South Eastern Sydney Local Health District

Health Care Services Plan 2023-2033

NSW GOVERNMENT





This artwork is **'South Eastern Boundaries'** and depicts the lands and waterways of the Traditional Custodians of the South Eastern Sydney area.

The artwork is based on the South Eastern Sydney Local Health District boundary map and replicates the locations of the facilities from Sydney's Central Business District in the north to the Royal National Park in the south. The Meeting Places (circles within circles) represent The Sutherland Hospital, St George Hospital, Prince of Wales and Royal Hospital for Women, Sydney and Sydney Eye Hospital, Calvary Health Care and War Memorial Hospital.

The lines with dots represent the patient's journey from their homes, to and from the facilities where people access our healthcare services. The other symbols are the local Aboriginal Community Elders, Men, Women and Children who call the South Eastern Sydney area their country and home. The dark and light blue circles are the strong currents and waves which surround the beautiful coastline of the east coast. The assortment of coloured dot patterns are of the surrounding Aboriginal Nations which surround and connect all Aboriginal Nations and our people to each other in respect and harmony.

Artist: **Brenden Broadbent**

Acknowledgement of Country

South Eastern Sydney Local Health District would like to acknowledge the Traditional Custodians on whose land we stand, and the lands our facilities are located on: the lands of the Dharawal, Gadigal, Wangal, Gweagal and Bidjigal peoples.

We would like to pay our respects to the Elders past, present and those of the future.

We also acknowledge Aboriginal peoples' connection to country, culture and heritage.

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Foreword

We are pleased to present the South Eastern Sydney Local Health District Health Care Services Plan 2023-2033 (the Plan).

The Plan represents our commitment to continued improvement and innovation in the services we provide to the more than one million people of South Eastern Sydney. It demands a focus on equitable access regardless of location or circumstance, and sustainable models of care that put the patient at the centre. Recognising that our sites and services operate most effectively within a connected health system, the Plan highlights opportunities for collaborative and integrated service models both within SESLHD and with our service partners.

The Plan aligns with the priorities identified in *SESLHD's Exceptional Care, Healthier Lives Strategic Plan 2022-25*, which focuses on working in partnership, improving health and wellbeing outcomes, and transforming experiences. It also aligns with the NSW Future Health Report and demonstrates a commitment to the delivery of sustainable health services that consider the environmental impact of their delivery.

Over the next ten years, SESLHD will strategically allocate its resources to deliver on four key missions:

- Continuously improve care that optimises the patient experience and outcomes;
- Enhance care in the community;
- Deliver safe, integrated and comprehensive, person-centred care; and
- Develop models for the delivery of specialised services at scale.

The *South Eastern Sydney Local Health District Health Care Services Plan 2023-2033* was developed through a process of extensive consultation with key stakeholders including SESLHD staff, consumers and key service partners. Consideration was given to historical activity trends as well as population and patient-base demographics. The opportunities and priorities identified in the Plan seek to address changing community needs and expectations and to reflect emerging models of care and technology appropriate for sustainable services.

Tobi Wilson

Chief Executive

Executive summary

Year in the life of SESLHD

236,927

Emergency Department (ED) presentations

20,866

Personal Health Record (Blue Book) checks

1,723,637

Non admitted Occasions of Service (OOS)
(Activity Based Funding (ABF) and non ABF)

7,768

People hospitalised overnight due to falls

129,807

Acute care hospitalisations

187,425

Telehealth episodes for non-admitted care

46,416

Surgical care/intervention care hospitalisations

2,818

Mental health hospitalisations

13,976

Sub acute and non acute hospitalisations

1,526

Hospital in the Home episodes

36,980

Admissions from other LHD's

Data sources: SESLHD Clinical Insights & Analytics Team, SESLHD internal Dashboards.

Drivers for change

Shifting consumer expectations and patient empowerment

Consumers need the option to be more involved in decision-making about their own care. There is a drive for communities to be involved in co-design of services, and people to be able to receive care when and where they need it.

Emerging technology and virtual health

As technology is ever evolving, remaining informed and up to date is crucial to providing flexible models of care to support people's care needs. Delivering care virtually increases flexibility in service delivery and has the potential to improve equity.

A need for connected, collaborative services

With increasing complexity of care needed, accessing and navigating services is a challenge. In delivering holistic care to our consumers, there is a need for improved integration of health services across the system.

Future focused infrastructure

Infrastructure needs to be adaptable to accommodate the transformation in service delivery that will meet consumer needs now and into the future.

Increasing demand for services

We anticipate a continued increase in the demand for health services due to the cumulative effects of an ageing population, the increasing prevalence of chronic disease and an increase in the proportion of the population with multi-morbidities.

Priority populations

Across SESLHD there exists a significant disparity in access to health services and in health outcomes. It is imperative that service design considers the needs of our diverse population and that models of care reflect their collective needs.

Workforce demands and wellbeing

With a growing population and increasing demands for services, along with shifting consumer expectations and an ageing workforce, workforce development and sustainability is of paramount consideration.

Sustainable healthcare

In a setting of finite resources, there is a need for service design to consider the sustainability of services into the future in environmental and fiscal domains.

The Plan on a page

A leading integrated healthcare provider, trusted by individuals for the care and compassion we deliver

We shape equitable, person-centred care in partnership with communities	Our staff feel valued, respected and proud of the quality of their service	We are a global leader in innovative and sustainable health services

Exceptional care, healthier lives

Missions

SESLHD will strategically allocate its resources to deliver on these missions.

- Continuously improve care to optimise the consumer experience and outcomes
- Enhance care in the community
- Deliver safe, integrated and comprehensive, person-centred care
- Develop models for the delivery of specialised services at scale

Priorities

These are the areas where transformation needs to occur in each to achieve our vision.

- Empower our communities to manage their own health and wellbeing
- Facilitate access to our services
- Tailor our services for Aboriginal and Torres Strait Islander people
- Prioritise access for the most vulnerable in our community
- Design services that minimise environmental impact
- Provide innovative care that is driven by research

- Support people to access their care in the community
- Provide consistent opportunities for care across our community
- Develop culturally appropriate models of care
- Provide earlier supports to prevent the need to present to hospital
- Prevent readmission with transition to community support for patients

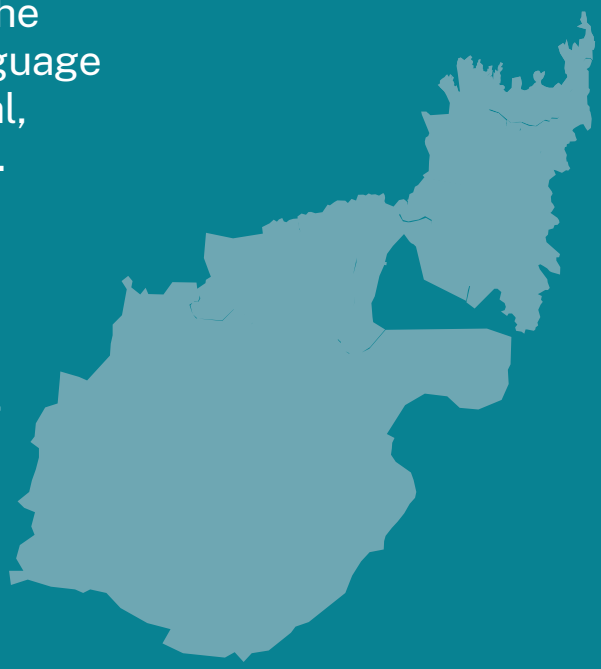
- Provide care for the whole person
- Prioritise the opportunities within the first 2,000 days
- Support the transition of adolescent and young people to adult health services
- Optimise care delivery in the last years of life

- Improve the delivery of care for people and communities through consolidation of appropriate services
- Embed whole of district models to support consistent access
- Foster a workforce that is responsive to the changing demands of the future

SESLHD Profile

The SESLHD geographical area is on the traditional lands of five Aboriginal language groups including the Dharawal, Gadigal, Wangal, Gweagal and Bidjigal peoples.

SESLHD provides a range of services across 468 square kilometres encompassing 7 Local Government Areas: Woollahra, Waverley, Randwick, Bayside, Georges River and the Sutherland Shire. SESLHD also provides a key role in supporting residents of Lord Howe Island.



Key points:

Population

902,904

1%

of people report identifying as Aboriginal or Torres Strait Islander

40%

of our residents are born overseas

34%

speak a language other than English

16%

of people who identify as homeless in NSW live in SESLHD

By 2033 our population is projected as being

1,002,560

30%

projected growth in people aged 70 years or older

37%

of people have long term health conditions

21%

live with multiple health conditions

11,191

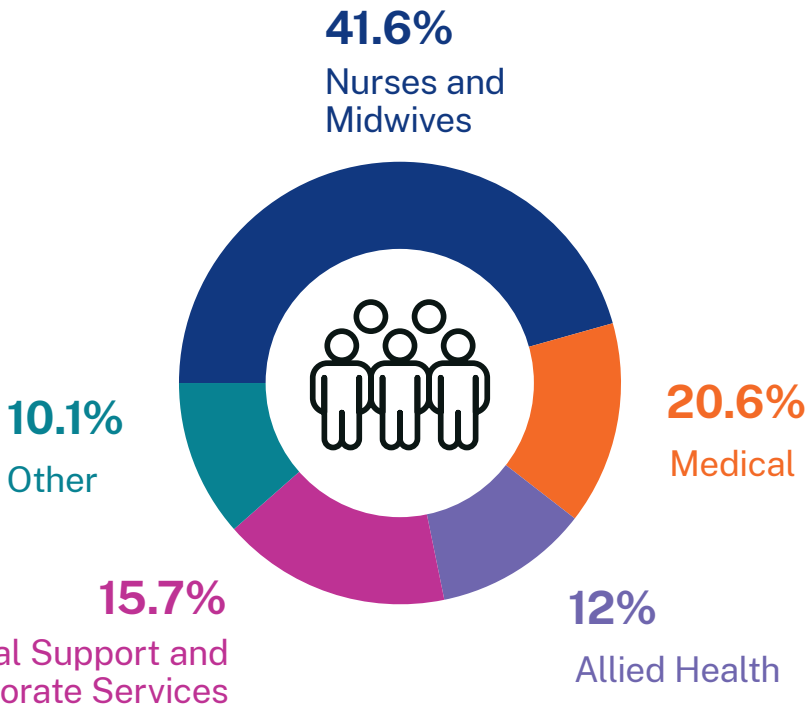
Babies born in SESLHD (2021/22)

Data sources: Australian Bureau of Statistics 2021 Census data, Public Health Information Development Unit (PHIDU), Ministry of Health (MoH), Clinical Services Planning Analytics Portal (CaSPA) Flowinfo v 22.0

Our services and facilities

Services offered across SESLHD include, but are not limited to, hospital and outpatient services, population health programs, community health, home based services, imaging and pathology.

Across the LHD we have approximately **13,571** staff which includes permanent and temporary staff and Visiting Medical Officers.



Within our LHD services are delivered from five major hospital and health service sites as well as a number of sub-acute and community facilities:

- Prince of Wales Hospital (Randwick)
- The Royal Hospital for Women (Randwick)
- St George Hospital (Kogarah)
- The Sutherland Hospital and Community Health Services (Caringbah)
- Sydney/Sydney Eye Hospital (Macquarie Street)
- Mental Health Services
- Population and Community Health
- Garrawarra Centre (Waterfall)
- Gower Wilson Memorial Hospital (Lord Howe Island)
- Calvary Health Care (Kogarah)
- Uniting War Memorial Hospital (Waverley)

PRINCE OF WALES HOSPITAL
(RANDWICK)

Prince of Wales Hospital (POWH) is a major tertiary, quaternary referral and teaching hospital providing excellent healthcare to South Eastern Sydney and specialist health and medical services to NSW. The facility provides specialty services in areas including hyperbaric medicine, neuroscience, emergency medicine, spinal medicine and cardiovascular care. POWH is affiliated with various Universities and premier medical teaching facilities which enables staff to provide excellence in healthcare in conjunction with quality clinical teaching and leading medical research. Services are provided in the inpatient, outpatient and community setting, including rural outreach services. POWH is the host for the LHD's virtual health hub.

