South Eastern Sydney Local Health District

NSW GOVERNMENT

SESLHD Safety & Quality Account

2021-22 Report
2022-23 Future Priorities

T22/64987

Acknowledgement of Country

South Eastern Sydney Local Health District would like to acknowledge the Traditional Custodians on whose land westand, 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.

Contents

Foreword

I am pleased to present the South Eastern Sydney Local Health District (SESLHD) Safety and Quality Account, for 2022/23 as endorsed by the Local Health District Board.

This account highlights our performance and achievements during 2021/22 and outlines our plans and priorities for 2022/23. It is an opportunity for the district to reflect on the challenges and opportunities presented to us over the last year and reminds us to be proud of the innovative and person-centred programs that teams have implemented. We also take the opportunity to consider feedback from consumers and staff, look at performance indicators and data, and use these to continually improve the quality and safety of care provided.

SESLHD is committed to providing the highest quality, evidence-based and safe care our community. We aim to provide compassionate and respectful care that places people at the heart of their care, and prioritises the unique goals, expectations and experiences of each person. We support our staff to prioritise safety and quality, and understand the needs of the local community.

Over the past 12 months, COVID-19 has continued to place significant strain on our health system. Parts of our community also faced multiple flood emergencies, and our teams provided support to the emergency response. Our staff have demonstrated incredible resilience and a willingness to find solutions to these ongoing challenges. I would like to take this opportunity to acknowledge our staff, all of whom provide compassionate and high quality healthcare to our patients and the community.

The performance information included in this report reflects the challenges SESLHD has encountered during 2021/22. We recognise that there are opportunities for improvement, and the District Executive, SESLHD Board, and I are committed to working with our clinical teams and patient safety leaders to once again achieve the healthcare outcome goals we strive to meet.

The new SESLHD Strategic Plan, Exceptional Care, Healthier Lives 2022-2025, was released in early 2022, following extensive consultation and engagement with SESLHD teams, our partners and the community. Exceptional Care, Healthier Lives aligns closely with the NSW Premier's Priorities, providing care closer to home, making the most of our limited health resources, and delivering exceptional care.

Supporting the Strategic Plan, and aligning with the National Safety and Quality in Health Service (NSQHS) Standards, the SESLHD Safety and Quality Account outlines three priority areas for quality and safety in 2022/23:

- Aboriginal and Torres Strait Islander Health
- Patient Experience
- Reducing Hospital Acquired Complications across SESLHD

I look forward to supporting and working with our teams, and with our community, to reach our goals in these priority areas over the coming year.

Tobi Wilson
Chief Executive

Introduction to SESLHD

South Eastern Sydney Local Health District (SESLHD) is one of the largest local health districts in Sydney. It covers a geographical area of 468 square kilometres from Sydney's Central Business District, the beaches from Bondi to Cronulla and down to the Royal National Park. SESLHD also provides a key role in assisting residents of Lord Howe Island with the provision of hospital and health services. SESLHD encompasses a complex mix of highly urbanised areas, industrialised areas and low density suburbs, across the local government areas (LGAs) of Woollahra, Waverley, Randwick, Bayside, Georges River, the Sutherland Shire and parts of the City of Sydney.

The SESLHD geographic area lies within both the Eora and Dharawal Nations. SESLHD acknowledges the Traditional Custodians on whose land we stand, and the lands our facilities are located on: the Dharawal, Gadigal, Wangal, Gweagal and Bidjigal peoples.

An estimated 898,675 people currently live within SESLHD. Aboriginal and Torres Strait Islander people make up 1.1% of the SESLHD population, approximately 9,885 residents. While the estimated SESLHD population has decreased over the last year, the population is forecast to increase by 11% by 2032.

The SESLHD community is highly diverse. 42.2% of people were born overseas, which is significantly higher that the NSW average of 29.3%. 37.8% of SESLHD residents report speaking a language other than English at home, with the top five languages other than English being Mandarin, Cantonese, Greek, Arabic and Spanish. This diversity is not consistent across the district: some parts of SESLHD are particularly diverse, with approximately 58% of the Bayside and Georges River LGA's speaking a language other than English. This is compared with 17% in the Sutherland Shire.

SESLHD population continues to age. Currently, 105,145 (11.7%) residents, are aged over 70 years of age. It is projected that this will grow to 14.6% by 2032, and demands on the health system are predicted to increase, as older people are proportionally higher users of health services and are more likely to have long term health conditions.

SESLHD manages the following hospitals and facilities:

- Prince of Wales Hospital and Community Health Services (Randwick)
- Royal Hospital for Women (Randwick)
- Sydney/Sydney Eye Hospital (Macquarie Street)
- St George Hospital and Community Health Services (Kogarah)
- Sutherland Hospital and Community Health Services (Caringbah)
- Garrawarra Centre (Waterfall)
- Gower Wilson Multipurpose Centre (Lord Howe Island).

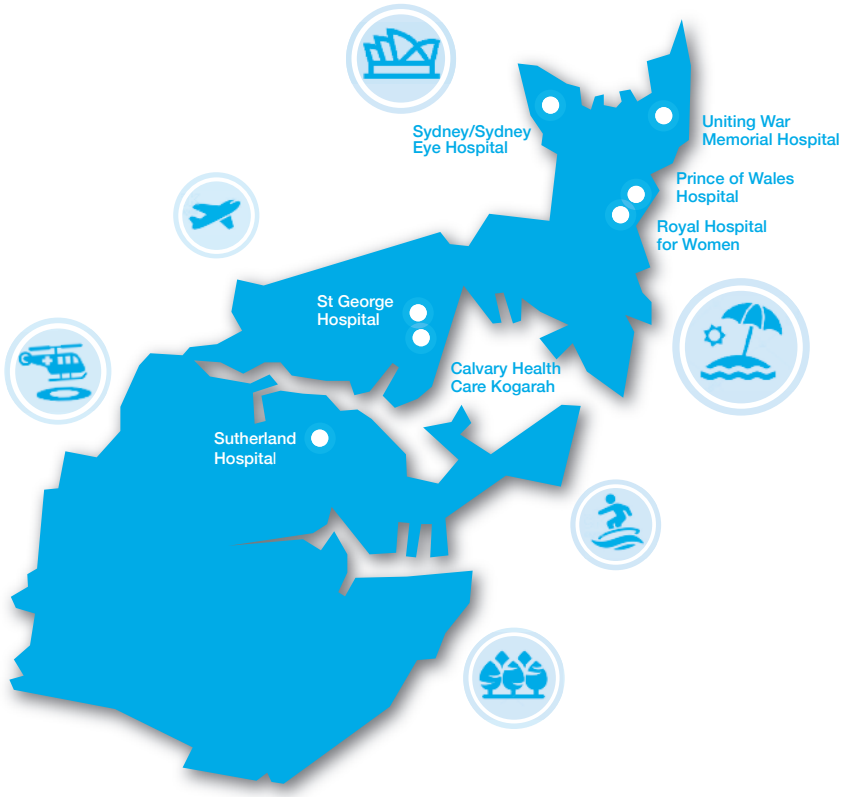
SESLHD also provides support to:

- Calvary Health Care (Kogarah
- Uniting War Memorial (Waverley)

In addition, health services are provided across a variety of community-based services ranging from pre-birth, child youth and family, drug and alcohol services, HIV and sexual health to palliative care.

During 2021/22, SESLHD hospitals managed 243,791 Emergency Department presentations and 173,279 hospital admissions. During this period, SESLHD also delivered 1.5 million outpatient and community occasions of service, with 23% of these provided by telehealth. The key health issues for SESLHD include diabetes, hypertension, cancer and mental health, as well as the challenges associated with an ageing population.

SESLHD in 2021/22



Our vision

Exceptional Care Healthier Lives

Our purpose

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

Our values

Collaboration, Openness, Respect and Empowerment

Our Aboriginal community

The Dharawal, Gadigal, Wangai, Gweagal and Bidjigal are the traditional owners of the land across SESLHD.

SESLHDs total population
898,675

42.2% of people were born overseas and 37.8% speak a language other than English

Aboriginal and Torres Strait Islander peoples make up about **1.1%** of our population

40,992
Surgeries performed, including planned and emergency (2021-22)

243,791
Emergency department admissions

173,279
Patients were admitted

7,840
Babies were delivered

Ageing population
By 2032, 14.6% of our population will be 70 years or older.
144,860

Projected population growth
The population is projected to grow by 11% by 2032 to
994,971

Top five health issues for the people in our district:

Diabetes, Hypertension, Cancer, Mental health, Ageing Population

Snapshot of Achievements

COVID-19 Response

Throughout 2021-22, SESLHD continued to respond to the COVID-19 pandemic, to meet the needs of the community. In addition to the direct clinical care provided to patients with COVID-19, a number of notable initiatives were implemented including:

- the Social Harms of COVID (SHOC) Social Work role;
- the SESLHD Public Health Unit collaborated with the Aboriginal Health Unit to implement a number of strategies and new models of care to support the needs of Aboriginal families and communities;
- COVID-19 Workforce Dashboard to assist management to monitor staffing;
- COVID-19 Community Management Centre, a virtual triage, assessment and monitoring service; and
- Antenatal Telehealth service; and Provision of compassionate cards during COVID-19 for patients and their carers.

Mental Health Prevention and Recovery Centre

Prevention and Recovery Centre (PARC) is a partnership between SESLHD Mental Health Service and Independent Community Living Australia (ICLA). The Centre offers alternatives to hospital for people who need intensive mental health support. An evaluation of the initiative has found:

- a reduction in Mental Health Unit admissions for consumers who have completed a PARC stay; and
- a 33% reduction in Emergency Department Mental Health attendances.

Consumers are provided with a supported discharge by moving from the hospital to the PARC. It is estimated that step down participants will spend 6.6 days less in hospital.

100 Homebirths

The Royal Hospital for Women's publicly funded homebirth program provides women with an evidenced-based, affordable way to birth at home with the expert care of registered midwives. 2021 saw the milestone of 100 homebirths achieved by the service. Outcomes of the service include:

- decreased rates of significant post-partum bleeding and major vaginal tears;
- increased rates of normal vaginal birth;
- improved staff engagement and satisfaction for midwives; and increased service provision, improved staff skills, resilience and responsiveness for women accessing maternity services.

Improving the Management of Patients who Deteriorate Afterhours

During 2021, The Sutherland Hospital identified that the escalation of clinical deterioration to senior clinicians was an area for improvement for the facility. A multidisciplinary working party implemented the introduction of an afterhours Clinical Emergency Response Clinical Nurse Consultant, and updated processes and guidelines to improve communication and escalation of care, and provided support for clinical teams.

As a result of these changes, there was a reduction in the number of deteriorating patient incidents reported, an improved time to documentation of medical plans following a rapid response call, and improved Clinical Emergency Response attendance at rapid response calls.

Acacia Cottage Breakfast Club

Garrawarra Centre is specialised in caring for residents living with Behavioural and Psychological symptoms of Dementia (BPSD). The Acacia Cottage Breakfast Club was implemented with the aim of improving the number of residents consuming breakfast, to assist in maintaining nutritional requirements.

The introduction of the breakfast club resulted in an improvement in resident weight. Of the six residents identified to attend, five residents gained weight during the trial period.

Safety and Quality Planning Processes

Safety and Quality Planning Process

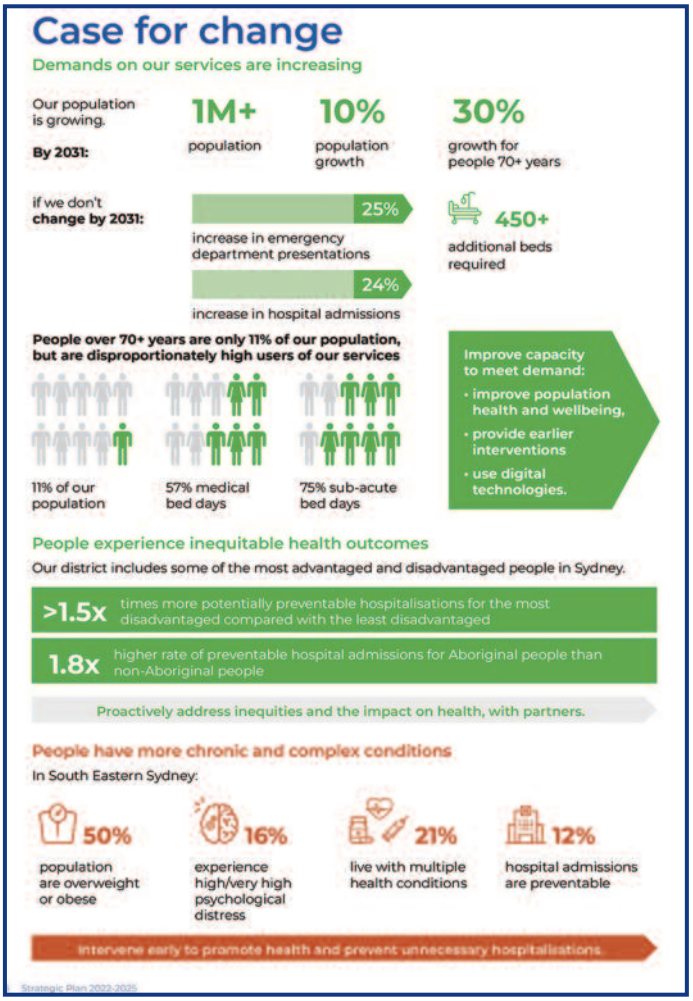
SESLHD Exceptional Care, Healthier Lives 2022 - 2025

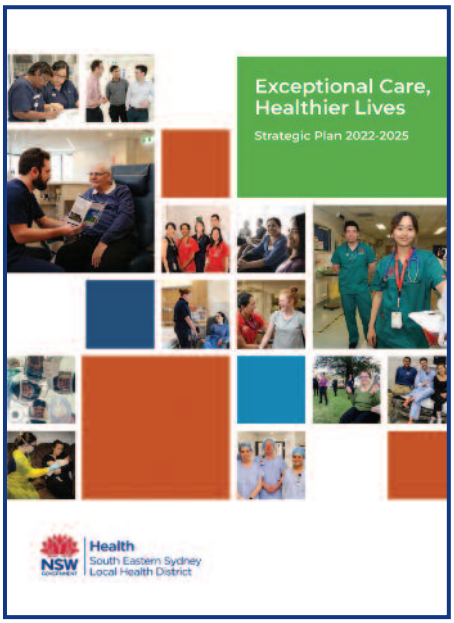
In early 2022, SESLHD released the new strategic plan, Exceptional Care, Healthier Lives 2022-2025.

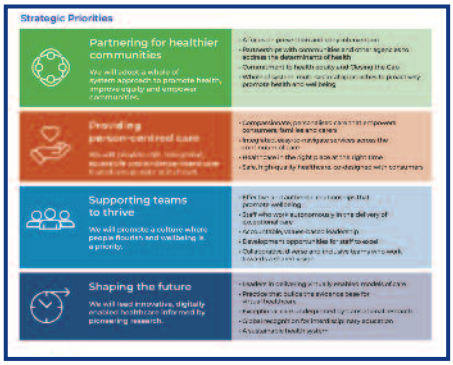
The plan details SESLHD's strategy to deliver exceptional person centred care closer to home. A statement of intent has been developed as part of the strategic plan to provide a clear and shared direction for our organisation to 2031.

SESLHD's vision

To become a leading integrated healthcare provider, trusted by individuals for the care and compassion we deliver







Planning for Safety and Quality

SESLHD's Clinical Governance Framework 2023-25: A world class system for ensuring Quality and Safety in the post CoVID-19 era

Building on SESLHD's new strategic plan, Exceptional Care, Healthier Lives 2022-2025, we are currently developing a refreshed clinical governance framework which will drive quality and safety across the organisation and address the challenges which confront us as we recover from the peak of the COVID-19 pandemic.

Key features of the framework will include:

- A strong partnership approach between patients, carers and their healthcare team
- Shared decision making and accountability for quality and safety at all levels of the organisation
- A world class system which draws on the latest thinking in effective clinical governance processes
- Clear roles and responsibilities for identifying risk as well as opportunities for improvement and innovation
- Robust goal setting and performance monitoring processes
- Financial stewardship
- A clear focus on a learning, patient-centred culture which drives "Joy at Work"

The Clinical Governance Framework 2023-25 will enshrine quality and safety as everyone's business, every day and set the scene for the new environment of short notice accreditation.

National Standards Accreditation

In 2022, all SESLHD facilities were assessed by the Australian Council on Healthcare Standards (ACHS) against the eight National Safety and Quality in Health Service (NSQHS) Standards (2nd edition). To prepare, a consultant conducted gap analyses and readiness surveys to assess progress, and to mentor Quality Managers. The vast majority of action items were met and any recommendations received have now been reassessed and are now compliant. Population and Community Health (PaCH) were assessed for the first time and received extraordinary praise from the assessors. The results have confirmed that SESLHD facilities provide safe and high quality healthcare to their patients.

Standard One: Clinical Governance

Governance, Leadership and Culture (1.1 – 1.6)

The peak SESLHD governing bodies are the SESLHD Board, Quality and Safety Board Sub-Committee, District Clinical and Quality Council, District Executive Council and District Corporate Executive Council. The District is governed by the SESLHD By-Laws. The Governing Body Attestation Statement, which is required annually for accreditation, was endorsed by the SESLHD Board Chair and Chief Executive for 2022 - see Appendix 1 (page 61).

