NSW HEALTH

NSW Health Subacute Care Reform Implementation Plan

December 2009

A component of the National Partnership Agreement on Hospital and Health Workforce Reform

1 Introduction

This updated NSW Health Subacute Care Reform Implementation Plan provides more detailed background information, identifies key strategies by care type and setting to be implemented over the period of the NPA, and provides the final 2007/08 activity baseline.

This Implementation Plan reflects our current understanding of models of subacute care service delivery in NSW, and the strategies proposed to increase growth in service activity. This plan may be modified, if necessary, to achieve the target growth in services required under the NPA or to meet emerging priorities in subacute care over the next four years.

2 NSW context

Under the subacute care component of the National Partnership Agreement (NPA) on Hospital and Health Workforce Reform, NSW has received $165.652 million for the enhancement of subacute care services.

This NSW Health Subacute Care Reform Implementation Plan has been developed from proposals formulated by each of the eight Area Health Services (AHSs) and The Children's Hospital at Westmead (a tertiary paediatric hospital with some statewide functions). These proposals address needs and gaps in local subacute care delivery.

As outlined in the earlier version of this Implementation Plan, NSW proposes to enhance services across all four subacute care types – rehabilitation, palliative care, geriatric evaluation and management, and psychogeriatric care. Within these care types, NSW will target older people, children and Aboriginal people, as well as residents in outer metropolitan and regional areas of NSW that are currently under-serviced.

2.1 NSW population

The NSW population of 6.9 million is heavily concentrated along the eastern seaboard, with 85% of residents living within 50km of the coast. The much smaller numbers who live inland tend to be clustered in the larger regional centres (for example Tamworth, Bathurst, Orange, Dubbo, Goulburn, Albury and Wagga Wagga), with a scattering of people living in or near smaller satellite towns and more remote communities.

The table below shows the striking differences in population density across NSW.

Table 1: NSW Area Health Services – population size and density

Area Health Service	Population*	No. of residents per km^2
Northern Sydney Central Coast	1,139,318	456
Sydney South West	1,405,136	220
South Eastern Sydney Illawarra	1,215,252	192
Sydney West	1,139,902	127
North Coast	498,495	19
Hunter New England	866,565	7
Greater Southern	485,226	3
Greater Western	301,157	1

* ABS & AHS Annual Reports 2007/08

The differences in these demographic profiles will intensify over coming decades as the east coast continues to experience population growth, while many rural and remote areas continue to experience population decline, as Figure 1 below shows.

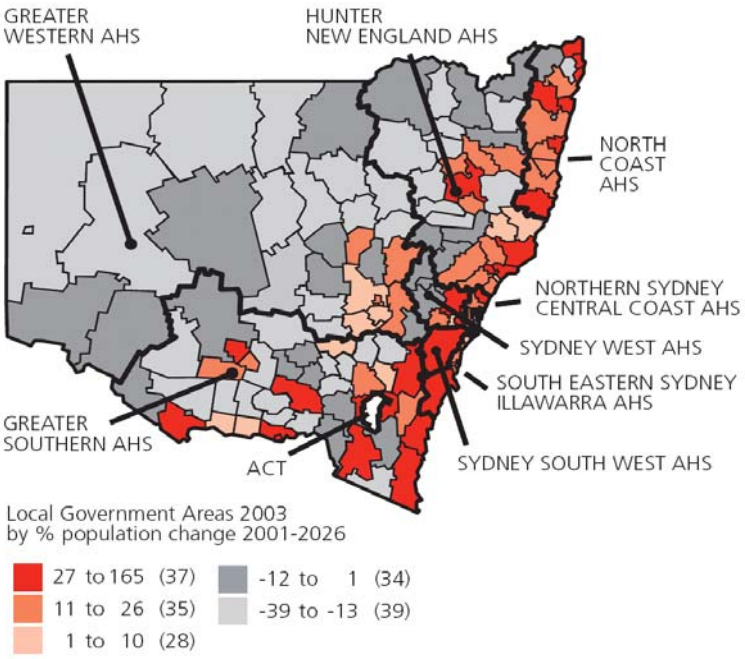

Figure 1: Projected change (%) in population, by AHS, 2001-2026

These demographic profiles are arguably the most significant factor contributing to differences in the level and configuration of subacute care services provided, both historically and into the future, by each of the eight AHSs that collectively cover NSW.