THE ROYAL HOSPITAL FOR WOMEN
(RANDWICK)

The Royal Hospital for Women (The Royal) has been one of Australia's foremost specialist hospitals for women and babies, since its early beginnings as New South Wales first 'lying-in' hospital for women in 1820. The Royal is the only facility of its kind in NSW that provides a combination of primary, secondary, tertiary and quaternary services for women. The main areas of specialisation include breast care, gynaecology, gynaecological oncology, maternity, maternal fetal medicine, menopause, newborn intensive care and reproductive medicine. The Royal has an important role in leading models of care, research and advocacy on women's health issues, fertility, birthing and neonates, and work with vulnerable women with complex needs. Services are provided in the inpatient, outpatient and community setting.

ST GEORGE HOSPITAL
(KOGARAH)

The St George Hospital and Health Services is among the leading centres for trauma and emergency management in NSW. Services are provided in the inpatient, outpatient and community setting. The Hospital has a very high trauma load and accepts referrals from outside its immediate area. The hospital's areas of special expertise also include cancer services, critical care, cardiothoracic surgery and women's and children's healthcare. St George Hospital is a teaching hospital and a leader in clinical innovation in palliative care (Community End of Life Pathway) aged care (geriatric case management), and general medical models.

THE SUTHERLAND HOSPITAL
(CARINGBAH)

The Sutherland Hospital was established in 1958 and is a major metropolitan hospital and teaching hospital. The vast majority of activity is provided to the local residents of the Sutherland Shire. The Sutherland Hospital offers a comprehensive range of inpatient and outpatient and community based healthcare services including emergency, critical care, surgery, medicine, cancer care, aged care, rehabilitation, women and children's health, outpatients, medical imaging, pathology and community/health/home based care.

SYDNEY/SYDNEY EYE HOSPITAL
(MACQUARIE STREET)

With a campus on historic Macquarie Street Sydney & Sydney Eye Hospital (SSEH) is a tertiary and quaternary referral unit for hand and ophthalmology specialties. Offering quality healthcare to patients from all over NSW, the clinical wards include the Peri-Operative Suite, Surgical (for hand and eye patients) and General Medicine wards, supported by specialist services such as infectious disease, cardiology, endocrinology, and drug and alcohol. Services are provided in the inpatient, outpatient and community settings. Other clinical services offered include a 24hr Emergency Department, outpatient departments for general medicine, eyes and hand, including orthoptics and hand therapy services, allied health, pharmacy and pathology services.

MENTAL HEALTH SERVICE

SESLHD Mental Health Service provides quality mental health care for people experiencing acute and/or severe and complex mental health conditions within both hospital and community settings. Inpatient and community services are provided to people of all ages via geographically-delineated Eastern Suburbs Mental Health Service, St George Mental Health Service and the Sutherland Mental Health Service; as well as a range of intra and inter-LHD specialty services delivered in person and virtually.

POPULATION AND COMMUNITY HEALTH

The Population and Community Health (PaCH) Directorate provides a range of clinical and population-based services across the life-span, focussing on promoting health and wellbeing, preventing disease and minimising harm. PaCH services have a strong focus on addressing health equity and work closely with communities and local partners, including primary care providers, non-government organisations and other government agencies to improve access to care and health outcomes.

GARRAWARRA CENTRE
(WATERFALL)

Garrawarra Centre is a historic site, having been in operation since 1909 and serving many purposes during its history. Today, Garrawarra Centre is a Commonwealth accredited dementia specific facility located just south of Waterfall NSW, specialising in the care of people who have advanced dementia, displaying high risk behaviours and who require care in a secure environment. Garrawarra Centre provides a high standard of dementia specific care for the complex residents referred to the Centre.

GOWER WILSON MEMORIAL HOSPITAL
(LORD HOWE ISLAND)

SESLHD provides a key role in helping residents of Lord Howe Island by providing access to hospital and health services, including state-wide services. Gower Wilson Memorial Hospital caters for the residents and tourists on Lord Howe Island, and is the only medical/nursing facility on the Island. Complex cases are transferred to the mainland.

CALVARY HEALTH CARE
(KOGARAH)

As an affiliated organisation sitting within SESLHD, Calvary Health Care Kogarah public hospital provides Specialist Rehabilitation and Palliative Care Services to the local St George and Sutherland Shire regions and extensive Community Health Services to the St George region. Calvary Health Care Kogarah is a 3rd schedule public hospital and one of the largest sub-acute hospitals in NSW.

UNITING WAR MEMORIAL HOSPITAL
(WAVERLEY)

Owned and operated by Uniting, Uniting War Memorial Hospital (WMH) is a 3rd Schedule Aged Rehabilitation hospital, situated in Waverley. WMH specialises in aged rehabilitation and assessment, and pioneers a holistic approach to the health and wellbeing of people over 65. Services are comprised of inpatient care, outpatient departments, and specialist community teams. 24 hour accommodation service is available for regional guests as well as the full range of hospital support services.

Trends in activity

Emergency care

- SESLHD Emergency Departments treated 236,928 patients in 2022/23.
- Presentations have increased by 7.7 percent (16, 657 presentations) since 2016/17 with a compound average annual growth rate of 1.2%.
- Trends in Emergency Department (ED) presentations were impacted by the Covid 19 pandemic with a decrease in presentations reported in 2020/21. These numbers increased to pre-pandemic levels in 2022/23.
- In 2022/23, ambulance (and other emergency transport) arrivals accounted for approximately 23 percent of presentations (compared with 24 percent in 2016/17). Patients arriving by their own transport accounted for most of the growth in ED presentations, with over 64 percent of arrivals (compared to approximately 61 percent in 2016/17).
- Analysis by age group shows no overall change in the pattern of presentations, however, growth is strongest in the younger and older age groups. The proportion of presentations for people in the 20-35 year age bracket has decreased.
- On average, 30 percent of presentations to SESLHD Emergency Departments are admitted to inpatient care. Children are less likely to be admitted than adults or older people with an average admission rate of around 8.5 percent for children 0-14 years. Almost 62 percent of people aged 65 years and older presenting to ED are admitted to hospital reflecting the often chronic or complex health needs and co-morbidities.
- Following the Covid-19 pandemic there has been a significant increase in the numbers of patients leaving the ED before the commencement of treatment (Did not Wait) and before discharge is complete (Left at Own Risk). Further investigation into this increase is underway.

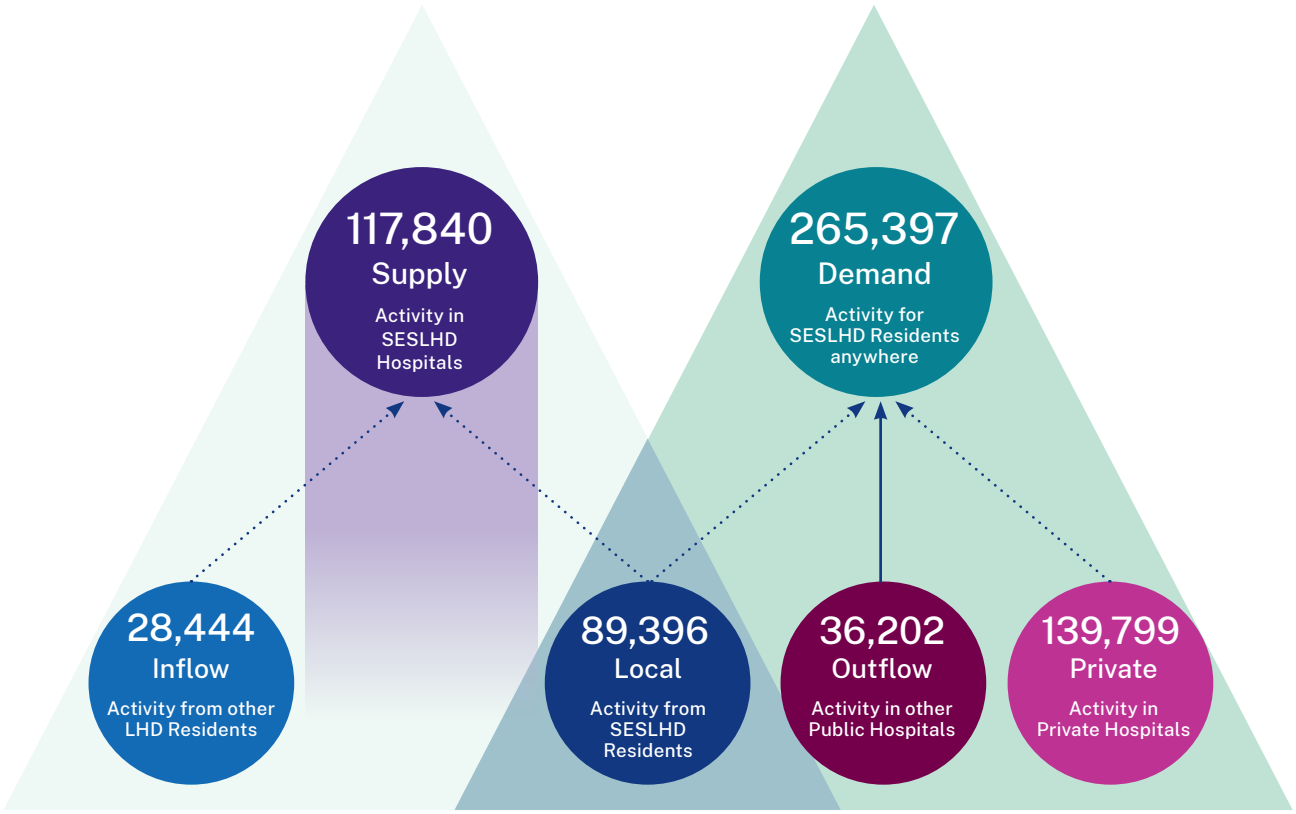
Table 1 - Emergency Department presentations 2016/17 – 2022/23

Triage Category	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Change n	Change %	Change annual
1	1647	1783	2024	1994	2086	2131	2222	575	34.9%	5.1%
2	22135	22845	24590	24004	26485	27884	30369	8234	37.2%	5.4%
3	88489	92931	102079	97802	102299	103036	106102	17613	19.9%	3.1%
4	85018	88454	88442	81523	81318	75726	81511	-3507	-4.1%	-0.7%
5	22498	22008	18485	37335	15913	16705	16657	-5841	-26.0%	-4.9%
N/A	280	240	166	67	50	58	67	-213	-76.1%	-21.2%
Grand Total	220067	228261	235786	242725	228151	225540	236928	16861	7.7%	1.2%

Source: Ministry of Health (MoH), Clinical Services Planning Analytics Portal (CaSPA) EDAA v21.0; SESLHD ED Dashboard.

Acute admitted care

Figure 1 - Acute episodes for SESLHD Hospitals and residents 2021/22



- In 2021/22 there were 265,397 acute hospital episodes for SESLHD residents of which 139,799 (52 percent) were in private hospitals, 89,396 (33.7 percent) were in SESLHD hospitals and 36,202 (13.6 percent) were in public hospitals outside SESLHD.
- SESLHD hospitals provided 28,444 acute episodes of care for patients residing outside SESLHD, equating to 24.1 percent of the total 117,840 episodes occurring.
- The average length of stay (ALOS) among all acute patients in SESLHD hospitals in 2021/22 was 4.1 days. ALOS was highest in the 0-4 years and 80+ age brackets at 5.4 days and 5.5 days respectively.
- The proportion of day only episodes has increased over the five years to 2021/22, from 28 percent in 2016/17 to 33 percent. This trend is expected to continue with an increase in care provided in the community and enhanced remote monitoring capabilities, reducing the need for extended hospital stays.