The SESLHD Executive Team are responsible for ensuring sound corporate and clinical governance assurance and performance, progress towards delivering the SESLHD key strategies and response to external demands. The strategic directions of SESLHD are outlined in the SESLHD 2022-25 Strategy: Exceptional Care, Healthier Lives, the SESLHD Quality Plan 2021-22, the SESLHD Clinical Governance Framework and the SESLHD Aboriginal Health Implementation Plan. District and facility Business Plans are developed annually to operationalise the SESLHD strategy and to outline key priority initiatives for the upcoming financial year. The SESLHD Burudi Muru Yagu Aboriginal Health Plan and Committee identify and monitors all local actions to inform safety and quality priorities to address the specific health needs of Aboriginal and Torres Strait Islander people.

The District Clinical Governance Unit (CGU) provides a link between site and service Clinical Practice Improvement Units (CPIUs) and the District Executive Team. CGU provides regular reports to the SESLHD Board, Safety and Quality Board Sub-Committee and Clinical and Quality Council.

Safe Environment for the Delivery of Care: (1.29 – 1.33)

The Directorates of People and Culture and Corporate and Legal support facilities to ensure the safe environment and staff safety. The SESLHD Security, Risk and Governance Committee provides governance, oversight and advice on the implementation of security risk management systems and processes. Maintenance services maintain buildings and respond to staff requests. Health Infrastructure supports redesign and re-development projects which comply with building requirements and include input from staff and consumers.

Consumers provide advice for access and wayfinding in facilities. Person centred care principles guide all patient services including visitors' access. Care is provided to people with special needs in purpose built units, for example dementia units are incorporated into aged care departments. COVID-19 restrictions have been put in place to protect patients and staff.

The Aboriginal Health Unit and Aboriginal staff from local communities provide advice on Aboriginal artwork to be used in all district facilities which welcome Aboriginal people into the facilities. A "Guide to Communicating with Aboriginal Communities" has been developed to assist staff and empower local Aboriginal voices which inform policy and programs intended to address local Aboriginal community needs. Acknowledgement to Country wall plaques have been developed following advice from the two Local Aboriginal Land Councils to appropriately acknowledge traditional custodians.

Standard Two: Partnering with Consumers

Our organisation met all of the requirements for Standard 2 in the 2022 organisational wide survey. Consumer partnerships at all levels are necessary to ensure that our health service remains responsive to consumer input and needs.

SESLHD's model for consumer partnership is outlined in the Consumer Engagement Framework. Sites have also developed local consumer frameworks and strategies.

SESLHD has a broad range of consumer engagement activities occurring from the individual to the system level. At the individual level, partnerships occur between individual patients, their families and carers, and our clinicians in shared decision making to enable the provision of person-centred clinical care. Programs that support our staff in the provision of person-centred care such as the Teach-back Tool, Health Coaching, Advanced Care Planning, and Patient Reported Measures demonstrate our commitment to sharing information appropriately with patients, supporting their own self-care and management.

Care Opinion, an online, independent digital platform is available where anyone can share their stories about their experience of care in a safe and confidential way and receive a timely response. Care Opinion provides an opportunity to capture stories from our patients that can support staff to improve services, acknowledge when care provided is of high standard, and provide a rich source of information that will support quality improvement.

At a service level, our partnerships draw on the experience of those who have used a service, are currently using a service, or may use it in the future, to improve the service, experience and outcomes for patients, families, carers and staff. Patient Reported Measures (PRMs) including Patient Reported Outcome Measures (PROMS), Patient Reported Experience Measures (PREMS), and Patient satisfaction surveys, support incorporation of the consumer voice in quality improvement and redesign programs and allow opportunities for consumers to participate in or provide feedback in how a service operates, as well as implementing and evaluating changes.

The Planning and Partnerships team in the Strategy, Improvement and Innovation (SII) directorate include resources to support the maintenance of external partnerships and implementation of the consumer and community engagement framework.

In line with SESLHD's Strategic Community Partnerships Governance Framework, broad engagement with consumers and partners has taken place throughout 2021/22, despite the operational challenges presented by COVID-19. The governance framework defines the Board Strategic Community Partnerships Committee (BSCPC) as a Board sub-committee for the purpose of oversight of SESLHD's strategic community partnerships. The Community Partnerships Alliance, a working group reporting to the BSCPC, facilitates implementation of the framework, and reporting on collaborative initiatives.

Key activities during 2021/22 include:

- Extensive partnerships through COVID-19, particularly in supporting vulnerable populations, people experiencing mental health challenges and residents living in Residential Aged Care Facilities;
- Engagement with partners to seek input into SESLHD's strategy, as well as broader planning activities;
- Launch of SESLHD's Consumer Partnership Framework and engagement with consumer representatives to plan delivery of key initiatives aligned to this framework;
- Collaboration to share information on community needs around social isolation and loneliness, and the services available across partners to manage this need;
- Knowledge sharing through the Community Partnerships Alliance meetings on the following topics: Integrated Response to Violence, Abuse and Neglect; Youth Health; Aboriginal Workforce Recruitment, Retention and Development and CESPHN's Head to Health Pop Up services; and

- A Consumer and Partner Forum was held, with approximately 100 attendees, including discussion on the District strategy, Research strategy, Virtual Health implementation, LGBTIQ+ strategy, Con sumer Partnerships Framework and Randwick Health and Innovation Precinct.

Our major facilities have Consumer Advisory Committees (CACs) chaired by consumers that provide an opportunity to shape the strategic direction of our services. The committees play a role in reviewing and developing patient information resources that reflect consumer involvement in health literacy. Consumers are recruited and participate in Health Consumers NSW training to support their roles. Governance for consumer participation is well supported with two sub-committees and a high level working group established at Board level. Consumers are members of all peak Safety and Quality Committees. The Strategic Community Partnerships Alliance, for which members are drawn from the local community, the Department of Communities and Justice, Central and Eastern Sydney Primary Health Network (CESPHN), other external agencies and selected Non-Government Organisations (NGOs), aims is to improve outcomes related to better physical health, and emotional and social well-being outcomes for the community.

Patient stories are shared through various avenues, including the SESLHD Quality and Safety Board Committee.

Clinicians work collaboratively with patients and family as care is planned and delivered, consent standards are adhered to and patient feedback is sought and acted upon. The development of written patient information is guided to ensure consumer input and health literacy is addressed. The use of teach-back techniques by trained staff enhances communication with patients and carers.

SESLHD sites and services have local initiatives for partnering with consumers and provide health care for vulnerable populations within the LHD.

For example, Population and Community Health (PaCH) strengthened and streamlined consumer and community engagement, launching a PaCH Consumer Engagement Framework and celebrated achievements at the PaCH inaugural consumer, community and carer engagement forum, co-designed and co-produced with consumers and carers. In 2022, PaCH expanded place-based care initiatives through the addition of the Wolli Creek Hub, a partnership with Karitane and maternity services, focusing on women, children and families experiencing disadvantage in the local area. PaCH leads a number of place-based care initiatives which are designed to address complex health issues through shared vision, key partnerships, and community engagement. Hubs are used to coordinate and deliver a range of mutually reinforcing health and social care activities, including primary health care and care-coordination, in collaboration with the community.

Update on 2021/22 Priorities

Update on 2021/22 Priorities

Aboriginal and Torres Strait Islander Health

Improve Aboriginal health outcomes and contribute to Closing the Gap

Our Goals

- Finalise and implement the ***Burudi Muru Yagu SESLHD Aboriginal Health Plan.***
- Review Aboriginal Health Governance to improve reporting mechanisms and address performance indicators in Aboriginal health
- Address falling rates of reporting of Aboriginality, which will then influence the following performance indicators: decrease did not wait and re-presentation rates for Aboriginal and Torres Strait Islander patients
- Increase the cultural responsiveness of services through the following actions:
  - the Ministry of Health mandated attendance at Respecting the Difference face to face cultural awareness sessions;
  - increasing Aboriginal workforce;
  - developing culturally welcoming spaces, through the use of artwork and the Aboriginal and Torres Strait Islander flags; and
  - acknowledging significant days for Aboriginal and Torres Strait Islander staff and community members such as Sorry Day, Reconciliation week and NAIDOC week by holding events.
- Continue the work of facility Aboriginal and Torres Strait Islander health working parties, including annual Aboriginal cultural engagement self-assessments tool and development of plans to address gaps in service delivery.

In 2021, the SESLHD Aboriginal Health Unit celebrated 25 years as an essential part of SESLHD's commitment to Closing the Gap. The Aboriginal Health Unit has been instrumental in engaging staff, consumers and community organisations to establish partnerships that support improved outcomes and promote equity for the local Aboriginal community.

Aboriginal and Torres Strait Islander Health

Improve Aboriginal health outcomes and contribute to Closing the Gap - Our Progress

During 2021-2022, SESLHD prioritised targeted activities that contributed to Closing the Gap, as well as building capacity of the Aboriginal and Torres Strait Islander health workforce, including:

- A comprehensive review of the Burudi Muru Yagu SESLHD Aboriginal Health Plan in partnership with a number of stakeholders. It is expected that a final document will be published in August 2022. The Burudi Muru Yagu Aboriginal Health Plan committee continued to meet during 2021 and 2022 to focus on key actions of SESLHD, including Aboriginal Health governance and cultural responsiveness of services. These actions assisted all facilities and services in preparation for accreditation.
- A focus within the Burudi Muru Yagu Aboriginal Health Plan on **Aboriginal workforce.**
  - There was a small decrease in the percentage of Aboriginal employees represented within the District's workforce from 2020/21 to 2021/22. The percentage at the end of 2021/22 was 1.12% compared to 1.17% in 2020/21. Given the impacts of the COVID-19 pandemic on the health workforce and difficulties presented by intermittent lockdowns, the decrease is not wholly unexpected. With the successful recruitment to the key positons of Aboriginal Employment Consultant and Aboriginal Development Consultant through 2021/22, this will bring stability and renewed focus to growing and support the SESLHD's Aboriginal workforce.
  - In 2021/22, SESLHD participated in the inaugural 2022 Indigenous Employment Index. The Index is the first comprehensive snapshot of Aboriginal workplace representation, practices and employee experiences ever to be carried out in Australia. The results from participation in the Index identified a range of opportunities to improve Aboriginal employment outcomes within SESLHD. These opportunities support a comprehensive and systematic approach to Aboriginal employment and will be developed over the coming year and into future years.
- Progress toward developing **Aboriginal Action Plans** at each facility in preparation for accreditation.
- Aboriginal Health **governance** was a focus in 2021/22 and will continue to be over 2022/23
  - This ongoing conversation will ensure consistent approaches to governance and support for cultural responsive service delivery across SESLHD. Many facilities and services considered how to develop more culturally responsive service delivery through a number of mechanisms including these discussions, the Aboriginal Cultural engagement self-assessment audit tool and facility Aboriginal Health working parties.
  - Discussion and accountability through reporting mechanisms, addressing performance indicators in Aboriginal health continued in 2021/22. This was facilitated by the Aboriginal Health Unit and Director of Population and Community Health, and executive leaders of the district. This continued in the forums: District Executive, Clinical and Quality Council, Emergency Department and clinical streams. Discussion continued to provide opportunities to improve health outcomes by Aboriginality, and other Aboriginal health performance measures influenced by this indicator.
- A district wide strategy for reporting of Aboriginality was delayed from implementation in early 2022 due to demands brought about by the COVID-19 pandemic. Implementation is planned in the first quarter of 2022/23 to address a decrease in rates of this indicator.

A focus on increasing the **cultural responsiveness** of services continued through 2021/22 and will continue beyond accreditation through the following actions:

- All facilities have established Aboriginal and Torres Strait Islander health working parties. These continued steps in 2021/22 to improve health outcomes for Aboriginal and Torres Strait Islander patients.
- All facilities addressed needs in an Aboriginal cultural engagement self-assessment tool in 2020 and have plans to address gaps in service delivery. This assessment will be undertaken annually.
- A review of the mandatory cultural awareness training module was undertaken in 2019. Consultants provided virtual training options through March to June 2022. The new Respecting the Difference: Be the difference Know the Difference module will be available from August 2022. This education is essential to provide a knowledge to support more culturally welcoming services, improving identification of Aboriginal people, referral to appropriate services.
- There was easing of COVID-19 health restrictions at times in 2021/22. This allowed the district to acknowledge some of significant days for Aboriginal and Torres Strait Islander staff and community members. These include Sorry Day, Reconciliation week and NAIDOC week and included options for both face-to-face and online events in 2021/22.

- Additional face-to-face events are planned for 2022/23, as these provide opportunities for SESLHD staff to observe and appreciate the significance of these events. This further informs all staff on the strengths of Aboriginal culture and supports an understanding of the physical, emotional, social and spiritual dimensions of wellbeing for Aboriginal and Torres Strait Islander individuals and communities and what assists Aboriginal people to trust and access services.

Aboriginal and Torres Strait Islander Health

Prince of Wales and Community Health Service Aboriginal Health Action Plan 2021-23

Prince of Wales Hospital and Community Health Services (POWH&CHS) acknowledges that we provide our services on the lands of the Gadigal and Bidjigal peoples. POWH&CHS are strongly committed to improving the physical, cultural, spiritual and family wellbeing of Aboriginal and Torres Strait Islander people. In 2020, POWH&CHS undertook the NSW Ministry of Health Aboriginal Cultural Engagement Self-Assessment.

An action plan was developed following the survey, which aims to improve the quality and safety of our care of Aboriginal and Torres Strait Islander people attending POWH&CHS. The action plan aligns with the National Safety and Quality Health Service (NSQHS) Standards for Aboriginal and Torres Strait Islander Health and the Burudi Muru Yagu SESLHD Aboriginal Health Plan.

The action plan identifies six key domains in which to improve the experience of Aboriginal and Torres Strait Islander patients and their families:

- Building trust through partnerships
- Implementing what works and building the evidence
- Ensuring integrated planning and service delivery
- Strengthening the Aboriginal workforce
- Providing culturally safe work environments and health services
- Strengthening performance monitoring, management and accountability

Examples of work currently underway include:

- surveys of Aboriginal patients post discharge;
- monitoring key quality and safety indicators for Aboriginal patients;
- improving patient follow up after discharge from the emergency department to the community, cultural safety training for staff;
- improving community partnerships through consultation workshops;
- staff training and auditing regarding identifying Aboriginal and Torres Strait Islander people on registration and each presentation; and
- developing a welcome pack and creating a more welcoming environment, such as Aboriginal names for wards and departments.

Quality Improvement

A key area of focus in SESLHD in 2021/22 was Quality Improvement. This encompassed a number of initiatives, ultimately striving to embed systems, processes and capability for improving service quality and patient care, including the implementation of the Clinical Excellence Commission's NSW Health Safety and Quality Curriculum.

Implementation of the Safety and Quality Curriculum

Throughout 2021/22 SESLHD committed to implementing the NSW Health Safety and Quality Curriculum across the district. The aim was to embed the foundational, intermediate and adept level pathways to create an organisational wide culture of safety and quality.

The aim of the NSW Health Safety and Quality Essentials Pathway (SQEP) is to contribute to better value, build infrastructure and mobilise safety and quality capability in order to meet the changing needs of our patients, workforce and system delivery priorities over the coming years.

Goal 1: Embed the Foundational & Intermediate pathway into SESLHD Orientation and onboarding processes with promotion to all staff

Progress

To date, SESLHD has had 680 staff enrolled in the Foundational learning pathway. Approximately 160 staff have enrolled across the two streams of the Intermediate pathway. The SQEP will be included in orientation for all new staff commencing employment with SESLHD from early 2023.

Goal 2: Commence applications for and recruitment to the first cohort of the Applied Safety and Quality Program

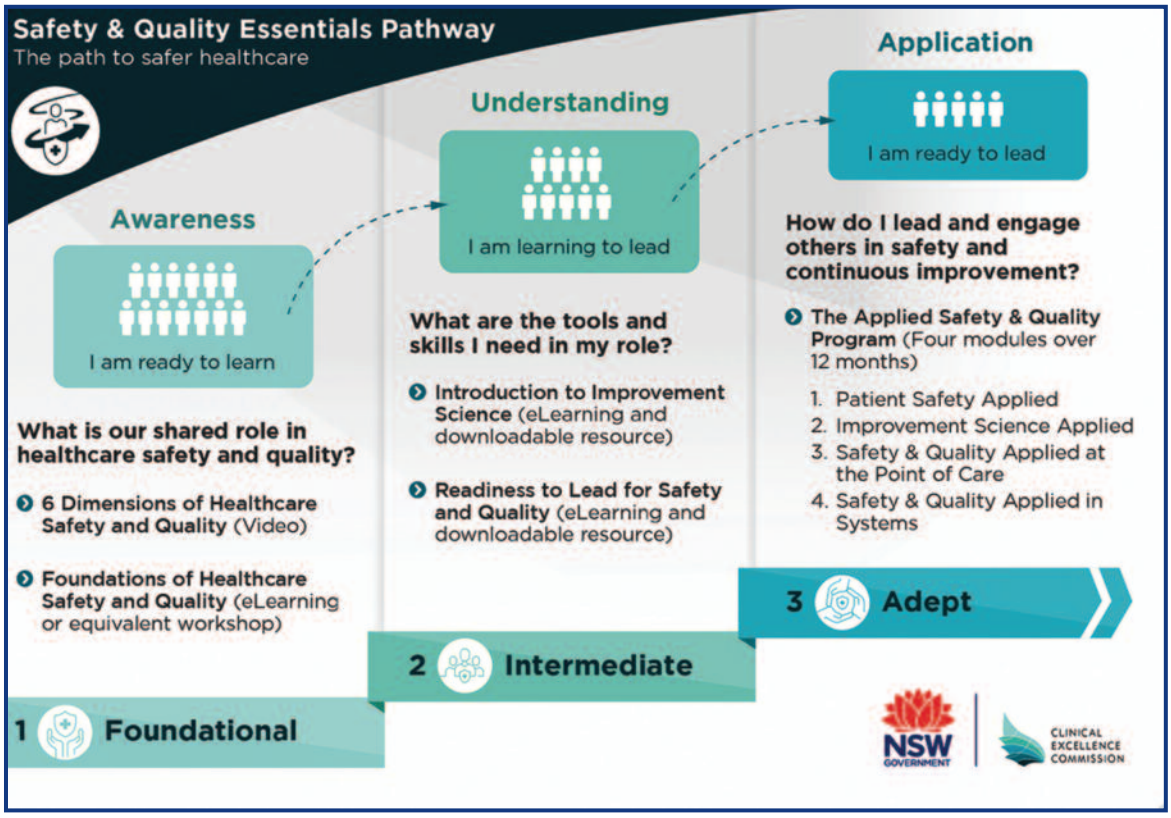
Progress

In 2021/22, 19 participants applied to commence the inaugural Adept program component of SQEP. The program will run for 12 months and will focus on building capacity and capability of participants to lead safety and quality improvement projects within their teams.

