharp rise in sick leave across the system in January and February 2022. As at February 2022, sick leave represents 4.3% of FTE, an increase of almost 1.8% when compared to previous years. Further variant surges were seen during April 2022, with sick leave accounting for 4.9% of FTE, and June 2022, where it has remained over 4%.



NSW Health state sick leave 2019-2022 - Source: NSW Corporate Analytics - internal NSWH data

Increasing excess leave balances

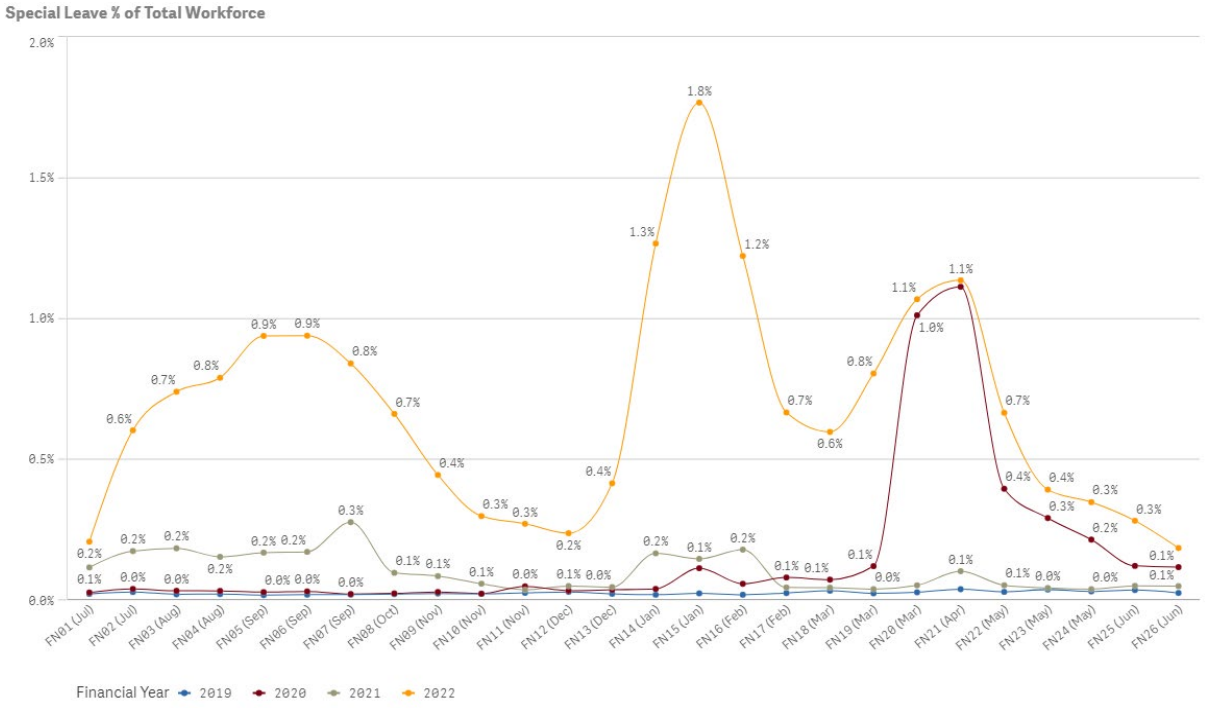
To manage employee wellbeing and forward liabilities, NSW Treasury requires all government agencies to reduce accrued employee recreation leave balances to 30 days or less. Agency heads are required to manage employee recreation leave balances within the current 30-day limit on an ongoing basis. During the past two years the workforce has taken little planned leave with trends well below previous years reflecting the commitment of the workforce to support COVID-19 demand. As shown in the figure below, as at June 2022, the percentage of staff with excessive annual leave (+30 days) has increased by 24% when compared to the same period in 2020. There are currently in excess of 58,000 staff with an excessive leave balance, up by over 11,000 from June 2020. The current excessive leave liability is in excess of $500m.



NSW Health state Workforce excessive leave 2019-2022 - Source: NSW Corporate Analytics - internal NSWH data

There are many anecdotal stories from across the system of staff feeling fatigued and burned out. While normal annual leave is factored into LHD/SHN budgets to cover backfill for leave, the need to rest and recuperate staff to mitigate any further decline in retention and increase in sick leave significantly outweighs normal leave arrangements. As such significant programs related to leave management and wellbeing are underway.

The NSW Government has funded NSW Health to support workforce recovery and resilience which includes an approach to managing staff excessive leave to support fatigue management and wellbeing. This is outlined in detail in section 4.1 of this document.



The chart above shows the increase in special leave accessed in line with community surges of COVID-19 infection. Source: NSW Corporate Analytics - internal NSWH data.

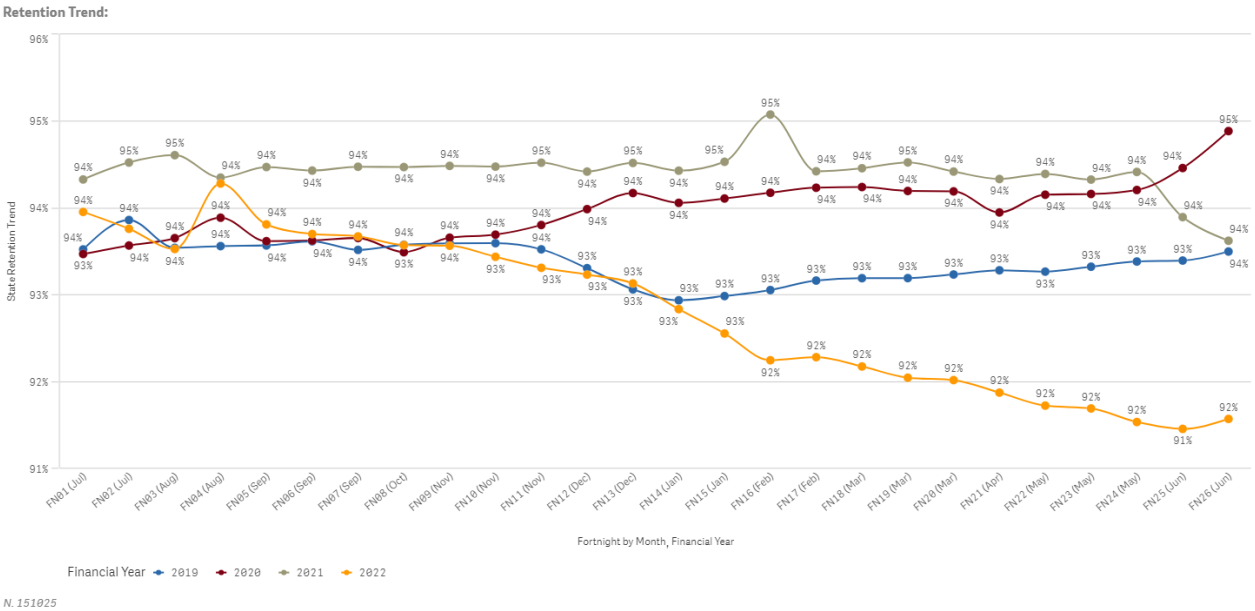
Special leave was utilised by staff to meet personal and caring responsibilities. After the 20 days total paid special leave has been used, health agencies may grant additional special leave on a case-by-case basis. While supporting staff and their wellbeing, the increased need to access leave during COVID-19 community infection also impacted the furlough effects.

Staff attrition

Staff retention throughout the early phases of the COVID-19 pandemic had been generally high with many workers who may have otherwise retired or left to pursue alternative careers staying with NSW Health to assist with the initial COVID-19 response.

NSW Health started to experience a decline in retention rates from February 2022. These retention patterns are not unique to NSW Health with health agencies across Australia and internationally reporting similar trends.

The chart below illustrates retention trends at the whole of NSW state level over the last four financial years. As at June 2022, retention has fallen by 2% in relation to pre-pandemic levels.



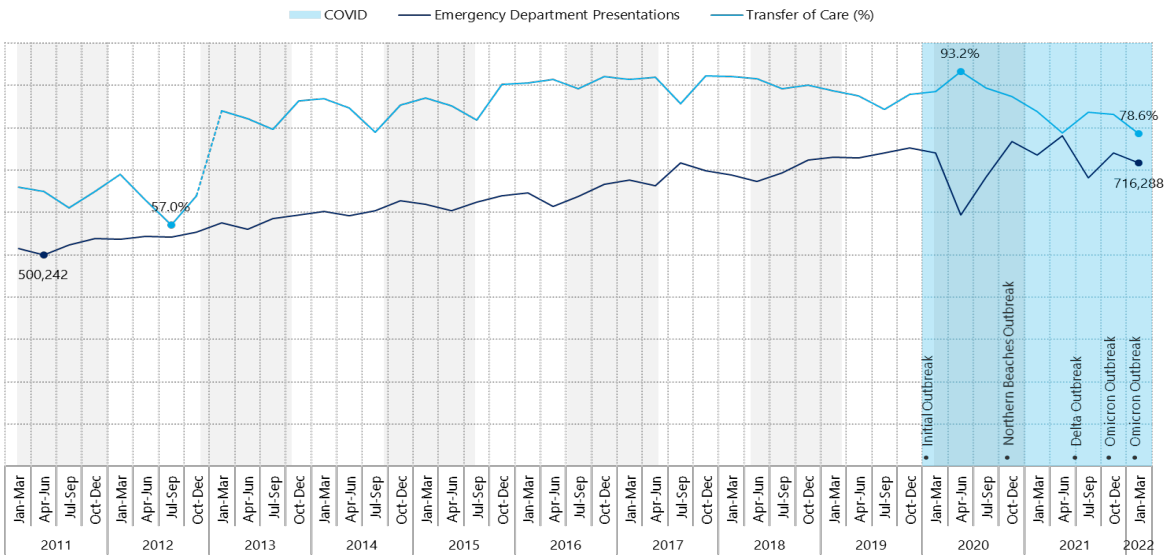
NSW Health state Workforce Retention 2019-2022 - Source: NSW Corporate Analytics - internal NSWH data

The increase in attrition is likely reflective of the prolonged and significant strain on workforce for the past two years as a result of the pandemic which has manifested as fatigue and burnout. This in turn creates capacity challenges to support leave relief, further exacerbating the impact on workers. NSW Health is closely monitoring retention rates across metropolitan and regional and rural health agencies as emerging impacts on key groups may cause a further downstream impact on skill mix and service delivery.