Table 2 - Trends in acute inpatient separations 2016/17 – 2021/22

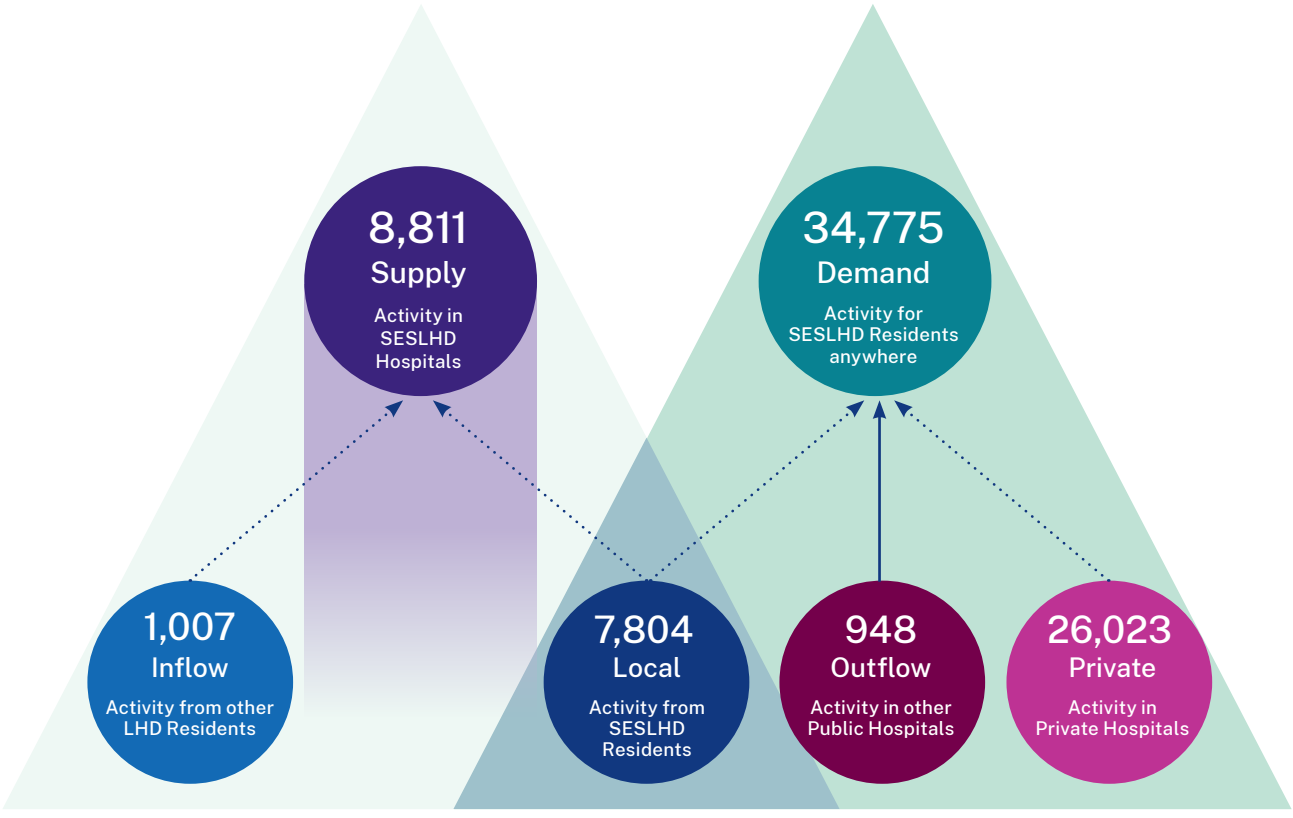
	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	Change n	Change %	Change av annual
Day Only Separations	32545	33914	39888	40824	49773	38774	6229	19%	3.0%
Overnight Separations	83607	83731	87610	84078	87858	78902	-4705	-6%	-1.0%
Total Separations	116152	117645	127498	124902	137631	117676	1524	1%	0.2%
Day Only Bed Days	32545	33914	39888	40824	49773	38774	6229	19%	3.0%
Overnight Bed Days	507578	511095	459817	431741	450291	440467	-67111	-13%	-2.3%
Total Bed Days	540123	545009	499705	472565	500064	479241	-60882	-11%	-2.0%
Day Only Av LOS	1.0	1.0	1.0	1.0	1.0	1.0	-		
Overnight Av LOS	6.1	6.1	5.2	5.1	5.1	5.6	-0.49		
Av LOS	4.7	4.6	3.9	3.8	3.6	4.1	-0.58		

Source: Ministry of Health (MoH), Clinical Services Planning Analytics Portal (CaSPA) Flowinfo v 22.0

Sub-acute care

Sub-acute care includes rehabilitation, maintenance and palliative care, along with some admissions for psychogeriatric care and non-acute mental health (the latter have been omitted from this analysis).

Figure 2 - Sub-Acute episodes for SESLHD Hospitals and residents 2021/22



- In 2021/22 there were 34,775 sub-acute hospital episodes for SESLHD residents of which 26,023 (74.8 percent) were in private hospitals, 7,804 (22.4 percent) were in SESLHD hospitals and 948 (2.7 percent) were in public hospitals outside SESLHD.
- SESLHD hospitals provided 1,007 sub-acute episodes of care for patients residing outside SESLHD, equating to 11.4 percent of the total 8,811 episodes occurring.
- The average length of stay (ALOS) among all sub-acute patients in SESLHD hospitals in 2021/22 was 14.9 days. This represents a significant increase compared to 2016/17. This reflects the reported difficulties discharging patients into appropriate settings due to limited medium term accommodation options and supports.

Table 3 - Trends in sub-acute inpatient separations 2016/17 – 2021/22

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	Change n	Change %	Change av annual
Day Only Separations	8698	8230	8029	7824	7418	2508	-6190	-71%	-18.7%
Overnight Separations	7394	7381	8086	7703	7446	6302	-1092	-15%	-2.6%
Total Separations	16092	15611	16115	15527	14864	8810	-7282	-45%	-9.6%
Day Only Bed Days	32545	33914	39888	40824	49773	38774	6229	19%	3.0%
Overnight Bed Days	101440	102724	107399	105234	102729	92651	-8789	-9%	-1.5%
Total Bed Days	133985	136638	147287	146058	152502	131425	-2560	-2%	-0.3%
Day Only Av LOS	3.7	4.1	5.0	5.2	6.7	15.5	0		
Overnight Av LOS	13.7	13.9	13.3	13.7	13.8	14.7	0.98		
Av LOS	8.3	8.8	9.1	9.4	10.3	14.9	6.59		

Source: Ministry of Health (MoH), Clinical Services Planning Analytics Portal (CaSPA) Flowinfo v 22.0

Non-admitted care

Non-admitted care includes outpatient services, community and home-delivered services.

Table 4 shows the number of service events in 2022/23 by National Tier 2 service category.

- A service event is defined as an interaction between one or more healthcare provider(s) with one non-admitted patient. To be recorded as a service event, these interactions which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record.
- Tier 2 service categories are divided into series 10 (procedures), series 20 (medical consultations), series 30 (diagnostic services) and series 40 (services provided by nurses and allied health practitioners). NB Procedures do not include in-centre renal dialysis, which is counted as admitted activity and considered separately.
- It is of note that not all community health consultations are reported through the non-admitted patient data system, for example mental health.

Table 4 - Non-admitted service events 2022/23 by tier 2 clinic type

Tier 2 Clinic Type						
Facility	**10 Series** Procedure	**20 Series** Medical Consultation	**30 Series** Diagnostic Services	**40 Series -** Allied Health and/or Clinical Nurse Specialist Intervention	**Total**	**% AH/Nursing**
Total	126733	422359	6257	638444	1193793	53.5%

Source: SESLHD Non-Admitted Patient (NAP) Dashboard.

Exclusions:
chemotherapy, day surgery, emergency department, medical imaging, mental health, pathology, pharmacy, renal dialysis, outpatient services focused on preparing a patient for admission

- In 2022/23 there were over 1.1 million non-admitted service events, equivalent to 3,000 per day.
- Allied health and nursing clinics accounted for over 53 percent of all service events.
- In 2022/23, approximately 74 percent of service delivery was in-person care, 13 percent was recorded as audio and 2.7 percent audiovisual.

Mental Health non-admitted care

- In 2022/23 there were 171,112 non-admitted service events delivered by mental health services across SESLHD.
- In 2022/23, approximately 31 percent of service delivery was recorded as in person care and approximately 32 percent recorded as audio.

Drivers for change

Increasing demand for services

We anticipate a continued increase in the demand for health services due to the cumulative effects of an ageing population, the increasing prevalence of chronic disease and an increase in the proportion of the population with multi-morbidities.

Our population is growing and the demand for health services is increasing. It is projected that by 2033 the SESLHD population will grow by approximately 8 percent to 1,002,560. The largest growth is expected for the City of Sydney (SESLHD portion) at an average of 1.7 percent per annum, Botany Bay at 1.6 percent per annum and Kogarah at 1.1 percent per annum. These growth projections mean that our current way of working is unsustainable. The increased demand will result in continued growth in waiting lists and further drive the need for improved efficiencies in the provision of services. We need to develop models of care that are innovative and flexible in order to meet the ever-increasing demand.

Our population is not just growing it is also ageing. Over the next 10 years, there is a projected 49 percent increase in the number of people aged 85 years+ and 27 percent increase in the number of people aged 70-84 years old across the LHD. The impact of an ageing population will be felt across all services in SESLHD, with projected increases in the over 70 age band ranging from 14 percent in Woollahra Local Government Area (LGA) to 38 percent in Sutherland LGA and 41 percent in Sydney LGA. People aged over 70 are known to be disproportionally high users of healthcare resources – in 2018/19 approximately 32 percent of all planned surgeries across SESLHD were for patients aged 70 years and older, despite this age group accounting for approximately 11 percent of the SESLHD population. Similarly, people aged 70+ accounted for 22 percent of emergency department presentations. An ageing population will continue to drive demand for the services of SESLHD and our partner organisations. Innovative approaches to healthcare delivery will need to be developed and delivered in partnership to support the sustainability of our healthcare systems.

Chronic diseases are long lasting conditions with persistent effects. The prevalence of chronic disease in the community is rising, placing excessive demand on health services. Treatment of chronic disease is reported to consume more than one third of health spending.[i] The growing burden of chronic disease is driving additional emergency presentations and greater case complexity. Within the wider community there is an increasing prevalence of health risk factors known to contribute to the development of many chronic diseases.

Across SESLHD:

- 50 percent of the population are overweight or obese
- 1 in 10 has high blood pressure
- 16 percent experience high/very high psychological distress
- 37 percent consume alcohol at a level that risks long-term health
- 10 percent young people (12-17 years) are smokers.[ii]

Many people with chronic conditions do not have a single, predominant condition, but rather experience multi-morbidities, resulting in additional care requirements. Within SESLHD, 21 percent of the population live with multi-morbidities, highlighting the need for integrated services. In general, multi-morbidity is associated with more complex clinical management, poor treatment outcomes, longer hospital stays, increased healthcare costs and increased risk of readmission.

The population is not just living longer, they are living longer in ill health, requiring even greater health resources. This increases the demand for connected patient care that flows across integrated services within the health system. There is an opportunity to provide services early to promote health, prevent ill-health and prevent unnecessary emergency department presentations and hospitalisations. Investment in health promotion with a focus on early invention and screening activities, improving health literacy within the population, and improving the potential for self-management of chronic conditions, will lessen the impact of health risk factors.

Priority populations

Across SESLHD there exists a significant disparity in access to health services and in health outcomes. It is imperative that service design considers the social determinants of health and the needs of our diverse population and that models of care reflect their collective needs.

An individual's health status is known to be related to a complex set of factors including health risk factors, access to and use of health services, environmental factors, and an individual's own health capabilities. Factors such as indigenous status, housing, socio-economic status and education are known to be intrinsically linked to health with the most disadvantaged people in our society accounting for 1.5 times more potentially preventable hospitalisations than the least disadvantaged.

There are a number of subpopulations within SESLHD that experience significant health inequities. These include people from culturally and linguistically diverse (CALD) backgrounds, people living with disability, people who are homeless or at risk of homelessness and members of the LGBTIQ+ community It is essential that we deliver integrated services across the care continuum, the lifespan, and also across our diverse populations. Our services need to be responsive to the needs of all patients, with particular consideration given to the known barriers to access to care for our most vulnerable.

Closing the Gap between health outcomes for Aboriginal and non-Aboriginal communities remains a matter of national and state priority. In SESLHD, we are committed to improving the health and wellbeing of Aboriginal people, in partnership with local Aboriginal communities, ensuring the system is safe, accessible and responsive. We need to establish models of care that integrate multiple services to provide a holistic approach that is culturally safe.

Workforce demands and wellbeing

With increasing demands for services and rising consumer expectations, an ageing workforce and increasing population, workforce sustainability is of paramount consideration.

In many SESLHD services, care delivery is constrained by staffing availability. A shortfall of approximately 110,000 nurses and around 2,700 doctors across Australia by 2025 has been projected,

owing to an ageing workforce and an increasing population. These shortages pose a particular challenge to the many services within SESLHD with specialised workforce needs.