Goal 3: Commence the first cohort of the Applied Safety and Quality Program

Progress

The Adept Program commenced is due to commence in early 2022/23. This first cohort is expected to graduate in August 2023.



Towards Zero Suicides

Towards Zero Suicides is a NSW Government $143.4 million investment over four years from 2022-23 in initiatives that address priorities in the Strategic Framework for Suicide Prevention in NSW 2018-2023 and contribute to the Premier's Priority to reduce the suicide rate by 20 per cent.

To date, SESLHD Mental Health Service has:

- Opened a SafeHaven service in proximity to St George Hospital, offering an alternative to the emergency department for people experiencing suicidal or emotional distress.
- Established a Suicide Prevention Outreach Team (SPOT) within Sutherland Mental Health Service, aimed at providing assertive care to people in the community who are in distress, suicidal or at risk of self-harm.
- Trained over 250 clinical staff in SafeSide suicide risk formulation training, updating the workforce's suicide prevention risk skills and response to people at risk of suicide within our system.

Despite the impacts of the COVID-19 pandemic, data indicates the suicide rate has remained relatively stable overall.

Over the next twelve months, SESLHD Mental Health Service plans to:

- Conduct a preliminary evaluation of the SafeHaven and SPOT services.
- Continue to roll out the SafeSide suicide risk formulation training, to support teams in engaging those who are suicidal, and reduce variation in clinical risk formulation and treatment approaches to suicidality.
- Commence development of localised Suicide Care Pathways, to provide a framework and guidance for providing comprehensive identification, assessment, intervention, and transition of care for all individuals who enter SESLHD facilities with suicidal ideation and suicidal behaviours.
- Explore ways in which current adverse event review processes can better support the restorative justice approach.

Achievements in Safety and Quality

Achievements in Safety and Quality

COVID-19 Pandemic Response

Throughout 2021/22, SESLHD continued to respond to the COVID-19 pandemic. From managing the outbreak of the delta strain in winter 2021, through to managing the increasing COVID-19 case numbers at the close of 2021 and into the New Year and holiday period, SESLHD hospitals, services and teams have adapted and implemented initiatives to meet significant service demands, respond to the needs of consumers, and manage the outbreak in the community. In addition to the continuing work of the COVID-19 testing clinics, the door screening program and the vaccination hubs, a number of notable initiatives were implemented.

The Social Harms of COVID (SHOC) Social Work

The Social Harms of COVID (SHOC) Social Work role was quickly established at the start of the pandemic and is primarily responsible for providing outreach and support to residents of SESLHD who are directly impacted by COVID-19 (either as a close contact or were positive themselves).

The role has also worked closely with accommodation providers across SESLHD to secure alternative accommodation for residents in need, as well as for staff who needed to access accommodation other than home, to allow them to continue to come to work if they had a household contact. This has assisted to keep our workforce agile and able to attend work on the frontline, and ensured that no vulnerable clients were left without safe accommodation options.

The SHOC Social Worker provided intervention to over 1,000 clients during the pandemic, and provided support to clients in isolation on issues such as mental health, accommodation, employment, immigration, food security, medication, domestic violence and child protection. This sole clinician worked closely with key stakeholders in the Public Health Unit (PHU), the COVID Management Centre (CMC) and the Aboriginal Health Unit (AHU) to ensure that vulnerable clients were able to access the practical and emotional support required to isolate safely.

The role has been flexible and adaptable and has surged to meet demand and scaled back during quieter times. Social Work continue to remain ready for what lies ahead in providing a pandemic response.

Supporting Aboriginal communities through COVID-19

During a pandemic, Aboriginal and Torres Strait Islander people are considered an ‘at risk’ population due to their higher risk of severe disease compared to non-Aboriginal people.

To support the Aboriginal community through the pandemic, the Public Health Unit (PHU) worked with the Aboriginal Health Unit to implement a number of strategies and new models of care to support the needs of Aboriginal families and communities. This included:

- Establishing an Aboriginal Support Officer (ASO) service to provide important, up-to-date information to the community, cultural support for people with COVID-19 and close contacts, answer questions and address concerns of the Aboriginal community. This included a website and dedicated support phone line, linking clients with social work, welfare support, mental health support and information on how to connect to local Aboriginal and Torres Strait Islander services via videoconferencing or telehealth.
- Running dedicated COVID-19 and influenza vaccination clinics for Aboriginal people in collaboration with the SESLHD Aboriginal Health Unit, Aboriginal Health Workers, La Perouse Aboriginal Lands Council, local businesses, and SESLHD and Sydney Children's Hospital vaccination hubs. 1,391 people were vaccinated across 21 clinics.
- Helping La Perouse Community Health Centre establish a COVID-19 testing service for their Aboriginal communities through training and supply of rapid antigen test kits.
- Vaccination clinics as a result of multi-organisation efforts, tailored from community survey results and consultation sessions. Culturally-appropriate resources were developed featuring Aboriginal artwork designed by Aboriginal Health Workers.

SESLHD was the first district to implement a dedicated phone service for Aboriginal communities. This was implemented following collaboration with multiple teams to establish new models of care and referral pathways. Hundreds of Aboriginal people and their families were provided with telephone cultural support, linked with social work, welfare support, mental health support and priority access to Special Health Accommodation.

The team drew upon Aboriginal Health Workers from across SESLHD to share a 7-day/week service, 12 hours per day. This provided people with COVID-19, close contacts and the community with cultural support and links to other healthcare services during peak COVID-19 waves, as well as providing access to basic necessities, masks and rapid antigen tests.

COVID-19 Workforce Dashboard

The Clinical Insights and Analytics (CIA) team developed the COVID-19 Workforce Dashboard to support executive and senior management teams in managing and monitoring the COVID-19 workforce impact across SESLHD. The dashboard provides insights to:

- identify the services where the COVID-19 workforce has been most impacted;
- allocate appropriate resources to the most critical services in timely manner; and
- provide support to the workforce to maintain their wellbeing and to minimise COVID 19 infection impacts to their health.

The Workforce Dashboard has been an instrumental tool for the Executive and the SESLHD COVID-19 Operations teams to minimise the impact of COVID-19 infection on the SESLHD workforce, therefore allowing the continuation of safe and high quality care for our patients.

Virtual Care: COVID-19 Community Management Centre

In response to the COVID-19 pandemic and a growing number of cases in NSW, the SESLHD COVID-19 Community Management Centre (CMC) was established in September 2021. The COVID-CMC, hosted at Prince of Wales Hospital, is a district-wide virtual service that enables a centralised approach to acute care, and adaptable service delivery in response to surging case numbers.

The CMC aims to: ensure that people isolating at home with COVID-19 remain safe; and to identify individuals who are at high risk of deterioration, enabling assessment and referral to their local Hospital in the Home team for management. The CMC combines three equally important functions: clinical care; remote monitoring; and administrative support, including the facilitation of delivery of equipment and resource packs for patients.

The COVID-19 CMC provides centralised intake, triage and risk assessment of people with COVID-19 across SESLHD. Patients with COVID-19, especially those be at higher risk of deterioration, can opt-in to remote monitoring using an oximeter and an application on their mobile device. This enables early identification of signs of deterioration and early escalation for clinical review.

The ability to rapidly risk assess patients and provide remote monitoring, together with timely referrals to Hospital in the Home for high risk individuals, resulted in increased clinician and patient confidence and reduced interruptions for patients through daily telephone check-ins.

From its establishment at the end of September 2021 through to June 2022, 9,617 patients were triaged by the COVID-19 Community Management Centre. Of these, 4,021 patients received monitoring through the service.

Antenatal Telehealth

The aim was to improve women's experience, enabling the presence of a support person for the booking (as hospital restrictions were introduced), and to reduce travel and time spent away from parenting or work commitments.

The Royal Hospital for Women (RHW) Maternity Outpatients initiated virtual antenatal appointments to minimise risk of transmission of COVID-19. Appointments are conducted by a midwife using myVirtualCare, a NSW Health-supported videoconferencing platform. Providing choice enhances person-centred care, and the option for face-to-face appointments remains if requested, or if complex issues are identified.

myVirtualCare delivered benefits during COVID-19, and it was demonstrated as a sustainable option for antenatal appointments in the future.

Antenatal telehealth appointments enabled care to continue despite COVID-19 restrictions, and allowed for increased flexibility of scheduling, for example, appointments made with limited notice as travel is not required. Transmission risk for COVID-19 was reduced, increasing safety for staff and pregnant women. Telehealth appointments also allowed for effective social distancing for patients in the antenatal waiting room, as the number of in-person appointments for pregnant women reduced.

Telehealth is now used across outpatient services, including for group education sessions, including Gestational Diabetes, Breastfeeding, Next Birth after Caesarean, and for women from Culturally and Linguistically Diverse backgrounds, with an interpreter present.

The initiative aligns with National Safety and Quality Service Standards - Standard 2, Partnering with Consumers. Virtual bookings have increased flexibility for women, facilitated partner support, reduced time away from work or caring commitments, and provided an ability to provide long-distance bookings for regional residents.

Compassionate cards during COVID-19

The aim was to provide St George Hospital consumers and their relatives/ families a card with sincerity of the current climate and difficulties being faced due to isolation and visitor restrictions during the COVID-19 pandemic.

The cards were developed for both patients and visitors with a simple message that acknowledged the difficulties for patients and their families as a result of the visitor restrictions.

The visitor card also provided a contact number for the family member or next of kin to be able to contact our hospital.

The cards were translated into our top five languages and were issues at the entry to the Emergency Department.

Regulating e-cigarettes in SESLHD

The use of e-cigarettes is an emerging public health issue across the world, particularly amongst young people. The NSW Population Health Survey shows vaping by young people (16-24 years old) in Australia doubled from 2016-17 to 2019-20.

A proactive approach by SESLHD Public Health Unit

As of February 2021, the SESLHD Public Health Unit (SESPHU) is the first district to have the majority of its Environmental Health Officers authorised under the Poisons and Therapeutic Goods Act, vastly expanding the team's capacity to undertake covert operations and seizures to effectively undertake large scale operations for vape offences.

Since May 2021, SESPHU have achieved the following results:

- 32 seizures of e-cigarettes containing nicotine from tobacco retailers to the street value of $616,291.
- 4 successful prosecutions for supplying a schedule 7 substance (liquid nicotine) without authority.
- 25 penalty infringement notices issued to tobacco retailers for allowing e-cigarette products to be visible to the public.
- 49 vape cartridges submitted to the Government Analyst for analysis with 41 found to contain nicotine.
- Joint operations with NSW Police and Ministry of Health.
- 1 project undertaking covert purchases of e-cigarettes from 18 tobacco retailers in suburbs near Aboriginal communities. Following the compliance test, seizures were undertaken in 6 tobacco retailers who sold e-cigarettes containing nicotine.
- Investigation of the e-cigarette used by the first diagnosed case of E-cigarette or Vaping Associated Lung Injury (EVALI) in Australia whereby the vape seller was prosecuted and fined $4,500. A report on the case and response was accepted and published in the Medical Journal of Australia, 2021.

Sydney/Sydney Eye Hospital Reduction in Hospital Acquired Complications - One is One Too Many

Hospital acquired complications (HACs) are patient complications for which risk mitigation strategies may reduce, but not necessarily eliminate, the risk of that complication occurring. HACs can affect the patient's recovery and increase the patient's length of stay, with a correlated increased cost of care.

The Sydney/Sydney Eye Hospital (SSEH) Executive team led a series of projects to reduce the number of HACs, in particular those linked to endocrine, cardiac, falls and delirium, from the baseline rate in 2018/19 of 44.0 HACs per 10,000 cases.

The hospital implemented the National Comprehensive Care Standard and utilised the Australian Commission on Safety and Quality in Health Care's Hospital Acquired Complications Toolkit and other evidence-based initiatives including:

- Creation of new diabetes nursing roles, extensive education resource development and delivery to address **endocrine complications**.
- Implementation of nurse-led clinical reviews and updates to Acute Chest Pain management to incorporate the NSW Health Pathway for Acute Coronary Syndrome to address **cardiac complications.**
- Upgrade of equipment and implementation of the Leading Better Value Care program for Falls Prevention to address **falls incidents.**
- Implementation of a nursing specific model of care, incorporating early referral to the Clinical Nurse Consultant and the use of the person-centred care Sunflower Tool, to address **delirium.**

This project utilised a multidisciplinary and multi-scoped approach to achieve a sustained change in practice. Executive support of the changes and strong leadership has helped create a culture of patient safety at SSEH, with a shared understanding that one complication is one too many. Ongoing measurement and monitoring of results is embedded as part of the SSEH Business Rule Sub-committee and the SSEH Patient Safety Improvement Committee.

Outcomes

Through this whole of hospital work, SSEH reduced their **HACs by 46%** to 26.2 per 10,000 cases, significantly lower than the state average of 248.4 in the 2020/21 financial year. The ongoing commitment to these projects has resulted in a sustained reduction, with the following results recorded over 2021/22:

- There were no endocrine hospital acquired complications between November 2021-March 2022
- There were no cardiac hospital acquired complications from December 2022-March 2022
- There were no falls or delirium incidents between January 2022 and March 2022

This project has directly led to improved patient outcomes, improved efficiency and reduced length of stay in hospital and reduced hospital costs.

100 Homebirths

Royal Hospital for Women mission statement: To provide women, their babies and their families with excellent care in a responsive and collaborative environment that promotes best practice, teaching, research and staff engagement

The Royal Hospital for Women's publicly funded homebirth program provides women with an evidenced-based, affordable way to birth at home with the expert care of registered midwives.

The program has been shown to increase promote an empowering birth experiences as well as increase satisfaction for women, their families and healthcare providers.

The homebirth program has achieved the following results:

- Decreased rates of significant post-partum haemorrhage and major perineal trauma.
- Increased rates of normal vaginal birth, intact, grazed or 1st degree perineal tears and increased rates of physiological third stage.
- Improved staff engagement and satisfaction for Midwifery Group Practice midwives.
- Increased service provision, improved staff skills, resilience and responsiveness for women accessing maternity services.

The Royal Hospital for Women's homebirth program is evidence of a robust and sustainable commitment to improved safety and quality for women accessing maternity services.

I truly believe education and preparation is the key to a safe and healthy homebirth, which was provided to us.

Birthing in the home creates more confident and calm parents , as it requires complete trust of your body to birth. That trust and love for your body transforms you as a parent. It's amazing to see!

Mental Health Service - Prevention and Recovery Centre

Prevention and Recovery Centre (PARC) is a partnership between SESLHD Mental Health Service and Independent Community Living Australia (ICLA). The Centre offers alternatives to hospital for people who need intensive mental health support. The model provides an evidenced based approach to prevention and early intervention community-based services.

PARC has improved access and transition of care for consumers by reducing hospital length of stays, emergency department presentations and readmissions to a mental health unit.

An evaluation of the initiative has found:

- 44% reduction in Mental Health (MH) Unit admissions for guests who have completed a PARC stay
- 29% of people whom had a MH Unit admission prior to PARC, did not have a MH admission at all post PARC
- 33% reduction in Emergency Department MH attendances
- Individuals are provided supported discharge by moving from the hospital to the PARC. It is estimated that step down participants will spend 6.6 days less in hospital

Feedback from guests and their families has been very positive

In the 25 years of trying to help my mum deal with mental illness and trying to guide her towards the most effective treatment and care, I have not come across anything of the standard of PARC, in fact before mum went there, I didn't think we would ever see anywhere like it. It is so reassuring to know that it is there and hopefully there will be more and more facilities like it

Staff have been very helpful, kind, understanding and caring… we felt very relieved that she had another option other than hospital when her mental health starts to deteriorate

Improving the Management of Patients who Deteriorate Afterhours

During 2021, The Sutherland Hospital identified that the escalation of clinical deterioration to senior clinicians was an area for improvement for the facility.

A multidisciplinary working party was established to identify issues as well as develop and implement solutions. Solutions implemented by the working party include:

- The introduction of an afterhours (AH) Clinical Emergency Response (CER) Clinical Nurse Consultant (CNC) from 12noon to 12midnight, 7 days a week
- Processes to support early and transparent communication about patient deterioration to senior managers, clinicians and families
- Guidelines updated to include parameters for when the surgical registrar must escalate to the Medical Officer In Charge following rapid response calls.