2.2 A profile of NSW Health subacute care services in 2007/08

In 2007/08, 35,524 subacute care separations and 1,336,406 occasions of service were provided by NSW public health services at a cost of $478 million.

The majority (71%) of NSW Health subacute care separations were for rehabilitation, with the second highest level for admitted activity being in palliative care (24%). GEM and psychogeriatric care were relatively less common in admitted settings.

The profile of NSW Health subacute care non-admitted activity is different, with rehabilitation, palliative care and GEM each accounting for about one third (37%, 33% and 27% respectively) of activity.

In NSW, community-based rehabilitation has been classified as either rehabilitation or GEM. Typically these care types are intermingled as they are provided by Aged Care and Rehabilitation services.

In many AHSs, psychogeriatric care is incorporated into GEM. In other AHSs, psychogeriatric care is provided by Mental Health Services. For the purposes of the NPA, psychogeriatric care provided by Mental Health Services has not been classified as subacute care.

3 NSW Implementation Plan 2009/10 to 2012/13

The strategies to be implemented by NSW Health seek to improve the health outcomes, functional capacity and quality of life of patients by increasing the volume and quality of subacute care services in both hospital and community settings. In developing and refining strategies for service enhancements, AHSs are drawing on their AHS Clinical Service Plans (which in turn are informed by the Clinical Service Plans of the clinical streams responsible for delivering subacute care in regional areas).

The structure and profile of subacute services varies across NSW. Services are better developed in areas with larger populations, and especially in Sydney's inner metropolitan area. Nevertheless, many of the strategies identified in the Plan involve the development or enhancement of subacute services in outer metropolitan and regional areas of NSW.

Specifically, NSW Health will use the funding made available under the National Partnership Agreement to establish and/or strengthen strategically important developments in the areas of:

1 Evidence-informed models of subacute care, including supported patient self-management and rehabilitation in acute care settings;
2 Effective service delivery models such as day hospitals, hub and spoke models where specialist teams in hubs provide support to generalist teams in community, and specialist networks;
3 The subacute care workforce by:
    - increasing the numbers of specialist and generalist clinical staff to increase the volume and quality of subacute services in hospital and community settings
    - investigating new roles and extended scope of practice for specific disciplines

including Nurse Practitioners and non-medical clinical specialists/"leads" in nursing and allied health to enhance the quality of care provided in the community and improve health outcomes for patients and clients
- designating Data and Performance Management positions to monitor performance in subacute care against agreed targets.

Enhancing subacute care services will also provide an opportunity for community health services to provide integrated primary health care, as well as to strengthen links with general practitioners. Improving access to subacute care in both hospital and community settings is also expected to assist in acute demand management.

NSW will implement information systems for the improved collection of activity and performance data.

The funding will also provide an opportunity to train and educate the generalist workforce in subacute care. In rural and remote NSW, services are necessarily small in size as the population numbers are small. There is therefore a need for the generalist workforce to be skilled across the range of subacute care types. The education and training of this workforce is critical to improving access to quality subacute care in rural and remote NSW.

The table below identifies key subacute care enhancements that are expected to be implemented over the next four years.

Additional detail on service enhancements by care type is given in section 3.3.

