Greenwich Health Campus Vision

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Executive Summary

The transformation of Greenwich Hospital into a specialised care campus will meet the growing health and aged care needs of the region's ageing population. The campus will provide an integrated and accessible model of care, welcoming patients, residents, visitors and the wider community to access specialist services including: inpatient and outpatient palliative care, rehabilitation, older persons' mental health, dementia care, restorative care, supported seniors' living, and emergency and short-term respite.

These integrated services will be provided flexibly to meet people's needs through a mix of day clinic services and short, medium and long-term accommodation options. This vision will transform a hospital facility suitable for the 1960s into a health campus able to meet the needs of the ageing population into the 2060s.

Who Are We?

Established in the 1930s, HammondCare is an independent Christian charity specialising in the provision of palliative care, rehabilitation, older persons' mental health services and dementia care. HammondCare is dedicated to supporting people who are financially and socially disadvantaged; our mission is to improve quality of life for people in need. Over time HammondCare has developed new services in order to meet peoples' changing needs. These services now include:

Subacute hospital services: HammondCare is an **affiliated health organisation dating back to 1907.** At any one time we currently support up to 170 people through inpatient services across three subacute hospitals in Sydney, 50 per cent of whom are public patients. We also provide specialist palliative care, end of life care and symptom management through in-reach, community and outpatient services, including an end-of-life in-home support service in metropolitan and rural areas of NSW. HammondCare's Centre for Learning and Research in Palliative Care has developed a palliative care training program for aged care workers delivering end-of-life care.

Residential Aged Care: HammondCare supports around 1,300 people in **residential aged care** across NSW and Victoria, more than two thirds of whom are living in expert designed dementia-specific homes, and over 45 per cent of whom are financially or socially disadvantaged. We operate Special Care Programs for people displaying severe and psychological symptoms of dementia.

Community aged care: on any given day, HammondCare cares for approximately 5,000 people living in their own homes, including people living with dementia, people transitioning home from hospital, and people requiring short term and episodic respite care.

Serviced seniors' living: HammondCare offers close to 300 villas and units to older people living in NSW. In accordance with our charitable purpose, 15 per cent of our seniors' living dwellings are provided to people with low means or low assets. All our seniors living villages are integrated with residential aged care, home care services and in some cases, with day respite, allied health and general practice.

Research and Positive Ageing Services; HammondCare's Centre for Positive Ageing and Wellness conducts research and partners with our services to **translate the latest research** into practice in the areas of ageing, restorative care and reablement, palliative care, rehabilitation and pain management. The **Dementia Centre** provides research, education and advice to the broader aged care sector. It leads the Dementia Support Australia partnership which provides consultancy services to carers and the health and aged care sectors in how to best support Australians with behavioural and psychological symptoms of dementia. This service, which includes the Commonwealth-funded Dementia Behaviour Management Advisory Service and the Severe behaviour Response Teams programs, is internationally unique.

The evolution of Greenwich Hospital

In March 1966 Greenwich Hospital was opened to provide inpatient palliative care and general subacute services to the local community. Since then, the hospital has developed a range of new services to meet community needs including: rehabilitation, specialist cancer rehabilitation, pain management services, older persons' mental health and outpatient services. At times it has provided long-term residential aged care for people living with dementia, as well as short term accommodation for country patients and their family members receiving treatment at Royal North Shore Hospital. Greenwich Hospital has further extended its reach through the development of specialist research and training centres, contributing to the health sector's understanding of best-practice pain management and palliative care through independent and collaborative research projects.

From its inception the mission of Greenwich Hospital has been to meet identified need in northern Sydney. However, despite numerous upgrades to address structural issues and the institutional character of the building, the Greenwich Hospital building is no longer fit for purpose and needs replacing. The need to redevelop the hospital has presented an opportunity to reassess the projected needs of the hospital's catchment area and to consider how best to provide specialist care to the people of Northern Sydney into the future.

In evaluating current services at Greenwich Hospital, HammondCare has recognised that traditional models of sub-acute service provision are not best placed to meet the emerging needs of the ageing Northern Sydney population. Siloed health services provide disjointed care which is unable to flexibly meet the changing needs of people with complex health needs. For this reason, HammondCare has drawn on evidence-informed models of sub-acute care, recommendations from health and aged care policy reviews and inquiries as well as local, state and commonwealth government health and ageing strategies to inform the development of this innovative health campus.

In response, our vision of care for Greenwich Hospital is predicated on the understanding that future health and aged care services must be flexible to people's needs and choices. Our vision for an integrated health campus incorporates a range of specialised services on the current hospital grounds, streamlining care to improve the experience for all people accessing services on the site.

This paper explores the current and future needs of the hospital's catchment area and articulates how the vision for an integrated health campus will meet those needs.

The need for change

Although Greenwich Hospital is recognised for excellent service delivery and quality of care, the current buildings are approaching the end of their usable lifespan and need to be replaced. The needs of the population the hospital serves have also changed, along with our understanding of best-practice care. In 2017-18 Greenwich Hospital admitted 2,910 patients, providing close to 28,000 inpatient bed days. Staff provided over 31,000 instances of care to outpatients, and more than 2,400 community visits were conducted.