Results achieved:

- Zero serious incidents reported
- A reduction in the number of deteriorating patient incidents reported November 2021 – June 2022
- Improved time to documentation of medical plans following a rapid response from 105 minutes in November 2021 to 34 minutes in February 2022
- Improved CERS attendance at rapid response calls from zero in November 2021 to 100% in February 2022
- Staff level of confidence and support with acutely deteriorating patients has improved from 76% reporting “confident” to 93% reporting “extremely confident”.

Clinical Insights and Analytics - Emergency Dashboard

The Clinical Insights and Analytics (CIA) unit at SESLHD worked with Emergency Departments across SESLHD to redevelop the Emergency Department dashboard. The project aimed to enhance the delivery of high quality and safe care as well as improve the patient experience.

The updated dashboard allows clinical staff:

- to view and analyse significantly more data in real time (20 min delay) data extracts across the organisation;
- to identify frequent presenters to all emergency departments over any period of time, including other key characteristics of the patient (including diagnosis, triage category, how they left the emergency department (Did not wait or admitted); and
- to view re-presentation data for all patients who represent within 24 or 48 hours from last presentation, which includes granular data on this patient cohort.

Identification of high risk patients and frequent presenters supports the implementation of targeted models of care to prevent patients having to attend emergency, including the introduction of management plans to reduce time in emergency and improve the patient experience.

Viewing re-presentation data allows staff to identify any trends or areas of representation that the department can address.

ECG Integration with eMR at Prince of Wales and Sydney/Sydney Eye Hospitals

In response to a number of patient safety events, Prince of Wales Hospital (POWH) and Sydney/Sydney Eye Hospital (SSEH) commenced a project to integrate all electrocardiographs(ECGs) performed, with the electronic medical record (eMR).

Prior to the project, ECGs were not readily available across SESLHD, instead restricted to the individual facility’s paper-based medical record or electronically only in the Emergency Department. This existing hybrid practice was identified as contributing to some patient safety events.

POWH and SSEH established a project steering committee comprising of Clinical Engineering, Health ICT, Health Records, along with front line clinical staff and executive sponsorship to define the clinical, technical and medical records requirements and improve access to ECGs.

The project team successfully enabled integration of ECGs into the eMR.

POWH also developed a clinical business rule to guide practice around performing and clinical reviewing ECGs. This reduces the risk of a patient having an ECG performed but not reviewed by a medical officer.

Outcomes

The ECG integration with eMR has resulted in:

- ECGs being readily available across SESLHD, no longer restricted to an individual facility’s paper record.

- ECGs being reviewed anytime/anywhere
- Improved documentation and communication where an ECG has been performed and reviewed or not reviewed
- ECGs transferred electronically either from an ECG cart or the patient monitoring system into the electronic medical record.

To date there have been 339,974 ECGs conducted across POWH and SSEH. ECGs performed at one facility are now available for viewing at another facility. For example, if a patient presents at SSEH Emergency Department and is transferred to POWH, any ECGs performed are available on arrival at POWH.

Acacia Cottage Breakfast Club

Garrawarra Centre is specialised in caring for residents living with Behavioural and Psychological symptoms of Dementia (BPSD). These symptoms can often lead to wandering behaviours which is a challenge during meal times that can also lead to poor intake and weight loss.

The Acacia Cottage Breakfast Club aims to improve the number of residents consuming breakfast to assist in maintaining nutritional requirements. To achieve the aims of the project, staff were realigned and environmental changes were made, including the introduction of soft music and redesign of the dining space.

The response to the change has been pleasing. Staff observed increased participation and enjoyment at breakfast by the residents and commented that the environment felt calm.

The introduction of the breakfast club resulted in an improvement in resident weight. Of the six residents identified to attend, five residents gained weight during the trial period.

Integrated Care Chronic Diseases Working Party

The Integrated Care - Chronic Diseases Working Party at St George Hospital was established to support improvement of communication between General Practice (GP) and St George and Sutherland Hospital clinicians.

The working party is a unique group, consisting of representatives from the hospital including staff specialists, chronic disease clinical nurse consultants (CNCs), information technology, pharmacy and community representatives from the primary health network, general practitioners (GPs) and health pathways. The working party meets bi-monthly to discuss initiatives and areas of concern that can be explored to improve the relationships between tertiary and primary care, and therefore improve patient outcomes.

A focus of the group has been standardisation of the discharge summary format across the chronic disease specialities. Audits of discharge summaries are completed regularly with the results circulated to the relevant departments. Junior medical officers receive annual education in best practice for writing discharge summaries from a CNC and GP.

The 2022 discharge summary audit results showed:

- 2% of discharge summaries contained excessive information.
- 30% of General Practitioners received a call if their patient was admitted for greater than seven days, up from 18% in 2019.
- A follow up audit specifically looking into whether or not correct General Practitioner details were included in the medical record showed that now 97% of records included correct details compared to 80% at the time of the original audit. This outcome is a direct result of adding the General Practitioner name in the eMR banner of the patient's record.

In addition, the working party has created a CNC contact list that is updated yearly and disseminated to the primary health network, following feedback from General Practice. GP's have been invited to attend the medical grand rounds at St George Hospital and to present to hospital staff on a yearly basis, again facilitated by this team. Most recently, a GP monthly online education series was established, a collaboration between St George Hospital and the Central and Eastern Sydney Primary Health Network.

Improving the Patient Experience

Improving the Patient Experience

Improving the Patient Experience Across SESLHD

As outlined earlier in this report (pages 14-16), patient experience information and feedback is captured and responded to in various ways across SESLHD, including:

- Consumer partnership strategies as outlined in the Consumer Engagement Framework.
- Consumer Advisory Committees (CACs) at major facilities, which are chaired by consumers and provide an opportunity to shape the strategic direction of our services.
- Shared decision making, including goal setting and care planning, at the individual level to enable provision of person-centred care.
- Care Opinion, an online, independent digital platform where anyone can share their stories about their experience of care. Information and stories provided on Care Opinion inform care and quality improvement initiatives.
- Patient Reported Measures programs to enable patients to give feedback to their care team on their healthcare outcomes and experiences that matter to them most.
- Patient satisfaction surveys at service level.
- Consumers as members of all peak Safety and Quality Committees, sub-committees and a high level working group established at Board level, as well as facility level involvement.
- SESLHD participation in the Strategic Community Partnerships Alliance.
- Patient stories are shared through various avenues, including the SESLHD Quality and Safety Board Committee.

Patient Reported Measures: Using patient feedback to improve care

Patient Reported Measures is a program that enables patients to give feedback to their care team on their healthcare outcomes and experiences that matter most to them. Patient Reported Measures are captured in surveys to give the patient's healthcare team an insight into the needs and expectations of patients at the point of care.

Patient Reported Measures can be grouped into two categories – Outcome measures and Experience measures.

Outcome measures capture the patient's perspective about how their illness and care impacts on their physical, mental and emotional health and wellbeing. Experience measures gauge the patient's experience and satisfaction with their healthcare. Experience measure surveys are completed anonymously.

Feedback from patients received through the Patient Reported Measures Program shows where we are performing well and where there are opportunities for improvement. This information helps to inform clinical care delivery so patients can have the best possible experiences and outcomes from their healthcare.

A purpose built IT platform called HOPE - Health Outcomes and Patient Experience - is being rolled out across SESLHD to support the Patient Reported Measures Program. HOPE captures the survey responses from patients, manages the online surveys and provides database functions. Translated surveys are now available in 10 non-English languages to improve access for people from culturally and linguistically diverse backgrounds.

22 services across SESLHD have successfully implemented Patient Reported Measures and HOPE, and another two services are scheduled to go-live with the system before the end of 2022.

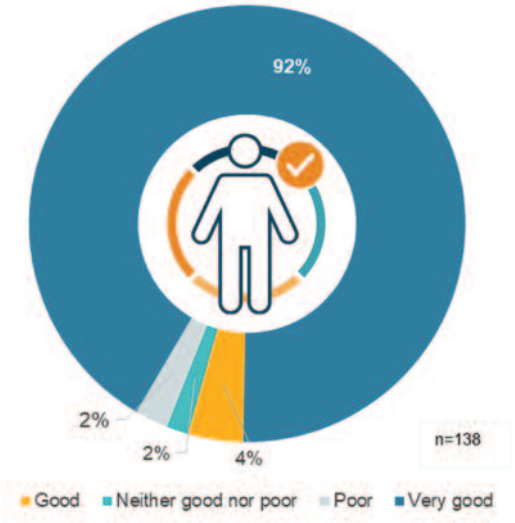
The HOPE system brings a number of benefits to the clinicians and patients. Patients can provide their responses at the point of care or in the privacy of their home; their healthcare providers can access the patient's responses in real time, which supports them to make informed decisions about care and treatment. Patients also have access to their own Patient Reported Measures information in HOPE – this enables patients to monitor their own healthcare and supports patient knowledge, engagement, confidence and self-efficacy.

Patient Reported Measures is a way for clinicians to improve communication and patient care:

"I see it as an opportunity for clinicians to communicate with patients and their carers - understanding what they need and care from their perspectives".

Expected enhancements to the HOPE platform later in 2022 will see the integration of Patient Reported Measures into the patient electronic medical record (eMR). This will improve access to patient responses so all members of the patient's care team can use this information to plan care with the patient around what matters most to them.

The chart below shows patient experience responses for overall rating of care of the services currently using the HOPE platform:



Patient Reported Measures: Using patient feedback to improve care

Patient Reported Measures in action:

A patient was referred to an outpatient heart and lung service following a number of hospital admissions and readmissions. The patient was asked to complete a quality of life measure and his results indicated he was experiencing anxiety. The healthcare team discussed the results with the patient, who described experiencing anxiety during admissions, resulting in him discharging himself from hospital too early. The patient also reported experiencing anxiety in the community at the thought of a hospital admission. This resulted in him disengaging with his care providers.

Using the information reported by the patient, the team were able to make early referrals that were relevant and important to the patient, and were able to prioritise the patient's mental health and wellbeing. In consultation with the patient, the healthcare provider referred him to his General Practitioner for consideration of a mental health care plan.

This example highlights how Patient Reported Measures are used to support communication between the patient and clinicians about other factors that were impacting their life, focusing the conversation on what matters most to the patient to encourage a holistic and person-centred approach.

Integrated Rehabilitation for Early Dementia (iREADi) Program

A stakeholder forum at War Memorial Hospital identified a need for a co-ordinated and anticipatory approach to dementia care in the local community, a gap also demonstrated in international literature.

In response, the Management of Dementia (MOD) Squad was formed. The MOD Squad's goal was to harness the expertise of the War Memorial Hospital Multidisciplinary Team to create an integrated rehabilitation program for people with early dementia and their carers. **Together they created the Integrated Rehabilitation for Early Dementia (iREADi) program.**

The iREADi Program consists of three components:

1. A 9-week small group dementia rehabilitation education course with topics provided by members of the MOD Squad

2. The iREADi Course facilitates the gradual development of peer and carer relationships in a supportive environment.

3. Individual goal-based rehab therapy is provided using cognitive rehabilitation exercises and the allocation of a MOD Squad clinician, as 'goal coordinator', to each client and carer dyad to facilitate goal setting and attainment.

The iREADi program has been co-designed with consumers engaged in the program. All participants (people living with dementia and their carers) enrolled in the iREADi Program are automatically designated as 'participant co-designers'.

Their role in helping to design and adjust the program is explained to them at the start of the program and they are reminded about this along the way. Each participant is encouraged to provide feedback (good, bad, or indifferent) about the suitability of the Program for them. Each subsequent program is then adjusted and updated accordingly.

The program has engaged a broad perspective including co-design with people identifying as Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse participants.

Outcomes

Approximately 112 people (carers and clients) have been involved in the iREADi Program since July 2020, including one online cohort.

Results have been overwhelmingly positive, demonstrating effectiveness in filling the gap in the early dementia post diagnosis support pathway in SESLHD. Over 90% of feedback received is positive. Drop out rates are less than 15% for each group.

The success and effectiveness of the iREADi model has been monitored by the Central & Eastern Sydney Primary Health Network (CESPHN) who are seeking to explore the capacity for the model to be replicated in other primary health network's across the state and beyond.

It was a good vibe with no rush… (I appreciated) being asked for ideas
John, husband, father and person with dementia*

The education sessions are encouraging, gently informative and very comforting
Mary, mother and person with dementia*

OMG – so much information, answers to questions that I had no idea that I needed to ask. Thank you sooooo much
Rose, daughter of person living with dementia*
**names have been changed*

Newborn Care Centre – Hospital in the Home

The transition to discharge home during the final weeks in hospital, for parents and their newborn babies, is largely determined by the establishment of full sucking feeds and adequate weight gain. If transition is not supported adequately, weight gain will remain poor post-discharge.

The Royal Hospital for Women's Hospital in the Home (HITH) model of care provides pre-discharge planning, parental education and an early transfer of care. Infants who are clinically stable will be managed with nasogastric tube feeds in the home environment. Home visits are offered weekly, with additional visits as required, along with the provision of daily telehealth video consultations, to ensure the wellbeing of the infant and parents in between home visits.

Since the program began in February 2022, 30 families have spent 400 days outside of the hospital as a result of being able to receive care in their own home. This program has provided an enjoyable family journey along while simultaneously creating bed capacity within the Newborn Care Centre. Families report feeling empowered, supported, and happier at home, and was described as "a brilliant program."

THIS IS ME

THIS IS ME aims to equip staff at the Garrawarra Centre with person-centred behaviour management strategies and replaces the Person Centred Life Story which was a generalised approach to information about patients and their past history.

The THIS IS ME document is written in the first person and is more person centred than existing tools, as it includes triggers, potential behaviours as well as interventions staff can use. The document is easily accessible and can be found in resident's care plan folders for staff members, new recruits, students and volunteers.

Staff feedback has been very positive and more recently, feedback was received from the Aged Care Safety and Quality Commission stating that "We (the commission) are amazed and pleased to see how well the care staff know the residents at Garrawarra".

Slide into headspace: Demand Management Strategy

Slide into headspace: Demand Management Strategy is a clinical redesign project grounded in innovation and co-design to address issues contributing to long wait times at headspace Bondi Junction.

Since headspace Bondi Junction's inception in 2016, increased demand for services have been experienced year-on-year. Service data showed a 50% increase on the average monthly intake data from 2016 to 2019 prior to the COVID-19 pandemic, continuing over the months the state was not in lockdown during 2020 and 2021. The increased demand for services has led to longer waiting times for young people aged 12-25 years seeking access to mental health support.

The project team, in conjunction with the centre's Youth Reference Group and key stakeholders, have developed and implemented three key solutions: Client pathway redesign including a new health information technology platform that supports triage and assessment, to fast-track access.

Establishment of a new Peer Worker role that includes digital navigation, to support and promote engagement with various technologies that enhance mental health care.

Development of group-based interventions, introducing the idea of 'active waiting' while on the waitlist for 1:1 mental health intervention.

Preliminary results demonstrate that in the first year, the project has achieved:

- the time from initial point of referral to access to care reduced from 8 days to 4 days;
- the time from intake and triage to assessment and treatment planning reduced from 28 days to 8 days;
- the number of young people reporting "waiting too long" reduced from 80% to 32%; and
- the wait for psychological treatment sessions under the Better Access Funding Scheme reduced from 3 months to 1 month.

A Workplace Culture that Drives Safe and Quality Care

Workplace Culture

Resetting the foundations for a patient safety culture at Prince of Wales Hospital

In 2020, 42 nursing teams began to implement the Quality Safety & Culture Framework, which incorporated standardised approaches to measure patient safety. These approaches included:

- Safety Huddles at every shift
- Quality and Safety Data Boards
- Safety Attitudes Questionnaire (SAQ)
- Nursing Clinical Leads Program (Champions Model)

Utilisation of available data is a key aspect of this approach. Data is collected through a variety of sources, including:

- Clinical data, such as Incident Management System (IMS+) and Quality Audit Reporting System (QARS);
- Staff experience data, through focus groups;
- Patient experience through completing patient stories, real time patient experience approaches; and
- Care environment using observational tools.

Reporting and documentation is completed in a Management and Planning System (MAPS).

Evaluation of the Quality and Safety Data Boards was undertaken in 2021 and early 2022. Methods used included observational audit of board content, leadership walk arounds and a staff perception survey. The survey showed:

- 66% of staff agree that monitoring safety data with the board leads to change
- Boards are discussed at multiple local forums including safety huddles, handover and ward meetings
- Implementation of leadership rounding by program managers where the board is presented was highly valued by leadership teams as a supportive governance approach. This has now lead to a commitment to quarterly Quality and Safety walk arounds by senior managers and Executive.

Introduction of the SAQ at POWH in 2020 provided baseline patient safety culture measures. 30% of staff completed the survey with 53 individualised unit booklets produced and facilitated feedback provided.

Two examples of improvements made from the results were:

- The Spinal unit noted a deficit in medical orientation regarding their “jobs white board” leading to miscommunication. This is now highlighted to MDT members on orientation. A wellbeing strategy was also formalised for the spinal unit MDT team.
- Changes were made to the Executive’s staff forum processes post SAQ feedback.

The SAQ was repeated in April-May 2022 with a 31% response rate.

Following the success of the Safety Attitudes Questionnaire (SAQ) at Prince of Wales Hospital, the questionnaire was implemented across SESLHD in 2022 by the Nursing and Midwifery Directorate. Evaluation of this initiative is underway.

Honouring death in the St George Hospital ICU

St George Hospital's intensive care unit (ICU) staff know how precious life is and have introduced special practices to honour patients who have passed away.