Table 2: NSW subacute care enhancement strategies

Care Type	Strategy
Rehabilitation $54m	• Develop rehabilitation in acute care services in SESIAHS and SWAHS • Expand inpatient bed capacity at Fairfield Hospital by 10 beds (SSWAHS) • Increase rehabilitation therapy intensity for inpatients in SESIAHS • Enhance community-based rehabilitation in SESIAHS and HNEAHS • Enhance community-based paediatric rehabilitation services in SESIAHS • Enhance hospital-based services for children with cerebral palsy at the Children's Hospital at Westmead • Develop community-based liaison service for young adults with disability in SSWAHS (Area-wide) • Develop rehabilitation services via specialist hubs to generalist spokes in rural NSW (GWAHS, GSAHS and HNEAHS)
Palliative Care $33m	• Enhance hospital consultation service in Wollongong and Port Kembla (SESIAHS) • Establish Day Hospital/ Day Therapy Centre in Camden Hospital and enhance service at Braeside Hospital (SSWAHS) • Enhance community-based service for Aboriginal clients in HNEAHS • Enhance RACF liaison service in SSWAHS and SESIAHS • Enhance paediatric services in SESIAHS and HNEAHS in hospital and community settings • Develop a Parent and Sibling Bereavement Service at The Children's Hospital at Westmead • Provide palliative care services via specialist hubs to generalist spokes in rural NSW (GSAHS and HNEAHS)
Geriatric Evaluation and Management $60m	• Staged development of designated GEM units in Long Jetty and Woy Woy Hospitals (NSCCAHS) • Staged development of designated GEM/ Psychogeriatric units at Lismore, Port Macquarie, Tweed and Coffs Harbour Hospitals in NCAHS • Establish Day Hospital services at Bankstown and Bowral Hospitals (SSWAHS) • Develop and enhance community-based services in SSWAHS, SESIAHS and SWAHS • Develop outreach service to RACFs in SWAHS • Provide GEM services via specialist hubs to generalist spokes in rural NSW (GWAHS, GSAHS and HNEAHS)
Psychogeriatrics $10m	• Develop outreach services for RACFs on the Central Coast (NSCCAHS) • Develop community-based services in HNEAHS
Service development support $8m	• Fund data improvement strategies in each AHS • Centrally upgrade non-admitted data collection system • Support statewide services • Disseminate best practice information

Key:

GSAHS	Greater Southern Area Health Service	NSCCAHS	Northern Sydney Central Coast Area Health Service
GWAHS	Greater Western Area Health Service	SESIAHS	South Eastern Sydney Illawarra Area Health Service
HNEAHS	Hunter New England Area Health Service	SWAHS	Sydney West Area Health Service
NCAHS	North Coast Area Health Service	SSWAHS	Sydney South West Area Health Service

3.1 Growth in activity

Baseline activity (2007/08) for the four subacute care types by setting - hospital, centre and home-based - is provided at Attachment 1. Baseline admitted and non-admitted activity has been converted to Bed Day Equivalents (BDEs). The conversion methodology is described in Appendix 3.

From this baseline, NSW is committed to achieving 20% growth over the four years of the NPA, that is from 2009/10 to 2012/13. As Appendix 2 shows, NSW will increase its subacute activity by 149,140 BDEs, from the 2007/08 baseline of 692,045 BDEs to 841,185 BDEs by 2012/13.

The short timeframe for the development of State and Territory implementation plans required NSW to make some early decisions regarding AHS growth targets and the subsequent allocation of funding to AHSs. It was agreed that all AHSs would contribute to achieving the targeted growth in their subacute care activity and receive enhancement funding. It was also agreed that the 5% per annum growth target for 2009/10 and 2010/11 would be combined so that 10% compounded growth would be the target for achievement by the end of 2010/11.

It was identified early in the process that redressing inequities in access to subacute care services across NSW would be challenging. The requirement under the NPA to increase subacute care activity by 5% annually required NSW to increase existing services to achieve this ambitious target. Expanding lower volume services, at the expense of high volume services, by 5% annually would also not deliver the required growth.

There will, however, be significant investment in GEM that will improve access to this under-represented care type.

As section 2.1 very clearly demonstrates, assessing activity on a regional basis must take account of the significant differences in population size and density across NSW. While every AHS will contribute to achieving the NSW growth target, each will invest in service growth according to a number of factors including population need, existing service infrastructure and availability and distribution of the health workforce. NSW also notes that comparisons between jurisdictions are not possible at this time due to the differences in classification and counting.

NSW will report growth in admitted services using separations, and growth in non-admitted services using occasions of service. NSW is unable to report episodes of non-admitted care. NSW will report growth in State and AHS-level activity using BDEs.

3.2 Funding

NSW has been allocated $165.652m over four years to improve health outcomes, functional capacity and quality of life of patients by increasing the volume and quality of the subacute care services in both hospital and community settings.

The financial resources required to achieve year on year 5% growth in service activity alone must be appreciated. While growth in activity is described as 5% per annum over 4 years, the compounding effect translates into a 21.55% increase in activity and a 60% increase in the funding over baseline over the same period. Therefore, in order to achieve the required growth target, NSW must invest considerable funds in addition to the allocation provided by the Commonwealth under the NPA, as the table below shows.

The funding ramifications of maintaining the achieved level of service provision beyond 2012/13 (when Commonwealth funding is currently scheduled to cease) are also significant. As demonstrated in Table 3, NSW will need an additional $70m per annum (plus escalation) to supplement its additional $52 million investment in subacute care. By 2013/14, the cost of maintaining the 2012/13 level of subacute care will be $714 million.