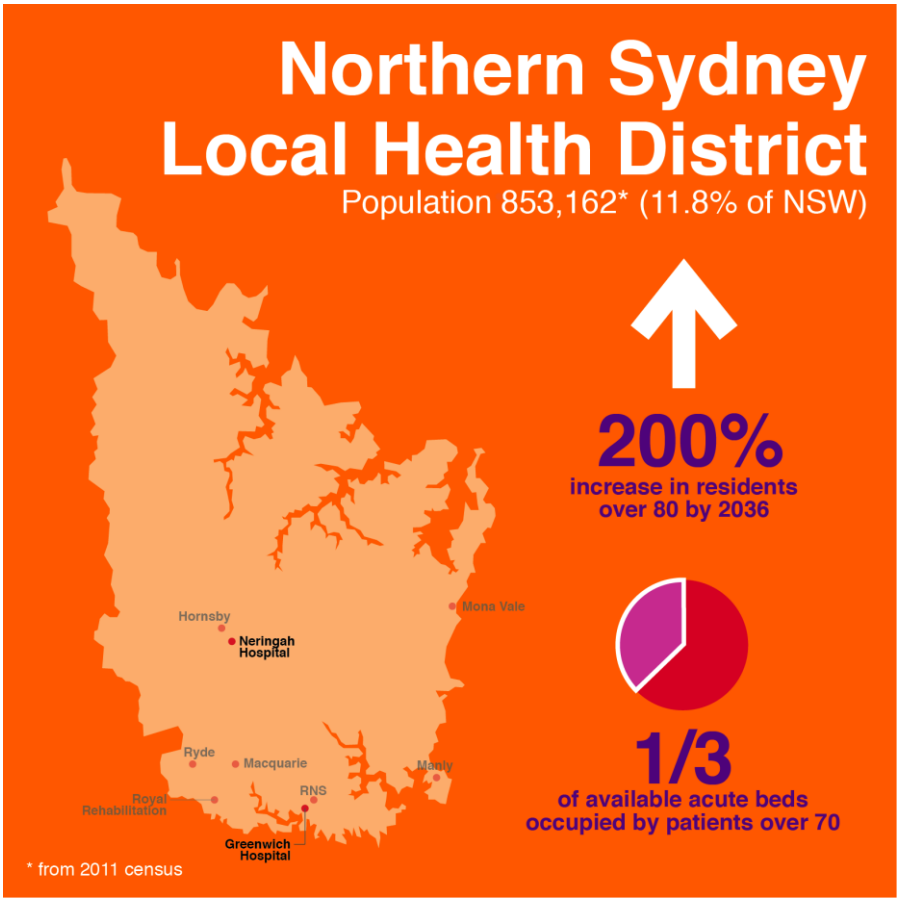
The redevelopment of the hospital will increase the number of service types available on-campus and will triple HammondCare's capacity to provide on-site care. Respite care, residential aged care, and supported seniors' living accommodation will be added to existing services and it is anticipated that the combined services will over time more than triple the number of people able to receive health and aged care services from Greenwich – whether as an in-patient, out-patient, aged care resident or community member receiving services in their own home.

Demographics and demand

Australia's population is ageing as never before and this trend will continue to at least the middle of this century. Even though older Australians are enjoying more years of good health, we will still experience a growing prevalence of age-related health conditions.

By 2057, more than a fifth (22 per cent) of Australia's population will be aged over 65 compared to just 15 per cent today. The fastest growing segment of the population is the over 85 bracket and it is expected that this group will make up 1 in 20 Australians by 2050 – compared to around 1 in 50 today. With every year that passes, older people will be more prominent and visible in Australian society.[1]

In Northern Sydney, the ageing of the population is even more acute than national projections. By 2031, close to 20 per cent of the population will be aged 65 or older and the population of people aged 80 years and older is projected to double by 2036.[2] The Northern Sydney Local Health District (NSLHD), which is the catchment area for the hospital's public patients, has highlighted the significant population increase of people aged 65 and older, noting that this population are the most frequent users of health services.