The practices aim to enable staff wellbeing through reflection and compassion for patients' lives at the end of life, and to improve the experience of patients, carers, family, friends and staff by acknowledging and honouring the lives of those who are dying or have died in ICU.

The Pause is a voluntary, but planned moment of silence that is held after the death of a patient. It is not about religious beliefs. It allows a group of people from different backgrounds to share an experience of honouring both the life lost and the care team's efforts. It enables a sense of closure and promotes self-care by allowing staff the time for personal reflection to acknowledge and process the patient's death.

The Honour Walk can provide donor families, as well as members of the care team, the opportunity to honour the intent and generosity of the decision of an individual becoming an organ and tissue donor. An Honour Walk is a quiet, yet profound and powerful way to give a loved one a hero's goodbye and to give thanks for a gift that will save and enhance the lives of many.

A Workplace Instruction has been developed to guide staff for implementation of the two initiatives, and to provide information to staff when 'caring for the carers'.

Royal Hospital for Women Simulation Centre

The aim of the Simulation centre is to provide opportunities for multidisciplinary exposure, training, feedback and debriefing on different obstetric emergency simulations, with a focus on improving decision making and management, communication, interaction and teamwork

Obstetric emergencies are rare clinical situations, and may be managed sub optimally. The initiative allows staff to simulate these circumstances in a safe and controlled environment so experiential learning can be optimised, with teamwork and communication the focus. It supports improved decision making and task management to ensure the best possible care for our women in a patient-centred fashion.

To date we have been using the centre to assist in the facilitation of Maternal and Perinatal safety training, Neonatal Intensive Care Unit (NICU) simulation, and Junior Medical Officer (JMO) simulation training.

By simulating those uncommon or rare adverse patient outcomes, we can improve our emergency management techniques to minimise the risk of adverse events in the patient population. This directly impacts safety and quality by providing opportunities to perfect these approaches before they happen, improving the care provided to our pregnant women.

Peak Time Support Program Allied Health and Nursing Partnership

Between January – March 2022, Allied Health and District Nursing and Midwifery partnered to provide peak time support to the aged care, neurology and rehabilitation wards at Prince of Wales Hospital and The Sutherland Hospital.

Discussions with hospital staff identified that late afternoon and early evenings are particularly busy times on these acute inpatient wards due to patients requiring additional support for meal set up, feeding and to facilitate calls to and from family.

During these peak times, Allied Health and Nursing staff were typically not available to provide additional support, and due to strict hospital visitor policies on background of the COVID-19 outbreak, families and volunteers who often assist with feeding patients were not permitted to visit the wards.

The program involved rostering two to four staff to each designated ward. These staff provided assistance with feeding, providing companionship and supporting mobility/transfer of patients as well as supporting ward nursing staff.

Support staff were able to connect families using virtual care, and give feedback to the multidisciplinary team about issues important to the patient. Additional tasks were undertaken to support patient care, including assistance with meals, tidying rooms, making beds, and setting up pressure care mattresses.

Feedback from staff indicated that the program was successful in providing physical and psychosocial patient care, relieving work burden of nursing staff and providing satisfaction to participating staff.

Formal Results

Formal Results

2021/22 Key Performance Indicators

NSW Health Outcome 1: Keeping people healthy through prevention and health promotion

Measures	Target	SESLHD Result	Reporting Period	Commentary
Effectiveness				
Childhood Obesity: Children with height and weight recorded (%)	70%	73.0%	Apr-Jun22	Target achieved
Pregnant Women Quitting Smoking: By second half of pregnancy (%)	41.2%	35.9%	Oct20-Sep21	SESLHD has not met the target for this KPI. A continued focus will be a priority in 2022/23.
Get Healthy Information and Coaching Service: Get Healthy in Pregnancy Referrals	1,195	1,608	FTYD Jun 2022	Target achieved
Children fully immunised at one year of age (%)	95.0%	94.9%	Jul21-Jun22	SESLHD has not met the target but performed within the tolerance range for this KPI. A continued focus will be a priority in 2022/23.
Hepatitis C Antiviral Treatment Initiation: Direct acting - by LHD residents (% variance)	410	116	FTYD Jun 2022	SESLHD has not met the target for this KPI. Reasons for decreased performance include: • Hepatitis C testing in both LHD and primary care settings in FY 2021/22 was approximately 30% lower than pre-COVID-19 levels, and • Many outreach testing and treatment activities with stakeholders outside of clinical settings could not be delivered due to the COVID-19 pandemic Risk mitigation strategies and initiatives include: • Partnerships with key GP practices • SESLHD Blood Borne Virus testing policy and implementation plan, with an Alcohol and Other Drugs and Mental Health focus • Increased opportunities for point of care and dried blood spot testing across SESLHD and community sectors • Support for nurse led care models in needle and syringe program sites • Opening of KRC Kellett Street primary care and harm reduction clinic above the Supervised Injecting Centre • Development of a harm reduction peer workforce • Stigma and discrimination training • Funding of Hepatitis CNC position at POWH
NSW Health First 2000 Days Implementation Strategy: Delivery of the 1-4 week health check (%)	85%	95.7%	Jan-Mar22	Target achieved

Legend: Performance at or better than target; Underperforming (within tolerance range); Not performing

2021/22 Key Performance Indicators

NSW Health Outcome 1: Keeping people healthy through prevention and health promotion

Measures	Target	SESLHD Result	Reporting Period	Commentary
Equity				
Smoking During Pregnancy: At any time (%): Aboriginal Women Non-Aboriginal Women	 34.2% 2.9%	 28.5% 2.6%	2020	Target achieved
Efficiency				
Hospital Drug and Alcohol Consultation Liaison: Number of consultations (% increase)	13,948	10,215	FYTD Jun 2022	SESLHD has not met the target for this KPI. Reasons for decreased performance include: • Cessation of weekend consultant liaison services at POWH/SSEH since Q2 21/22 • Workforce shortages • The data source is not an eMR extracted data collection system; current data collection methods rely on individual staff recording information – resulting in variable data collection quality Risk mitigation strategies and initiatives include: • Review of Hospital Drug and Alcohol Consultation Liaison service resources and advocacy for the service to reflect demand (including weekend services) • Management of staff leave: less leave issues are expected in 2022/23 • Improvements in data collection, through eMR changes, and implementation of a state-wide data collection system, when available.

Legend: Performance at or better than target Underperforming (within tolerance range) Not performing

2021/22 Key Performance Indicators

NSW Health Outcome 2: People can access care in and out of hospital settings to manage their health and wellbeing

Measures	Target	SESLHD Result	Reporting Period	Commentary
Effectiveness				
Mental Health: Acute Readmission – Within 28 days (%)	13.0%	14.6%	Jun 2022	SESLHD has not met the target but performed within the tolerance range for this KPI. Subsequent results demonstrate improved performance. This will continue to be monitored and reviewed.
Mental Health Acute Post-Discharge Community Care – Follow up within seven days (%)	75.0%	85.4%	FYTD Jun 2022	Target achieved
Domestic Violence Routine Screening – Routine Screens conducted (%)	70.0%	74.0%	FYTD Mar-2022	Target achieved
Sustaining NSW Families Programs – Families completing the program when the child reached two years of age (%)	50.0%	70.6%	Jan-Mar 2022	Target achieved
Families enrolled and continuing in the program (%)	65.0%	86.7%		
Appropriateness				
Potentially Preventable Hospital Services (%)	16.5%	16.4%	FYTD May 2022	Target achieved
Patient-Centred Culture				
Mental Health Peer Workforce Employment – Full Time Equivalents (FTEs) (Number)	12.9	17.7	Apr-Jun 2022	Target achieved
Electronic Discharge Summaries – Sent electronically and accepted by General Practitioners (%)	51%	71.1%	FYTD Jun 2022	Target achieved
Timeliness and Accessibility				
Telehealth Service Access - Non-admitted services provided through telehealth (%)	10.0%	3.4%	FYTD Jun 2022	SESLHD has not met this KPI. As at June 2022, 90 services have been established on the state-wide telehealth platform myVirtualCare. SESLHD staff continue to utilise the Pexip videoconferencing platform to support virtual care provision. SESLHD has published its "Virtual Health Strategy, 2022-24" of which telehealth is a key pillar for the organisation.

Legend: Performance at or better than target; Underperforming (within tolerance range); Not performing

2021/22 Key Performance Indicators

NSW Health Outcome 3: People receive timely emergency care

Measures	Target	SESLHD Result	Reporting Period	Commentary
Timeliness and Accessibility				
Emergency Treatment Performance – Admitted (% of patients treated in <= 4 hrs)	50%	27.3%	FYTD Jun 2022	SESLHD has not met the KPI target for this period. SESLHD was impacted in 2021/22 in reaching this target by a number of factors impacting patient flow due to the pandemic. These include but are not limited to: • The need for increased isolation capacity in the ED's and inpatient areas, and the impact of COVID-19 patients "blocking" beds for admission into the Hospital (bed block). • Increases in COVID-19 testing and respiratory virus screening has meant a greater number of patients are waiting in ED pending results or waiting for a screening bed in an inpatient ward. • SESLHD was impacted by workforce shortages due to COVID-19 outbreaks with substantial increases in sick and carer's leave. This impacted the organisation's ability to maximise its operational and surge capacity during high demand periods, causing delays across the organisation. Improving Emergency Treatment Performance (ETP) continues to be a priority for SESLHD.
Emergency Department Extended Stays – Mental Health presentations staying in ED > 24 hours (Number)	0	18	FYTD Jun 2022	SESLHD has not met the KPI for this period. Processes are in place to review all cases not meeting target, to determine risks and mitigation strategies.
Emergency Department Presentations – Treated within benchmark times (%): Triage 1: seen within 2 minutes	100%	100%	FYTD Jun 2022	Target achieved for Triage 1
Triage 2: seen within 10 minutes	95.0%	74.2%		SESLHD has not met the target for Triage 2 and Triage 3 KPIs. SESLHD has been impacted by a significant increase in Triage 1 and Triage 2 patients within our ED's in 2021/22. This increase in acuity of patients is impacting on SESLHD's ability to meet its Triage KPI.
Triage 3: seen within 30 minutes	85.0%	59.0%		
Transfer of care – Patients transferred from ambulance to ED <= 30 minutes (%)	90.0%	69.9%	FYTD Jun 2022	SESLHD Transfer of Care (ToC) has been impacted by the COVID-19 pandemic. A significant driver has been the need to isolate offloading patients and or place them in COVID-19 / non-COVID-19 zone ED beds. Improving ToC continues to be a priority for SESLHD.

Legend: Performance at or better than target; Underperforming (within tolerance range); Not performing

2021/22 Key Performance Indicators

NSW Health Outcome 4: People receive high-quality, safe care in our hospitals

Measures	Target	SESLHD Result	Reporting Period	Commentary
Safety				
Refer to Hospital Acquired Complication reports, pages 55-68				
Mental Health: Involuntary patients absconded inpatient mental health unit – Incident Types 1 and 2 (rate per 1,000 bed days)	0.80	0.86	FYTD Jun 2022	SESLHD has not met the target but performed within the tolerance range for this KPI. Processes are in place to notify and review all involuntary abscond incidents, to determine risks and any mitigation strategies, including review of anti-climb solutions at Eastern Suburbs MHS.
Appropriateness				
Mental Health: Acute Seclusion Occurrence (Episodes per 1,000 bed days)	5.1	2.7	Apr-Jun 2022	Target achieved
Duration (Average Hours)	4.0	3.0		
Frequency (%)	4.1%	1.7%		
Effectiveness				
Unplanned Hospital Readmissions – All admissions within 28 days of separation (%):				
All persons	6.5%	5.5%	FYTD May 2022	Target achieved
Aboriginal persons	7.9%	7.9%		
Efficiency				
Elective Surgery Overdue – Patients (Number):				SESLHD did not met target for Category 1 in 2021/22 due to ongoing global supply shortages of equipment required to maintain best practice. SESLHD has outsourced this activity to other facilities who do have the equipment however conflicting priorities for those services has impacted ability to reach target. SESLHD did not meet targets for Category 2 and 3 in 2021/22 due to the postponed non-elective surgery in NSW public hospitals in greater Sydney on 2 August 2021 to mid-January 2022. SESLHD is committed to reduce patients waiting times for overdue surgery.
Category 1	0	2	FTYD Jun 2022	
Category 2	0	1 005		
Category 3	0	2 946		
Elective Surgery Access Performance – Patients treated on time (%):				
Category 1	100%	99.7%	FYTD Jun 2022	
Category 2	97.0%	66.0%		
Category 3	97.0%	40.5%		

Legend: Performance at or better than target; Underperforming (within tolerance range); Not performing

2021/22 Key Performance Indicators

NSW Health Outcome 4: People receive high-quality, safe care in our hospitals

Measures	Target	SESLHD Result	Reporting Period	Commentary
Equity				
Discharge against medical advice for Aboriginal inpatients (%)	1.4%	2.0%	FYTD Jun 2022	SESLHD did not meet the target for this KPI. A number of initiatives are in place to address this, including, a strategy to address low rates of reporting of Aboriginality will be launched in October 2022. It is expected this strategy will influence KPIs including discharge against medical advice. Establishment of a strategy and project to provide education and support to enhance the cultural responsiveness of front facing services, such as Emergency Departments, is in early stages. This will include face to face provision of Respecting the Difference: Aboriginal Cultural Training and education for medical staff on culturally safe and welcoming service delivery. The 2022 Aboriginal Cultural Engagement Self-Assessment Audit tool is being addressed within SESLHD. This tool provides a framework for how each clinical service, considers the needs of Aboriginal and Torres Strait Islander consumers to inform a more culturally responsive delivery of care.
Patient-Centred Culture				
Mental Health Consumer Experience: Mental Health consumers with a score of Very Good or Excellent (%)	80%	74%	Apr-Jun 2022	SESLHD did not achieve the target for this KPI, however performance is above the state average. Improvement evidenced over the following quarter. For continued monitoring and review.
Overall Patient Experience Index (Number) Adult admitted patients Emergency department	8.50 8.50	8.62 9.07	Oct-Dec 2021	Target achieved
Patient Engagement Index (Number) Adult admitted patients Emergency department	8.50 8.50	8.44 8.30	Oct-Dec 2021	SESLHD did not achieve the target for this KPI during this period. Patient involvement in decision has been identified as an area for improvement for adult admitted patients, and is being addressed through the *Elevating the Human Experience* and *Good to Great Projects*. In the Emergency departments (EDs), taking family situation into account, involvement in decisions on treatment in the ED and involvement in discharges decisions have been identified as areas for improvement This is being addressed through *Good to Great* program participation and the support of Patient Experience Officers in the ED.
Timeliness and Accessibility				
Paediatric Admissions from Elective Surgery Waiting List – % variance from target (Number)	605	269	FYTD Jun 2022	SESLHD NSW Health postponed non-elective surgery in NSW public hospitals in greater Sydney on 2 August 2021 through to mid-January 2022. SESLHD is committed to reducing patient waiting times for overdue surgery in 2022/23.