NSW is also committed to funding the non-activity generating requirements of the NPA such as improving data collection and reporting arrangements, and enhanced electronic communications; as well as strengthening capacity of the multi-disciplinary subacute care workforce.

Table 3: Funding required to achieve subacute care growth target

	2007/08	2009/10*	2010/11*	2011/12	2012/13	TOTAL
2007/08 Baseline activity (Total BDEs)	**692,045**					
Activity	**BDE**	**BDE**	**BDE**	**BDE**	**BDE**	
Admitted	**533,138**	559,795	587,785	617,174	648,033	
Annual growth (5%)		26,657	27,990	29,389	30,859	
Compounded growth			54,647	84,036	114,895	
Non admitted*	**158,907**	166,852	175,195	183,955	193,152	
Annual growth (5%)		7,945	8,343	8,760	9,198	
Compounded growth			16,288	25,048	34,245	
ACTIVITY Growth (BDEs)		**34,602**	**70,935**	**109,084**	**149,140**	
Average Cost per BDE		**$740**	**$766**	**$793**	**$820**	
Cost to deliver target growth		$25,600,964	$54,318,845	$86,455,397	$122,339,649	**$288,714,855**
Source:						
Commonwealth		$14,688,717	$31,165,786	$49,604,339	$70,193,158	**$165,652,000**
NSW		$10,912,247	$23,153,059	$36,851,058	$52,146,491	$123,062,855

Note: Refer to Appendix 3 for an explanation of Bed Day Equivalents (BDE) and their Average Cost.

***** In practice, the 5% pa growth targets for the first 2 years will be combined to provide a 10% compounded growth target to be achieved by the end of 2010/11.

3.3 Rehabilitation

Rehabilitation services are provided to people with a loss of function or ability due to injury or disease who can reach the highest possible level of independence (physically, psychologically, socially and economically) through a combined and co-ordinated use of medical, nursing and allied health professional skills. Rehabilitation is a vital service, typically but not always following an acute episode, which is aimed at restoring function, with clearly defined treatment goals. The best results are achieved when a patient is highly motivated, well-supported and has the physical and cognitive capacity to take or share responsibility for their program. Rehabilitation is not only important as a means of improving individuals' (and families') quality of life, but can also assist in reducing avoidable demand for acute services.

The need for the establishment and/or enhancement of rehabilitation services has been identified by most AHSs in NSW. There is a demand for hospital, centre based and home based rehabilitation services across NSW, both for high complexity rehabilitation such as in paediatrics and lower complexity rehabilitation such as that provided in geriatrics. Older people represent a large proportion of the patient referrals to rehabilitation services, but the rehabilitation needs of young people and working-aged adults are also being considered by AHSs.

The following issues are addressed within individual AHS plans based on regional and local identification of needs, gaps and longer term projections in relation to expected demand:

- A number of AHSs have identified the need for hospital rehabilitation services to commence in the acute care setting. It has been shown that patients in acute care benefit from early intervention to improve functional capacity and quality of life, and that this can also shorten the subsequent rehabilitation average length of stay. AHSs are also developing plans to increase the volume and quality of hospital rehabilitation services by recruiting medical specialists. A number of these staff will be able to be accommodated in new facilities. The proposed increases in hospital staff will also enable consultative services to be provided to community-based clients.
- Increased community geriatric rehabilitation services are planned by some Areas to address the needs of older people, people with chronic disease or dementia. Allied health enhancements proposed include neuropsychology, podiatry, speech pathology and dietetics. Recruitment will be subject to workforce availability. One AHS will increase centre based rehabilitation for older people with complex needs by providing services through some of its existing Community Health Centres. The expansion of home based services, particularly allied health services, is also proposed for those people who are less mobile and may not otherwise receive services.
- In general, the intended creation of new medical specialist, nursing and allied health positions in subacute care will improve the capacity of AHSs to provide clinical student placements and clinical supervision. In rural NSW where workforce supply problems are more serious, the appointment non-medical "clinical leads" in rehabilitation will be pursued in a number of hospitals. Clinical leads are senior nursing or allied health staff within a clinical stream providing clinical leadership and supervision. The hospitals appointing these staff would act

as service hubs with services delivered primarily in the community. This strategy is proposed to improve clinical supervision and clinical systems and processes which in turn are aimed at improving the quality and efficiency of service delivery.

