SESLHD

Primary Integrated and Community Health

SESLHD Context

Tony Jackson A/Director

Primary Integrated and Community Health

July 2019

OUR SESLHD CONSUMERS

Information source: Vulnerable and priority populations in South Eastern Sydney Local Health District[33]

930,000
People live within our District

By 2027 The population is projected to grow by 20% to 1,022,000 people

ABOUT **8,720**
RESIDENTS OR 0.9% OF OUR POPULATION IDENTIFY AS ABORGINAL

30%
OF OUR POPULATION WERE BORN IN NON ENGLISH SPEAKING COUNTRIES

37%
of our population have long term conditions

395,000 PEOPLE
SPEAK A LANGUAGE OTHER THAN ENGLISH

TOP 3 LANGUAGES SPOKEN ARE
MANDARIN (67,034)
CANTONESE (33,797) &
GREEK (30,824)
EMERGING COMMUNITIES INCLUDE
NEPALESE SPEAKING (9,812) &
BENGALI (5,817)

21% of our population
live with multiple morbidities increasing to 82% for those aged 85 and over

6.9%
of our population have diabetes

7,945
BABIES BIRTHED IN OUR FACILITIES

15% of our population is over 65 years

10% of the population over the age of 15 years are carers with 80% of the carer population being women.

In 2016 the number of people in SESLHD with a disability was estimated at
100,350

20% of NSW's homeless persons reside in SESLHD

IF WE DON'T CHANGE, BY 2027 WE WILL HAVE

112,500 (50%)
more Emergency Department presentations

21,685 (20%)
more acute admissions

a need for 480
additional acute beds

Health
South Eastern Sydney
Local Health District

Vulnerable and priority populations

in South Eastern Sydney Local Health District

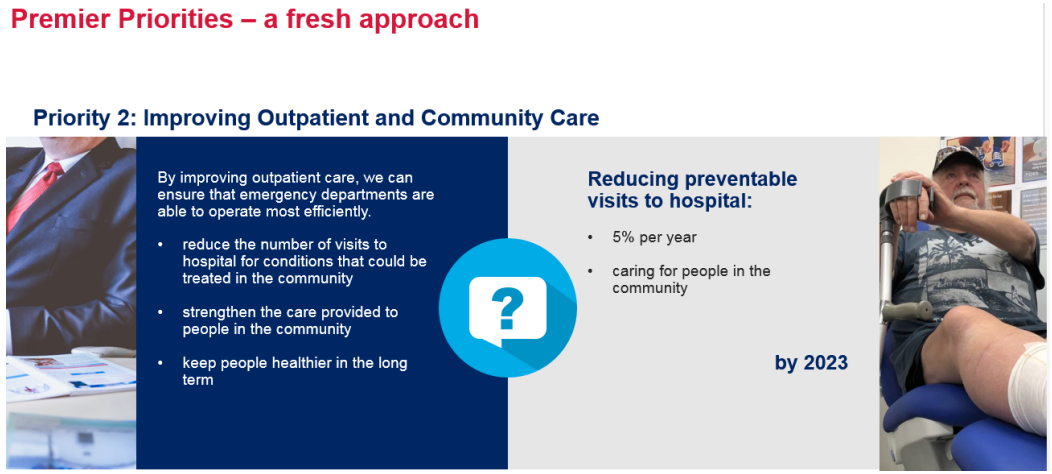
Analysis of ABS Census 2016

Population Profile

APRIL 2018

NSW GOVERNMENT

Planning Context



South Eastern Sydney Local Health District

Journey to Excellence Strategy 2018 – 2021

"Exceptional care, healthier lives

Our strategic priorities

SESLHD STRATEGY

South Eastern Sydney Local Health District Journey to Excellence Strategy 2018-2021

Our Purpose:

To enable our community to be healthy and well; and to provide the best possible compassionate care when people need it.