Legend: Performance at or better than target; Underperforming (within tolerance range); Not performing

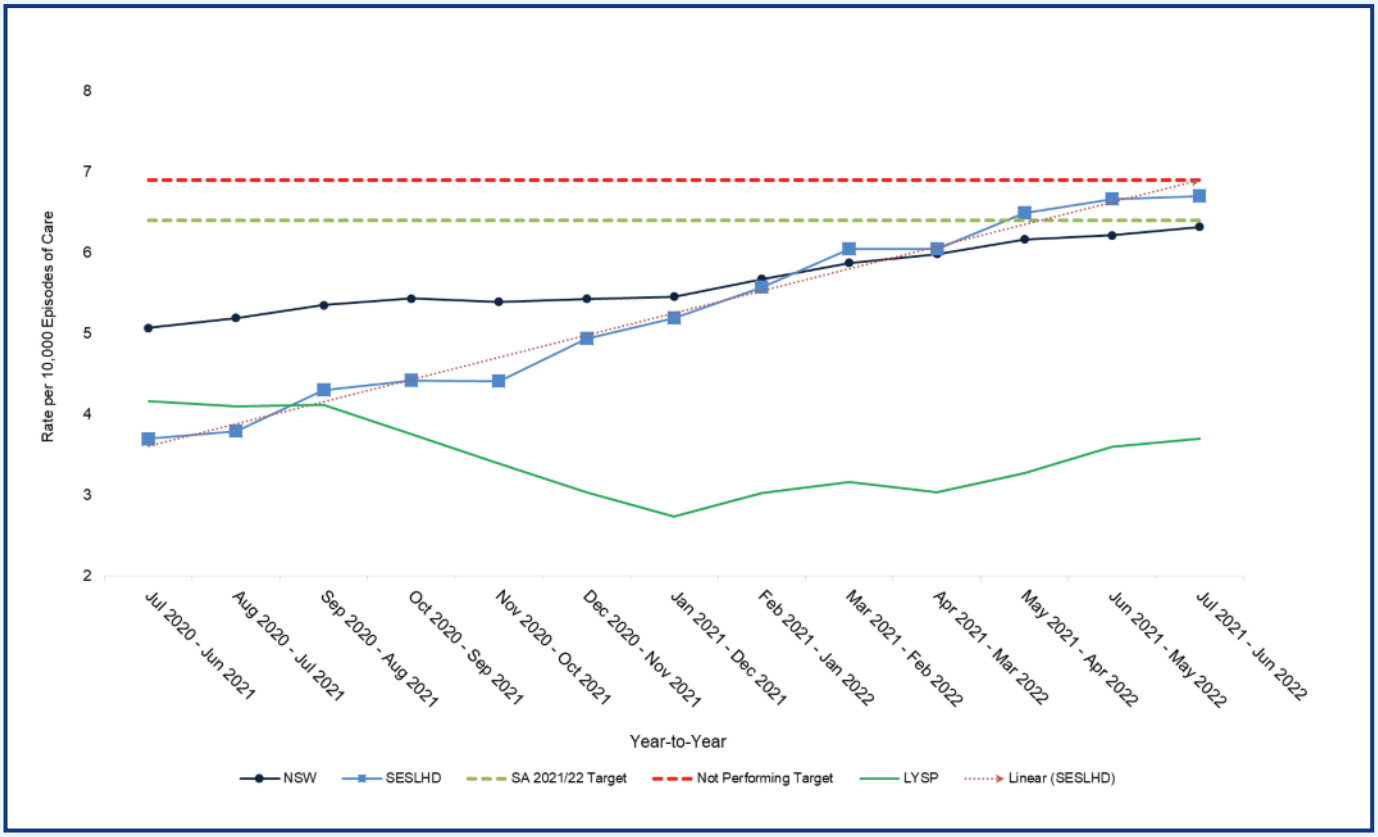
2021/22 Key Performance Indicators

NSW Health Outcome 5: Our people and systems are continuously improving to deliver the best health outcomes and experiences

Measures	Target	SESLHD Result	Reporting Period	Commentary
Patient-Centred Culture				
Workplace Culture – People Matter Survey Culture Index – Variation from previous year (%)	-1.0%	-1.0%	2020/2021	Target achieved
Take Action - People Matter Survey – Take action as a result of the survey – Variation from previous year (%)	-0.1%	-1.0%	2020/2021	Target achieved
Staff Engagement - People Matter Survey Engagement Index – Variation from the previous year (%)	-1.0%	-1.0%	2020/2021	Target achieved
Staff Engagement and Experience – People Matter Survey – Racism experienced by staff – Variation from previous survey (%)	5.0%	3.0%	2020/2021	NSW Health and SESLHD did not participate in the People Matter Engagement Survey (PMES) in 2020. SESLHD continues to work through PMES action plans based on findings from the 2019 survey. Some actions taken in 2020/21 include: • Establishing an intranet site – 'Addressing Racism in Health Care'. • Establishing resources for staff and managers in relation to responding to racism in SESLHD. • Creation of a tag line 'Racism Harms – Act on it'. • Design and delivery of training 'Understanding and responding to racism in health care'. • Discussion and facilitation of cultural issues at a leadership forum.
Staff Performance Reviews – Within the last 12 months (%)	100.0%	46.2%	Oct20-Sep21	The COVID-19 pandemic response has impacted the number of performance reviews completed. It is recognised that the data may not be a true reflection of the rate of completed performance reviews. It is known that reviews are not consistently uploaded in the StaffLink system. Implementation of the Performance and Talent (PAT) system has improved this in 2022.
Compensable Workplace Injury – Claims (% of change)	41	27	Jun 2022	Target achieved
Equity				
Aboriginal Workforce Participation – Aboriginal Workforce as a proportion of total workforce at all salary levels (bands) and occupations (%)	1.8%	1.4%	2020/2021	Target achieved
Employment of Aboriginal Health Practitioners (Number)	1.0%	0.0	Jan22-Jun22	SESLHD did not meet this KPI in this period. An Aboriginal Employment Consultant and Aboriginal Development Consultant have been recruited in 2021/22 to assist growing SESLHD's Aboriginal workforce.
Effectiveness				
Research Governance Application Authorisations – Site specific within 60 calendar days – Involving greater than low risk to participants (%)	75.0%	82.1%	Apr-Jun 2022	Target achieved
Ethics Application Approvals – By the Human Research Ethics Committee within 90 calendar days – Involving greater than low risk to participants (%)	75.0%	81.8%	Apr-Jun 2022	Target achieved

Legend: Performance at or better than target; Underperforming (within tolerance range); Not performing

Fall-related Injuries in Hospital



The rate of falls causing injury has increased in 2021/22. This rate is now above the service agreement target, however remains below the Not Performing target. Strategies are in place to improve performance and reduce the rate of falls resulting in injury across SESLHD.

The SESLHD Steering Committee for Falls Prevention in Health Facilities, provides oversight and leadership for the implementation of best practice and evidence-based care in regards to falls prevention, and all SESLHD facilities have an established facility-specific working party or committee to address the complex nature of falls within the hospital setting. Quality improvement initiatives are in place across a number of services.

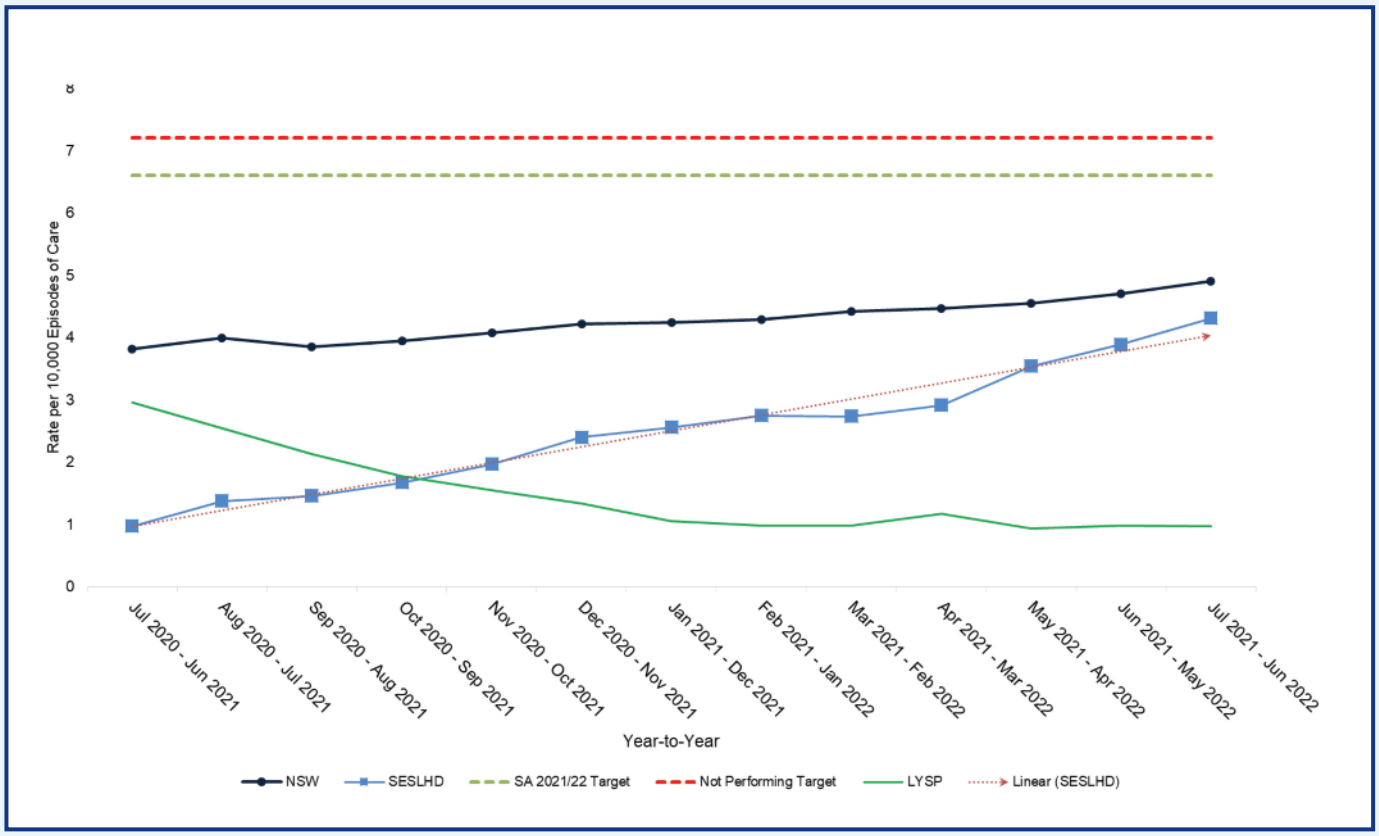
At St George Hospital, a research project has commenced to investigate the impact of COVID-19 on falls in hospital, and a quality improvement tool, 'HUDDLE UP' for multidisciplinary team (MDT) post fall huddles has been promoted.

Prince of Wales Hospital's Falls Working Group is working with wards to develop localised projects based on clinical risk and falls data; is auditing the maintenance of sensor alarm mats on the wards; and continues regular auditing of quality informatics to monitor falls screening within 24 hours of admission to the ward.

The Nursing and Midwifery Directorate has established falls champions at each facility to exchange ideas, projects and learnings, and the Mental Health Service has worked to strengthen 'post fall huddles'.

SA 2021/22: Target set by NSW Health in the 2020/21 Service Agreement
LYSP: Last year same period

Hospital Acquired Pressure Injuries



The rate of hospital acquired pressure injuries increased over the course of 2021/22, however performance continues to remain below the state average and target levels.

Pressure injury prevention remains a priority area or SESLHD, with the Pressure Injury Committee providing district commitment and oversight to the Hospital Acquired Pressure Injury (HAPI) state-wide project, which commenced in May 2021. A number of projects are in progress at facilities across SESLHD.

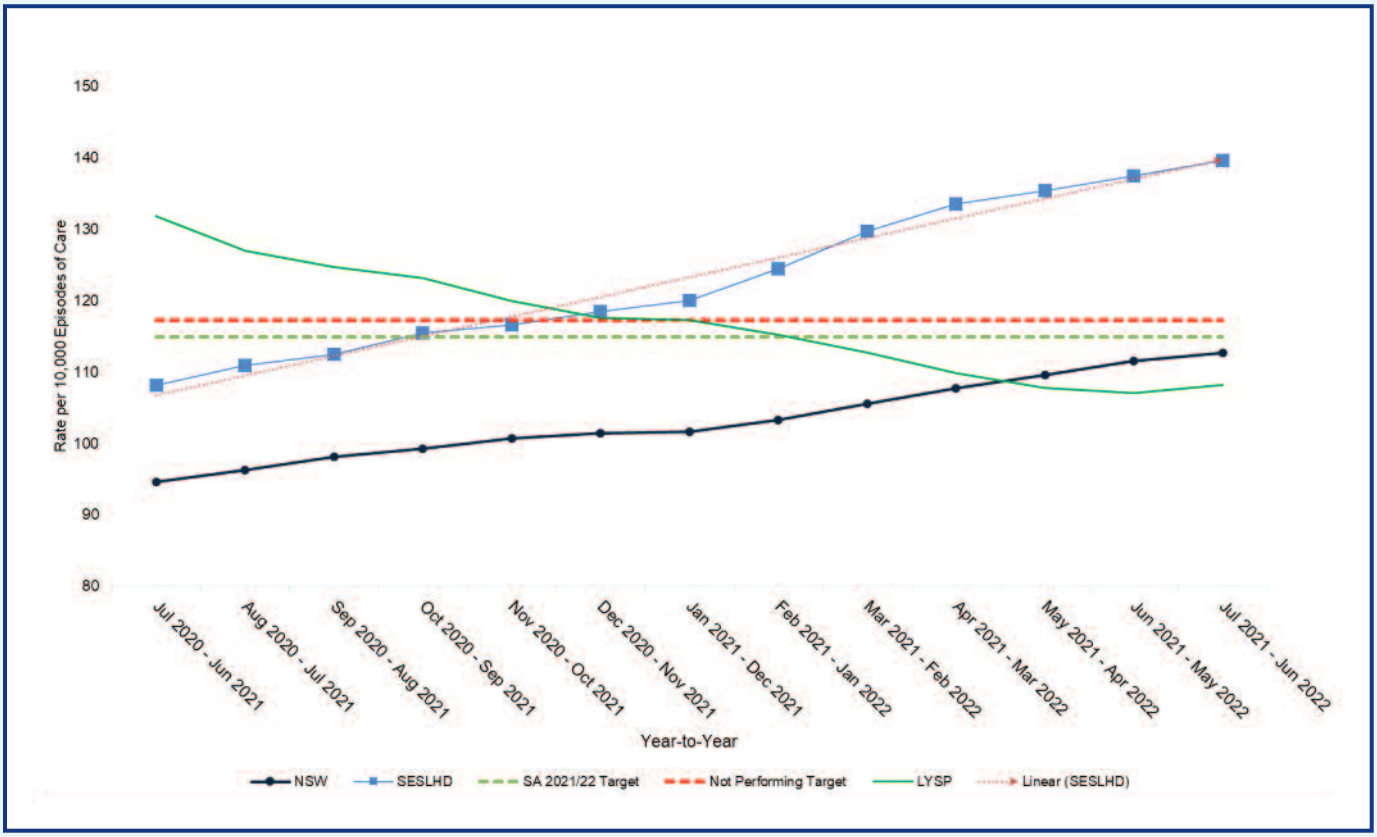
At Prince of Wales Hospital, the Intensive Care Unit was identified to be part of the HAPI project. A survey of nurses' knowledge was completed and a focus group conducted. Bedside teaching sessions were completed on the staging of pressure injuries. Completion of pressure injury risk screening within 8 hours of admission to ward has been regularly monitored since March 2021, and is an area targeted for improvement.

At St George Hospital, an increased HAPI rate over last 6 months was recorded and subsequently tabled at the peak Patient Safety and Clinical Quality Committee. The Wound Care Clinical Nurse Consultant is completing a retrospective audit on all incidents, including a data analysis, to brief the facility executive.

The Sutherland Hospital (TSH) have been actively monitoring data, and have a documented target goal to reduce the rate of hospital acquired pressure injuries by 2022/23. Data is reported and monitored by the TSH Skin Integrity Committee. This committee has recently focused on educational strategies to ensure correct staging of wounds.

SA 2021/22: Target set by NSW Health in the 2020/21 Service Agreement
LYSP: Last year same period

Healthcare Associated Infections (HAIs)



SESLHD's Healthcare Associated Infection (HAI) rates have risen over the last 12 months. HAI rates are above the state average and above the Not Performing target. HAIs are a high priority area for the district, with oversight governed by the SESLHD Infection Prevention Control Committee. Facilities and services also continue to work on reducing HAIs through a number of initiatives.

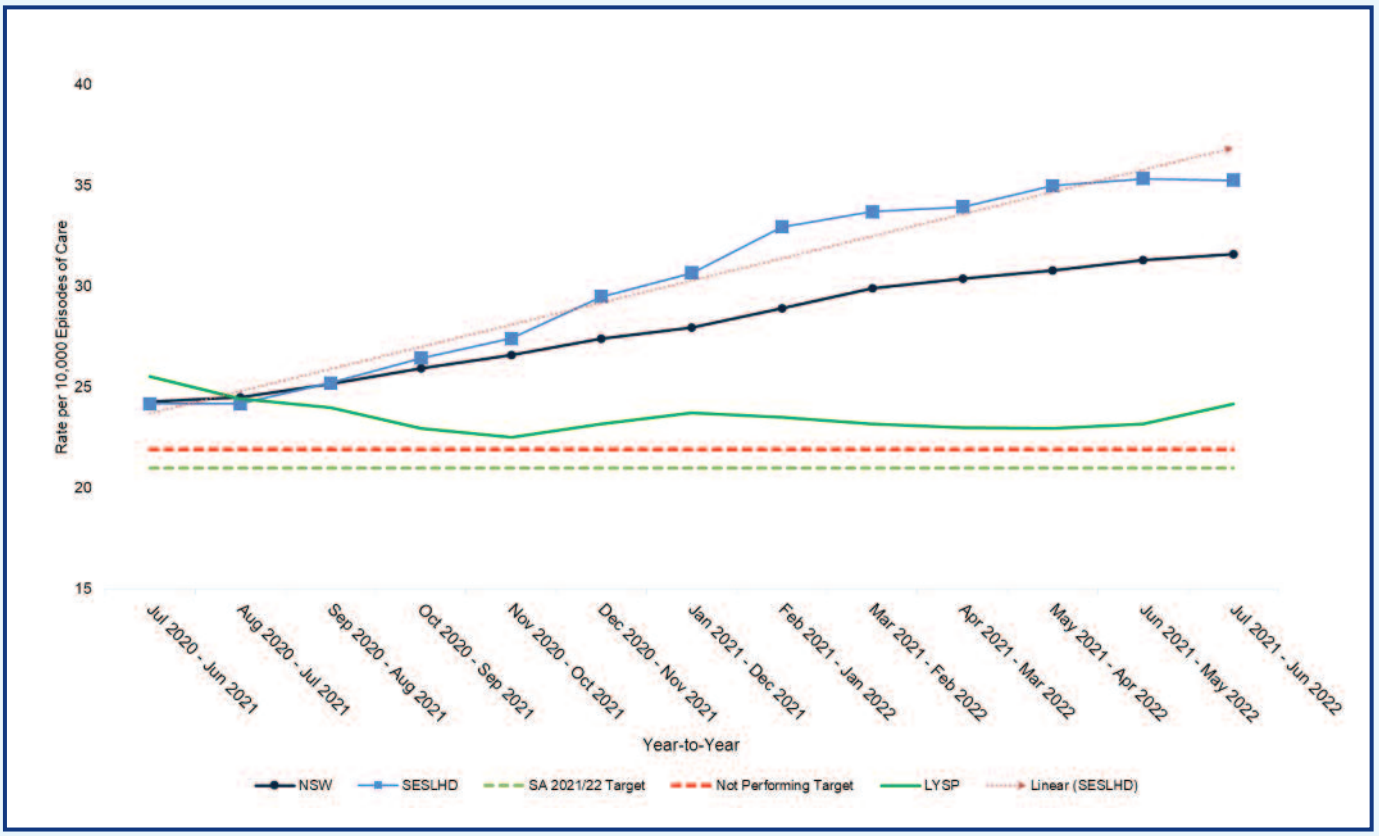
The SESLHD Mental Health Service (MHS) has upgraded all Sterile Stock storage in all MHS units to achieve commission advisory compliance. SESLHD MHS is building the capability of the National Standard 3 Champions within its workforce and is increasing the numbers of Hand Hygiene Auditors. SESLHD MHS has partnered with the facility infection control teams since the onset of COVID-19, to build capacity and capability within the workforce and to meet required infection control practises.