[1] Australian Government, 2010. Australia to 2050: future challenges – the 2010 intergenerational report OVERVIEW, Canberra, p.5.
[2] New South Wales Government, 2017. NSLHD Draft Strategic Plan 2017-2022, Sydney, p.7. Retrieved from https://www.nslhd.health.nsw.gov.au/AboutUs/StrategicPlan/Documents/Strategic%20Plan%20Draft%20.pdf

Understandably, the LHD is concerned about the availability of aged care services and places to support timely discharge from acute care as approximately one third of all available acute beds in the LHD are occupied by patients over the age of 70.[3]

People aged 85 and over are the biggest users of sub-acute and healthcare services (Figure 1) and people aged 65 and over are the largest demographic presenting at emergency departments in NSW and throughout Australia.[4]

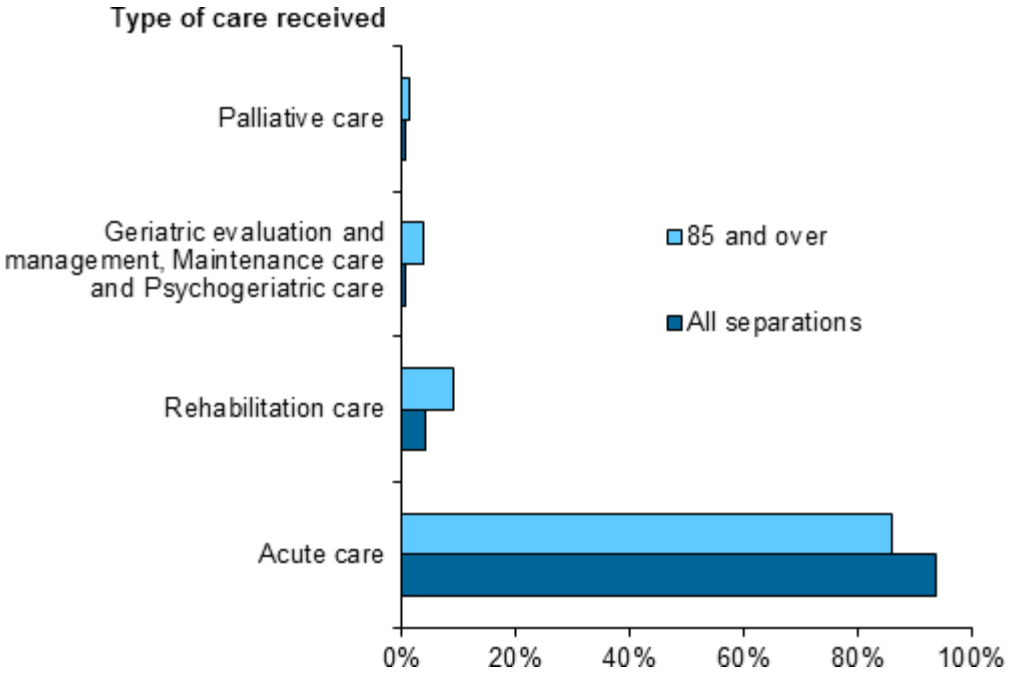


Figure 1: People aged 85+ are greater users of sub-acute services than other demographics[5]

The ageing population ought to be celebrated as a triumph of public health and advances in medical care. On average, men aged 65 in 2015 could expect to live 9.2 years without disability, 7 years with some level of disability, and 3.4 years with a severe or profound limitation. Similarly, women in 2015 could expect to live 10 years without disability, 6.7 years with some limitations, and 5.6 years with a severe or profound limitation.[6] Older people will require more complex care and support to cope with the health and medical conditions associated with older age.

Even though older Australians are enjoying more years of good health, we will still experience a growing prevalence of age-related health conditions. Like many developed nations, Australia is experiencing increasing rates of chronic and complex health conditions.

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[3] New South Wales Government, 2017. NSLHD Draft Strategic Plan 2017-2022, Sydney, p.8, 10. Retrieved from https://www.nslhd.health.nsw.gov.au/AboutUs/StrategicPlan/Documents/Strategic%20Plan%20Draft%20.pdf
4 https://www.aihw.gov.au/reports/hospitals/emergency-dept-care-2017-18/contents/use-of-services/variation-by-age-and-sex
[5] https://www.aihw.gov.au/reports/hospitals/hospital-care-for-patients-aged-85-and-over-2014/contents/summary/what-type-of-care-did-patients-aged-85-and-over-receive
[6] Australian Institute of Health and Welfare,2017. Life expectancy and disability in Australia: expected years living and without disability. Accessed via: https://www.aihw.gov.au/reports/disability/life-expectancy-and-disability-in-australia-expected-years-living-with-and-without-disability/contents/table-of-contents

Nearly all people aged 65 or older have a least one long-term condition while almost half (49 per cent) of all Australians aged 65-75 have five or more long-term conditions. This rate increases to 70 per cent for those aged 85 and over.[7]

The number of Australian who die each year is expected to double in the next 20 years.[8] This will increase the need for high quality palliative care services. While approximately 60 to 70 per cent of Australians would prefer to die at home, only 14 per cent currently do so. 54 per cent of Australians die in hospital and a further 32 per cent die in residential aged care.

The growth in demand for health and aged care services requires new approaches to meet increasingly complex needs while making the most of limited resources.

Changes to the Healthcare System

These demographic changes provide a strong impetus to improve the way health services are delivered. Although Australia's healthcare system meets high standards, it is characterised by fragmentation and a lack of communication.[9] Over the past decade, increasing focus has been turned on the role of integrated health models with an emphasis on preventative and restorative care.