Our vision:

Exceptional care, healthier lives

Safe, person-centred and integrated care

Everyone in our community will have access to safe, compassionate and high quality healthcare. That care should be provided either at home, or as close to home as possible

- Decrease the hospital standardised mortality ratio by **5% each year**
- Increase the number of staff using systems to review data
- Decrease adverse events by **10% each year**
- Improve patient satisfaction of care by **20% each year**
- Reduce emergency department presentations by **5% each year**
- Decrease the percentage of patients admitted to the emergency department by **5% each year**

Workforce wellbeing

We will create an environment where our people will be accountable and can be happy, well and supported to reach their potential

- Increase percentage of staff who recommend SESLHD as a place to work by **10% each year**
- Increase percentage of staff who recommend SESLHD as a care setting by **10% each year**
- Increase the number of staff who have had a performance review by **10% each year**
- Decrease absenteeism by **5% each year**
- Reduce workers compensation claims by **10% each year**

Better value

We will deliver value to our patients and community through maintaining financial sustainability and making investments consistent with our vision

- Increase the number of hours given back to patients and the community e.g. reduce waiting times/reduce number of visits
- Shift care into the community or outpatient settings
- Operate within the budget allocated to the organisation

Community wellbeing and health equity

We will work together with our partners to achieve health, wellbeing and equity for our shared communities

- Increase community reporting of good health by five percent (proportion of population self-reporting health as "good" or 'better")
- Increase the number of children reaching developmental milestones at 18 months and four years by five percent.
- Reduce discrepancies in median age of death between geographic areas and priority populations
- Decrease the rate of preventable hospitalisations due to long-term and vaccine-preventable conditions by five percent

Foster research and innovation

We will focus on translating research and innovation into clinical service models that deliver positive health outcomes

- Increase staff participation in research/innovation education and training
- Increase references to research/ innovation outcomes based in SESLHD in the media
- Increase overall research/ innovation funding
- Increase the number of translational research projects
- Increase the number of SESLHD submissions to innovation awards
- Increase the number of projects that use SESLHD Big Data

930,000
People live within our District

37%
of our population have long term conditions

98,281
ADMISSIONS
TO ADULT Medical Acute, Surgical & Mental Health per year

2019-20 SERVICE AGREEMENT

AN AGREEMENT BETWEEN:

Secretary, NSW Health

AND THE

South Eastern Sydney Local Health District

FOR THE PERIOD

1 July 2019 – 30 June 2020

NSW GOVERNMENT Health

Summary of Indicators and Targets for 2019-20 Service Agreements

Strategic Priority	Safety & Quality Framework Domain	Measure	Target	Not Performing X	Under Performing ↘	Performing ✓	ID
Strategy 1: Keep People Healthy							
1.1	Effectiveness	Childhood Obesity – Children with height and weight recorded (%)	70%	<65%	>=65% - <70%	≥70%	MS1102
1.2/1.6		Smoking During Pregnancy – At any time (%):					
	Equity	• Aboriginal women	Decrease from previous year	Increase on previous year	No change	Decrease from previous year	PH-013A
	Equity	• Non-aboriginal women	Decrease from previous year	Increase on previous year	No change	Decrease from previous year	SPH007
	Effectiveness	Pregnant Women Quitting Smoking - By second half of pregnancy (%)	4% increase on previous year	<1% increase on previous year	≥1% and <4% increase on previous year	4% increase on previous year	DPH_1201
1.3	Efficiency	Hospital Drug and Alcohol Consultation Liaison - number of consultations (% increase)	Per cent increase on 2018-19 baseline	>=10% decrease from 2018-19 baseline	<10% decrease from 2018-19 baseline	Maintain or increase from 2018-19 baseline	PH-015A
1.4	Effectiveness	Hepatitis C Antiviral Treatment Initiation – Direct acting - by LHD residents: Variance (%)	Individual - See Data Supplement	<98% Target	>=98% and <100%	>=100%	PH-014C
1.6	Effectiveness	Get Healthy Information and Coaching Service - Get Healthy in Pregnancy Referrals (Number of referrals)	Individual - See Supplement	<90%	>=90% - <100%	≥100% target	PH-011C
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First							
2.1	Safety	Hospital Acquired Pressure Injuries – Rate (Rate per 10,000 episodes of care)	Individual - See Data Supplement				KS2114
	Safety	Fall-related Injuries in Hospital – Resulting in fracture or intracranial injury – Rate (Rate per 10,000 episodes of care)	Individual - See Data Supplement				KS2115
	Safety	Healthcare Associated Infections – Rate (Rate per 10,000 episodes of care)	Individual - See Data Supplement				KS2116
	Safety	Hospital Acquired Respiratory Complications (Rate per 10,000 episodes of care)	Individual - See Data Supplement				KS2117
	Safety	Hospital Acquired Venous Thromboembolism – Rate (Rate per 10,000 episodes of care)	Individual - See Data Supplement				KS2118
	Safety	Hospital Acquired Renal failure (Rate per 10,000 episodes of care)	Individual - See Data Supplement				KS2119
	Safety	Hospital Acquired Gastrointestinal Bleeding (Rate per 10,000 episodes of care	Individual - See Data Supplement				KS2120
		Hospital Acquired Medication Complications					

What is Integrated Care ?