At St George Hospital, the Medicine and Cancer division completed a fistula fundamentals and central line-associated bloodstream infections (CLABSI) cluster monitoring and education to minimise associated HAIs. A reduction in the number of CLABSI and fistula related HAIs was achieved.

Prince of Wales Hospital have implemented a multidisciplinary action plan to reduce surgical site infections in the cardiothoracic operating theatres. The action plan covered human behaviour, clinical practice and environmental factors, and to date there have been zero post-operative sternal surgical site infections since implementation of the action plan.

SA 2021/22: Target set by NSW Health in the 2020/21 Service Agreement
LYSP: Last year same period

Hospital Acquired Respiratory Complications



The rate of hospital acquired respiratory complications in SESLHD has risen over the reporting period. This is now at a level above the state average and above the Not Performing target. Work continues across the district to improve performance in this area.

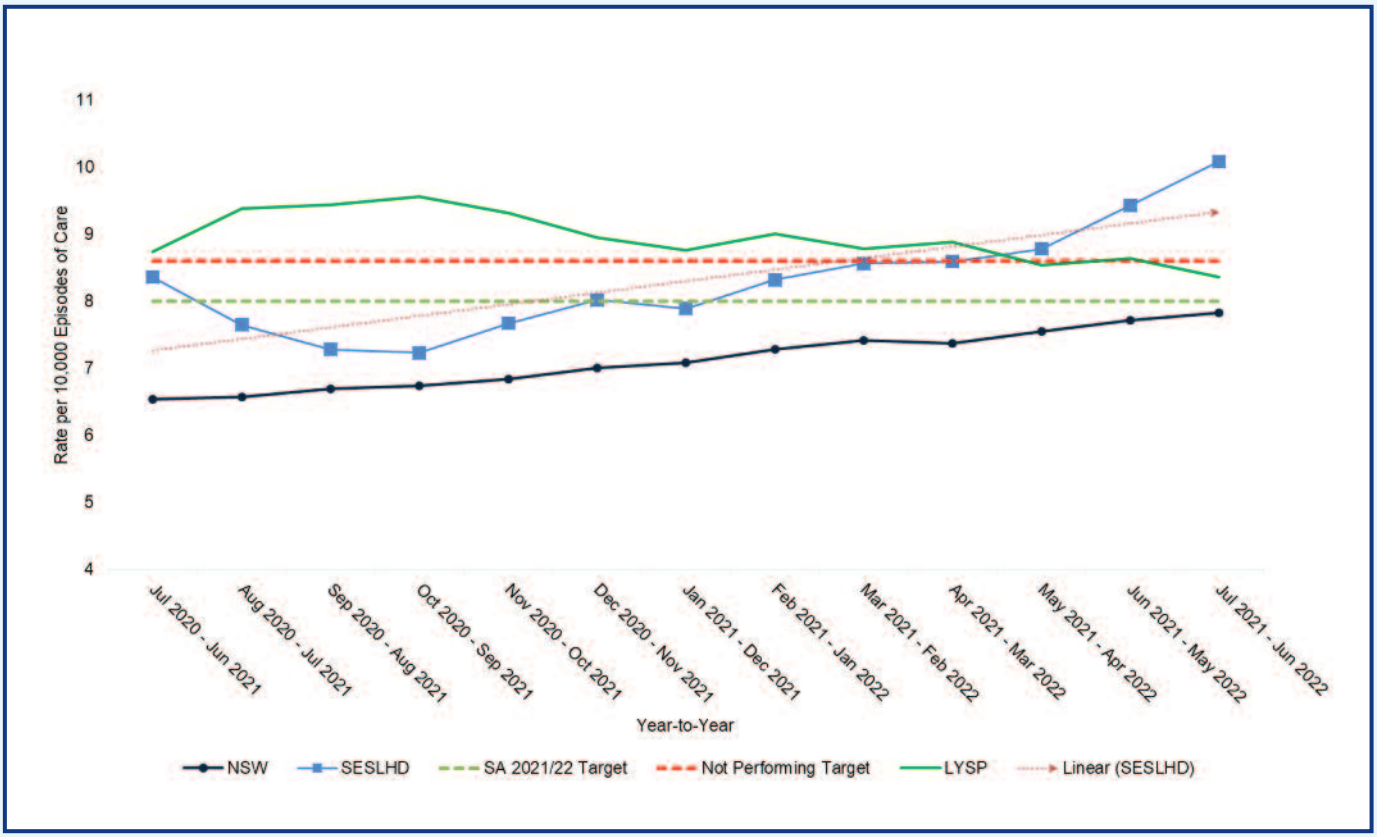
Prince of Wales Hospital continues its focus on aspiration pneumonia cases. The multidisciplinary project team, formed in 2019 consisting of doctors, nurses, medical records and speech pathologists continues to review identified cases of Hospital Acquired Aspiration Pneumonia (HAAP). Recent action includes staff education in risks and prevention strategies at nursing grands rounds, and review of the coding requirements for comfort or risk feeding. Data demonstrated a significant increase in ventilator assisted pneumonia towards the end of 2021, aligning with the COVID-19 outbreak in late 2021 and early 2022.

The War Memorial Hospital Speech Pathology team have reviewed all respiratory complications identified as HAC's in the previous 12 months, and are reviewing documentation with the medical team and clinical coding processes.

At The Sutherland Hospital all aspiration pneumonia cases are reviewed by Speech Pathology, and all Respiratory HACs are reviewed monthly and reported to the facility Patient Safety and Clinical Quality Meetings. Cases considered as possible or likely avoidable are referred to Departmental Morbidity and Mortality meetings.

SA 2021/22: Target set by NSW Health in the 2020/21 Service Agreement
LYSP: Last year same period

Hospital Acquired Venous Thromboembolism (VTE)



Rates of hospital acquired venous thromboembolism (VTE, or blood clots) increased during 2021/22. Rates remained consistently above the state average, and above the Not Performing target in the last quarter of 2021/22.

Reporting to the SESLHD Clinical and Quality Council, a district-wide VTE Working Party meets bi-monthly to provide governance of VTE risk assessment processes and VTE prevention and management strategies. Work also continues at facility level to improve performance in VTE rates.

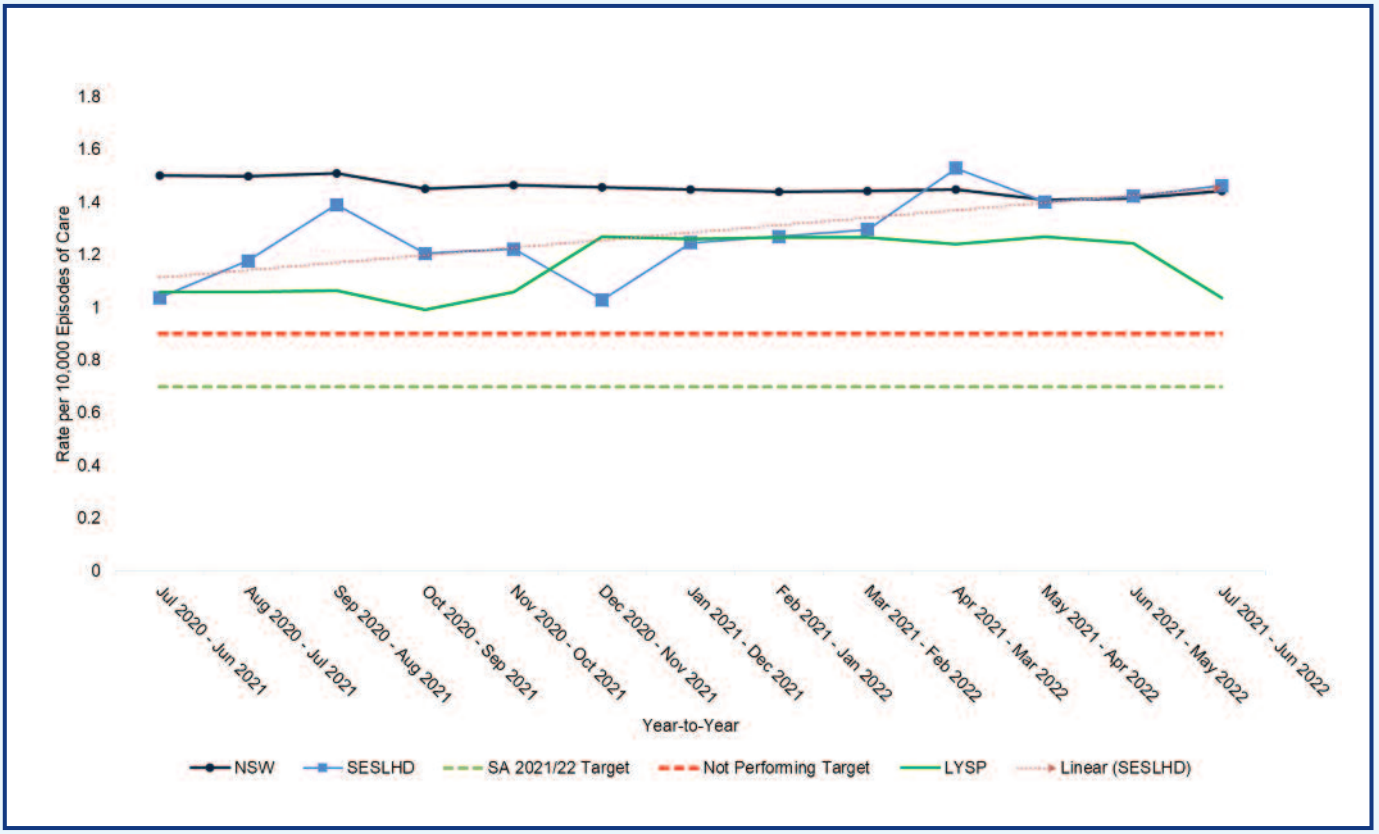
Prince of Wales Hospital has a VTE Working Party in place, reviewing all cases that have been assigned a serious harm score. The VTE Business Rule has been reviewed and all junior medical officers complete a VTE learning package on induction.

St George Hospital also has a VTE working party, currently focused on identifying barriers to risk assessments being completed by junior medical officers .

The Sutherland Hospital monitors data at its Patient Safety and Clinical Quality Meeting and Clinical Council. Data and any concerns are sent to Heads of Departments monthly, and known clinical complications are tabled at Departmental Morbidity and Mortality meetings.

SA 2021/22: Target set by NSW Health in the 2020/21 Service Agreement
LYSP: Last year same period

Hospital Acquired Renal Failure



The rate of hospital acquired renal failure in SESLHD has increased over 2021/22. These rates remain above the Not Performing target. Strategies are in place across SESLHD to address performance in this area.

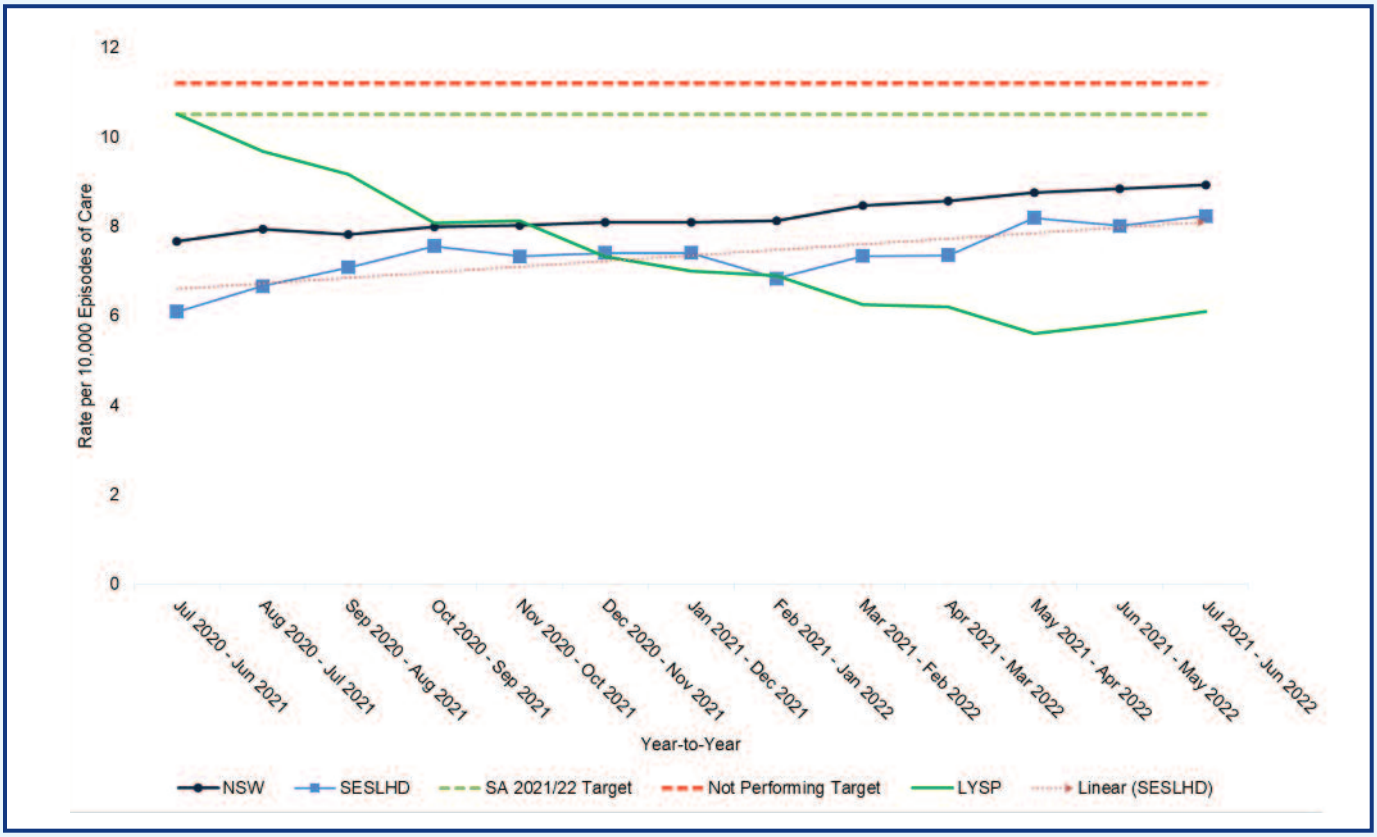
Prince of Wales Hospital has continued to improve responsiveness to acute kidney impairment (AKI) since implementation of an AKI alert in the electronic medical record in 2019. Each patient with AKI that requires haemodialysis or continuous veno-venous haemodialysis is reviewed for preventability. Key patient populations are patients with cardiac disease or post-operative surgical patients.

The Mental Health Service has introduced collection of blood samples on admission to screen for pre-existing vulnerabilities and baseline renal function.

The Sutherland Hospital reviews all renal HACs and reports these to the facility Patient Safety and Clinical Quality Meeting and Clinical Council. Data and any concerns are sent to Heads of Departments monthly, and known clinical complications are tabled at Departmental Morbidity and Mortality meetings and relevant cases reviewed at the Clinical Emergency Response System (CERS) Committee.