The wellbeing of our workforce was adversely impacted by COVID-19 and retention of staff remains a challenge. Many staff report feeling overworked as the impact of the pandemic continues to be felt across the health system, leading to concern for the sustainability of work practices. Staff must be supported to foster new approaches to learning and working, with support for flexible work practices, wellbeing management, and opportunities for capability development. Our teams are increasingly working in new ways; using technology, working in partnership with community providers, and in more flexible roles. With an ageing clinical workforce, our future models of care must embrace new approaches to learning and working. Innovative approaches to using our resources effectively will be essential to manage increasing demand and staffing shortages. Ensuring staff feel safe and supported will be achieved through the integration of leadership skills, consistent and clear communication channels, education and training, and the provision of best practice support.

Sustainable healthcare

Service design needs to consider the quadruple aim of value-based healthcare (VBHC) which seeks to improve the health of the population, improve the patient experience of care, reduce healthcare costs and improve the work life of health providers. Achieving these four principles supports environmental and fiscal sustainability of services in an uncertain future.

Healthcare delivery requires significant resources which can have unintended consequences on the health of our community. Impacts on health come from the significant plastic waste we generate, air pollution, and greenhouse gas emissions that fuel global warming. Healthcare is known to be a significant contributor to Australia's carbon footprint, constituting 7 percent of all Australian emissions.

Environmentally sustainable actions will advance us toward the World Health Organisation definition of an environmentally sustainable health system, one that "improves, maintains or restores health, while minimising negative impacts on the environment and leveraging opportunities to restore and improve it, to the benefit of the health and wellbeing of current and future generations". [iii]

Environmental sustainability must be a key consideration in the design of future services, to deliver carbon-neutral models of care in alignment with the NSW Government target to achieve net zero emissions by 2050. It is estimated that 80 percent of healthcare's carbon footprint comes from the delivery of clinical services. Actions to become more environmentally sustainable will reduce the impact on our environment, provide social benefits, economic sustainability, and deliver better outcomes for patients. The implementation of the models of care highlighted in the Plan provides the opportunity to improve the health of our population and reduce our impact on the environment.

The cost of delivering safe, quality healthcare is increasing and budgetary resources do not always align with this increase. There is a need to consider where efficiencies can be enhanced to improve the financial sustainability of health services. Efficiencies can be gained through collaboration between primary and acute care providers. Delivering services in a coordinated manner will reduce duplication of services and minimise unnecessary interventions, with added benefit of reducing environmental impact.

Our systems and processes need to be adaptable with flexibility for change as needed. Our response to COVID-19 demonstrated that we can be flexible, responsive, and resilient. We need to continue to develop these learnings to ensure we provide sustainable healthcare.

Shifting consumer expectations and patient empowerment

Consumers are more involved in their own care with an increased drive to be involved in co-design of services, and access to care when and where they need it.

Patients must be empowered to make decisions and be full partners in their own care. The results of the Bureau of Health Information (BHI) admitted patient summary tell us that 45 percent of admitted adult patients would like to be more involved in decisions about their care and treatment.[iv] Access to supportive care, including psychosocial and allied health services as well as non-clinical supports, will help to ensure services meet the full needs of patients.

There is a need to deliver care that optimises patient experiences and outcomes. Demand for the provision of services closer to home is increasing within the community with a growing recognition of the benefits of providing care for people in their own communities and close to their homes, families, carers and supporters. More patients are wanting to stay longer in their own homes, despite often complex needs, resulting in increasing demand for services such as Hospital in the Home and the Geriatric Flying Squads. Co-designing services and providing options for care in a convenient and more comfortable environment can improve the patient's experience and management of their health conditions.

The *Future Health Report* states, "There is a shared sentiment that the concentration of services in acute settings is high and is not sustainable nor conducive to optimal patient outcomes and experiences".[v] Services need to improve functional capacity to enable people to remain in their homes, and for community services to support them. Care in the community also alleviates demand on the limited bed availability within our acute facilities and is supported by new and emerging technologies adopted by an increasingly skilled workforce.

Providing effective services closer to home, for prevention, early intervention, treatment or follow up, will require collaboration with service partners within the community, including primary care and non-government organisations. Strengthening existing partnerships and building new relationships is key to success in bringing care closer to our consumers.

Emerging technology and virtual health

As technology is evolving, remaining informed and up to date is crucial in providing flexible models of care to support care needs. Delivering care virtually increases flexibility in service delivery and has the potential to improve equity and access for our consumers. Adopting hybrid models of care, integrating both virtual and in-person care as appropriate, allows for a range of preferences and accessibility.

Technology is evolving at a fast pace and COVID-19 has accelerated healthcare transformation and increased the capacity to test new models of care. Emerging technology provides the opportunity for greater flexibility in service provision and to provide care closer to home, optimising our patients' experiences and outcomes. Consumers are increasingly adopting new technologies including apps and wearables, with a variable evidence base. Limitations in integrating these consumer-led technologies in care delivery present a significant challenge in SESLHD meeting consumer expectations.

As technology is ever evolving, remaining informed and up to date is crucial to providing flexible models of care and services to support people's care needs. Opportunities exist to incorporate technologies into our clinical services, including personalised clinical interventions in advanced analytics and genomics,

advancements in ventilation technology and remote patient monitoring. New technology has the potential to transform the services we deliver. Clinical service delivery can continue to transform through technological advances, from digital care pathways to Artificial Intelligence and Robotics.

Virtual health capability has grown organically in SESLHD with significant innovation now occurring across the LHD. To date, these initiatives have been developed largely in isolation, without the required technology to facilitate efficiency, experience and growth at scale. Continuing on this trajectory brings risk of inefficiency and service inconsistency.

While virtual health technology enables increased flexibility and care closer to home, robust clinical governance must lead virtual care delivery to maintain focus on safety and quality. Virtual health systems can be challenging to navigate for some people and can pose significant barriers to accessing appropriate healthcare. Consumer engagement and co-design of virtual health services will ensure service design considers these barriers and addresses the limited access to technology for some communities.

Appropriate investment and service/model of care redesign is now underway to support the use of virtual health. The establishment of the SESLHD Virtual Health Hub provides the opportunity for a centralised, coordinated service to embed virtual health within existing and new models of care at scale. The Virtual Health Hub will support the curbing of demand through proactive management of patients in the community, focusing on hospital avoidance, inpatient early discharge and virtual rehab and pre-hab.

A need for connected, collaborative services

Accessing and navigating services is a challenge and impacts most heavily on our vulnerable populations. In delivering holistic care to our consumers, there is a need for integration of our services.

Navigating services across the LHD is challenging for consumers. In our current way of working, patients with similar presentations will often have a different journey through services depending on their point of entry. Our patients' experience of siloed services often leads to confusion, constant retelling of their story, missed opportunities for care and duplication of tests.

Health services that are integrated and offer coordinated care to consumers are essential to address the increasing number of consumers with multi-morbidities. To provide whole of person care, improved integration is needed across SELSHD services and with our healthcare partners to facilitate the provision of seamless, effective and efficient care.

To deliver holistic patient care, there is a need for services to be integrated across the care continuum. Better connected healthcare models will allow patients to navigate the services they require more easily, reduce avoidable hospital admissions, reduce duplication of services, and improve patient outcomes and experiences. Co-location of services as well as centralised referral systems will assist in improving equity and assisted navigation throughout the care journey. In providing seamless transfer of care and transition between services, care becomes more effective and efficient, and delivers on the promise of patient-centred care.

A need for future focused infrastructure

Many services have outgrown current infrastructure, impacting the way in which services are provided and offered particularly within community settings.

Infrastructure includes the built environment and other elements including equipment, information technology (IT), systems and processes. Current infrastructure for the delivery of community services is ageing and, in some cases, no longer fit for purpose. This ageing infrastructure and equipment can adversely impact patient experience. Purpose designed infrastructure would improve patient experience, the effectiveness and efficiency of services, and allow for timely and safe delivery of care.

IT infrastructure poses a challenge to improved integration and communication with service partners. There is a need to improve integration across systems through enhancing secure communication capabilities between providers.

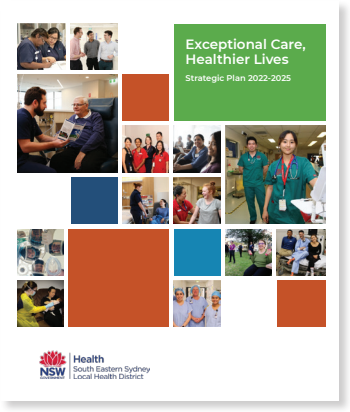
While building infrastructure is a crucial aspect of service provision, we need to consider other aspects of our environment such as urban green spaces. Evidence indicates there are health benefits when communities have 'green spaces' such as areas with tree canopies. Not only do we see environmental benefits including negating urban heat and offsetting greenhouse gas emissions, they also provide urban residents with places for physical activity and social connection. Objective and subjective measures show positive health benefits of green spaces including for allergic respiratory conditions, cardiovascular conditions and psychological wellbeing.[vivii] The creation of culturally safe spaces is another important aspect of infrastructure that needs to be considered when supporting the health of Indigenous patients and their families. When healthcare settings are not culturally safe it can lead to disengagement. By ensuring culturally safe spaces are embedded into our healthcare settings we increase the likelihood of health improvements for Aboriginal and Torres Strait Islander people.[viii]

It is integral that infrastructure, in all its manifestations, accommodates evolving service delivery to meet consumer needs now and into the future.

Planning context

The *South Eastern Sydney Local Health District Health Care Services Plan 2023-2033* was prepared within the context of *SESLHD's Exceptional Care, Healthier Lives Strategic Plan 2022-25*. In alignment with the Strategic Plan, working in partnership to improve health and wellbeing outcomes, and transform experiences, underpins the Health Care Services Plan. As SESLHD provides care for the 1 million people of South Eastern Sydney it is crucial the two plans work synergistically in order to provide exceptional care across our LHD. The foundations of the Strategic Plan are embedded throughout the Health Care Services Plan. Our Missions are reinforced by SESLHD's Strategic Priorities and the NSW Health CORE values, of Collaboration, Openness, Respect and Empowerment.

SESLHD Exceptional Care, Healthier Lives Strategic Plan 2022-25



Providing person-centred care

We will provide safe, integrated, accessible and evidence-based care that places people at its heart

Supporting teams to thrive

We will promote a culture where people flourish and wellbeing is a priority

Partnering for healthier communities

We will adopt a whole of system approach to promote health, improve equity and empower communities

Shaping the future

We will lead innovative, digitally enabled healthcare informed by pioneering research

Underpinned by

Connected people	Engagement, collaboration and co-design meet the diverse needs of our people.
Technology	Innovative technologies shape the future of health and social care.
Data and insights	Data and insights support decision-making and unlock value.
Places	Facilities designed for the future enhance consumer and staff experiences, and improve outcomes of care.

The *South Eastern Sydney Local Health District Health Care Services Plan 2023-2033* aligns with other relevant plans and guiding documents. The Plan works in conjunction with the existing site specific and service plans; aligning so that we can continue to provide safe and exceptional care as we move forward with innovative and flexible ways of working. Below are examples of other guiding documents that have informed the development of the plan.

Other guiding documents

Future Health: Guiding the next decade of healthcare in NSW 2022-2032

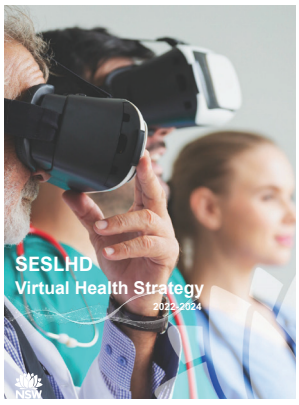
'A sustainable health system that delivers outcomes that matter most to patients and the community, is personalised, invests in wellness and is digitally enabled'. (The Future Health Strategic Framework)

The *South Eastern Sydney Local Health District Health Care Services Plan 2023-2033* reflects the goals and aspirations of our community, workforce and partners in the same way the Future Health Report reflects the goals and aspirations of the community, patients, workforce and partners of NSW. Foundational elements from the *Future Health Strategic Framework* that are reflected in the Plan include: staff who are well supported, research and innovation, digital advances that inform service delivery, and a sustainably managed health system. Underpinning both is the understanding that our health system needs to be adaptable, preventative, equitable and responsive to our consumers.