- New and/or enhanced paediatric rehabilitation services will be established/ enhanced in the major healthcare facilities providing services to children in NSW. Enhancements in paediatric services include those for spinal injury and general neuro-rehabilitation. Positions proposed include Medical Rehabilitation, Case Manager, Clinical Psychologist and Neuropsychologist.

3.4 Palliative care

The emergence of palliative care as a discrete specialty over the last 20 years has been accompanied by an increase in clinical knowledge, skills and expertise in managing complex life-limiting conditions, and particularly in caring for those with advanced chronic disease or other terminal illness. The importance placed on supporting individuals and their families through psycho-social and pastoral care is one of the characteristics that can distinguish end of life care from other types of subacute care. A further distinguishing feature of palliative care is the need for professional advice and support to be accessible around-the-clock for patients being cared for at home.

The following issues are addressed within individual AHS plans based on regional and local identification of needs, gaps and longer term projections in relation to expected demand:

- Enhancement of existing palliative care services include expanding designated palliative care units in selected hospitals, creating new services for paediatric inpatients, and increasing the clinical workforce (including possibly Nurse Practitioners). The expanded workforce is expected to enable the establishment or improved availability of consultative services for community-based clients.
- Enhancing medical, nursing and allied health staffing in palliative care will improve AHSs' capacity to provide clinical supervision and student placements. A number of AHSs will establish advanced medical and nursing training places.
- As is the case for rehabilitation services, some AHSs are planning enhancements to the capacity of nursing and allied health staff to provide quality palliative care by appointing non-medical clinical leaders in a number of hospitals. Under this arrangement, the hospitals would act as service hubs with services delivered primarily in the community.
- Establishing networked Cancer Care and Palliative Care Clinical Services using a hub and spoke service model is also proposed in rural NSW.
- Another strategy proposed to increase the efficiency of the workforce and the quality of care provided is to employ nurses to support the existing Palliative Care Clinical Nurse Consultants in rural clusters. The new nurse positions would provide clinical services to clients and carers, advice to other health care professionals, and would develop and evaluate care management plans for clients with complex care needs.
- There is also a recognised need for a much larger number and range of clinical

staff to build their competence in addressing the needs of people with end stage chronic disease. To this end, a number of AHSs have included plans to educate their clinical workforces on the “Palliative Approach” to care.

- Improving access to culturally competent palliative care services for Aboriginal people is being explored by one AHS, through the recruitment of an Aboriginal Health Worker in palliative care services.
- Day Hospital/Day Therapy Centre services will be expanded in a metropolitan AHSs to enhance access to multidisciplinary assessments, procedures and treatments to enable palliative care clients to remain at home. Day Hospitals are a service model used primarily in urban areas in NSW.
- The development of community (centre and home based) palliative care services with the recruitment of additional medical, nursing and allied health staff, and procurement of necessary equipment, is being considered by many AHSs.
- There are currently relatively few palliative care services targeting children and their families in NSW. New paediatric palliative care services are proposed in urban parts of the State. A new Parent and Sibling Bereavement Service is also proposed for children requiring end of life care and their families.
- The need for specialist palliative care support services for residents of Aged Care facilities will also be addressed.

3.5 Geriatric evaluation and management

Australia’s population is ageing and has an increased life expectancy. This demographic trend is particularly important for the health system given the higher per capita use of health services by older people. For example, people aged 70 and over represent 9.7% of the population but account for 41.6% of total public hospital utilisation in NSW. Older people requiring health services often have complex needs relating to a cluster of medical conditions, disabilities and psychosocial issues. Such older people in particular benefit from multidisciplinary care management and regular assessments against management plans that are working towards negotiated goals within indicative timeframes.