As noted above NSW Health has been funded to support workforce recovery and resilience which includes an approach to managing staff fatigue and wellbeing. This is outlined in detail in section 4.1 of this document.

2.3 Impact on EDs and transfers of care

EDs have been impacted by waves of patients presenting with acute respiratory infections which peaked in mid-January 2022, with up to 1,400 presentations each week during the height of the initial Omicron outbreak. These rates have not returned to the low inter-wave levels seen in 2021.[21]



Transfer of Care Performance in NSW Hospitals (The percentage of patients transferred from Ambulance to ED staff within 30 minutes)[22]

The BHI reports regularly on activity and performance for the NSW Health system as part of the Healthcare Quarterly report series. Key measures provide broad insights into the flow of patients through the health system over time and pressure points. The most recent results show that, in January to March 2022:[23]

- The proportion of patients who were admitted to a hospital bed from the ED within the benchmark time of 4 hours has reduced from 44% in the January to March 2017 quarter down to 25.8% in 2022.

- **Increased ambulance responses** – There were 326,544 ambulance responses, up 17.8% (from 277,218) compared with the same quarter in 2017. Of these, 9,360 were responses to P1A cases for patients with life-threatening conditions, the most since BHI began reporting in 2010 and up from 5141 in the same quarter in 2017.

- **Increased patients arriving by ambulance** – 169,250 patients arrived by ambulance, up 13.0% from 149,729 five years earlier.

[21] NSW COVID-19 Weekly Data Overview, 'Epidemiological week 31, ending 6 August 2022', available at: 'https://www.health.nsw.gov.au/Infectious/covid-19/Documents/weekly-covid-overview-20220806.pdf', Figure 13.
[22] Bureau of Health Information, Data Portal, available at: 'https://www.bhi.nsw.gov.au/data-portal'.
[23] Bureau of Health Information, Data Portal, available at: 'https://www.bhi.nsw.gov.au/data-portal'.

- **Almost 80% (78.6%) of patients who arrived by ambulance had their care transferred to ED staff within 30 minutes**, down 12.9% compared with the same quarter in 2017.

- **70.5% of patients in the ED had their treatment start on time**, down 5.2% compared with the same quarter in 2017.

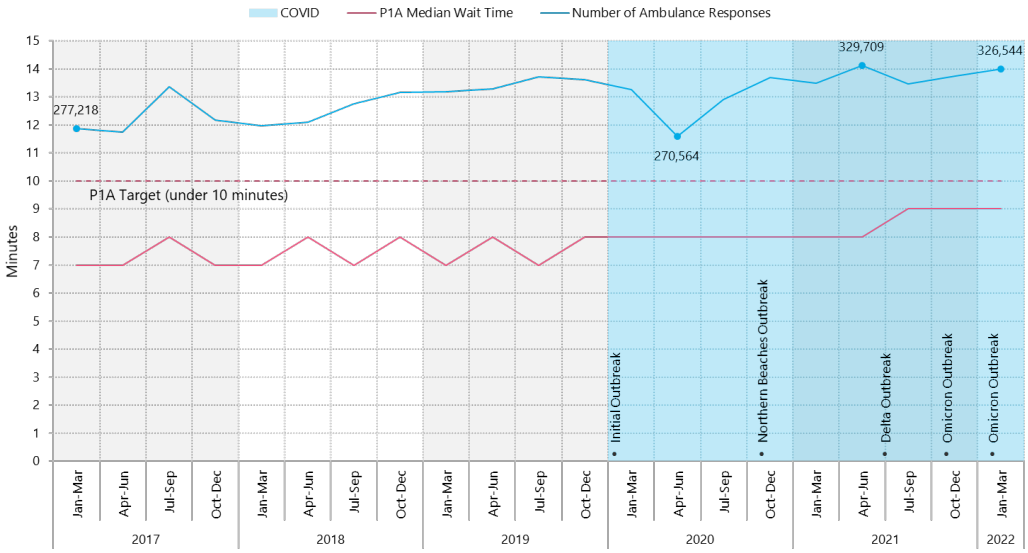
- **62.3% of patients spent less than four hours in the ED**, down 11.5% compared with the same quarter in 2017. The median time patients spent in the ED was 3 hours 15 minutes, up from 2 hours 40 minutes five years earlier.

Median Wait Time and Ambulance Responses

NSW Health has a target that 50% of the most urgent cases are responded to within ten minutes. NSW has consistently achieved this target since 2010. As the need for ambulance responses has increased, the median response time has also increased slightly but remains below the target. Ambulance responses are categorised as:

- Priority 1: Emergency (emergency response under lights and siren)
- Priority 1A: Highest priority (patients with life-threatening conditions)
- Priority 2: Urgent (undelayed response without lights and siren)
- Priority 3: Time critical (undelayed response required)
- Priority 4–9: Non-emergency.

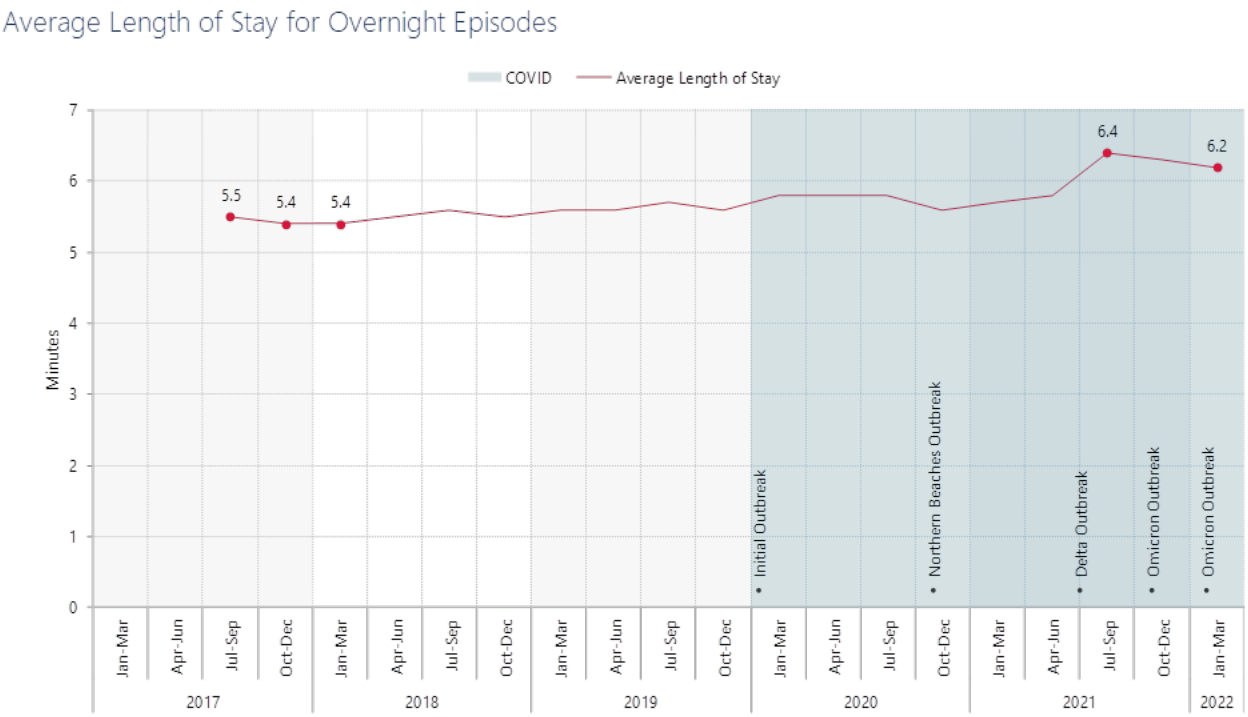
P1A Median Wait Time (minutes) and Number of Ambulance Responses[24]



2.4 Impact on average hospital length of stay

The graph below shows, the average length of stay in hospital for admitted patients also increased from the time of the Delta wave, impacting on the availability of beds to admit new patients. Increasing lengths of stay partly reflect the cumulative effect of patients with more severe illness from previous months.

[24] Bureau of Health Information, Data Portal, available at: 'https://www.bhi.nsw.gov.au/data-portal'.