Health accounts for close to a third of the NSW state budget and ongoing demand pressures will require more cost-effective methods of delivering health services. Resource scarcity and the ageing population will dictate that acute hospitals will have to be for acute patients only, while non-acute patients will be supported in other locations, not least their own homes.

Studies evaluating preventative and integrated models of care delivery have shown that, when operated well, such models can result significant savings to government though improved system efficiencies (reduction in Potentially Preventable Hospital admissions [PPH] and cost savings) and user outcomes , particularly for people with complex and chronic needs (quality of life, reduced risk of hospital borne diseases and infections).[10] Evidence indicates that the integration of sub-acute, aged care and rehabilitation will alleviate burden on acute hospitals and reduce the number of PPH, which the Australian Institute of Health and Welfare state accounted more than 2.8 million bed days during 2016 – 2017.[11] In the Northern Sydney Primary Health Network alone, 8,068 of every 100,000 hospital admissions for people aged 65 and over were deemed to be PPH, had their care needs been better addressed at an earlier stage.[12]

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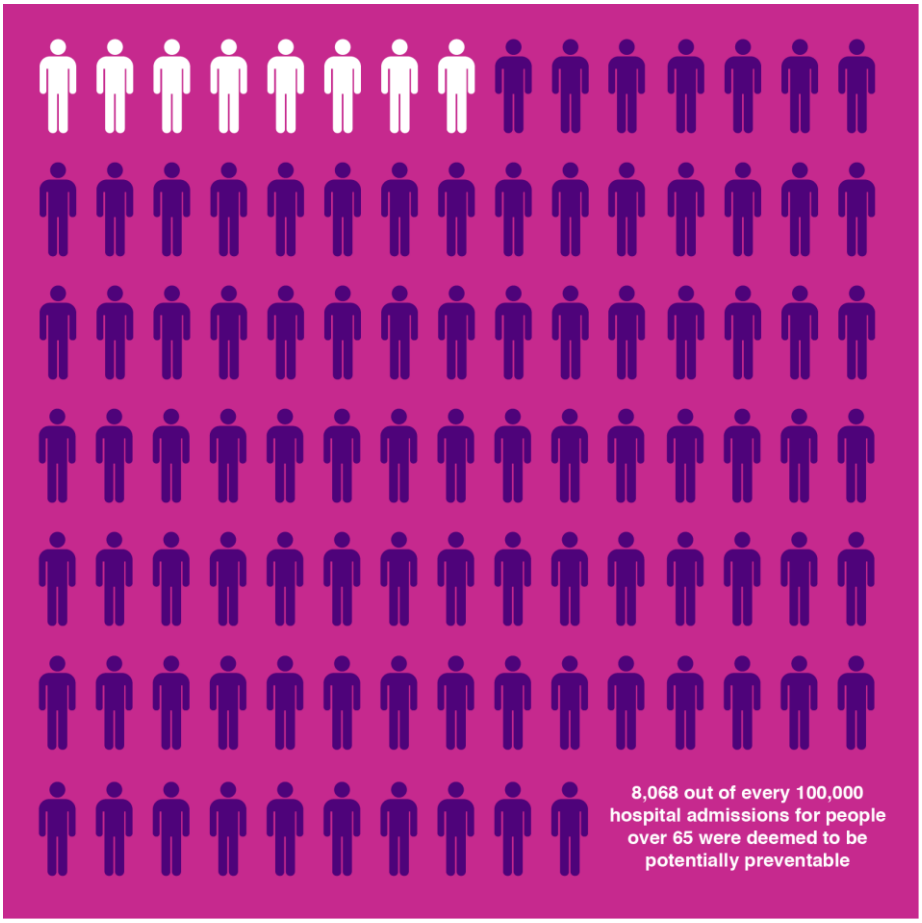
[7] Australian Institute of health and Welfare, 2012. Australia's health, 2012: The thirteenth biennial report of the Australian institute of Health and Welfare. Canberra. p.108.
[8] Swerissen H, and Duckett S, 2014. Dying Well. Grattan Institute p.2.
[9] Australian Healthcare and Hospitals Association, 2017 https://ahha.asn.au/event-reports/preventable-hospitalisations-think-tank-may-2017
10 L, J. C., J, O. D., Carnell, K., Critchley, A., Curry, R., Cutter, M., … Pegram, R. (2006). Australian Primary Health Care the University of Queensland. Governance An International Journal Of Policy And Administration, (September).
[11] https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations/contents/overview
[12] Australian Institute of Health and Welfare, 2016-2017 https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations/data



From HammondCare's own experience, there is strong and growing demand for non-institutional health and aged care services. Over the past five years, we have opened four separate residential aged care homes, each one based on small scale, domestic and familiar design principles, for example, including fresh cook domestic kitchens at the heart of each home, providing easy access to outdoor living areas, and limiting the size of each home to a small group of residents. These same enabling design principles, which will be in used in the design of all future services at the Greenwich Health Campus, were the subject of an academic study that found significant total health savings and improved quality of life associated with this model.[13] While Greenwich Hospital has undergone renovations to reduce the institutional feel of the environment and include more family-friendly spaces, the redevelopment will circumvent the limitations imposed by the building's current shell and layout.