The following issues are addressed within individual AHS plans based on regional and local identification of needs, gaps and longer term projections in relation to expected demand:

- Enhancement of GEM services in hospitals. Enhancements include the recruitment of additional medical specialists, nurses and allied health professionals to deliver multidisciplinary team care, the development of new units and the expansion of existing services. New teams should also have the capacity to provide services in the community.
- Several rural AHS plan to expand inpatient capacity for GEM, or GEM combined with Psychogeriatric or Rehabilitation services.
- In rural NSW, AHSs are planning to establish hub and spoke service networks in rehabilitation and aged care services. In these networks, generalist service providers across the AHS would be supported by specialist multidisciplinary

teams. New non-medical clinical specialist positions will be created in each network to improve the quality and efficiency of GEM services. The capacity of the workforce will be further increased by recruiting at least one additional Aged Rehabilitation Physician and more nursing and allied health staff. Utilising GPs with an interest in aged care will help address workforce shortages and difficulties in attracting specialist staff to rural NSW.

- Centre based services will be developed as day hospital services in metropolitan Sydney. This model has been established and evaluated in other parts of Sydney. Day hospital services provide a mix of medical, nursing and allied health interventions to assist people to improve functional outcomes, reduce the need for hospitalisation and achieve earlier discharge from hospital. The service is usually associated with the provision of a range of therapies over the course of 4 hours, which provides opportunities for socialisation and a shared meal. Transport to and from the Day Hospital facility is also provided.
- Enhance home-based GEM services, particularly allied health services, for those people who are less mobile and may not receive services otherwise. Some services will target specific disciplines such as Occupational Therapy to enhance their multidisciplinary team and address clients' needs.

3.6 Psychogeriatric care

Psychogeriatric care is care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement of function, behaviour and/ or quality of life for a patient with age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance.

Psychogeriatric care in NSW is provided by aged care and rehabilitation services and mental health services. NSW Health data for both hospital and community psychogeriatric care indicates both significant variation in classification and coding practices across the state, and a strong probability of under-enumeration.

For the purpose of this NPA, activity funded by Mental Health has been excluded. Admitted activity classified as subacute care in psychiatric hospitals and designated units has been excluded since the first NSW Implementation Plan was submitted in May 2009.

The following issues are addressed within individual AHS plans based on regional and local identification of needs, gaps and longer term projections in relation to expected demand:

- Enhancement of psychogeriatric care services address access to both hospital and community-based services. For example, combined GEM/psychogeriatric units for selected hospitals in northern NSW will be developed over the next 4 years.
- Workforce supply, in particular in rural and remote NSW. Options are being explored to recruit geriatricians or physicians with an interest in geriatric medicine to improve access to services, across settings, for people with dementia.

- The enhancement of community psychogeriatric services will enable support to be provided to residents and staff in residential aged care facilities.

3.7 Accountability and reporting

NSW Health has implemented a governance structure to oversee the implementation of the non-workforce elements of the National Partnership Agreement on Hospital and Health Workforce Reform. The structure has been developed to manage the interfaces and overlap between the schedules of the NPA, and to facilitate reporting against agreed performance indicators.

NSW Health has committed resources to improving data collection and electronic reporting arrangements. Each AHS is participating in the NSW data improvement strategy that has a reporting line through to the NSW NPA governance structure. Phase 1 of this strategy has been to upgrade the non-admitted data application to improve subacute care data quality.

4 Risks and constraints

A number of risks and constraints have been identified in relation to NSW Health's achievement of the agreed performance measures set out in the National Partnership Agreement. These are listed in the table below, along with proposed mitigation strategies that will be further developed as AHS-level plans are finalised.

Identified Risk	Mitigation Strategies
The availability of workforce will greatly influence NSW's capacity to deliver agreed increases in activity across settings and care types.	Strategies to address workforce issues being investigated at AHS level (and particularly for rural AHSs) include use of private and fly-in services, GPs with an interest in subacute care and nurse practitioners. The use of allied health assistants is also being considered in some Areas. It is also expected that progressive national implementation of the Health Workforce Reform NP will assist.
The data collected relating to clinical activity in subacute care in NSW is of varying reliability. The rollout of information systems for the collection of activity and performance data across the State may also impact on NSW's capacity to record the required increase in activity.	Additional designated data collection and quality staff are proposed to strengthen data management and analysis practices.
Variations in practice exist across NSW (and very possibly across all jurisdictions) in relation to recording changes in the type of care that a patient receives during their stay in hospital (eg. their progression from acute to subacute care). This variation raises questions about the accuracy and completeness of data on inpatient subacute care activity.	NSW will work with the Commonwealth, other States and Territories to develop guidelines for care type changes during hospital admission.
Currently there is a 6 month lag in the availability of accurate activity data.	The NSW Department of Health will work with AHSs to improve data quality and completeness to reduce lag.
The lead time for capital works and equipment such as modified buses to accommodate wheelchairs (day hospital) and other specialised equipment may impact on NSW's capacity to deliver the required increase in activity.	AHSs will commence the detailed planning required as soon as their implementation proposals are approved.
Lack of formal in-service training opportunities for the generalist health workforce in subacute	The NSW Department of Health will work with AHSs to investigate and pursue