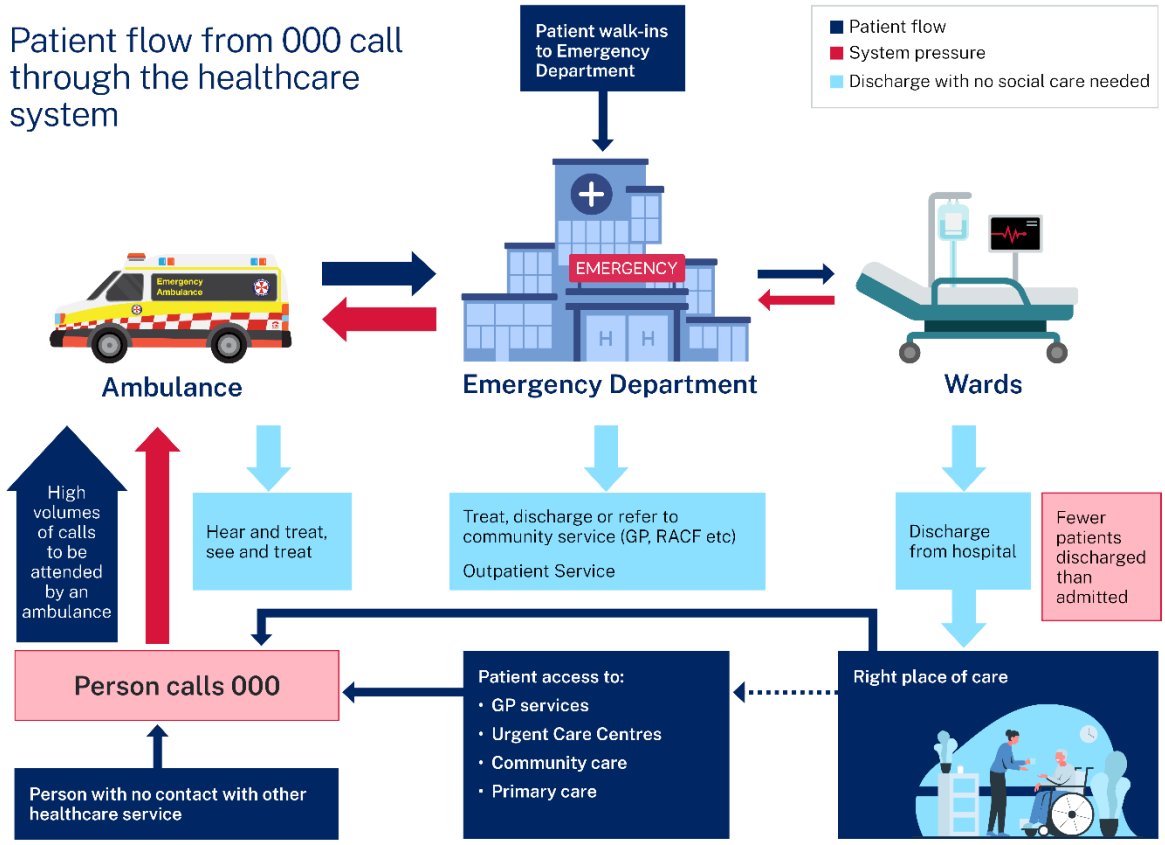


Source: Bureau of Health Information, Data Portal, January to March 2022, available at: 'https://www.bhi.nsw.gov.au/data-portal'.

3. Other factors impacting transfer of care

Demand on services, the availability of beds and patient flow through hospitals (including the discharge of patients to social and community care) affect the ability of ambulances to hand over patients to ED teams. When people who are already in hospital – and who are medically well enough to be discharged to a different place of care – experience delays getting into community and social care, this creates pressure through the entire hospital system. This pressure is most clearly felt by the ED and ambulance services.

Patient flow through the hospital system is shown in the infographic below.



The pandemic has directly impacted the primary care system, aged care sector and disability services. This affects patient inflow and outflow in the NSW Health system.

3.1 Patient transport impacts of patient movement through the system

Patient transport delays can impact transfer of care when ED discharges or inter-hospital transfers are delayed or unable to occur. HealthShare NSW Patient Transport Service (PTS) liaise with LHDs twice each day to understand local demand, pressure areas and priorities to best support effective patient flow.

PTS began COVID-19 Positive Discharge Shuttles to facilitate discharge of ambulant and self-caring COVID-19 patients. These shuttles can transport up to ten people at

the same time, supporting timely discharges and effective patient flow. The shuttles significantly increased PTS availability and responsiveness, and has resulted in an overall increase in COVID-19 patient transport timeliness from 63% at 31 August 2021 to 87% at 30 September 2021.

3.2 Inflow - Access to General Practitioners and Primary Care Services

The effectiveness of the primary care system, especially GP services, is a key driver of public hospital demand. Some hospital ED presentations are more appropriately addressed by primary care prevention, early intervention, treatment and management.

An increase of preventable presentations creates additional pressures on ambulance and EDs. It is widely accepted that improved access to primary care services can reduce the demand for low-acuity presentations, especially for the elderly, people with chronic disease, and socioeconomically disadvantaged and vulnerable populations. Australia, however, is facing a significant shortfall in the GP workforce over the coming years. The 2022 GP Workforce Report[25] prepared by Deloitte has found:

- With an ageing and growing population, demand for GP services is projected to increase by 38% by 2032 (and by 47% in our cities).
- Despite this significant increase, supply of GPs will decrease by 15% in cities and by 4% overall.
- This will result in a shortfall of 11,392 GPs by 2032, or almost one in 3 (28%) of the GP workforce.

The main driver of this trend is workforce renewal. The general practice workforce is ageing. The proportion of GPs over the age of 65 increased from 11.6% in 2015 to 13.3% in 2019.

At the same time, not enough medical graduates want to be GPs. The proportion of final-year students listing general practice as their first preference specialty has fallen to just 15.2% – the lowest since 2012.

More than half of GPs surveyed in the Royal Australian College of General Practitioners' 2021 survey said they would recommend general practice as a career to their junior colleagues, but 48% indicated they are less likely to do so now compared to a decade ago. Those who would not recommend general practice as a career have concerns around their remuneration, recognition and Medicare billing requirements.

Data from surveys of COVID-19 positive patients being transferred to primary care, and from patients calling COVID-19 and influenza support lines, suggest that limited access to primary care influences the likelihood of EDs presentations:

- Between May and July 2022, 66% of cases who called HealthDirect and were referred to a GP, were unable to book an appointment within required timeframes. This can adversely impact demand for EDs with increases in presentations.
- Around 25% of high-risk patients did not nominate a primary care provider or GP as their regular healthcare provider. Of those being connected to primary care, with a regular GP, 30% of patients were unable to be connected to their GP due

[25] Deloitte, 'General Practitioners Workforce Report 2022. Prepared for Cornerstone Health Pty Ltd', May 2022, available at: 'https://www2.deloitte.com/content/dam/Deloitte/au/Documents/Economics/deloitte-au-cornerstone-health-gp-workforce-06052022.pdf'

to a lack of after-hours and weekend access and/or their GP not conducting COVID-19 related care.

- Patients calling the NSW Health Flu & COVID-19 Care at Home Support line reported that 49% of callers had tried to book a GP appointment but were unable to get one within the next 48 hours. 7% of patients highlighted that their GP refused to see patients with respiratory symptoms.

Improving access to GP and primary care is important but it will not prevent presentations to ED alone. Access to rapid pathology, imaging, and diagnostics, are more readily available in EDs, and allow for fast tracked assessment and care in medical emergencies.

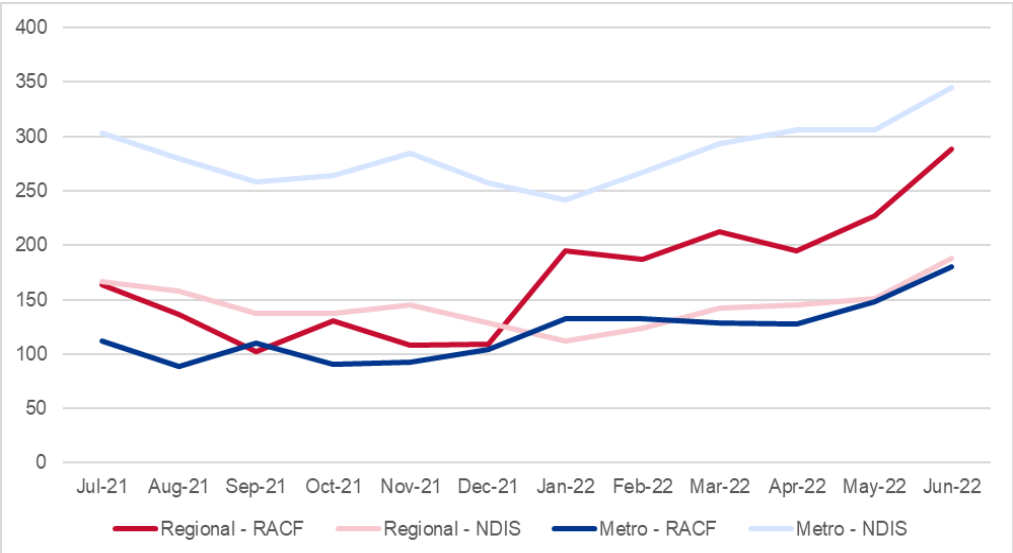
3.3 Outflow – Available capacity in aged care facilities, and disability services sector

Reduced capacity in the community for residents at aged care facilities and delays in accessing care under the NDIS, has caused significant outflow constraints from hospital inpatient units. These outflow constraints to aged care facilities or to NDIS facilities directly impact hospital flow and reduce capacity. This, in turn, affects ED throughput and ambulances' ability to transfer care.

Patients may sometimes remain in hospital despite being medically ready for discharge as they are waiting for a place at a RACF or NDIS services. During periods of outbreak some patients were not able to return to their facility due to COVID-related lockdowns.

As of 3 August 2022, there were 519 RACF inpatients in NSW Health facilities with 327 (63%) exceeding their estimated date of discharge (EDD). There were 557 NDIS inpatients with 293 (53%) exceeding their EDD. Overall, there were 1,076 RACF and NDIS patients with 620 (58%) exceeding their EDD.

The table below outlines the trend in patients waiting for discharge on the 21st day of each month over the 2021-22 financial year.