NSW Health Workforce Plan 2022-2032

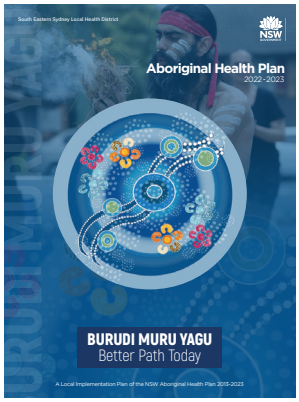
The *NSW Health Workforce Plan 2022-2032* provides a delivery framework to guide the implementation of *Future Health's* workforce-related strategies across the health system. The Workforce Plan aims to build positive work environments, strengthen workplace diversity, empower and equip staff, and support staff to build work practices for the future. Common denominators across the Health Care Services Plan and the *NSW Health Workforce Plan 2022-2032* include new ways of working, supporting innovation, and tailoring existing programs to meet future needs. Supporting our workforce to deliver person-centred care, will drive the best outcomes and experiences for our LHD.

SESLHD Virtual Health Strategy



The *SESLHD Virtual Health Strategy* supports the Health Care Services Plan as we work towards models of care that are sustainable, innovative and offered closer to home. Providing integrated person-centred care through virtual health allows consumers and patients to access care without having to visit the hospital. It also enables greater flexibility and potential for a 24-hour connection between the patient/consumer and their care team. Virtual care promotes consumer engagement and choice and the ability to connect specialists to increase the efficacy of interventions. Virtual health will be provided in layers, from local services to facility based services through to SESLHD wide models. The *SESLHD Virtual Health Strategy* aligns with, and has been a key document, in the development of the Plan.

Burudi Muru Yagu (Better Path Today): A Local Implementation Plan of the NSW Aboriginal Health Plan 2013-2023



Health equity for Aboriginal people is reliant on a health system that is safe, accessible and responsive which is why the *Burudi Muru Yagu Plan*, a Local Implementation Plan of the NSW Aboriginal Health Plan 2013-2023, is one of the key documents that has supported the development of the *South Eastern Sydney Local Health District Health Care Services Plan 2023-2033. Burudi Muru Yagu* acknowledges that Aboriginal health means not just the physical wellbeing of an individual, but the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their Community. The strategic directions of the *Burudi Muru Yagu Plan* and the missions within the Health Care Services Plan align. Both plans acknowledge the need for collaboration, strong partnerships, integrated planning and service delivery, supporting research, providing culturally safe health environments and health equity.

Statement of purpose

The *South Eastern Sydney Local Health District Health Care Services Plan 2023-2033* provides the roadmap for SESLHD's clinical services over the next ten years. Referencing the current and anticipated future challenges for our health services, the Plan outlines the priorities and aspirations for the Local Health District. The Plan encompasses all clinical and associated support services provided in public facilities across SESLHD. These include acute and sub-acute inpatient, outpatient and ambulatory services, primary health, community health, mental health services and clinical support services.

SESLHD is committed to ensuring safe and quality healthcare is available to all members of the community, regardless of location or circumstance. With equitable access to care as a focus, it is important that services are designed with the specific needs of the population in mind. It is anticipated that population needs will change over the next ten years and services will need to respond to these changes to continue to deliver safe and effective care. Flexibility within models of care is essential to this, as is co-designing services with consumers and service partners to best understand these changing needs.

Responsivity to both the internal and external environments in which our healthcare is delivered is fundamental to the continued provision of safe and effective care. Anticipated changes, including an increasingly ageing population, significant advances in technology, financial and budgetary requirements and constraints, and workforce development, will impact the way in which our health services are provided ten years from now. Supported by innovation, we will approach these changes with a sustainability focus that considers the environmental and financial sustainability of the services as well as the sustainability of our workforce models.

The *South Eastern Sydney Local Health District Health Care Services Plan 2023-2033* aligns with the priorities identified in SESLHD's *Exceptional Care, Healthier Lives Strategic Plan 2022-25,* which focuses on working in partnership, improving health and wellbeing outcomes through innovative, person-centred care, and supporting staff development and wellbeing. It also aligns with the *NSW Future Health Report* and demonstrates a commitment to the delivery of health services that are sustainable and consider the environmental impact of their delivery.

With a future focus, clinical services across SESLHD will continually innovate to meet increasing and changing demands, providing care that is driven by research and meets the patient when, where and how they need it, through utilisation of both virtual health and in-person care.

Over the next ten years, SESLHD will strategically allocate its resources to deliver on four key missions:

- Continuously improve care that optimises the patient experience and outcomes;
- Enhance care in the community;
- Deliver safe, integrated and comprehensive, person-centred care; and
- Develop models for the delivery of specialised services at scale.

The priorities identified within each of these missions demonstrate the changes that need to happen to achieve our missions.

Missions

Our mission is to transform the way we deliver care in response to the changing environment in which our services operate. The core of this mission is to innovate services and models of care to provide optimal outcomes for residents of SESLHD. The aim of this mission is to meet people where they are and deliver services in the way they can best receive them.

There is a need to ensure that the changing needs of the population continue to be met, and that people, including priority populations, are empowered to partner in their own care. With increasing demand for services, there is a need to ensure that services are sustainable and that decisions made now consider the impact into the future.

A key focus for our service is healthcare for priority populations, including Aboriginal and Torres Strait Islander people. There are barriers to accessing care for many people across SESLHD, including those related to socioeconomic, cultural, linguistic and geographical barriers, as well as difficulties related to specific health conditions. It is known that when collaborative and culturally responsive healthcare is available, health outcomes are improved. It is essential to ensure everyone from the community can access the healthcare they need.

The healthcare landscape is shifting, and patients and families are becoming increasingly engaged in steering their healthcare experiences. Consumers provide unique insights that shift healthcare design can enhance the quality of care. The NSW Ministry of Health *Future Health Report* sets the objective and emphasises the importance of partnering with patients and communities to make decisions about their own care as well as co-designing models of care[ix].

Providing sustainable healthcare is an important challenge in healthcare delivery, both now and into the future. As the landscape of medical needs, technological possibilities, and patient demographics continues to evolve, there is an increasing demand to deliver high-quality care in an economically and environmentally responsible manner. With a goal of creating a healthcare system that is financially sustainable, environmentally responsible, and capable of delivering high-quality patient outcomes over the long term, we will embed environmental sustainability into our decision-making processes. The transition to a more sustainable model is beneficial for the healthcare system's long-term financial health and the health and wellbeing of the community it serves.

Healthcare needs are rapidly changing with the advancements in technology, medicine, and the changing demographics of our communities and our infrastructure is not always suitable for these changing demands. To meet these evolving needs, our approach to infrastructure must be both future-focused and based on the requirements of the communities we serve. We will work with communities to deliver care in culturally safe spaces that are adaptable and technology enabled. Delivering on our commitment to a greener future, investing in greener, more efficient, and resilient infrastructure will lead to reduced operational costs and improved patient care in the future.

The vision of value-based healthcare (VBHC) is to provide a sustainable health system that delivers outcomes that matter to patients and the community, is personalised, invests in wellness, and is digitally enabled[x]. With a VBHC approach, SESLHD will prioritise patient-centred care that emphasises health outcomes significant to the individual and integrates digital solutions to enhance patient experiences, streamline operations, and facilitate data-driven decision-making.

We are committed to increasing accessibility, particularly for those who cannot access healthcare elsewhere, and through research-driven innovation, we will elevate the quality and effectiveness of care. By focusing on the patient in the context of their home, community and environment we are building a healthcare system that is sustainably designed for the future.

Supporting people to be partners in their own care, we will develop innovative models for safe and quality healthcare that both utilise and contribute to the evidence base. We will collaborate with primary care and community-based providers to ensure that people have the knowledge and support they need to actively engage in decision making processes.

"I just want to express my heartfelt thanks to the incredible team there from the wonderful doctors, nurses, allied health, maintenance, dietetics and catering crew to the porters. Everyone has been so caring and kind.

They were fantastic support, both clinical and emotional through the ups and downs of my recovery journey. I am constantly so blown away by their professionalism, patient advocacy, thoughtfulness, empathy and care that they bring to all the patients"

SESLHD patient

Empower our communities to manage their own health and wellbeing

With an ageing population and an increasing number of people living with chronic disease, it is pivotal that people are empowered to take control of their own health and wellbeing and be involved in decision making about their care.

We will endeavour to find new ways to deliver services to the residents of SESLHD, moving towards new and innovative models of care that equip people with the tools they need to write their own narrative of their healthcare journey.

Through partnering with patients, SESLHD will deliver care that is human-centred and responsive to the needs and preferences of the individual and carers. Providing access to quality information about health and health services will be key to enabling patients to be involved in informed decision making about the care they receive.

Through implementing co-design, bringing people and their families and carers together with staff in planning for the future, services will best meet the needs of the community and provide care when and how it is needed.

Focus areas

- Embed health promotion at all points in the patient journey
- Consistent consumer-led models for the management of chronic disease
- Collaborate with partners to improve health literacy in the community
- Engage with community leaders and elders to co-design innovative and culturally appropriate approaches
- Encourage and empower people to engage in advocacy and decision-making

Facilitate access to our services

The needs of consumers are changing and will continue to evolve over time. To continue to provide safe, quality healthcare, that meets these needs, our services need to be flexible and able to adapt.

We will change the parameters within which our services are offered to align with the changing needs of the people we care for, recognising that care needs are not limited to specific hours of the day, nor days of the week. We will push to provide options for care when and where people need it, improving the equitability of our services and helping to ensure that consumers are not left behind.

Through co-design processes we will leverage the resources within our communities to ensure that all of our spaces for care are culturally safe, be they hospital, community or home-based.

Focus areas

- Develop a single entry for non-admitted services
- Extend hours and refine locations of primary and secondary services to align with community needs
- Design service options that offer people choice
- Invest in facilities that are fit for purpose

Tailor our services for Aboriginal and Torres Strait Islander people

Continuously improving care for Aboriginal and Torres Strait Islander people is essential to building a culturally safe and responsive health system, where Aboriginal people have the same health outcomes as non-Aboriginal people.

We will provide culturally safe, co-designed environments that are welcoming, comfortable and that enable Aboriginal and Torres Strait Islander people to uphold cultural practices and beliefs.

Through collaboration, engagement and continuous improvement we will ensure the needs of Aboriginal and Torres Strait Islander people are supported to optimise both outcomes and experiences.

Focus areas

- Engage with community leaders and elders to co-design innovative and culturally appropriate approaches
- Adopt cultural models to support shared decision making

Prioritise care for the most vulnerable in our community

Presentations to health services are not necessarily reflective of the needs within the population. Vulnerabilities are intrinsically linked to health and health outcomes and it is known that some groups require additional support to access services than others particularly for subpopulations including culturally and linguistically diverse (CALD) backgrounds, people living with disability, people who are homeless or at risk of homelessness and members of the LGBTIQ+ community.

We will work with communities and subpopulations to design services that are responsive to community needs and consider the barriers which contribute to health inequities. Pathways of care when people interact with our services will be optimised to facilitate ongoing care needs.

Through collaboration with our partners we will ensure that care is offered in locations that are amenable to the needs of our communities, facilitates access to services and improves health outcomes.

Focus areas

- Collaborate with partners to embed coordinated models where our communities can access
- Maximise the health benefits delivered when vulnerable individuals interact with health services
- Implement innovative models that equalise and ultimately enhance access to tertiary services for those most vulnerable

Design services that minimise environmental impact

Environmental sustainability is central to continuing good health. Minimising the environmental impact of health services has benefits for the health and wellbeing of current and future generations.

We will focus on service innovations that embed environmental sustainability across the system, from models of care through to resource use and infrastructure developments.

Through the implementation of the SESLHD Environmental Sustainability Plan, we will work towards sustainability targets that benefit all people.

Focus areas

- Deliver value-based healthcare to improve patient outcomes, save costs and reduce carbon emissions
- Embed environmental sustainability into clinical operations

■ Provide innovative care that is driven by research

The health environment is quickly evolving and there is a need to be forward thinking to continue to provide quality healthcare. Innovations driven by research will enable us to provide care that keeps up with the changing health environment.