Identified Risk	Mitigation Strategies
care.	training options.
The quality of Information regarding clinical training places for the workforce categories in subacute care in NSW needs to be improved.	The Department of Health will work with AHSs to ensure that appropriate data capture and reporting systems are in place.
Opportunities and systems for knowledge management and information sharing at both a statewide and national levels.	NSW supports the establishment of a national web-based knowledge management centre.
Increasing subacute care activity is likely to have flow-on effects in terms of increasing demand for other services for which no additional funds are available.	The NSW Department of Health will work with AHSs to address these issues in the wider budget context, as far as possible. Inter-agency discussions may also be required in terms of managing flow-on demands on non-health community care services.
Minimal capacity to sustain increased activity beyond 2013 in the absence of ongoing NP funding.	On current estimates NSW will require an additional $70m per annum (plus escalation) to maintain activity from 2013/14.

5 NSW's commitment

As agreed in the National Partnership Agreement on Hospital and Health Workforce Reform, NSW will:

1. Review this plan at least biannually to take account of emerging issues (unless otherwise agreed nationally).
2. Participate in national arrangements established to address:
    1 Enhanced provision and mix of subacute care services, with a particular focus on the types of subacute care most needing expansion and on regional areas with the greatest need for enhanced services.
    2 Quality and data improvements through agreed models of care, including improved data collection and reporting arrangements.
    3 Strengthened capacity of the multi-disciplinary subacute care workforce; including improved geographical distribution, an increase in the supply of the workforce and development new workforce models.
3. Provide agreed data to the Commonwealth—including performance information as set out in the National Partnership agreement—and participate in work with national data collection agencies to collect and evaluate data on subacute care.
4. Publicly report (in a nationally agreed format) on its performance against the annual growth targets for subacute care published in this plan. The first report will measure the first 6 months of progress (June-December 2009) while subsequent reports will measure progress over a full financial year.

NSW will work with the other States and Territories and the Commonwealth to achieve national agreement on improved measurement and data for subacute care including an auditable method for measuring growth in service provision for subacute care.

NSW will nominate and support representatives on a Subacute Care Measurement Working Party to steer the following stages, as agreed to by all jurisdictions:

1. Define the measures and data required to report the Subacute NPA performance indicators.
2. Develop and agree data item definitions.
3. Undertake a cost study to establish suitable conversion ratios to enable annual growth in services to be measured for:
    - both hospital and community-based services,
    - each of the four care types; and
    - subacute care as a whole.

    The conversion study is to develop resource weightings to be used to:
    - recalculate 2007/08 baselines, for reporting from 1 July 2010; and
    - measure growth against those baselines.
4. Identify suitable benchmarks for all subacute care types.
5. Develop business cases for the addition of new data items to existing National Minimum Data Sets (NMDSs) for ongoing reporting.

Appendix 1 – 2007/08 subacute care baseline activity

	Type of care				
	Rehabilitation	**Psychogeriatric Care**	**Geriatric Evaluation and Management**	**Palliative Care**	**Totals**
	Admitted				
Separations (patients)					
Hospital based	25,094	264	1,764	8,402	35,524
Hospital-in-the-home	0	0	0	0	0
Total admitted separations	25,094	264	1,764	8,402	35,524
	Non-admitted				
Occasions of service (volumes)					
Centre based	426,787	33,914	252,796	265,789	979,286
Home based	44,025	5,237	47,950	154,521	251,733
Other (please specify)	9,004	1,512	38,722	2,647	51,885
Total centre & home based occasions of service	479,816	40,663	339,468	422,957	1,282,904
Total group sessions	32,626	1,271	17,177	2,427	53,502
Total occasions of service					1,336,406

Notes and definitions

- All HITH in NSW at present is regarded as acute care provided in the community.
- NSW Health classifies non-admitted occasions of service by 'clinic type'. For the purpose of reporting baseline data, NSW Health has mapped clinic types to the four subacute care types.
- NSW is unable to report episodes of non-admitted care.
- Further work has been undertaken since the first Plan (May 2009) to ensure that only relevant activity is included in the baseline data. This has resulted in amended baseline data being presented in this Plan.