Integrated care represents an organising principle for care delivery that aims to respond to the "quadruple aim" and to contribute to reducing hospital demands. It is effectively two inter-related activities that put the person at the centre of care:

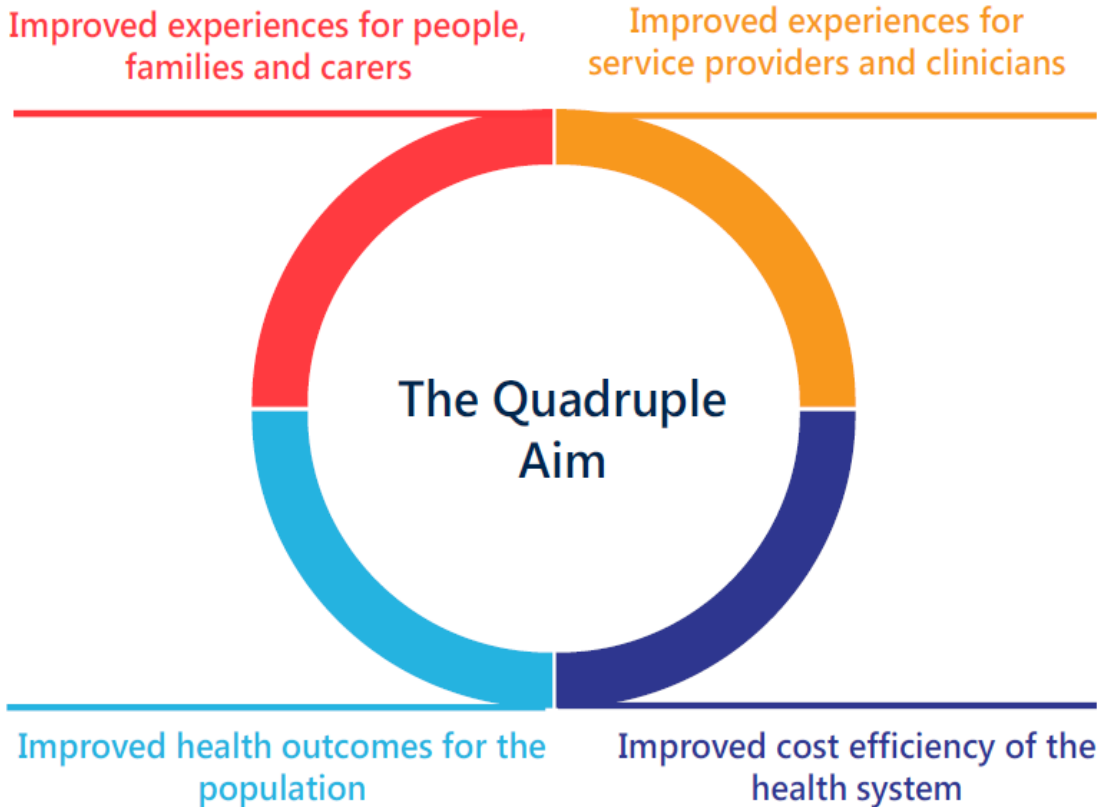
1. Creating a seamless patient experience / journey throughout the health service.
This is the remit of the health service in general as articulated in the NSW State Health Plan (Direction 3: Delivering truly integrated care) and the SESLHD Journey to Excellence (Safe Person Centred and Integrated Care)