We will establish ourselves as a research-led organisation and build a culture of research, bridging the gap between research and clinical practice. Our service design will translate research into practice with our services at the forefront of innovation.

Through our research initiatives, we will lead and contribute to research that advances knowledge about human health, leading to innovations in prevention and treatment and better care for all.

Focus areas

- Clinical trials are made accessible to all
- Facilitate the translation of research into evidence-based practice
- Contribute to better understanding the basic mechanisms of health and disease

Our mission is to enhance the provision of safe, quality healthcare in the community. The core of this mission is to build community services that provide an alternative to hospital care and reduce unnecessary hospital presentations. We aim to strengthen partnerships with community providers and capitalise on the opportunities presented by virtual healthcare.

With increasing demand for services there is a need to ensure that services are provided sustainably. Enhancing care provided within the community is responsive to consumer demand to receive care closer to home.

There have been significant shifts to providing quality healthcare in the community, both within SESLHD and in the broader NSW health context. Whilst a need for complex care to be delivered at specialised hospital sites remains, the NSW Ministry of Health *Future Health Report* identifies a need for selected hospital-based outpatient services to be relocated to community health facilities. Enhancing the provision of care within the community promotes patient-centred services, improves integration with our service partners and supports a reduction in the environmental impact of our health services.

For some people, there are barriers to accessing services in a hospital setting. Working with community leaders to ensure models and location of care are culturally sensitive and increasing the opportunities to receive care within the community, overcomes many of these barriers, improving equity.

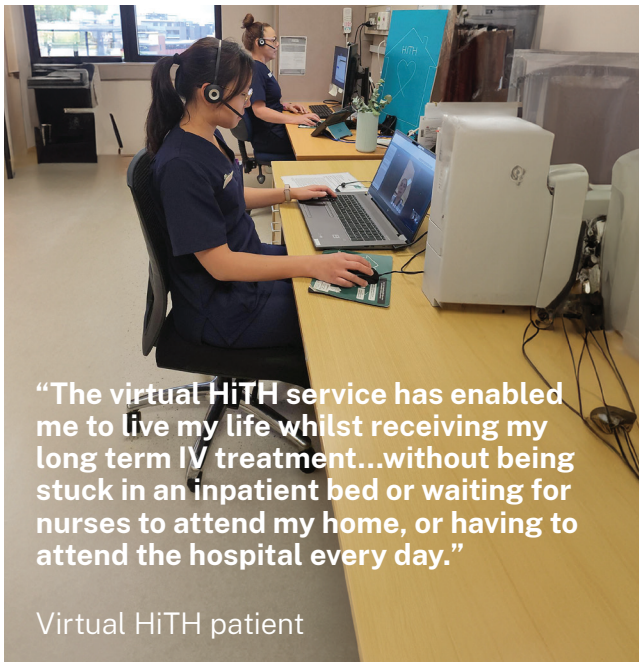
Overall demand for services to be provided closer to home is increasing. There is a growing number of people living longer with chronic disease, bringing greater need for people to be empowered to manage their own health in the community. With this, comes an increase in the need for virtual technology such as telehealth and remote monitoring to be embedded across clinical care. Increasing the use of virtual technology will improve efficiency in the system and alleviate some of the environmental impacts.

The opportunities presented through the development of the SESLHD Virtual Health Hub are significant in offering people choice in where and how care is delivered. The Virtual Health Hub will support the proactive management of patients in the community, focusing on early intervention and escalation management, curbing the growing demand for hospital services.

With improved coordination across services, including alignment of admission criteria and treatments, we will provide consistent access to care for all people across SESLHD. We will work with community members to co-design services and ensure that models of care delivered in the community are culturally appropriate.

Through partnerships with primary care and community providers to provide access to early community-based support, we can reduce unnecessary hospital presentations. Working with partners to provide targeted integrated care in the community will support people who are at risk of hospital readmission. Through improving data sharing capabilities and clear delineation of roles, we will enhance the delivery of shared models of care.

Patient feedback



■ Support people to access their care in the community

A commitment to strengthening care in the community reflects changing population needs as people are living longer with increasingly complex conditions. The desire for people to continue to be actively engaged in society for as long as possible drives the demand for care to be provided closer to home.

We will support access to care in the community through the integration of services with primary care partners as well as increasing options for virtual care across our services, enabling people to receive care where they want it.

Through the provision of care closer to home, we will have a meaningful impact on clinical outcomes and recovery for the people we care for.

Focus areas

- Increase the number of specialties delivering shared care models with primary care
- Provide options for virtual care across all ambulatory services

Provide consistent opportunities for care across our community

As a Local Heath District, it is important that we provide equitable access to care across South Eastern Sydney. Care parameters should not differ across places of residence and access must be based on need rather than where you reside.

We will work together across SESLHD to align like services and provide consistency in care, regardless of geographical location. Consistency of admission criteria and service availability across the LHD will support care pathways and improve the transition of care when needed.

Through a coordinated approach, we will find new ways to facilitate access, including the utilisation of generalist services to support care and improve access to specialist care.

Focus areas

- Align catchments, admission criteria and treatments across like services
- Refine home-based services to increase access to generalist services with specialist support
- Allocate resources to reduce duplication across the system, in response to changing community needs and other care providers

Develop culturally appropriate models of care

Cultural responsiveness can improve access to, and the quality of healthcare. Developing models of care that are culturally appropriate can improve equity.

We will provide options for care closer to family, communities and Country. By enhancing care in the community we will improve access to healthcare resulting in a health service that addresses inequity and values cultural strengths and differences.

Through the provision of flexible services that are culturally safe and responsive, we will deliver healthcare that is safe, connected and respectful.

Focus areas

- Establish a district-wide approach for services for Aboriginal and Torres Strait Islander people
- Prioritise place-based care with co-location of services to improve access
- Provide alternate models of care for people with chronic disease

Provide earlier supports to prevent the need to present to hospital

As a Local Health District our role is to support people in their health journey with the aim of keeping them well and out of hospital, where possible. Early supports can reduce avoidable hospital admission leading to improved quality of life, a reduction in possible adverse events and be an economically and environmentally viable way to care for people with a range of health conditions.

We will deliver and support community-based services, building on effective health practices in order to deliver value-based healthcare that reduce the need to present to hospital.

Through flexible and innovative models of care, that leverage increasingly adaptable technologies, we will transform the way we support people in the community.

Focus areas

- Leverage the Virtual Health Hub to support innovative models that proactively manage patients in the community

Prevent readmission with transition to community support for patients

By providing the right care, in the right place, at the right time, SESLHD can help prevent avoidable readmissions to hospital. A reduction in avoidable hospital readmissions can improve patient safety, support better health outcomes, and improve efficiency within the health system.

We will provide early supports using innovative technology to identify patients most likely to re-present for care in order to provide, and facilitate, appropriate care and services. We will work collaboratively with community services supporting their capacity to deliver effective care in the community.

Through innovation of virtual healthcare, collaboration with community partners, and the provision of targeted care services, we will improve outcomes for patients by supporting a smooth transition to the community and preventing avoidable re-admissions to hospital.

Focus areas

- Identify those patients most at risk of readmission and connect people to community services and primary care while they are in hospital
- Targeted integrated care services to support patients most at risk of readmission
- Collaborate with partners to improve data sharing and interoperability between healthcare providers
- Innovate through the Virtual Health Hub to empower individuals to remain well in the community

Our mission is to deliver care that is focused on the specific needs of the individual. The core of this mission is to implement integrated care across the lifespan. We aim to improve navigation of health services, and support changing care needs.

Increasing prevalence of chronic disease and multi-morbidities is leading to a significant number of patients presenting to hospital. People with multimorbidities typically require input from multiple disciplines. Navigating care can be complex and highlights the need for connected patient care that integrates services within the health system.

Integration of the various aspects of care leads to improved outcomes. It enables care to be collaborative and coordinated around the specific needs of the individual patient. Integration also facilitates care navigation across complex health systems, reducing avoidable hospital admissions and improving patient outcomes and experience. The delivery of connected, collaborative services that optimise patient care requires continuous improvement processes to reduce risks and errors. These processes contribute to a safe work culture that improves patient outcomes, staff wellbeing and contributes to value-based healthcare.

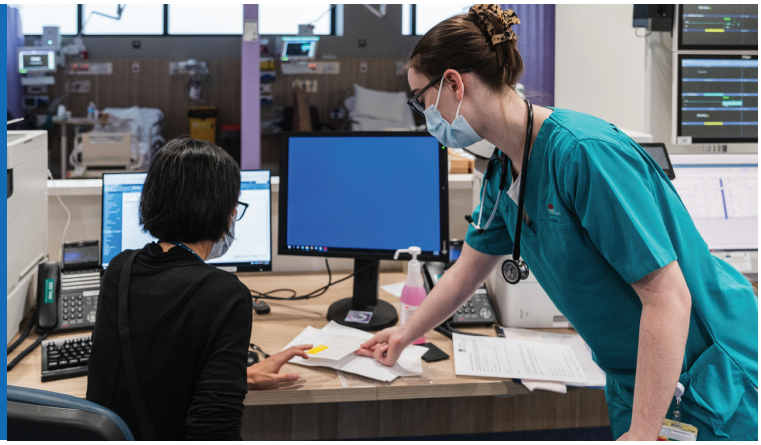
Service design must be responsive and consider the needs of our diverse population to develop sustainable integrated models of care. By engaging community leaders and elders in co-design we will ensure that our services are culturally appropriate and meeting the needs of our diverse populations.

Effective integration requires a system-wide approach, encompassing the breadth of care from population health, primary, community and non-acute services through to acute services. The delivery of high quality, integrated care is reliant on effective partnerships – both across our services and with external service providers. Leveraging the strengths and resources of our partners will improve the provision of person-centred, comprehensive care.

Effective person-centred and comprehensive care needs to be evidence-based. In delivering care across life stages, we recognise the importance of the health and wellbeing of current and future generations. By providing safe, comprehensive care from the first 2000 days through to the last 1000 days, we will meet patients where they are and move with them across the care and life continuum. Services will continue to innovate new models, with identified areas of need prioritised.

Patient Story

“My mother-in-law received excellent care at all points, from her admission to ED, to consults from cardiology, gastroenterology, and aged care through to nursing staff, Occupational Therapy, Physio and Speech Pathology. It was so reassuring to see such collaborative and supportive care.”



Provide care for the whole person

Providing person-centred care can increase safety, improve quality of life and improve satisfaction with care. With an increase in chronic conditions and people with multi-morbidities, it is imperative that SESLHD consider the biopsychosocial model of healthcare and deliver comprehensive person-centred care.

We will develop models of care that wrap around the individual and communities. We will integrate services to support to support the physical and mental health of all people who interact with our services.

Through re-designing services for people with complex conditions and multi-morbidities we will support safe integrated care that considers their physical and mental health.

Focus areas

- Redesign healthcare for people with multi morbidities
- Deliver integrated services that support physical and mental health concerns, irrespective of the setting
- Develop co-located multidisciplinary clinics to streamline care for people with complex conditions

Prioritise the opportunities within the first 2,000 days

The first 2,000 days of a child's life are a strong predictor of their physical, cognitive, social and emotional health outcomes. Optimal early childhood development is achieved through an integrated approach to programs and services.

We will continue to implement the First 2,000 Days Framework to ensure children in SESLHD have the best possible start in life, including specific models of care to support priority populations.

Through our services and teams, we will contribute to the implementation of programs, services and models of care that will lead to positive outcomes.

Focus areas

- Consistently implement the First 2,000 Days Framework across our LHD
- Prioritise targeted care for vulnerable families

Support the transition of adolescent and young people to adult health services

The transition from paediatric healthcare to adult healthcare presents many challenges. Without good coordination, vulnerable young people can miss out on receiving a service re-presenting later with additional unmanaged complexity.

We will place the young person at the centre of care, supporting them as they transition to adult services. We will consider those young people who may need additional support including young people who are Aboriginal, those who have experienced trauma, who are living with a disability or mental health condition.

Through a district wide approach we will implement a developmentally appropriate and trauma informed approach. We will support integrated care planning aimed at achieving self-management.

Focus areas

- Develop a district wide approach to embedding the ACI transition care principles

Optimise care delivery in the last years of life

There are currently gaps in services for people in the last 12-24 months of life with difficulty accessing palliative care services. By providing person centred care, SESLHD can contribute to improved quality of life and a more positive experience for people and their families.