*Number of patients awaiting discharge to aged care facilities or NDIS services in 2021-22 by month**

The number of patients waiting for discharge to aged care facilities or NDIS services rose throughout 2021-22. This trend was consistent across both metropolitan and regional LHDs and SHNs. Patients waiting for discharge to NDIS services was significantly higher across metropolitan districts and networks than in regional districts.

Disability sector factors impacting capacity

Avoidable admissions and discharge delays of people with disability impacts the capacity of the NSW health system. Access to timely and secure supports for people with disability, including NDIS participants, is critical to avoid preventable hospitalisation, and timely and safe hospital discharge when people are medically ready.

As at 3 August 2022, there were 557 NDIS inpatients with 293 exceeding their EDD. For NDIS, the estimated cost of total bed days past EDD for regional is $14,591,500 and for metropolitan is $18,255,600. There is no Commonwealth Government-subsidised program like the Transitional Aged Care Program (TACP) for people on the NDIS or people in hospital with a disability waiting for an NDIS package. NSW Health is exploring potential out-of-hospital care models to facilitate more timely discharge of people with a disability.

People with disabilities have a high use of emergency and acute care services. For example, of patients that have had more than 10 presentations to a South Western Sydney LHD (SWSLHD) ED in the past 12 months, 14% (36/249) are NDIS participants, accounting for 19% (887/4760) of hospital presentations for this group. Reasons for this include challenges for clients accessing GPs in the community and a requirement for sedation for transport and minor procedures, such as blood tests or dental care.

Hospitals are often seen as providers of last resort when a person loses disability supports and/or accommodation. Rapid growth in disability providers, especially group home providers that have limited experience supporting people with complex needs, has led to clients being directed to EDs for management of their needs.

In SWSLHD it is common for people with behaviours of concern, who also have a diagnosed mental illness and require medication for behavioural management, to require ongoing support from a psychiatrist that can only be accessed through the public health system. In the SWSLHD there are only two private psychiatrists who accept and manage people with an intellectual disability.

Long wait periods for NDIS funded supports to be issued and implemented for clients in many LHDs are common. These supports are critical to enable discharge of NDIS patients back to community-based living. The volume of patients in this category may not be high but the delays have a significant impact on access to beds and patient flow. In Nepean Blue Mountains LHD, a stroke unit bed was occupied by a patient for greater than 500 days while waiting for multiple NDIS decisions and service provider identification.

The NSW Government, in collaboration with other states and territories, is working with the Australian Government through the national governance framework on

strategies, to reduce unnecessary hospital admission and discharge delay for people with disability.

Aged care sector factors impacting capacity

LHDs report increased hospital discharge delays for older people waiting for placement in a RACF. NSW Health analysis suggests that the number of older people medically ready for discharge to a RACF, but remaining in hospital, has doubled since 2020.

In 2021-22, Aged Care Assessment Team (ACAT) assessments in LHDs were on average completed within 1.6 days from referral to delegation in a hospital setting. The primary driver for delayed discharge was a lack of locally available RACF places, particularly for older people with more complex behaviours, and bariatric patients. The Commonwealth Government holds funding, regulatory and policy responsibility for the aged care sector, including allocating RACF places to specific regions across Australia.

In some parts of regional NSW, a lack of GPs available to be involved in the RACF admission process is also a contributing factor. GPs are responsible for prescribing medications and overseeing primary care treatment, including visiting the older person in the RACF when required.

Australian Institute of Health and Welfare data shows that while the total number of aged care places in NSW is increasing (63,866 places in 2012 to 72,552 places in 2021), this is not keeping pace with NSW's ageing population. There are currently 73 RACF places per 1,000 people aged 60 years and over (target population). This number has reduced from a high of 85 places per target population in 2012. The Commonwealth target is 78 places per target population.

There is a growing trend of closures of RACFs in regional, rural and remote areas in NSW. These closures impact small communities and the acute health system.

In 2021-22, 17 RACFs closed in NSW, equating to around 700 aged care beds. This does not include RACFs which have reduced their operational bed numbers but remain open. Closure of facilities and reduction of aged care beds is occurring due to several factors. These include COVID-19 pandemic challenges, increased regulatory and administrative requirements, reduced operational bed numbers, financial viability issues and difficulty recruiting and retaining staff.

4. NSW Health initiatives to address demand on public hospital services

NSW Health is undertaking a range of initiatives to address internal factors that adversely impact the transfer of care and patient flow.

4.1 NSW Budget commitments and current workforce strategies

Since March 2011, recurrent funding for the NSW public health system has increased by more than $15.2 billion, up from $15.5 billion in 2010-11 – which is a 98.3 per cent increase in recurrent funding. Expenditure on health accounts for 25.5 per cent of the NSW Budget, demonstrating the NSW Government's commitment to ensuring world-class health services and outcomes for the community.

In June 2022, the NSW Government invested $4.5 billion in the NSW Health workforce to recruit 10,148 full-time equivalent staff to hospitals and health services across the State. This aims to ease pressure on existing health workers and support the delivery of quality health care. This commitment also includes $1.8 billion to enable NSW Ambulance to recruit 2,128 staff and open 30 new ambulance stations.

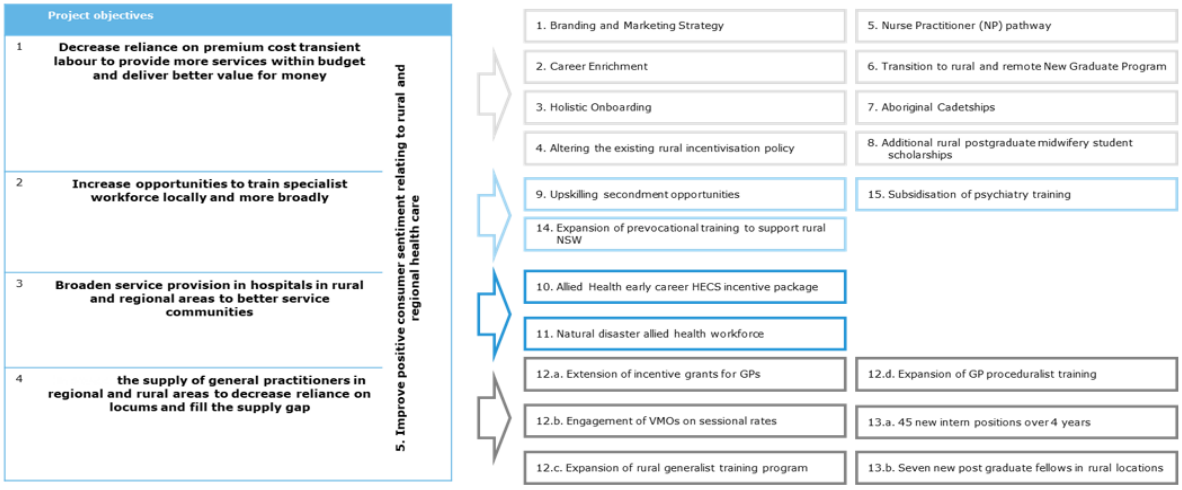
NSW Health has released the NSW Health Workforce Plan 2022-2032, which outlines the strategic priorities to 2032. There has also been an ongoing workforce strategy to support the COVID-19 response throughout the pandemic.

Building and sustaining the rural health workforce

The regional and rural NSW Health workforce has also been impacted by the pandemic. The NSW government has invested over $800 million to support workforce requirements and increase the workforce supply. Enhancements to several existing programs and implementation of new initiatives are designed to support the ongoing attraction, recruitment and retention of workforce into the regions.

The 15 strategies address each aspect of current and projected gaps in workforce. As summarised in Figure 2.

Figure 2 - Program strategies and objectives alignment



NSW Health Building and sustaining the rural health workforce new policy proposal (endorsed)

Workforce wellbeing, resilience, and COVID-19 recovery

NSW Health has been funded to uplift a number of existing wellbeing programs and establish new support mechanisms. This funding was distributed to NSW health agencies and some affiliates and is currently being utilised as part of a system approach to supporting wellbeing.

These programs will be centrally monitored by NSW Health. It includes targeting an increase in workforce numbers, a reduction in overtime and a decrease in employee excessive leave balances. In late 2021, a Workforce Wellbeing Collaborative was also established to prioritise and promote wellbeing for all NSW Health staff.

An additional workforce resilience package is also being rolled out over 2022-23 to create workforce capacity and improve resilience acknowledging the ongoing impacts of COVID-19. LHDs, SHNs and NSW Ambulance have been allocated funding and can use this funding to build capacity through additional workforce supply to backfill for furlough and leave, as well as offsetting attrition and other staff absence due to fatigue.

4.2 Monitoring transfer of care performance

The NSW Health Performance Framework outlines NSW Health's process – as the health system manager – for setting performance expectations and assessing public sector health services performance. Under the framework LHDs and SHNs enter into an annual service agreement with NSW Health that establishes the performance expectations for the funding provided, and details key performance indicators (KPIs) against which performance is assessed.

Transfer of care performance is a service agreement KPI for all LHDs and SHNs (excluding Justice Health and Forensic Mental Health Network).

As a KPI, transfer of care is subject to monitoring, including monthly reporting and regular performance meetings. NSW Health, LHD and SHN staff are able to monitor real time performance through the ambulance dashboard on the PFP which shows information such as where ambulances are waiting to transfer care and how long they have been waiting.

Processes are in place to escalate extended transfer of care delays. In addition to local processes between LHDs, SHNs and NSW Ambulance, LHDs and SHNs are required to escalate transfer of care delays to NSW Health when:

- ambulance delay has reached 90 minutes with no transfer of care plans within the next 30 minutes
- hospital capacity means that significant delays are likely to occur.
- There are critical infrastructure or operational issues that affect patient flow.

Where delays persist, processes are in place to escalate, and take options to expedite transfer of care.