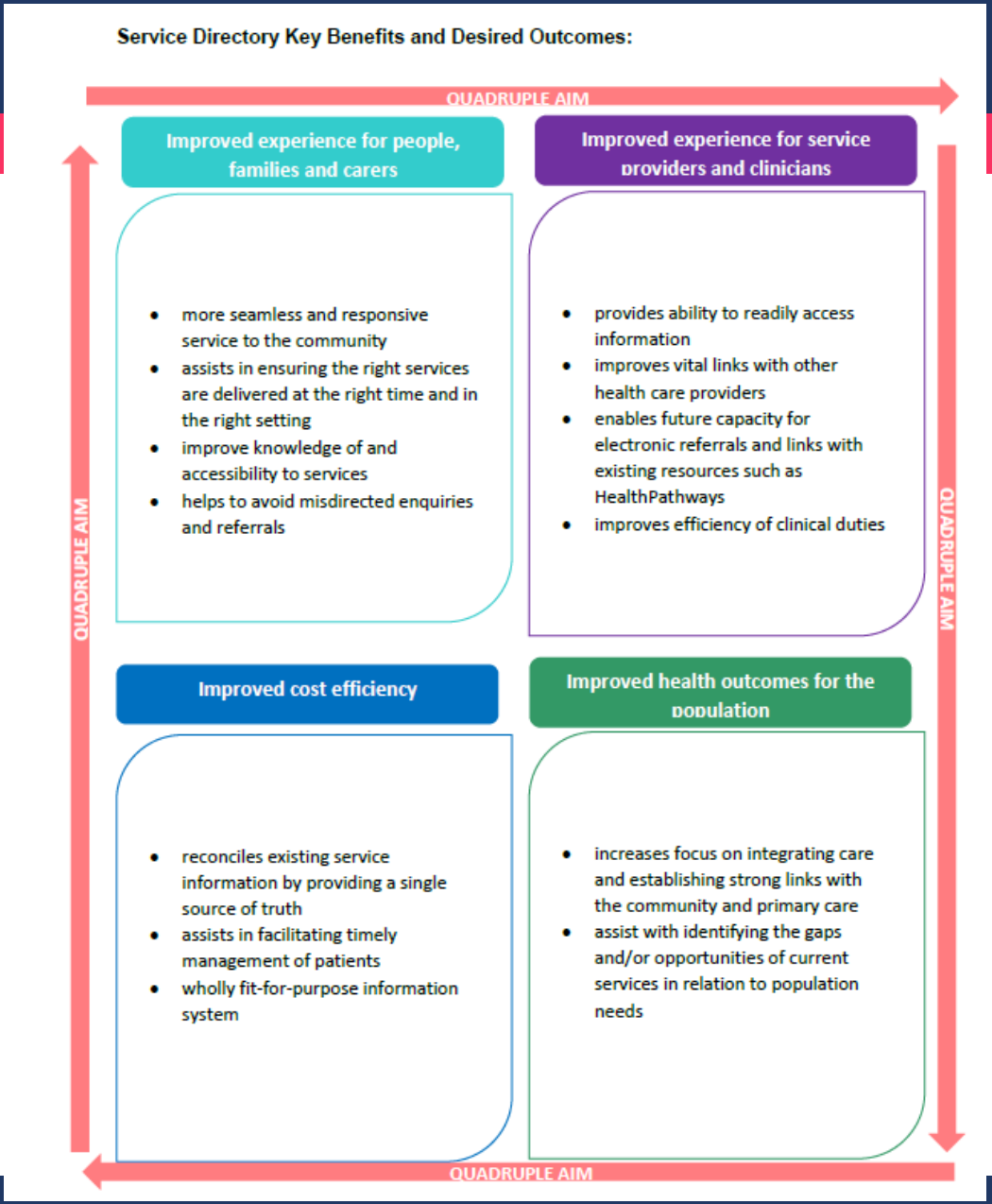
2.Providing holistic (or "wrap around") care to an identified cohort of vulnerable people with complex conditions.
This is the focus of the SESLHD Integrated Care Unit. Identified cohorts include vulnerable people with complex, chronic ("long term") conditions and Aboriginal people. In working with these cohort through its care coordination programs, the Integrated Care Unit aims to link people with the services they need to live well in the community. While this involves linking people with the health care they need, it also extends beyond this to connect people with social care and working with primary care to strengthen community based services.