Data item	**Meteor ID or other definition**
	Admitted
Admitted patient	268957
Separations	327268
Care type	270174
Patient day	270045
Hospital-in-the-home	327308
	Non-admitted
Non-admitted patient	268973
Episode	N/A to NSW
Group Session	A group service is provided where a group of non-admitted patients who are not members of the same family receive any health care service(s) directly from an employee/s of a service unit of a health care facility and a record is made of the occasion showing the nature of the service(s) and the number of participants.
Care type	270174 (this is the admitted definition and does not apply to NSW)
Occasion of Service	313837

Appendix 2 – 2009/10 to 2012/13 growth

National Partnership Agreement on Hospital and Health Workforce Reform
Subacute care reform component — Plan to enhance Subacute Services

Year	Patient type Unit of measure for services	Admitted Separations[1]	Non-admitted NAPOOS[2]	Combined Bed Day Equivalents[3]	State-wide strategies: care types to be grown and the modes of care to be emphasised (e.g. out-patient rehabilitation, admitted GEM, etc.). Consideration of regional aspects and regional service provision should be discussed where appropriate.
2009-10	Services in 2007-08	35,524	1,336,406	692,045	
2009-10 2010-11	Targeted growth for 2 years			70.935 BDEs (5% + 5% compounded)	In the first 2 years (2009/10 and 2010/11), NSW will deliver 5% plus 5% compounded growth on 2007/08 baseline data ie an additional 70,935 BDEs by the end of 2010/11. It is expected that a number of the strategies to be implemented will have a lead time of 6-12 months. Strategies to enhance subacute services across care types and settings are outlined in the body of the document. Each AHS will contribute to the compounded growth target of 21.55% for subacute care activity in NSW.
2011-12	Services in 2010-11			762,979	
2011-12	Targeted growth for year			38,149	
2011-12	Targeted growth (%)			5%	
2012-13	Services in 2011-12			801,128	
2012-13	Targeted growth for year			40,056	
2012-13	Targeted growth (%)			5%	In summary, over the 4 years, NSW will deliver an additional 149, 140 BDEs across the different care types and settings

1 To convert separations to bed day equivalents (BDEs), separations are multiplied by ALOS (15.01 days in NSW)
2 In NSW, based on cost, 1 admitted bed day is equivalent to 8.41 NAPOOS.
3 Bed Day Equivalent (BDE) is unit of measure used to describe combined admitted and non-admitted activity for the purposes of measuring growth in total subacute care activity.

Appendix 3 – Conversion methodology

NSW will convert both separations and occasions of service to bed day equivalents (BDEs) to enable activity in admitted and non-admitted settings to be added. Growth in service activity in NSW will therefore be measured and reported as BDEs.

Admitted activity methodology
NSW will report separations, and will convert separations to BDEs using the average length of stay across the four care types.

NSW has used NSW Health cost data as it is comprehensive expenditure data for admitted subacute care. It has not used NHCDC admitted data, as this is based on the 2007/08 SNAP data and only 48% of SNAP admitted data is costed after matching expenditure to activity in district and larger hospitals.

Non-admitted activity methodology
Cost data for non-admitted activity is limited, therefore NSW has used an indicative occasion of service price of $82 for non-inpatient services based on the NSW Health Schedule of Fees for 2007/08. The NHCDC does not contain non-admitted cost data. As noted elsewhere (NSW discussion paper), per capita non-admitted subacute care services differ significantly between the states and territories.

Conversion methodology

Service	Cost/Unit ($)	Conversion factor
Subacute care		
Admitted[1]	$691	**8.4**
Non-admitted[2]	$82	

[1] Weighted bedday cost based on level of admitted activity by care type in 2007/08 (source: NSW Health cost data)
[2] Indicative price for non-admitted OOS (source: NSW Health Schedule of Fees 2007/08).

In determining the weighted bedday cost, NSW reviewed the admitted activity across the 4 care types to arrive at the following activity weightings.

Activity weightings 2007/08, admitted activity (beddays)

Care type	Proportion
Rehabilitation	74.7%
GEM	18.4%
Palliative care	2.8%
Psychogeriatric care	4.1%