NSW Health System Flow Centre

The NSW Health System Flow Centre (SFC) also supports LHDs and SHNs to coordinate whole-of-system patient flow during peak activity periods. The SFC operates between 12 to 16 hours a day, 7 days a week. The SFC oversees and coordinates capacity management across the Sydney greater metropolitan area as well as regional and rural NSW, as required.

The SFC monitors ED, acute hospital, and intensive care unit capacity to support appropriate distribution of patients across the entire system to improve ambulance offload times, ED performance, and whole-of-system patient flow.

The SFC was reactivated in mid-July 2022 to support the NSW Health response to the current issues impacting patient flow. Key functions of the SFC are:

- support of LHD/SHN operations
- act as a single point of contact for LHDs and SHNs to escalate patient flow issues
- proactive identification and management of patient flow issues
- support system and agency connectivity
- support distribution of hospital admissions across the system
- facilitate transfers between hospitals across Sydney/NSW (inter-LHD)
- assist with decompression of hospitals during periods of peak demand
- assist with prioritisation of patient transfers and allocation of transport resources
- monitor ED, acute ward, and intensive care unit capacity
- proactive adjustment of distribution pathways to match capacity
- negotiate adjustments to the NSW Health Patient Allocation Matrix.

Patient Flow Portal

The Patient Flow Portal provides a transparent view of the hospital flows from ED through to inpatient discharge from a facility back into the community. The PFP was developed by clinicians for clinicians and shows real-time demand and capacity, short term escalation plans, transfers, allocations, and COVID-19 patients being managed in the community.

NSW Health Patient Allocation Matrix

Ambulance patient flow is managed through the NSW Health Patient Allocation Matrix in matrix enabled zones (greater Sydney, Lower Hunter region, Central Coast and the Illawarra). This system wide approach has been shown to more effectively distribute flow to get the right patient to the right care the first time. The ‘matrix’ was first introduced in 2005 and has received various iterations, categories, and enhancements to improve usability.

The ‘matrix’ is reviewed bi-annually, and it considers a variety of criteria including patient acuity, clinical transport category, ED capacity for ambulance arrival and location.

NSW Ambulance's system of escalation

NSW Ambulance has a well-established system of escalation for transfer of care delays, from local management through to NSW Health coordination. This system of escalation relies on local and senior level relationships facilitated by local NSW Ambulance Health Relationship Managers.

The Health Relationship Manager's role is to establish and maintain close working relationships with hospital and stakeholders, to improve working partnerships between NSW Ambulance and primary health providers. Health Relationship Managers promote shared NSW Ambulance / Health demand management initiatives, programs, and policies to enhance the efficiency of integrated service provision to the community.

In 2018, the NSW Ambulance Patient Safety & Distribution Unit (PSDU) was introduced to support monitoring and escalation of a range of patient flow and operational matters, in real time. The PSDU is based on a Queensland Ambulance Service model and helps operational managers identify emerging patient flow pressures and provide an informed, broader view of operations.

The Emergency Care Institute (ECI)

The ECI aims to promote, facilitate, and share research and quality improvement activities that improve the way emergency care is provided, work with clinicians to produce resources for information and identify and help NSW respond to system challenges experienced by clinicians working in EDs. Some initiatives ECI is either leading or partnering on that have an impact on timeliness of care include:

- Emergency Protocols Initiating Care Project (EPIC): aims to develop and implement nurse-initiated protocols that standardise and improve emergency care provided to patients, safely reduce the time a patient waits for treatment, improve patient's length of stay in the ED and reduce unwarranted clinical variation within all NSW public hospitals. EPIC is a key initiative to contribute to the Premiers priority of Improving Service Levels in Hospitals.
- Clinical Tools and patient factsheets to provide clinical guidance and support decision making for clinicians.
- Coordination of committees to ensure multidisciplinary representation of clinicians on key projects and initiatives (Clinical Advisory Committee/ Information Systems and Technology and Advisory, Rural and Regional Advisory/ Research and Innovation). The committees engage clinicians and provide opportunities to highlight real-time issues, share ideas and develop potential strategies to address challenges.
- ED COVID Community of Practice, adjusting to meet the needs of the ED community and developing urgent models of care, working with health infrastructure to inform capital works and escalate issues to NSW Health for consideration and appropriate action.
- Research to improve the efficiency and effectiveness of acute care – ECI is partnering with 3 successful MRFF grant ($8.5 million) research groups for Models of Care to Improve the Efficiency and Effectiveness of Acute Care:
    - Working together: innovation to improve ED performance, and patient outcomes
    - Reshaping low back pain management in the ED.

- Giving patients an EPIC START: An evidence-based date driven model of care to improve patient care and efficiency in EDs.

NSW Health Whole of Health Program

Each year, the NSW Health Whole of Health Program invests $2.4 million to fund improvement leads in all LHDs and specialty health districts. These positions focus on improvement projects to support better patient flow and access. In 2017, the program was externally evaluated. It was found to have supported LHDs and SHNs to address local needs through project support and knowledge sharing between facilities.

The program team also provide intensive performance support to LHDs and SHNs to establish patient flow governance, identify current challenges, and design locally tailored solutions.

4.3 Initiatives to manage demand on hospitals

To meet increasing demand for health services and changing community expectations NSW Health is exploring new models of care that improve value using available resources. The change in emphasis from volume to value challenges the NSW Health system to better understand outcomes and experiences, review how and where care is delivered, and reduce unwarranted clinical variation.

The goal is to use healthcare resources optimally, consistently, and equitably using evidence-based practice. NSW Health is taking a coordinated long-term approach in implementing value-based healthcare. It requires effort and investment over time to provide our people and services with the environment, tools, support, and information to deliver the care and outcomes that matter to patients.

To achieve this NSW Health is implementing statewide programs to pilot key elements of value-based healthcare and target identified cohorts, while supporting structural system changes and capabilities across a range of enablers. Statewide programs including Leading Better Value Care, Integrated Care, Commissioning for Better Value and Collaborative Commissioning are improving outcomes for patients now, as well as building capacity and applying learnings to inform future change.

Leading Better Value Care (LVBC)

Every LHD across the state is implementing thirteen LBVC clinical initiatives. The initiatives address unwarranted clinical variation and support care in settings that result in better outcomes for patients and better value for the system. Preliminary data analysis shows that at the state-wide level, LBVC initiatives contribute to a reduction in demand for admitted activity compared to projected business as usual activity and support a positive patient experience. The 2019-20 results for the three early implemented and scaled initiatives (Osteoporotic Refracture Prevention, Osteoarthritis Chronic Care Program, and High Risk Foot Services) indicate that as provision of patient centred care in outpatient settings increased, the demand for hospitalisation overall is flattening against business as usual projections.

In 2019-20, the system avoided around 4,900 patient admissions for osteoporotic refractures due to the intervention. Improving value for patients not only focuses on

patient health outcomes but also their experience of receiving care. A greater proportion of LBVC patients report their experience in non-admitted settings to be "very good" relative to admitted settings.

Integrated Care

To deliver better outcomes for patients and reduce pressure on hospital services NSW Health is integrating care both across its own services through state-wide scaling of the long-established Integrated Care Program, as well as across regions in partnership with primary care and other providers through the new Collaborative Commissioning model. Integrated Care in NSW coordinates services around a patient to improve their care experience and health outcomes. Interventions target vulnerable and at-risk populations, and people with complex health and social needs. They offer people the opportunity to live healthier lives for longer, manage their own care in more appropriate settings such as primary and community care and reduce unnecessary hospital visits.

The 8 evidence-based initiatives currently being scaled are:

- Emergency Department to Community
- Residential Aged Care
- Vulnerable Families
- Paediatric Network
- Specialist Outreach to Primary Care
- Planned Care for Better Health
- Secondary Triage
- Alternate Referral Pathways

Collaborative Commissioning is a whole-of-system approach designed to enable and support delivery of value-based care in the community. This is achieved through the establishment of collaborative working relationships with other stakeholders and service providers across the range of care, to achieve desired outcomes.

The central platform of Collaborative Commissioning is the establishment of regionally based partnerships between Primary Health Networks, LHDs and other affiliated health organisations. These partnerships will lead change at the local level, focusing health care on local priority population health needs with local resources.

COVID-19 Care in the Community

NSW Health operates an influenza and COVID-19 Care at Home support line which provides nurse triage and virtual medical assessment for symptomatic callers. Each week, this line supports around:

- 3,000 calls;
- 1,000 virtual nurse triage assessments; and
- 700 virtual medical assessments which may otherwise have presented to EDs.

Reducing ED visits and providing care to people in the community and their homes

In 2020-21 NSW Health launched the statewide initiative – Planned Care for Better Health (PCBH), one of the Integrated Care flagship programs. PCBH aims to identify people at risk of hospitalisation early, strengthen the care provided to them and improve their experience of receiving care to keep them healthier over the longer term.

The target population is people with complex chronic disease and social care needs, identified through the risk of hospitalisation algorithm. Enrolment into the PCBH initiative enables proactive delivery of patient centred targeted interventions in the community that support patients to self-manage their illnesses and to reduce dependence on acute hospital resources.

In 2022, NSW Health will launch the ED to Community (EDC) initiative state-wide. This comprehensive care approach supports patients who have frequently presented to an ED, identified through an algorithm. It is expected to go live in late 2022.

Through the PCBH program and other integrated care initiatives, patients will receive appropriate care in the right setting for them. There have been 640,000 instances of low acuity ED attendances and bed days avoided collectively as a result of these initiatives over the past three years.