NSW Health Strategic Framework for Integrating Care

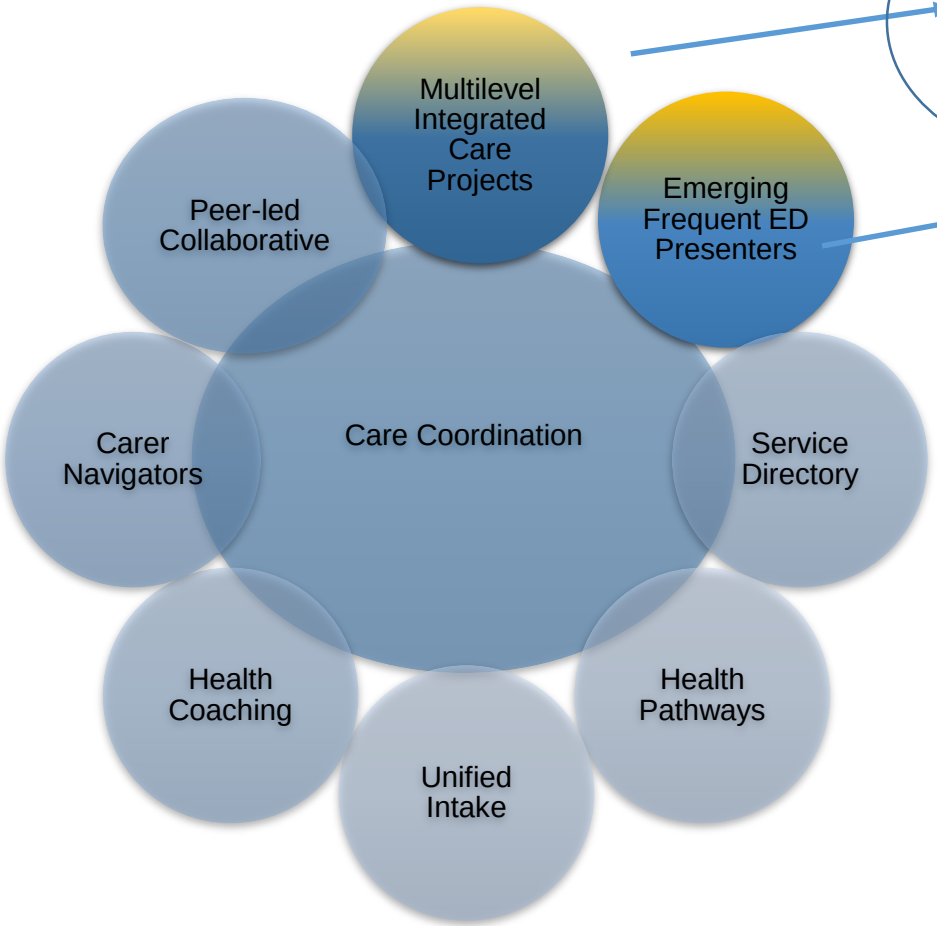
- Aligned with NSW Health's move towards value-based health care
- System-wide approach, encompassing population health, acute, non-acute and community services
- Focuses on creating greater efficiencies in service delivery

Value-based health care is centred on the quadruple aim




Service Directory Key Benefits and Desired Outcomes:
QUADRUPLE AIM
Improved experience for people, families and carers
more seamless and responsive service to the community
assists in ensuring the right services are delivered at the right time and in the right setting
improve knowledge of and accessibility to services
helps to avoid misdirected enquiries and referrals
Improved experience for service providers and clinicians
provides ability to readily access information
improves vital links with other health care providers
enables future capacity for electronic referrals and links with existing resources such as HealthPathways
improves efficiency of clinical duties
QUADRUPLE AIM
QUADRUPLE AIM
Improved cost efficiency
reconciles existing service information by providing a single source of truth
assists in facilitating timely management of patients
wholly fit-for-purpose information system
Improved health outcomes for the population
increases focus on integrating care and establishing strong links with the community and primary care
assist with identifying the gaps and/or opportunities of current services in relation to population needs
QUADRUPLE AIM

Focus Areas



ED to Community	Residential Aged Care	Vulnerable Families	Specialist Care in Primary Care	Paediatrics Network
• Reducing ED attendance for frequent users	• Targeted support for Residential Aged Care settings	• Community support for vulnerable parents and children	• NSW Health outreach to Primary Care	• Reducing travel burden for regional paediatric patients