HammondCare's community services, including home care packages, flexible, day and overnight respite, and Short-Term Restorative Care programs (STRC), have experienced significant growth over the past five years. In 2014 HammondCare At Home provided community-based services to 1,700 people, which has grown to over 5,000 in 2019. The

[13] Dyer, S. M., Liu, E., Gnanamanickam, E. S., Milte, R., Easton, T., Harrison, S. L., … Crotty, M. (2018). Clustered domestic residential aged care in australia: Fewer hospitalisations and better quality of life. Medical Journal of Australia, 208(10), 433–438. https://doi.org/10.5694/mja17.00861

range of care needs, and the acuity of those needs, have also grown, with clients and their carers managing increasingly complex health conditions at home. We have noted clients' growing preference to remain living in their own homes for as long as possible, and a willingness to explore new models of care that will help them do this. This trend of community service growth is confirmed by the data: nationally, home care services grew by 16 per cent in FY 16/17, compared to residential aged care which grew by 0.97 per cent.[14]

Government consultation and HammondCare's own experience shows that people are seeking services that are flexible, responsive to their *individual* needs, and which can be delivered in familiar surrounds – often in their own homes. Older Australians are increasingly eschewing traditional, institutional services in favour of alternative models of care delivery. The early hearings of the Royal Commission into Aged Care Quality and Safety have supported this preference while also highlighting the importance of access to quality clinical care. The transformation of the Greenwich Hospital site presents a prime opportunity to provide specialised, quality clinical care while also delivering individual and social dividend, saving the health system significant costs through integrated care.

[14] ACFA 2019, Seventh report on the Funding and Financing of the Aged Care Industry, Aged Care Funding Authority, Canberra.

Integrated Care: Case Studies

A small yet growing number of studies have been conducted over the past 20 years, exploring the effect and outcomes of integrated care across varying health domains and outcomes. Below are three case studies, one from an Australian context, one from an international pilot, and one from HammondCare's own experiences, that illustrate some of the benefits of integrated care models.

1. International case study: improving care integration for older people at risk of emergency hospital admission

In 2008, the English Department of Health commissioned a number of healthcare providers to address the fragmentation of health care services, particularly for older people, through the development and implementation of integrated care services. Six of these solutions focused on providing integrated care to elderly people who were deemed to be at-risk of emergency hospitalisation with the aim of achieving more personal, responsive care and better health outcomes. Their theory was that the provision of high-quality care in the patients' own homes could improve care and reduce the need for specialist intervention and emergency hospital admission. All patients who were deemed to be at-risk were assigned a case manager, usually a nurse, who worked to integrate the person's primary care with appropriate secondary and social care. The outcomes of these pilots varied – outpatient attendance and elective admissions dropped, which resulted in a net reduction in combined inpatient and outpatient costs, even though emergency admissions did not decrease. Patients with case managers were more likely to be told they had a care plan, felt that follow up arrangements after discharge were clearer and that they knew who to contact. Patients also reported that they were less likely to be given the wrong medication. They did, however, say that they were less likely to be given choice about which doctor or nurse they were able to see, which is a good piece of feedback to consider for the integrated services at Greenwich. Staff who participated in the pilot programs were very positive in their assessment of patient outcomes, and indicated that their own sense of engagement and job satisfaction increased as they saw patient outcomes improve.[15]

2. NSW case study: Central Coast Integrated Care Program (CCIP)

In 2014 the Central Coast Local Health District (LHD) partnered with public and private health entities to become one of three integrated care demonstrator sites in NSW testing new ways of providing health care. It is important to note that this project is still ongoing, however, the

[15] Roland, M., Lewis, R., Steventon, A., Abel, G., Adams, J., Brereton, L., … Ling, T. (2012). Case management for at-risk elderly patients in the English integrated care pilots: Observational study of staff and patient experience and secondary care utilisation. *International Journal of Integrated Care*, *12*(JULY-SEPTEMBER 20).

following findings are published in an evaluation report outlining key learnings to date.[16] The program aimed to develop a person-centred integrated care system, moving away from reactive models of care for people with high needs towards a model of anticipatory care. Three key groups were identified for the CCIP: vulnerable young people, vulnerable older people and people with chronic and complex conditions. The CCIP team had a central operational leader and were co-located. Managers shared a central administration and was structured to work collaboratively with key partners outside the LHD. The report found that progress has been made in refocusing and tailoring care to best meet the needs of individuals and their family members. It also found that general health literacy has improved and there has been a notable improvement in the organisations' ability to work collaboratively and provide interdisciplinary care. While further information on health outcomes is pending, it is useful to note the importance of shared common goals, strong leadership and communication for the successful implementation of integrated care