Urgent Care Services

The NSW Government has announced the establishment of 25 Urgent Care Services in partnership with GPs. These Services will help ease the pressure on EDs, give people faster care for urgent but non-critical conditions and free up critical resources for patients with more serious needs. Services will operate for extended hours and patients will not be charged for services irrespective of whether they have a Medicare card. These new services will be commissioned in partnership with PHNs, with locations determined following consideration of population, community needs and ED demand.

These Services will complement, where possible, the urgent care centres that the Commonwealth has committed to establish.

Virtual Care Strategy

Virtual care safely connects patients with health professionals to deliver care when and where it is needed. Telephone, video conferencing, and remote monitoring are examples of virtual care. The Virtual Care Strategy supports timely access to care with increased NSW Health capacity to expand remote patient monitoring enabled models of care with service benefits to increase efficiency care delivery, reduce potentially preventable hospitalisations, reduce length of hospital stays and improve system integration between primary care and acute care.

The RPA Virtual Fracture Clinic has been running for 22 months. It has enrolled 500 patients in virtual fracture, physiotherapy led care. These patients have been drawn initially from the EDs but from end August 2022 will be accepted from general practice, eliminating the need for an ED presentation for minor fractures.

Services such as the Remote Medical Consultation Service in Murrumbidgee LHD, and the Virtual Rural Generalist Service in Western NSW LHD, support emergency consultation and acute medical care through virtual care consultation provided by a remote Medical Officer. The service does not replace onsite doctors but is used as a safe alternative when one is not available locally.

COVID Virtual Clinical Care Centre

In September 2021, NSW Ambulance fast tracked the implementation of a COVID Virtual Clinical Care Centre (VCCC) The COVID VCCC has transitioned to NSW Ambulance VCCC in line with the 5 June 2022 NSW Government announcement to invest $1.76 billion over four years..

The primary function of a VCCC is to provide a secondary triage of low acuity incidents by a VCCC Specialist Clinician. Requests for ambulances are triaged according to urgency and clinical need to ensure the most appropriate response to all patients. Virtual care by a VCCC specialist clinician ensures that patients with lower acuity needs who can safely remain in the community do so thereby preserving frontline paramedics for life threatening emergencies.

Where an ambulance is not required immediately the NSW Ambulance VCCC provides a comprehensive and integrated secondary triage to better understand the needs of patients where capacity exists.

For patients who do not require an ambulance to attend an ED and can be managed safely at home, they are provided over the phone health care advice.

For patients identified as suitable for referral to a General Practitioner, Pharmacist, LHD Referral Pathway or other health care provider the VCCC specialist clinician connects the patient to appropriate care providers.

VCCC Clinical Support Assistant's (CSAs) are also within the VCCC where their primary task is to monitor the Triple Zero (000) incidents that extend past their triaged timeframe for an ambulance response and perform callbacks when capacity exists. A callback is to advise of delays and to establish if the patient's condition has altered since the initial Triple Zero (000) call in which case the CSA escalates the incident to a VCCC specialist clinician for a clinical review.

NSW Health GP Deputising Service

HealthDirect triages all patient calls and can organise a patient's appointment in primary care where deemed clinically appropriate. The NSW Health commissioned GP Deputising Service aims to ensure that patients who call HealthDirect and require an appointment with a GP in the next 2 to 6 hours, and unable to get a primary care booking, are managed with a virtual GP consult.

Traditionally, when a patient calls HealthDirect in a non-emergency situation and is unable to access a GP, they often present at an ED which causes additional pressure on the NSW Health system.

NSW Out of Hospital Care Program

The NSW Out of Hospital Care (OHC) program (ComPacks, Safe and Supported at Home, and End of Life home support packages) supports patient discharges and prevents avoidable admissions. OHC provides eligible patients with immediate access to non-clinical case management and home care services across NSW. This strategy

assists in patient flow and alleviates access block to NSW public hospitals with high bed demand.

In 2021-22 the OHC program delivered $49 million worth or 24,231 packages of care to patients across NSW, representing potential efficiency savings of $80 million.

It is estimated that the OHC packages saved 72,693 hospital bed days in 2021-22 with most of these patients avoiding a presentation to a hospital ED.

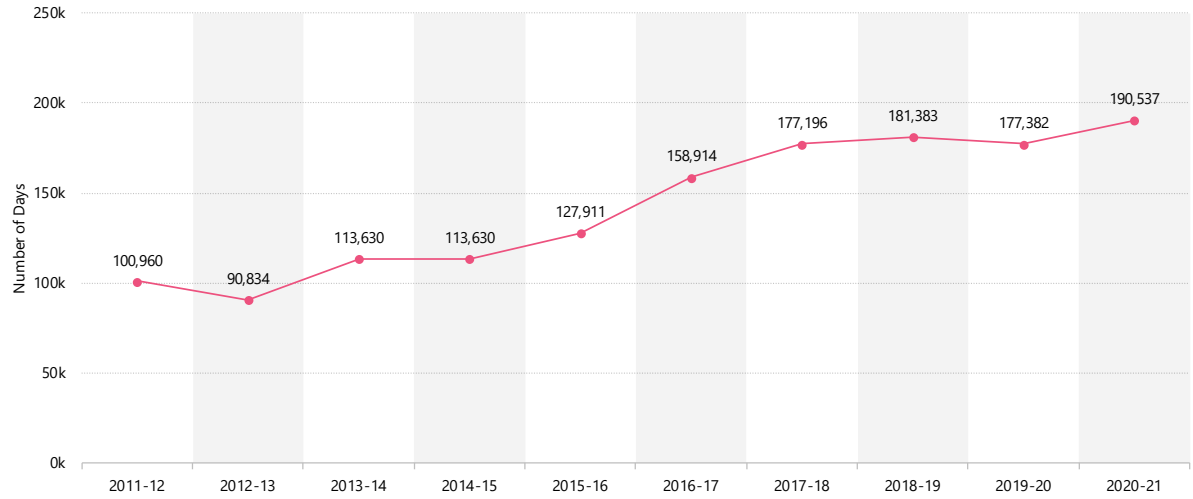
Hospital in the Home (HITH)

HITH provides an opportunity for patients to receive care in their own environment while relieving pressure on the hospital. Direct referral pathways from general practice and NSW Ambulance support ED avoidance. HITH is an admitted acute/sub-acute care in the patient's home or in the community as a substitute for in-hospital care.

This model of care is available in every district and network in NSW. HITH successfully combines face to face and virtual care as an alternative approach to hospitalisation. HITH successfully manages complex infections, chronic disease exacerbations and post-surgical care reducing or completely substituting a hospital stay.

The total number of HITH bed days has been steadily growing in NSW, with data demonstrating the peak in 2020-21. The ongoing COVID-19 pandemic has demonstrated that when circumstances dictate, health services can quickly and successfully mobilise to deliver home based care, that is enhanced with virtual care modalities. HITH was one of the key models of care used during the pandemic, particularly during the Delta variant to support patients with COVID-19 to receive remote monitoring and care while at home.

Total number of Hospital In The Home days



Source: Australian Government, Australian Institute of Health and Welfare, 'Admitted Patient Care reports', available at 'https://www.aihw.gov.au/reports-data/myhospitals/content/reports'.

Outpatient Services

Outpatient Services are a critical interface between inpatient care and primary care systems, and an important ongoing component in a patient's care pathway. NSW Health offers over 7,000 outpatient clinics and 17 million non-admitted episodes of care per year. Access to outpatient services supports flow and reduces demand on the ED and inpatient system.[26]

Rapid Access Clinics

Rapid Access Clinics (RACs) exist to reduce the demand for ED and other inpatient hospital services and support patients to receive care in the community and at home. In a self-assessment completed by LHDs and SHNs in June 2022 there were 17 hospitals that indicated that had RACs in operation. The most common specialties were cardiology, alternatives to ED and orthopaedics. A guide for Acute Respiratory Rapid Access Clinics was released in June 2022.[27]

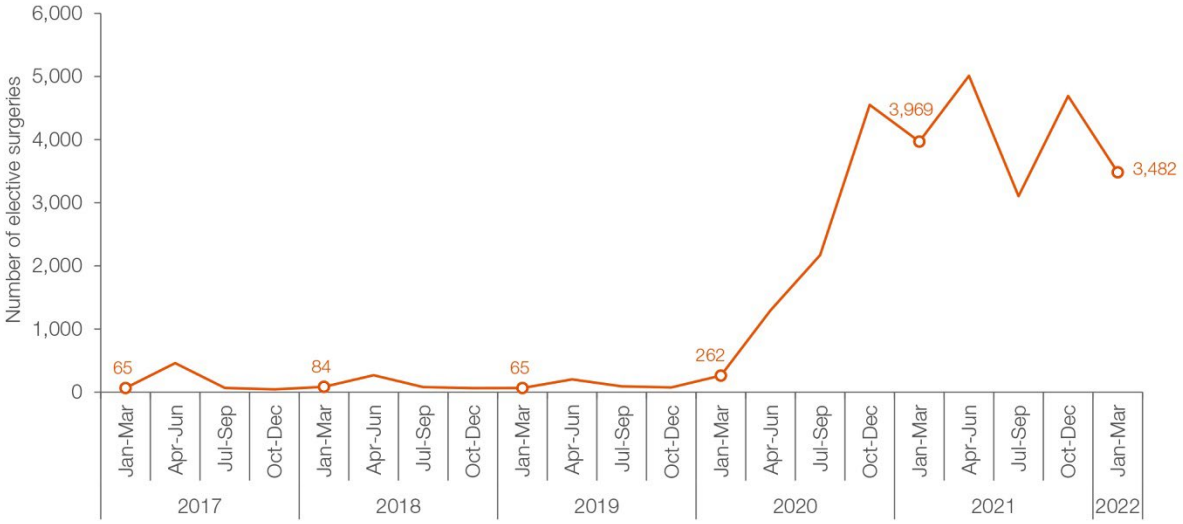
Partnerships with Private Hospital sector

In response to the COVID-19 pandemic, a partnership with the private hospital sector was established under the National Partnership Agreement on Private Hospitals and COVID-19 in 2020. NSW Health is partnering with private hospital operators to deliver additional health system capacity in NSW in response to the COVID-19 pandemic. This supports the private sector's capacity and viability to resume hospital services after the pandemic.