The next horizon for the Integrated Care Strategy

IC- ED to Community

IC- Residential Care

IC- Vulnerable Families

IC- Specialist Outreach in Primary Care

IC- Paedriatric Network

Collaborative Commissioning

Value

Horizon 1:
Demonstrators and Innovators – seeding innovation in Integrated Care

Horizon 2:
Scaling what works: moving from innovation to standardisation

Horizon 3:
Focus on harnessing value through integrating care in the community: integrating across providers, organisations and settings

Time

Centre for Primary Health Care and Equity Research Priorities Forum

Sydney Local Health District

Presenter: **Lou-Anne Blunden**

Executive Director,
Clinical Services Integration and
Population Health

16 July 2019

NSW GOVERNMENT Health Sydney Local Health District

Integrated and collaborative care: Flagship Programs

Living Well, Living Longer	Healthy Homes & Neighbourhoods	IC for People with Chronic Conditions Xtend workers
Better Pathways to Housing Healthy Strong communities	Healthy Families, Healthy Children	HealthOne @ Green Square Primary Care Academic Unit
Sydney Institute for Women, Children & their Families	Residential Aged Care Outreach	Place-based Hubs

Current Activities in Primary Health Care/integration of health care in SLHD

- Healthy Strong Communities
- Implementing first 2000 days framework
- Diversity Hub in Population Health (57 cultural support workers)
- A healthy and resilient Waterloo (Forums; HIA; Healthy Living Program Manager)
- Cross Agency Homelessness Plan
- Sydney Dental Hospital holistic approach to addressing complexity
- Diabetes Information Hub MOU SESLHD SLHD CESPHN
- Regional Mental Health Plan with PHN

NSW GOVERNMENT Health
Sydney Local Health District

Current Issues being faced in PHC integration/equity of services in SLHD

- Co-commissioning - MoH new direction for community health
- Partnerships maintaining through leadership and policy direction changes
- Medication errors/compliance - transition from Acute to Primary – XTend showing 43% patients had medication issues/confusion post discharge
- Lack of linked community nursing data
- New cross agency programs being introduced and understanding impact e.g. *Their Futures Matter, Home and Healthy*

NSW GOVERNMENT Health Sydney Local Health District

Research ideas

- eMEDs/ if MBS items are consistent/GP follow up/ readmissions/ characteristics of people who fill or don't fill prescriptions/ number of meds/etc
- Anything useful we can do with PSS access data? Correlation between uptake and poor health outcomes?
- Quantum of superannuation upon retirement
- Given already research informing first 2000days is there any point asking about their childhood? Any trauma in first 5 years etc
- Oral Health putting the mouth back into health

phn
CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Research Priorities in Primary Care

Dr Michael Moore Chief Executive Officer
Dr Brendan Goodger General Manager for Primary Care Improvement

Central and Eastern Sydney PHN

Overview

The Plan: What we will do...

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Our Vision: Better health and wellbeing

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Our vision is better health and wellbeing of the people who live and work across our region. We recognise that this is a long-term, collaborative vision and that results may not be demonstrable within the life of a plan.

Strategies that will ultimately contribute to individual and population health outcomes including:

- Fewer preventable deaths
- Fewer preventable hospitalisations
- Reduced health risks such as smoking, alcohol and drug use and overweight/ obesity
- Reduced health inequities
- More prevention behaviours such as immunisation and cancer screening

To achieve our vision, we focus on:

- People and places experiencing disadvantage and inequities
- Complex issues in service provision e.g. Ageing, mental health, social determinants of health
- Prevention and earlier intervention including a focus on wellbeing and resilience.

How we work

We are an agent of change

We respond to local needs

We support primary health

Key Research Priorities

- Has the implementation of **PIP QI** achieved improvements in the quality of patient care?
- What are the **returns of investment** to the health system from programs being implemented by CESPHN?
- What strategies are most effective in promoting **readiness for change** amongst health professionals?
- What proportion of patients are delivered the right care at the right time, at the right place? **Who is missing out and why?**
- What is the **base level of social connectedness** and well being necessary for a healthy community?
- How can we make better of use of **BIG data** to better understand patterns of service provision in primary care and drive system efficiency and improvements in patient care?

Contacts

For further information please contact either

- Dr Michael Moore CEO m.moore@cesphn.com.au
- Dr Brendan Goodger General Manager Primary Care Improvement b.goodger@cesphn.com.au