We will ensure people have optimal access to end of life care no matter where they live, their condition, age or who they are. We will support staff, the wider community, individuals, families and carers to talk more openly about death, dying, and end of life decisions.

Through improving knowledge of, and access to services, we will increase awareness of palliative and end of life care, empowering individuals and communities. We will ensure end of life care is provided in the right place at the right time.

Focus areas

- Co-design culturally appropriate models of care that support Aboriginal and Torres Strait Islander people
- Empower our staff to support end of life care discussions and Advance Care Planning
- Ensure equitable access to end of life services across our LHD

Our mission is to ensure that all SESLHD residents have access to high quality specialised services. The core of this mission is to ensure that services are sustainable and continue to meet the needs of people into the future. We aim to optimise efficiencies in our workforce and resources, reducing unnecessary duplication and providing people with the support they need.

The needs of the population are changing and will continue to do so over the next ten years, with a shift in demographics and increasing complexity of care required. However, resources are not unlimited. Innovative models of care and allocation of resources, including workforce, are required to ensure that safe, quality services are accessible for all people into the future.

Demand for services is on the rise and health and population projections indicate that this increase will continue over the next ten years. Ensuring safe, high quality specialist services are available to all SESLHD residents who need them is increasingly challenging as demands grow and resources do not.

The wellbeing of our workforce is essential for the delivery of high-quality patient care. A workforce that is well-supported in terms of mental health, work-life balance, and professional development is more likely to be engaged and effective in their roles. Supporting the workforce to work in new ways is key to improving the sustainability of services as is providing staff opportunities to work at the top of their scope of practice. Facilitating cross-site collaboration increases opportunities for professional growth and learning, promoting a sustainable workforce.

Sustainability involves healthcare systems that are adaptable and built to last, ensuring efficient use of resources resulting in improved health and wellbeing. To continue to meet the needs of our population, it is necessary to ensure that models of care optimise efficiencies. Through coordination and integration, unnecessary duplication of services will reduce. By reducing duplication and delivering specialised services at scale, financial sustainability improves.

By focussing on enhancing the quality of patient care and maximising resource efficiency, sustainability of services improves. Service design will consider community needs, service volume and the complexities of care. We will coordinate with our partners to increase efficiencies across the system, enabling specialised care to be accessed as required.

The following principles guide decision making for service model development.

Principles for service model development

- **Patient safety and quality**
  - Patient safety and the provision of high-quality care are at the centre of decision making
- **Flexibility in model design**
  - Recognition that there is no singular right way to do this – consideration is given to all aspects of the service, including the patient population
- **Data informed decision making**
  - All decisions regarding service design are informed by data, including patient demographics, current and projected activity data
- **Equity and access**
  - All patients, regardless of their place of residence, have access to the services they need
  - The needs of vulnerable/priority populations are considered in the development of models

- **A culture of trust**
  - Foster a workforce culture built upon mutual respect, communication, and a shared commitment to success
- **Sustainable workforce**
  - Create a culture of continuous learning, adaptability, and innovation in the workforce
  - Workforce is supported to work with a dynamic environment, and respond to changing community needs

Staff perspectives

"We need to have dialogues and work collaboratively between different hospitals to achieve an understanding of how different units can help each other in the district."

SESLHD staff member, Medicine stream

Improve the delivery of care for people and communities through consolidation of appropriate services

Across NSW, healthcare systems are facing growing demand from increasing prevalence of chronic disease and multi-morbidities, an ageing population and staffing shortages.

We will seek opportunities to implement innovative models of care that leverage our existing strengths while also seeking new and emerging opportunities for development.

Through collaboration across our sites and services we will provide value-based healthcare for the residents of SESLHD.

Focus areas

- Implement models that separate emergency and elective demand
- Leverage existing specialisation through hosted services
- Collaborate across the LHD to host new and emerging technologies in one site with consolidated volumes

Embed whole of district models to support consistent access

There are currently inconsistencies in service delivery models and opportunities to receive care across the LHD.

We will align our like services across the LHD to ensure we are meeting the needs of all SESLHD residents, irrespective of postcode.

Through embedding whole of district models, we will provide consistent access to care, improving health outcomes and removing some of the barriers people face when accessing healthcare.

Focus areas

- Leverage the Virtual Health Hub to support virtual care at scale
- Align criteria for entry to services
- Develop consistent referral pathways

Foster a workforce that is responsive to the changing demands of the future

With an ageing clinical workforce, our future models of care must embrace new approaches to learning and working. Staffing shortages and increasing demands are driving the needs for innovative, flexible approaches that use resources effectively.

We will support staff to adopt new approaches to learning and working and ensure we provide opportunities for development. We will give staff opportunities to develop knowledge, skills and experience that support them to work at the top of their scope of practice.

Through clear communication, education and training, and integration of leadership, we will develop and nurture a workforce that is responsive to changing demands to support staff, patients and the wider community of SESLHD.

Focus areas

- Optimise scope of practice for the entire workforce
- Consolidate on-call rosters where subspecialisation challenges workforce capacity
- Leverage multidisciplinary teams with team members working at top of scope

Sarah and Tom* had been married for five years when Tom was diagnosed with stage 4 bowel cancer at the age of 45. The couple were advised that Tom would require emergency surgery followed by extensive chemotherapy. It was recommended that if they wished to conceive in the future, they would need to 'bank' Tom's sperm. The couple made the decision to proceed with the sperm storage and progress IVF at an appropriate time. A referral was made to the RHW Fertility and Preservation Centre.

A plan was developed for Tom's cancer treatment at St George Hospital including chemotherapy and a liver resection. Eight months following his initial diagnosis and following the gruelling surgery and treatment Tom was given the news of being 'in the clear'. The couple then began to investigate their IVF options at the Royal Fertility and Research Centre under the Onco-preservation program. The couple took advantage of the free counselling service provided to help them navigate the decision and any challenges that might arise if Tom's cancer were to return.

Tragically in the following weeks Tom was admitted to St George Hospital and was advised that the cancer had returned and was incurable, he commenced palliative care along with more chemotherapy and an operation to give him the best prognosis possible. However, he was not expected to live more than six months.

Sarah and Tom report that the decision to proceed with IVF was profound. Weeks after the ICU admission Sarah underwent her first egg retrieval process at RHW. Unfortunately, the first round was unsuccessful. However, the next round of treatment was successful, and Sarah and Tom were finally pregnant. 'The next 12 weeks were a heart-stopping journey. Every scan we got to, was a blessing. Not only to see our baby girl growing but to also be able to share it together.'

Tom continued to have chemotherapy in intervals throughout the pregnancy and was also in and out of ICU with complications. He defied all odds and medical expectations, welcoming a little girl Samantha alongside Sarah in April of 2022 at St George Hospital.

'The hospital was incredible and very supportive. Tom was admitted under respite care when I went into labour so he could be there and participate as much as possible. They even had an extra bed in the room with me as by that stage he was so weak and couldn't stand for more than 30 seconds at a time. Watching Tom enjoy her was the happiest moments of my life and now that he is gone, having her is the greatest gift he could have ever given me.'

*Names have been changed

Appendix

Planning approach

The Plan was carefully developed through thorough consultation with various stakeholders. Between June 2022 and June 2023, the planning team engaged in comprehensive consultations with Board members, Executive members, site and service leadership teams, representatives from the Clinical Streams, partners, and consumers to shape the Clinical Services Plan. The Health Care Services plan works in conjunction with the existing site specific and service plans to provide a coordinated approach to planning, considering how the LHD can equitably meet population needs.

Over **800** staff consulted

44 working group meetings

15 Staff surveys and **340** completions

16 forums with **350** attendees

Representatives from **30** Key Partner organisations and **26** consumers

Over the course of the Plan's development, we undertook three distinct consultation phases to ensure a comprehensive and inclusive approach:

Phase 1: Foundational oversight

Establishment of District Health Care Services Plan Steering Committee:
A steering committee was formed to oversee the entire development of the Plan and ensure alignment with SESLHD's strategic directions in the Exceptional Care Healthier Lives 2022-2025 Strategy. This committee provided strategic direction throughout the development of the Plan. Comprising of the Chief Executive, Clinical Streams leads, General Managers, executive directors, and planning team members, this committee served as the Plan's backbone.

Phase 2: Deep collaboration and insights gathering

- **Engagement with clinical streams:** The planning team coordinated with the clinical streams and service areas through the following methods:
  - **Preliminary meetings:** Identifying key stakeholders to join the working groups for the Plan and understanding service-specific change drivers.
  - **Clinical Working Groups:** These groups met multiple times throughout the Plan's formulation, allowing for a profound integration of clinical insights.
  - **One-on-One Sessions:** These direct interactions with clinicians and stream leaders facilitated discussions into specific issues and priorities.
  - **Tapping into Existing Governance Structures:** Participated in various departmental, service, and stream meetings to gather input to the Plan.

- **Staff surveys:** Surveys were distributed within service groups to receive broader clinical staff input to the Plan.
- **Forums:** Several forums furthered stakeholder involvement in shaping the Plan:
  - **Clinical stream staff forums:** Conducted staff forums in individual clinical streams on Wicked Challenges, Big ideas.
  - **Future Forum (January 2023):** This centred on visualising SESLHD's future direction and exploring potential opportunities. The attendees were board members, executive directors, clinical leads, consumers, and partners.
  - **Consumer and Partner Forum (May 2023):** The aim of the forum was to understand the insights and feedback from consumers and partners' regarding the Plan. Representatives from partner organizations, consumers, and SESLHD staff actively participated and contributed during this forum.
  - **Health Services Plan Forum (June 2023):** This aimed to foster collaboration across streams, dissolve boundaries, and develop a collaborative service delivery approach. The participants were executive directors, clinical stream directors and mangers.
- **Specialised consultations:** Targeted discussions with identified groups, for example nursing, allied health, Aboriginal health workers and people and culture.
- **Environmental sustainability:** Collaborated with the environmental sustainability project officer to ensure that environmental sustainability principles were seamlessly incorporated and highlighted as a core direction for the future.

Throughout this multifaceted phase, our objective was to craft a plan that was both forward-thinking and widely endorsed, addressing the needs and visions of all stakeholder groups.

Consultation papers were drafted to reflect the conversations within the working groups and, along with other Executive, Partner and Consumer consultations, have informed the directions established in the SESLHD Health Care Services Plan. These papers are included in a separate appendix.

Phase 3: Finalisation and submission

- **Consultation papers:** Clinical stream consultation papers were prepared and sent to clinical stream directors and managers for feedback.
- **Development of the Plan draft:** The overarching draft plan was reviewed by the steering committee, executive council, and board for their insights and suggestions.
- **Finalisation of the Plan:** incorporating feedback from the above drafts, the Plan was completed.
- **Submission** of the plan to the NSW Ministry of Health.

Role delineation

Role delineation is a planning tool used to describe the minimum support services, workforce, and other requirements for the safe delivery of clinical services. It delineates the level of clinical services, not hospitals or health facilities. Each service standard has up to six levels of service in ascending order of complexity. The role delineation of clinical services at individual SESLHD facilities is outlined below.