To incorporate the next stage of the NSW Government's COVID-19 pandemic response, NSW Health has developed new state-wide agreements to create a stable partnership between Districts, Networks, and private operators for the delivery of elective activity services and the provision of future COVID-19 services.

The latest Bureau of Health Information's *Healthcare Quarterly* report (for the January to March 2022 quarter),[28] indicates that 3,482 elective surgeries were contracted to private hospitals across the state. This is fewer than in the January to March quarter in 2021 when 3,969 elective surgeries were contracted out which could be due to the impact of the Omicron outbreak on staff furloughing in the private sector.

[26] Australian Government, Australian Institute of Health and Welfare, available at 'https://www.aihw.gov.au/reports-data/myhospitals/content/reports'.
[27] Agency for Clinical Innovation, 'Management of stable acute respiratory infections during winter surges in NSW', June 2022, 'https://aci.health.nsw.gov.au/__data/assets/pdf_file/0008/730367/ACI-Management-of-stable-acute-respiratory-infections-during-winter-surges-in-NSW.pdf'.
[28] Bureau of Health Information, 'Healthcare Quarterly', Tracking public hospital and ambulance service activity and performance in NSW, January to March 2022, available at: 'https://www.bhi.nsw.gov.au/__data/assets/pdf_file/0009/730197/BHI_HQ48_JAN-MAR-2022_REPORT.pdf'.



Source: Bureau of Health Information, 'Healthcare Quarterly' - NSW Health Elective surgeries contracted to private hospital NSW – January 2017 to March 2022

The NSW Government is investing a further $408 million over two years as part of the 2022-23 Budget, to fast-track elective surgeries delayed due to the COVID-19 pandemic response. This funding boost will take the Government's total commitment to reducing wait times impacted by COVID-19 to almost $1 billion. This investment is in addition to usual annual elective surgery expenditure of around $2 billion. The funding will increase elective surgery activity in our public hospitals and continue our collaborative care arrangements with private hospitals, meaning public patients will get faster access to the care they need.

Educating the NSW Community

NSW Health continues to run public education campaigns to support appropriate use of services and mitigate the impact of non-emergency situations to EDs and calls to ambulances. These communication resources are focused on highlighting the appropriate healthcare service for various levels of concerns or symptoms (self-care, pharmacy, GP, HealthDirect, ED/000), and helping to keep EDs for emergencies.

Criteria Led Discharge

Criteria Led Discharge (CLD) is a process to enable patients to safely be discharged according to documented criteria without the need for a further review by a specialist. It has been shown to reduce unnecessary bed days. In a self-assessment completed by LHDs and SHNs in June 2022, 19 hospitals indicated they had CLD models in place for selective specialities. The most common specialities are Orthopaedics, Surgery and Cardiology. The ACI has a toolkit to support implementation of CLD.

Waiting for What Sprint

In 2022 a short project was undertaken across NSW Health hospitals to better understand the delays in discharging patients from hospital through the Waiting for What (W4W) information collected in the patient flow portal. As a result, a patient flow self-assessment tool was developed to help hospitals identify targeted areas for improvement in patient flow and a series of information sessions were delivered to the Chief Executives addressing some of the challenges identified.

Short Term Escalation Plans

The Whole of Health Team provides support to LHDs and SHNs to review and update Short Term Escalation Plans (STEP). STEP plans aim to actively manage short-term demand and capacity mismatches, where unforeseen limited capacity is compromising core business.

In 2020, in response to the COVID-19 pandemic, the Whole of Health Program reviewed LHD/SHN STEP documents and provided tailored feedback about opportunities to strengthen the plans. In January 2022, education and guidance was provided to LHDs and SHNs about developing Pandemic STEP documents to support services in managing increased demand due to COVID-19.

5. NSW Health is working with the Commonwealth and other partners in care

The health system is an intricately interlinked complex ecosystem and is dependent on many other sectors working well in tandem. NSW Health is working closely with Commonwealth Government partners to address the external drivers that impact on transfer of care within the hospital system.

5.1 Commonwealth responsibilities

The Commonwealth Government has lead responsibility for the primary health care system, NDIS and RACF including:

- policy and funding for GP and primary health care services;
- maintaining PHNs to promote coordinated GP and primary health care service delivery, and service integration over time;
- continuing to focus on reforms and invest in programs in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions;
- funding the MBS to ensure equitable and timely access to affordable primary health care and specialist medical services;
- funding, regulatory and policy for the aged care sector, including allocating RACF places to specific regions across Australia; and
- administering the NDIS Act and exercises statutory powers with the agreement of states and territories, including a power to make the NDIS Rules and direct the NDIA.

The Strengthening Medicare Taskforce began work in July 2022. It is focusing on:

- improving patient access to general practice, including after hours;
- improving patient access to GP-led multidisciplinary team care, including nursing and allied health;
- making primary care more affordable for patients;
- improving prevention and management of ongoing and chronic conditions; and
- reducing pressure on hospitals.

5.2 Disability sector joint initiatives

The NSW Government, in collaboration with other states and territories, is working with the Commonwealth Government through the national governance framework on strategies to reduce unnecessary hospital admission and discharge delays for people with disability.

Access to timely and secure supports for people with disability, including NDIS participants, is critical to avoid preventable hospitalisation, and timely and safe hospital discharge when people are medically ready.

There is currently no nationally agreed minimum data set to report on the number of NDIS participants who experience hospital discharge delays. This is a priority for action outlined in recent communications from the Minister for Health and Disability Reform Minister Meetings.

National Cabinet has recognised this as a significant issue and has committed to identify practical improvements to the health system and specifically the connections between GPs and hospitals. This includes working together to identify practical ways to support NDIS participants who are medically ready for discharge to leave hospital and move to a more appropriate community setting.

Much of this work occurring in NSW is intertwined with NSW Health strategies, such as Integrated Care. In SWSLHD, for example, its implementation of integrated care has led to a rapid increase in services and activity which aim to reduce preventable ED presentations and hospital admissions. Preliminary outcomes from combined integrated care models indicates a 19% reduction in ED presentations, a 72% reduction in unplanned admissions, and a 127% reduction in bed days compared to those who declined services.

While improving capacity to deliver integrated care, the models created challenges for healthcare providers and consumers to navigate services. In particular, the complexity of this patient group, limited staff experience in working with people with disability, limited staff knowledge of the NDIS system, and uncertainty regarding about the ongoing role of Health advocating for this patient group all contributed and impacted on the delivery of collaborative and coordinated care.

In April 2022, scoping work began to better understand how people with disability were represented in the SWSLHD EDC list on the PFP.

Of the patients on the EDC list, 14% (36 / 249) are identified NDIS participants. The identified NDIS participants account for 19% (887 / 4,760) of the hospital presentations within the EDC cohort. NDIS participants have an average of 24.6 presentations in 12 months, compared to the average of 19 presentations in 12 months for the rest of the cohort. The length of stay to date for NDIS participants in SWSLHD hospitals in August 2022 is 134 days. In response, the LHD has established an integrated care central access and service point which streamlines access, personalises, care and allows for innovation, with projects underway to deliver targeted enrolment for NDIS participants and shared care planning with primary care.

The project targeting enrolment for NDIS participants aims to provide clinicians with resources and education to better equip them to navigate the disability sector and respond to unmet disability-related needs. Integrated Care services can play a pivotal role in coordinating and improving patient care and outcomes for patients that have several supports already in place.

5.3 Primary care joint initiatives

Primary Care is principally a Commonwealth responsibility. The Commonwealth funds programs such as GP Access After Hours to support access to primary care. Under the National Health Reform Agreement (NHRA), all jurisdictions have committed to work in partnership to ensure the public hospital and primary care health systems effectively and efficiently connect to provide the best outcomes for people, including:

- jointly identifying rural and remote areas where there is limited access to health and related services and developing new models of care to address equity of access;

- introducing reforms to improve how local health organisations (such as PHNs, LHNs and primary and community health services) collaborate when planning health services and making investment decisions; and
- working together on system-wide policy and local, regional, and State level planning and funding for GP and primary health care given the impact on the efficient use of hospitals and other State funded services

10 Year Primary Healthcare Plan (Commonwealth)

In March 2022, the Commonwealth Government published its 10 Year Primary Healthcare Plan which commits the Commonwealth to working collaboratively with State and Territory governments to deliver quality healthcare. The Commonwealth has since established the Strengthening Medicare Taskforce, which aims to improve general practice access and affordability to improve health outcomes and care pathways, and to decrease pressure on hospitals.

Urgent Care Clinics to ease pressure on EDs

The Commonwealth Government has also committed to the establishment of Urgent Care Clinics (UCCs) to take pressure off EDs. NSW Health is working with the Commonwealth to identify suitable locations and models of care. Where possible, this work will align with the NSW Urgent Care Services initiative.

Healthdirect and Triage to ease pressure on EDs

NSW Health funds the NSW Ambulance Secondary Triage to support the management of emergency resources by ensuring the availability of ambulances for the most urgent situations. Callers who dial 000 and do not meet the criteria of requiring an emergency ambulance are transferred to the Healthdirect helpline, a 24 hour, seven day a week telephone based nurse triage and advice service. Healthdirect was established as a limited company with all Australian Governments (except Queensland) as Shareholders.