3. HammondCare case study: continuity of care at Hammondville

Bob and Jane moved into a seniors' living villa at HammondCare's Hammondville site when both were in their late 70s. The move was initiated after Jane experienced a broken hip and Bob had a serious medical crisis with myeloma. It was a comfort to them and their family that their new home incorporated accessible design features to help them navigate their new environment, that there was a nurse call system in case of emergency, and the small gardens were maintained for them. Once they had settled into the community, they found it easy to build relationships with like-minded people, and often enjoyed meals at the community café and visited the gym to improve their mobility. Both Jane and Bob enrolled in *Arts on Prescriptions* classes and Jane, who had always loved arts and crafts, thrived in this artistic approach to wellbeing. Bob had never painted but discovered he had his own style. Through the classes they met new people and grew in confidence. Walking around the campus to the visit the GP or the dentist not only saved on bus and car travel, but was another opportunity to exercise and socialise with their neighbours. The exercise physiologist from the *Centre of Positive Ageing* guided them to build strength and mobility, and Sunday morning church in the on-site chapel provided another chance to get out of their house and meet friends.

After several years, despite remarkably better health than when they arrived, the effects of ageing began to increase and so the community care team, HammondCare At Home, started providing flexible support. With time, Jane's dementia progressed and she applied to the waiting list for the residential dementia care home, also on site. This care home was very familiar to Bob and Jane as they were accustomed to visiting friends from the seniors' living community who had moved there. Bob regularly visited friends in palliative care, which is

[16] Dalton, H., Read, D., Handley, T., Booth, A., Davies, K., Goodwin, N., … Perkins, D. (2018). Central Coast Integrated Care Program Formative Evaluation Report. In *Centre for Rural & Remote Mental Health*.

also located on site, something that would not have been possible if he had been living further away. Throughout this time, family were able to visit regularly with Jane and Bob, and so by the time Jane was living in a dementia-specific residential aged care cottage and later, when Bob went into palliative care, it all felt like home. Family knew their way around, were on first name basis with many staff, and felt relieved that their parents and grandparents' needs were so carefully attended to.

Model of care and objectives for the Greenwich Health Campus

Figure 2: Artist's impression of Greenwich Health Campus

All HammondCare's services are underpinned by a model of care[17] that clearly articulates a methodology of care which focuses on the individual, their relationships and ensuring the care environment and our staff ensures comfort, maximises choice and care in a way that nurtures the whole person; physically, emotionally and spiritually. This same model will inform all care and service delivery at the Greenwich Health Campus.

[17] Figure 3

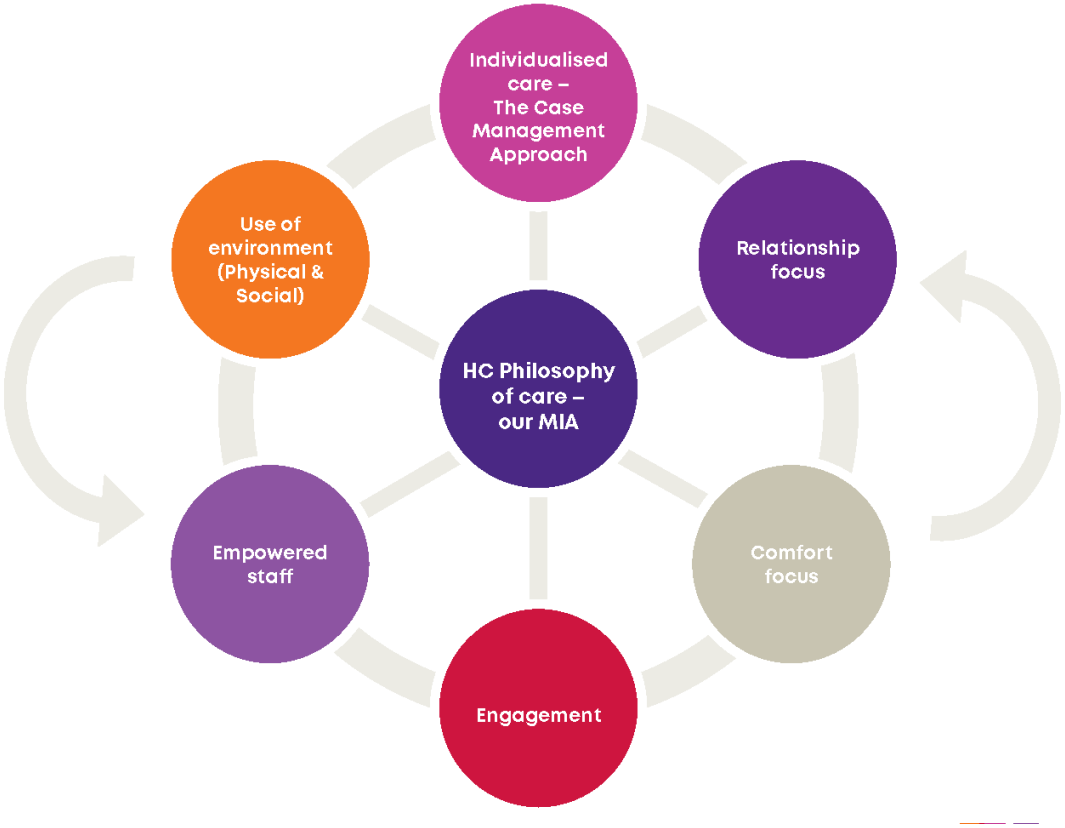


Figure 3: HammondCare's Model of Care

Individualised Care: we devote time and energy to getting to know and understand each patient, resident and client. We partner with the person and their family to understand and tailor care to best meet their needs.