SERVICE TYPE	SPECIALTY	POWH	RHW	SGH	TSH	SSEH	GC	CHCK	WMH	GW
Core Services										
	1. Anaesthesia and Recovery	6	6	6	5	4	NPS	NPS	NPS	1
	2. Operating Suite	6	6	6	5	4	NPS	NPS	NPS	1
	3. Close Observation Unit (COU)	6	4	4	4	3	NPS	NPS	NPS	NPS
	4. Intensive Care Service (ICS)	6	6	6	5	NPS	NPS	NPS	NPS	NPS
	5. Nuclear Medicine	6	6	6	5	4	NPS	NPS	NPS	NPS
	6. Radiology and Interventional Radiology	6	6	6	5	4	NPS	NPS	2	1
	7. Pathology	6	6	6	6	5	1	NPS	NPS	1
	8. Pharmacy	6	6	6	5	6	1	3	3	1
Clinical Services										
A. Emergency Medicine	Emergency Medicine	6	6	NPS	6	5	3	NPS	NPS	NPS
B. Medicine	Cardiology and Interventional Cardiology	6	6	NPS	6	5	3	NPS	NPS	NPS
	Chronic Pain Management Services	6	NPS	NPS	5	3			NPS	NPS
	Clinical Genetics	6	6	5	NPS	NPS	NPS	NPS	NPS	NPS
	Dermatology	6	NPS	6	NPS	3	NPS	NPS	NPS	NPS
	Drug and Alcohol Services	5	5	6	5	6			NPS	NPS
	Endocrinology	6	6	6	5	3	NPS	NPS	NPS	NPS
	Gastroenterology	6	NPS	6	6	3	NPS	NPS	NPS	NPS
	General and Acute Medicine	6	4	6	4	4	NPS	NPS	NPS	2
	Geriatric Medicine	6	NPS	6	6	3	2	3	5	NPS
	Haematology	6	NPS	6	4	3	NPS	NPS	NPS	NPS
	Immunology	6	NPS	5	NPS	2	NPS	NPS	NPS	NPS
	Infectious Diseases	6	NPS	6	5	2	NPS	NPS	NPS	NPS
	Neurology	6	NPS	6	5	3	NPS	NPS	NPS	NPS
	Oncology – Medical	6	5	6	5	NPS	NPS	NPS	NPS	NPS
	Oncology – Radiation	6	4	6	4	NPS	NPS	NPS	NPS	NPS
	Palliative Care	6	4	6	3	NPS	3	6	NPS	2
	Rehabilitation Medicine	6	NPS	6	4	NPS	2	5	4	NPS
	Renal Medicine	6	NPS	6	4	3	NPS	NPS	NPS	NPS
	Respiratory and Sleep Medicine	6	NPS	6	5	3	NPS	NPS	NPS	NPS
	Rheumatology	6	NPS	6	NPS	2	NPS	NPS	NPS	NPS

SERVICE TYPE	SPECIALTY	POWH	RHW	SGH	TSH	SSEH	GC	CHCK	WMH	GW
	Sexual Assault Services	1	NPS	4	1	NPS	NPS	NPS	NPS	NPS
	Sexual Health	5	1	4	1	5	NPS	NPS	NPS	NPS
C. Surgery	Burns	4	NPS	4	NPS	NPS	NPS	NPS	NPS	NPS
	Cardiothoracic Surgery	6	NPS	6	NPS	NPS	NPS	NPS	NPS	NPS
	Ear, Nose and Throat Surgery	6	NPS	6	4	4	NPS	NPS	NPS	NPS
	General Surgery	6	6	6	5	NPS	NPS	NPS	NPS	1
	Gynaecology	NPS	6	6	4	NPS	NPS	NPS	NPS	NPS
	Neurosurgery	6	NPS	6	NPS	NPS	NPS	NPS	NPS	NPS
	Ophthalmology	6	NPS	1	3	6	NPS	NPS	NPS	NPS
	Oral Health	6	NPS	3	4	NPS	NPS	NPS	NPS	2
	Orthopaedic Surgery	6	NPS	6	5	6	NPS	NPS	NPS	NPS
	Plastic Surgery	6	4	6	NPS	NPS	NPS	NPS	NPS	NPS
	Urology	6	NPS	6	5	NPS	NPS	NPS	NPS	NPS
	Vascular Surgery	6	NPS	6	4	NPS	NPS	NPS	NPS	NPS
D. Child and Family Health Services	Child and Family Health	NPS	NPS	4	5	NPS	NPS	NPS	NPS	NPS
	Child Protection Services	NPS	NPS	4	3	NPS	NPS	NPS	NPS	NPS
	Maternity	NPS	6	5	4	NPS	NPS	NPS	NPS	NPS
	Neonatal	NPS	6	4	3	NPS	NPS	NPS	NPS	NPS
	Paediatric Medicine	NPS	6	5	4	NPS	NPS	NPS	NPS	NPS
	Surgery for Children	NPS	6	4	3	NPS	NPS	NPS	NPS	NPS
	Youth Health	NPS	NPS	3	3	NPS	NPS	NPS	NPS	NPS
E. Mental Health Services	Adult Mental Health	6	NPS	5	5	NPS	NPS	NPS	NPS	NPS
	Child and Youth Mental Health	4	NPS	4	4	NPS	NPS	NPS	NPS	NPS
	Older Persons Mental Health	6	NPS	6	4	NPS	NPS	NPS	NPS	NPS
F. Aboriginal Health	Aboriginal Health	6	6	4	4	4	2	2	2	NPS
G. Community Health	Community Health	4	3	4	4	4	NPS	3	3	1

Aboriginal Health Impact Statement

Attachment 1:

Aboriginal Health Impact Statement – Question Template

Title of the initiative:	South Eastern Sdyney Local Health District Health Care Services Plan 2023-2033
Organisation/Department/Centre:	South Eastern Sydney Local Health District
Contact name and title:	Natalie Tuffin Planning and Partnerships Lead Lisa Altman Director, Strategy Innovation and Improvement
Contact phone number:	0430 318 744
Date completed:	

Once approval has been received from your Organisation please provide a copy of the finalised Aboriginal Health Impact Statement and related policy document to the Centre for Aboriginal Health by email: CAH@moh.health.nsw.gov.au.

If your Organisation assesses that the initiative has no impact on Aboriginal people you are still required to provide a rationale for how this decision was reached by completing the summary section and questions 1 and 2 of the template.

Summary

Provide a 200-300 word summary that demonstrates how the Aboriginal Health Impact Statement has been considered. This summary is required in addition to a more detailed response to the three components below

SESLHD is committed to ensuring safe and quality health care is available to all members of the community, regardless of location or circumstance. With equitable access to care as a focus, it is important that services are designed with the specific needs of the population in mind. It is anticipated that population needs will change over the next ten years and services will need to respond to these changes to continue to deliver safe and effective care. Flexibility within models of care is essential to this, as is co-designing services with consumers and service partners to best understand these changing needs.

The ongoing and continuing impacts on the health and wellbeing of Aboriginal and Torres Strait Islander people are evident with gaps in infant and child mortality, chronic disease, and life expectancy apparent in comparison to non-Aboriginal people.

Significant barriers to accessing effective and safe health care contribute to these gaps. Therefore, it is important that Aboriginal and Torres Strait Islander people experience safe and high-quality health care based on need.

Closing the Gap in Aboriginal and Torres Strait Islander health is a national priority. It is the responsibility of all health service organisations to consider and action their part in closing the gap in health disparities experienced by Aboriginal and Torres Strait Islander people.

The Aboriginal and Torres Strait Islander population of South Eastern Sydney Local Health District (SESLHD) is reported to be approximately 10,350 , which represents approximately 1.1% of the population.

Aboriginal and Torres Strait Islander people can expect to die about 8 to 9 years earlier than non-Aboriginal Australians. On average, Aboriginal males live 71.6 years, 8.6 years less than non-Aboriginal people and Aboriginal women live 75.6 years, 7.8 years less.

Aboriginal and Torres Strait Islander people experience higher prevalence of chronic diseases, and chronic disease risk factors compared to non-Aboriginal and Torres Strait Islander.

The South Eastern Sydney Local Health District Health Care Services Plan 2023-2033 provides the roadmap for SESLHD's clinical services over the next ten years. The plan has been developed in alignment with the SESLHD Burudi Muru Yagu Aboriginal Health Plan 2017 - 2022 and identified priorities and focus areas specific to the health and wellbeing for Aboriginal people. The Plan recognises the importance of developing and implementing effective strategies that address environmental, economic and social inequalities.

1. The health context for Aboriginal people

The SESLHD Geographical area lies within both the Eora and Dharawal Nations. This area encompasses the traditional lands of five Aboriginal language groups including the Dharawal, Gadigal, Wangal, Gweagal and Bidjigal peoples.

There are reported to be 10,350 Aboriginal and Torres Strait Islander people living in SESLHD constituting approximately 1.1% of the population. The highest densitiy within the district is within the Randwick LGA, where over 1.8% of the population identify as Aboriginal, closely followed by the Sutherland and Sydney LGA's, where approximately 1.4% of the population identify as Aboriginal.
It is of note that the reported numbers are likely to under represent the actual Aboriginal population due to under reporting of Aboriginality.

Higher rates of mortality and shorter life expectancy for Aboriginal people are due to a range of factors including
- higher prevalence of risk factors (e.g. smoking, overweight and obesity);
- higher prevalence of some long term conditions and multiple morbidities (for example, renal, cardiovascular, diabetes, respiratory and injury);
- higher levels of psychological distress than non-Aborginal people and
- social determinants of health which include connectedness to family, culture, identity and country, education, employment, and housing

Given the higher prevalence of some risk factors, long term conditions and rates of mortality for Aboriginal people it would be expected they would have higher utilisation of health services than non-Aboriginal people.

Across SESLHD Aboriginal people had higher rates of admission for some potentially avoidable hospitalisations. Admission rates for conditions, including diseases of the circulator, endocrine and respiratory system, in SESLHD are similar to the rates in NSW and Australia, except for Mental Health disorders where rates can be two times higher within SESLHD when compared to NSW and Australia. (Source: R Schwanz (2018) Final Burden of chronic disease among Aboriginal people in SESLHD).

The South Eastern Sydney Local Health District (SESLHD) Health Care Services Plan 2023-2033 (The Plan) is focused on the transformaion of our helath service over the next ten years with consideration given to the way our services are provided for those who need them most. The Plan aligns with the SESLHD Burudi Muru Yagu Aboriginal Health Plan 2021 with both acknowledge the need for collaboration, strong partnerships, integrated planning and service delivery, supporting research, providing culturally safe health environments and health equity.

2. The potential impact of the policy, program or strategy on Aboriginal people including approaches to mitigate any potential undesired effects

The South Eastern Sydney Local Health Health Care Services Plan 2023-2033 provides the roadmap for SESLHD's clinical services over the next ten years. Referencing the current and anticipated future challenges for our health services, the Plan outlines the priorities and aspirations for the Local Health District.

The Plan identifies four key missions to which SESLHD will strategically allocate its resources over the next ten years:
- Continuously improve care that optimises the patient experience and outcomes;
- Enhance care in the community;
- Deliver safe, integrated and comprehensive, person-centred care; and
- Develop models for the delivery of specialised services at scale.

Within each of these, specific priorities and focus areas are identified and provide the guidance on way in which these missions will be achieved.

The plan supports the transformation of health services to better meet the needs of Aboriginal people through specific initiatives, including:
- Tailoring services for Aboriginal and Torres Strait Islander people
  - Engaging with community leaders and elders to co-design innovative and culturally appropriate approaches
  - Adopting cultural models to support shared decision making

- Developing culturally appropriate models of care
  - Establishing a district-wide approach for services for Aboriginal and Torres Strait Islander people
  - Prioritising place-based care with co-location of services to improve access
  - Providing alternate models of care for people with chronic disease

- Co-designing culturally appropriate models of care that support Aboriginal and Torres Strait Islander people

3. Engagement with Aboriginal people

Engagement and consultations with the SESLHD Aboriginal and Torres Strait Islander community, stakeholders and Aboriginal Health Workers have occurred and have been productive.

At the commencement of the health service planning process for the Plan discussions were held with SESLHD's Manager Aboriginal Health Unit to identify key issues for Aboriginal people in relation to the Plan.

Throughout the development of the plan:
- consultations were held with Aboriginal Health Workers across SESLHD to identify key challenges and opportunity areas for clinical services.

- consumer and partner engagement sessions have included representation from Aboriginal people and Community.

- consultation with SESLHD's Director Aboriginal Health to further identify priority areas and discuss culturally appropriate language within the plan

Approved by:	Margaret Broadbent
Date:	21st November 2023
Title/position:	Deputy Manager
Organisation/Department/Centre:	Aboriginal Health - SESLHD
Contact phone number:	0410 604 050
Signature:	MBroadbent

By signing this document you agree that the initiative satisfactorily meets the three key components of the Aboriginal Health Impact Statement.

Note: Must be approved by the relevant Executive Director or Director of the local health district, pillar organisation or Centre within the NSW Ministry of Health

T23/79208

References

i 4.2 Chronic disease—Australia's biggest health challenge (Feature) (Chapter 4 – Leading types of ill health; Australia's health 2014) (aihw.gov.au)

ii Phidu, Torrens University Australia. Social Health Atlas of Australia. https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlases-of-australia-local-government-areas

iii World Health Organisation https://www.who.int/publications/i/item/WHO-EURO-2017-2241-41996-57723

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