Collaborative Commissioning to accelerate value-based healthcare

Collaborative Commissioning, as discussed in section 4.3, is designed to incentivise locally developed integration across the entire continuum of care, and embed local accountability for delivering value-driven, outcome-focused, and patient-centred healthcare. The objective is to integrate pathways across one system of care, to build capacity and capability in primary care to manage priority cohorts more appropriately within the community. Formal partnerships between LHDs and PHNs are established to deliver locally designed care pathways for priority cohorts. The care pathway is commissioned through a mix of realigned State and Commonwealth funds along with new funding provided by NSW Health. Collaborative Commissioning community-led models of care will reduce the burden on the acute system (including emergency presentations, potentially preventable admissions, and associated ambulance transfers).

There are now 4 partnerships across metropolitan, regional, and rural areas of NSW:

- The **Western Sydney partnership**, between WentWest PHN and Western Sydney LHD is focussed on reducing non-urgent presentations to the ED. In

Western Sydney ED presentations increased by 14.8% between FY16-FY19,[29] almost double that of the population growth.[30] 37% were determined to be low or semi-urgent (Category 4 or 5).[31]

The partnership has established four Urgent Care Services within existing general practices in their region and set targets that up to 20% of all Category 4 and 5 presentations will be able to seek timely care within the community.

- The **Northern Sydney partnership** between the Sydney North PHN and the Northern Sydney LHD has focused on frail and older people. In Northern Sydney ED presentations increased by 12.5% between FY15-FY19 for those aged 75+, exceeding the population growth rate of 4.4%.[32] People living in RACFs make up 16.4% of these ED presentations.

  The approach aims to reduce preventable emergency attendances and hospital admissions for the 75+ cohort by 25% through targeted and proactive care in the community.

- The **Murrumbidgee partnership** between Murrumbidgee LHD and PHN is focussing on patients with uncontrolled or undiagnosed chronic obstructive pulmonary disease (COPD) or Chronic Heart Failure (CHF).

  The partnership is targeting a 15% reduction in Triage 3 – 5 ED presentations and a 15% reduction in all COPD/CHF potentially preventable hospitalisation admissions.

- **Western NSW partnership** between Western NSW LHD, Far West LHD, Rural Doctors Network and Western NSW PHN is focussing on patients with uncontrolled or undiagnosed Type 2 Diabetes. In 2021, more than 20,000 Western NSW PHN residents were registered with the National Diabetes Services Scheme with a significantly higher mortality rate than the state average.[33]

  The partnership is targeting a 15% reduction in ED presentations and a 5% reduction in admissions for persons with Type 2 Diabetes in the region.

[29] Bureau of Health Information, Data Portal, available at: 'https://www.bhi.nsw.gov.au/data-portal'.
[30] HealthStats NSW, 'Population estimates Local Health Districts NSW – All ages by Sex', available at: 'https://www.healthstats.nsw.gov.au/#/indicator?name=-dem-pop-lhd-abs&location=LHD&view=Trend&measure=Population&groups=Age%20(years),Sex&compare=Age%20(years),Sex&filter=LHD,All%20LHDs&filter=Age%20(years),All%20ages&filter=Sex,PersonsBased,Males'.
[31] Bureau of Health Information, Data Portal, available at: 'https://www.bhi.nsw.gov.au/data-portal'.
[32] HealthStats NSW, 'Population estimates Local Health Districts NSW – All ages by Sex', available at: 'https://www.healthstats.nsw.gov.au/#/indicator?name=-dem-pop-lhd-abs&location=LHD&view=Trend&measure=Population&groups=Age%20(years),Sex&compare=Age%20(years),Sex&filter=LHD,All%20LHDs&filter=Age%20(years),All%20ages&filter=Sex,PersonsBased,Males'.
[33] National Diabetes Services Scheme, 'Australian Diabetes Map', available at: 'https://www.ndss.com.au/about-the-ndss/diabetes-facts-and-figures/australian-diabetes-map/'.

The Lumos Program

The Lumos program is a pioneering program that provides new insights on the patient journey through the NSW health system. In Lumos, de-identified data from general practices is linked with other health service data to provide a more comprehensive view of patient pathways. This can help identify opportunities for improving patient outcomes and experiences. The data asset is continually growing and spans regional, remote, and metropolitan areas across NSW.

Lumos is the largest collaboration NSW Health has ever undertaken with PHNs and general practices. Following five successful pilot linkages, in early 2020, Lumos transitioned to a state-wide program with all 10 NSW PHNs and a rapid growth in practice participation. In July 2022, almost 600 practices are participating and this continues to grow.

Integrated Care

The NSW Health Integrated Care Program includes statewide strategies that coordinate and encourage better communication and connectivity between health care providers in primary care, community, and hospital settings, and provide better access to community-based services closer to home. The interventions target vulnerable and at-risk populations and people with complex health and social needs.

Integrated Care Programs

- **Residential Aged Care:** This program promotes partnerships between NSW Health and RACFs to better manage the health care needs of residents. It aims to improve the skills of RACF staff to better identify the health needs of their residents and to avoid unwarranted ambulance callouts, ED presentations and hospital admissions.

- **Vulnerable Families:** This program provides care coordination for families who require health and social care support from multiple agencies. This improves access to better-coordinated care thereby, enabling more families with complex health and social needs to stay well in the community.

- **Paediatric Network**: This program upskills local health services staff using telehealth and virtual care services. This enables greater access to specialist paediatric care for children with complex needs. The use this technology reduces the travel burden for families, especially in regional and rural areas of NSW.

- **Specialist Outreach to Primary Care**: This program builds the capability of GPs to provide patients with specialist assessment and care in the community. GPs are linked with medical specialists to enhance their ability to assess and manage a variety of conditions such as early-onset dementia, heart disease, and diabetes.

Integrated Care – Hospital Avoidance Initiatives

- **Planned Care for Better Health**: This initiative identifies patients at risk of hospitalisation early and strengthens the care provided to them with the aim of keeping them healthier over the long term. It is focused on the needs of people who are at risk of hospitalisation in the next twelve months and involves the provision of care coordination, care navigation, and/or health coaching to improve their experience and outcomes.

- **ED to Community**: This initiative provides tailored intensive case management and specialist care to patients in the community, which improves their health and reduces the likelihood of hospitalisation. It is designed to support patients under the age of seventy who have been identified as frequent ED presenters with complex chronic health and social care needs. Patient are identified through an algorithm, which considers ED admission history from the last four years, existing chronic conditions, and several demographic and social determinants.

- **Referral Pathways:** This project involves the use of the NSW Ambulance Virtual Care Clinical Call Centre (VCCC) as an integrated in-house virtual triaging service, which addresses the needs of low acuity calls through the use of an alternate care pathway where appropriate.

5.4 Aged care joint initiatives

NSW/Commonwealth Protocol to support joint management of a COVID-19 outbreak in a RACF in NSW

As part of the NSW Health response to the COVID-19 pandemic, a protocol was formalised with the Federal Department of Health and Aged Care and the Aged Care Quality and Safety Commission to work together in a co-ordinated and collaborative way to prevent, prepare for and respond to, an outbreak of COVID-19 in an Australian Government-funded RACF in NSW. The aim was to optimise care for all residents in impacted RACFs (irrespective of their COVID-19 status) and to contain and control outbreaks or exposures to bring them to an end as quickly and safely as possible. The intent of the Protocol was to ensure that the appropriate level of support was made available to the aged care provider to enable them to continue to manage care locally in response to an outbreak or exposure.

Secondary Triage for Residential Aged Care Facilities

In March 2020, NSW Health, in partnership with NSW Ambulance, began implementing the Secondary Triage for Residential Aged Care Facilities (ST-RACF) initiative in NSW. The ST-RACF was initiated in response to the COVID-19 pandemic as a way of reducing unnecessary transfers from RACF to EDs and/or hospitals.

Although initially developed to respond to residents experiencing COVID-19 symptoms, the ST-RACF has subsequently been expanded to support a broader range of non-critical Triple Zero (000) calls from RACFs. It has potentially resulted in:

- 2,607 avoided ambulance attendances;
- 2,210 avoided ED presentations;

- 553 avoided hospital admissions;
- 2,210 avoided transports back to RACFs; and
- 394 additional PTS journeys to the ED.

An evaluation found that secondary triage program generated an estimated net saving of $4.1 million in the first year of the program.

Between June 2020 and June 2021, NSW Ambulance received 106,254 calls from residential aged care facilities; 47,833 were classified as low acuity calls (45%). Of these, 12% (5,885) were managed by the Secondary Triage process with 57% (3,343) of residents receiving their care in residence, with no transfer to hospital required.[34]

The Transitional Aged Care Program

All local health districts and the St Vincent's Health Network deliver Transitional Aged Care Program (TACP) services to support timely discharge of aged care patients. The TACP started in 2005-06 and is jointly funded by the Commonwealth Government (75%) and NSW Government (25%), with total funding of around $127 million in 2020-21.

The TACP is provided in the community (home-based) and in residential aged care facilities for older people in hospital ready for discharge. There are currently 1,478 TACP places operational in NSW.

The TACP delivers an important service in the health system, bridging acute and community settings. It is a flexible aged care program that provides time-limited, therapy-focused care for older people following discharge from hospital. The TACP is delivered as a package of services, including low intensity therapy such as physiotherapy and occupational therapy, as well as social work, nursing support or personal care. The overall aim is to optimise functioning and independence. The TACP supports patient bed flow and reduces hospital readmissions and premature admission to residential aged care.

[34] New South Wales Health, 'Annual Report 2020-21', available at: 'https://www.health.nsw.gov.au/annualreport/Publications/annual-report-2021.pdf', p. 24.