Relationship focus: staff strive to build and sustain positive working relationships with each other, care recipients *and* their families. It is only *through* these relationships that we can deliver high quality care.

Comfort focus: we aim to be consistently aware of and prioritise the physical, emotional, spiritual and social comfort of care recipients, based on holistic and ongoing assessment of each individuals' needs.

Life engagement: staff encourage and support care recipients to be involved *as the individual chooses* with activities that bring meaning, pleasure, contentment and/or purpose to their life.

Empowered Staff: we trust and support our staff to work flexibly and imaginatively to meet the needs of those they serve.

Use of environment (physical and social)**:** we are mindful of the important role a person's environment can play in supporting dignity, maximising independence and autonomy and promoting feelings of comfort, safety and security.

Grounded in this model of care, the proposed Greenwich Health campus will be underpinned by five objectives to ensure services will:

1. Be person-centred, providing individualised and holistic care regardless of the person's level of ability, function or need.
2. Offer people choice about how and where they receive care: services will be provided to people in their homes, in outpatient clinics, as short-stay inpatients, or as a long-term resident.
3. Meet demonstrated need through the provision of integrated, specialised care by linking the following services: palliative care, older persons' mental health services, dementia-specific residential aged care, community aged care, rehabilitation services, transition care services, and positive ageing and restorative care programs.
4. Be committed to a preventative and restorative approach to treatment delivery to help people to live independently in their own home, or a supported homelike environment, for as long as possible.
5. Be provided in appropriate and therapeutic built environments to support independence and function.

All HammondCare services are unified by the overarching mission to improve the quality of life for people in need, whether they are being supported to live independently in their own homes, or at end of their life in an inpatient setting. Likewise, all the services provided at the Greenwich Health Campus will have this same purpose. The services will be structured to offer a continuum of care which can be accessed by people as and when appropriate for their individual care needs. The integration and range of the specialist services that will be provided will provide local residents with the opportunity to remain living within their community and maintain social connection.

These specialised services will include:

Palliative Care

Greenwich Hospital's current palliative care services – inpatient, outpatient, community-based and in-reach – will remain unchanged. High quality, compassionate palliative and end of life care will continue to be provided, however, the integration of residential aged care, supported seniors' living and the community aged care team will provide HammondCare with the ability to extend this expertise and support into these other areas. Staff specialists, such as palliative care nurses and physicians will extend their services cross-campus, broadening in-reach services to include care for people living in the supported seniors' homes or the residential aged care home, as well as the potential to create a palliative care-specific residential unit. We anticipate that this integration and sharing of staff expertise will help reduce the number of potentially preventable hospital admissions, increase the number

of people able to die in a setting of their own choice and increase the confidence and capacity of other staff to provide a palliative approach to care.

The Centre for Learning and Research in Palliative Care, which conducts research into best-practice palliative care will continue its role at the Greenwich Health Campus, integrating current academic research with the services operating on-site to improve care delivery and outcomes.

Rehabilitation and preventative health care

The Greenwich Health Campus will continue to provide specialist inpatient and outpatient rehabilitation services, catering for people with:

- a neurological diagnosis (e.g. stroke) with functional problems
- a cancer diagnosis and cancer treatment
- mobility and functional problems after falls, fractures and any musculoskeletal impairment
- significant impairment after any medical and surgical illness

A team of resident multidisciplinary health professionals will deliver these services and will include physicians, nursing staff, physiotherapists, dietetics and clinical psychologists. Care will extend beyond the hospital bounds, with comprehensive discharge planning to help people transition into their homes in the community or to the supported seniors' living accommodation. The Rehabilitation team will work closely with the Centre for Positive Ageing to ensure a restorative and reablement approach is integral to service delivery. Rehabilitation specialists will be available to provide services on an as-needed basis to residential aged care residents, including access to the onsite hydrotherapy pool and rehabilitation gym. Staff will collaborate with family members to ensure individualised and sensitive care is provided.

Older persons' mental health

The current Riverglen unit provides specialist services for older people in the acute phase of a mental health disorder. This includes comprehensive multidisciplinary assessment, treatment and management with the aim of supporting people to transition back into the community. This service will continue to be provided at the Greenwich Health Campus with the added benefit of a range of on-site discharge options. The staff team includes psychiatrists, nurses, allied health staff and consulting geriatricians. These staff will be further supported by the dementia and behaviour management expertise held by the residential aged care staff who often care for people with behavioural and psychological symptoms of dementia.

Dementia-specific residential aged care

Residential aged care will be provided in a purpose-built environment, especially designed for people living with dementia. Internationally recognised dementia-design principles will inform the design of the small-scale cottages and apartments, with a focus on creating non-institutional, homelike environments that provide opportunities for residents to continue to

participate in the rhythms and routines of everyday life. The proximity of the residential aged care home to inpatient rehabilitation and palliative care services will allow for greater cross-service expertise sharing and service provision, helping to reduce the rate of unnecessary transition to hospital. Dementia Australia and the AIHW have both recently highlighted the adverse effect of hospitalisation for people living with dementia *and* their carers, citing increased risk of adverse hospital events, increased levels of distress and increased carer burden.[1819]

Supported seniors' living

Recognising that a sense of choice and independence is critical to quality of life, dedicated supported seniors' living will be an important element of the Greenwich Health Campus. Bridging the gap between general community living and residential aged care, this long-term accommodation option will provide social and clinical support for older people who choose not to live in the general community. This may be due to a lack of family support – the number of lone-person households is increasing[20], particularly in the catchment area for the Greenwich Health Campus, or because they require specialised care but still want to live as independently as possible. People living in this accommodation will be able to receive in-home rehabilitation services, including cancer rehabilitation, in-home aged care support including clinical support and, if needed, dementia-specific care. HammondCare's Centre for Positive Ageing will provide in-home and on-campus group programs to improve function and provide an opportunity to socialise with other residents of the campus. These programs currently run at other HammondCare sites and include:

- Arts on Prescription, a program where professional artists work alongside older people to explore creativity and learn new skills. https://www.youtube.com/watch?v=OEzx4y13zEc
- Eat Well, Live Well, a program that helps people prepare nutritious and delicious food and is delivered by an interdisciplinary team of allied health professionals.
- Smooth Moves, a program that assists older people to maintain balance and strength
- I Can Do That, a program to help people stay healthy and active including guidance on managing personal care, meal preparation, public transport and everyday tasks like going to the supermarket.

[18] Dementia Australia. (2019). *Hospital Care for People Living with Dementia*. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=55615222&site=ehost-live

[19] Australian Institute of Health and Welfare. (2019). *Hospital Care For People With Dementia 2016-17*. Retrieved from https://sa.fightdementia.org.au/sites/default/files/SA/documents/Hospital Care for People With Dementia Conversations 2014.pdf

[20] Australian Bureau of Statistics, 2010. Australian Social Trends, Australian households: the future, Canberra, p.3. Retrieved from: www.abs.gov.au/socialtrends

Too often peoples' first experience of health and aged care services occurs during a crisis.[21] The provision of supported seniors' living will help mitigate this, promoting a preventative and reablement approach to ageing.

Respite care

On-site and community-based respite will be provided to offer a break to carers of people with complex and chronic conditions, and people living with dementia. Timely access to respite care is recognised as a critical element of good health and aged care provision, and it is important to recognise the beneficial impact of respite for carers.[22] A multipurpose, stand-alone respite centre will provide flexible and emergency respite – both day respite and overnight respite. The service may be accessed by people living in the local community whose need a break from their caring role, or by people living in the supported seniors' living community who likewise require additional support to care for their loved one. Flexible arrangements will be available to people in receipt of sub-acute services who may need to access residential, overnight or day respite. Community-based respite will be available and delivered by HammondCare At Home, HammondCare's community services team.

Community aged care

Linking with inpatient and aged care services, HammondCare's Northern Sydney community services team will operate within the Greenwich Health Campus, providing care and support services to older people living in the general community and the supported seniors' living service. Using a care management approach, they will deliver transition care services – helping people to transition back into their home environment after a hospital episode, and will offer private care and flexible respite care while partnering with the onsite staff specialists and allied health teams to ensure clients receive timely and appropriate care.

Conclusion

HammondCare recognises that older people are significant users of Australia's health system and will need a wide range of specialised care to meet their needs as they age. The Greenwich Health Campus will offer an integrated continuum of services targeting those care needs. The integrated nature of the campus will increase the opportunities for access, flexible service delivery and offer older people choice about how, when and where they would like to receive their care. As the health and aged care sectors grapple with system fragmentation, HammondCare views the redevelopment of Greenwich Hospital as an opportunity to implement an evidence-informed, best practice model of service delivery – in the words of HammondCare's Chief Medical Director, older people should not have to 'bounce between

[21] Australian Government Department of Health. (2016). *Aged Care Roadmap How will the formal and informal Why Australia needs an Aged Care Roadmap*. Canberra.

[22] Carers Australia. (2018). Improving access to aged residential respite care. (February).

the place where they live and …[the] hospitals and allied health services they need.'[23] This vision takes a hospital facility suitable for the 1960s and transforms it into a health campus able to meet the needs of the ageing population into the 2060s.

[23] Lake, M. (2013). *Faith In Action: HammondCare*. Sydney: NewSouth Publishing, University of New South Wales Press Ltd. p.333.