SA 2021/22: Target set by NSW Health in the 2020/21 Service Agreement
LYSP: Last year same period

Hospital Acquired Gastrointestinal Bleeding



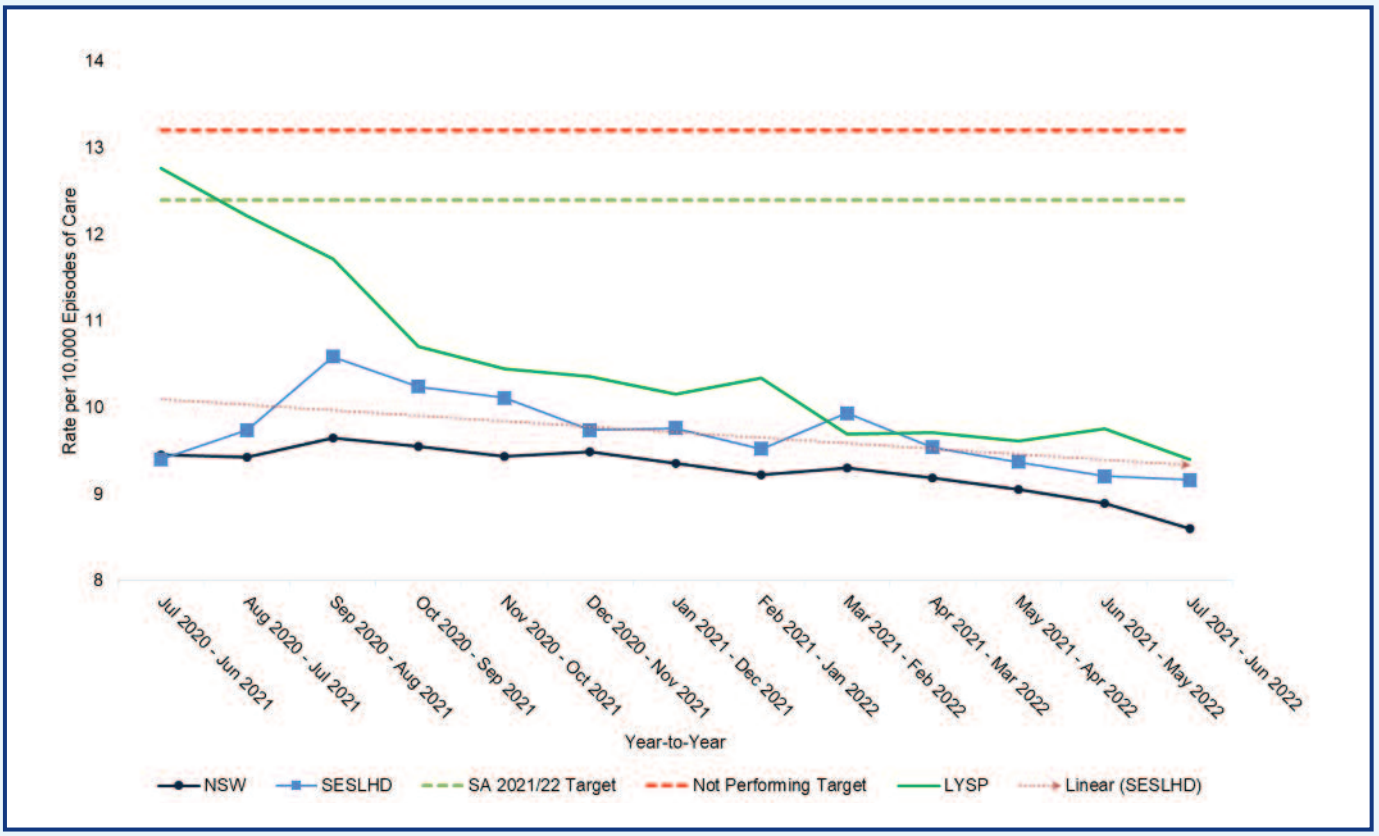
SESLHD has continued to meet the target for this complication. The rate of hospital acquired gastrointestinal (GI) bleeding in SESLHD has increased in parallel with the NSW rate during 2021/22. Strategies are in place to continue to perform in this area.

At Prince of Wales Hospital, the GI Clinical Nurse Consultant and specialists review data in regards to this complication. It has been identified that some GI bleeding complications are consistent with disease progression. Morbidity and Mortality (M&M) reviews are also conducted by specialist teams.

The Sutherland Hospital actively monitors cases of GI bleeding and has set a target to reduce the rate of gastrointestinal bleeding complications during 2022/23. All GI bleeding HACs are reviewed monthly and reported to the facility Patient Safety and Clinical Quality Meeting and Clinical Council. Data and identified concerns are sent to Heads of Departments. Known clinical complications are tabled at Departmental Morbidity and Mortality meetings. The Enhanced Recovery After Surgery (ERAS) for colorectal surgery quality initiative has also commenced.

SA 2021/22: Target set by NSW Health in the 2020/21 Service Agreement
LYSP: Last year same period

Hospital Acquired Medication Complications



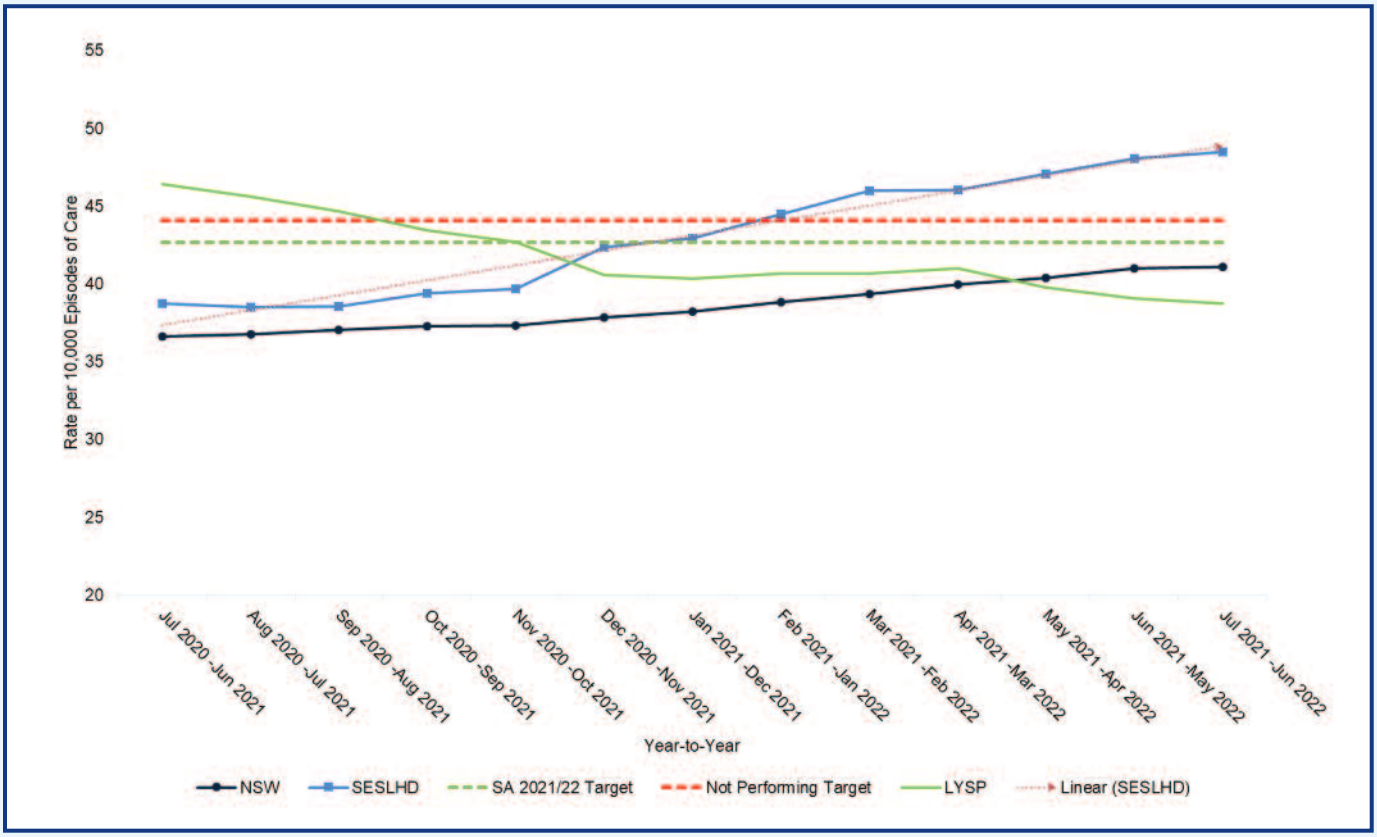
The rate of hospital acquired medication complications has improved over this reporting period, and is performing better than the target rate. Initiatives are in place across SESLHD, contributing to this improvement.

The SESLHD Mental Health Service completed a deep dive audit into medication complications. This found that the hospital acquired medication complications are largely due to "expected complications" when titrating Mental Health medications rather than "adverse complications." The Mental Health Service is exploring opportunities for benchmarking with similar services.

St George Hospital have commenced a rate stable medication discharge pilot project on 3 South, Surgical ward. The Sutherland Hospital have implemented the facility-wide project, 'Check Please', to reduce administration errors.

SA 2021/22: Target set by NSW Health in the 2020/21 Service Agreement
LYSP: Last year same period

Hospital Acquired Delirium



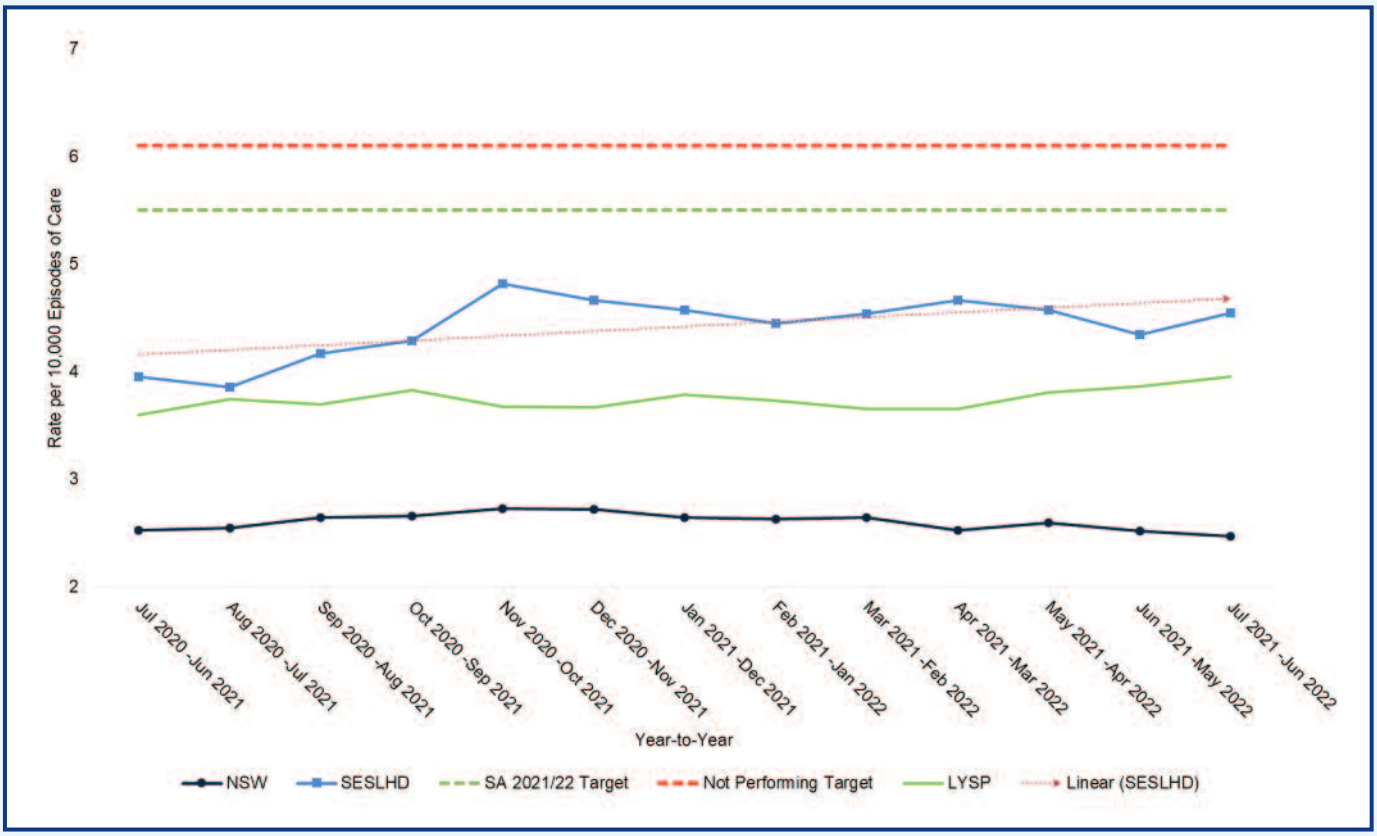
Rates of hospital acquired delirium in SESLHD have trended upwards during 2021/22 and are now above the Not Performing target.

Across SESLHD, work continues to improve prevention and management of delirium. This includes an update of the SESLHD Procedure - Prevention, Assessment and Management of Delirium in Older People, to align with the revised Delirium Clinical Care Standard, working groups supported by the Nursing and Midwifery Directorate across all sites, and the promotion of World Delirium Awareness Day. Facilities have completed reviews, action plans and/or audits of the Delirium Clinical Care Standard.

Initiatives to improve the care of consumers at risk and diagnosed with delirium are in progress at all sites. This includes the Person Centred Care project at War Memorial Hospital, which is actively seeking to increase non-pharmaceutical skills for staff to use when caring for patients with delirium; education in the delirium screening tool 4AT with target groups including emergency department, peri-operative and admissions, surgical and aged care wards at St George Hospital; and implementation of the Sunflower Project, to support the provision of person centred care for hospitalised older persons, at Sydney / Sydney Eye Hospital and War Memorial Hospital. The THIS IS ME person centred communication tool, was implemented at Garrawarra Centre. An Aboriginal-specific Dementia Person Centred Care project is also nearing completion by the Nursing and Midwifery Directorate, which will include an A4 poster, information for families and carers, and a resource for staff.

SA 2021/22: Target set by NSW Health in the 2020/21 Service Agreement
LYSP: Last year same period

Hospital Acquired Incontinence



SESLHD has continued to meet targets for hospital acquired incontinence during 2021/22. There has been an increase in rates of this complication, and work continues across SESLHD to monitor rates and cases of hospital acquired incontinence, aiming to improve performance.

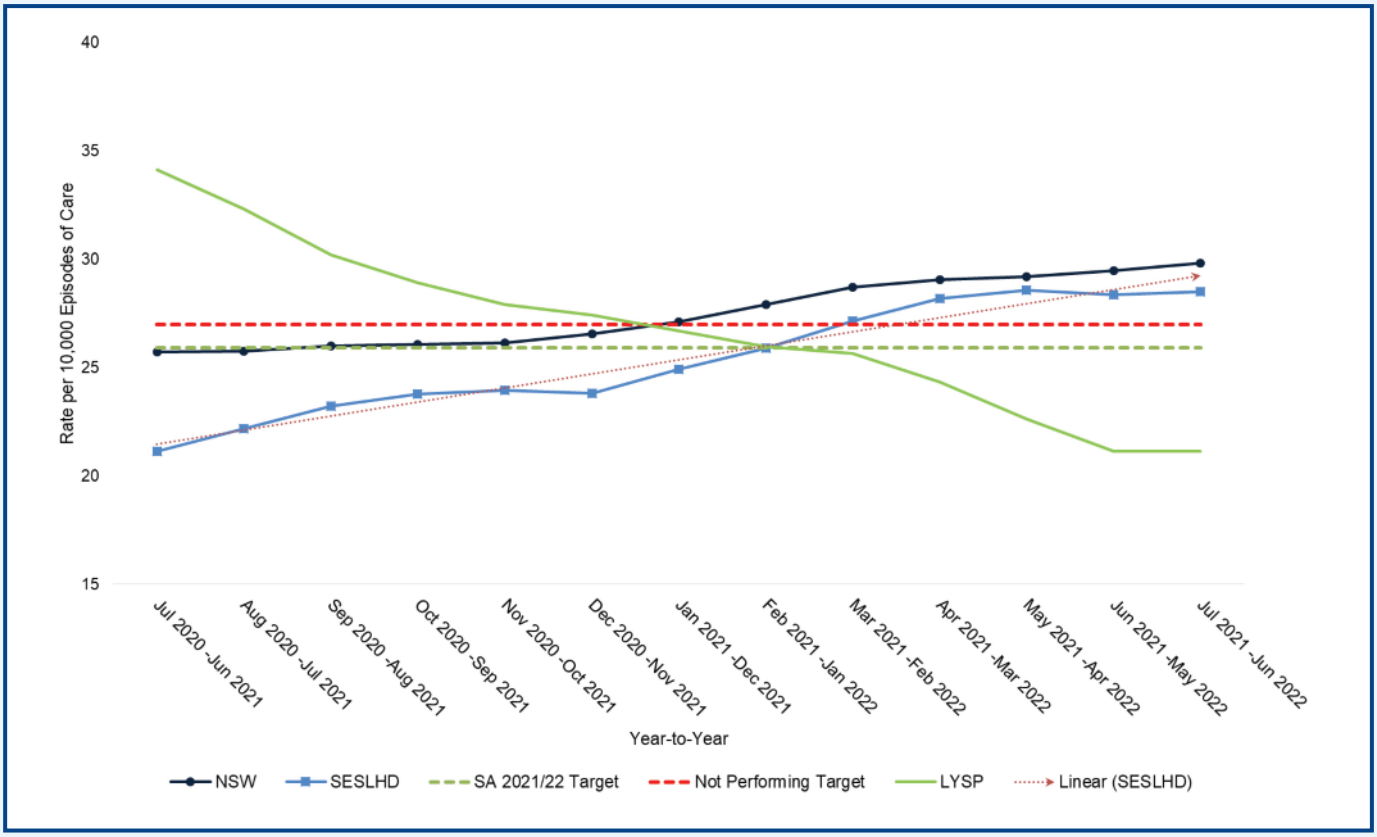
At the Royal Hospital for Women, a project continues to investigate the financial costs of this hospital acquired complication, with support from the finance department. The project will map the patient journey of five women who were diagnosed with urinary incontinence, including the costs incurred.

At Prince of Wales Hospital, hospital acquired incontinence is monitored by the Comprehensive Care Committee, as a strong relationship with falls and pressure injuries has been identified. The Community Continence Clinical Nurse Consultant leads a working party that has identified key focus areas for management of incontinence in the inpatient setting.

The Sutherland Hospital continues to monitor rates of persistent incontinence complications and has set a target of a reducing these rates in 2022/23. The Sutherland Hospital did not register any cases of hospital acquired incontinence in the last five months of the reporting period.

SA 2021/22: Target set by NSW Health in the 2020/21 Service Agreement
LYSP: Last year same period

Hospital Acquired Endocrine Complications



The rate of hospital acquired endocrine complications in SESLHD has increased over 2021/22. This rate remains below the state average, however is now above the Not Performing target. This category includes malnutrition and hypoglycaemia (low blood sugar). Initiatives are in place across SESLHD to improve performance in these areas.

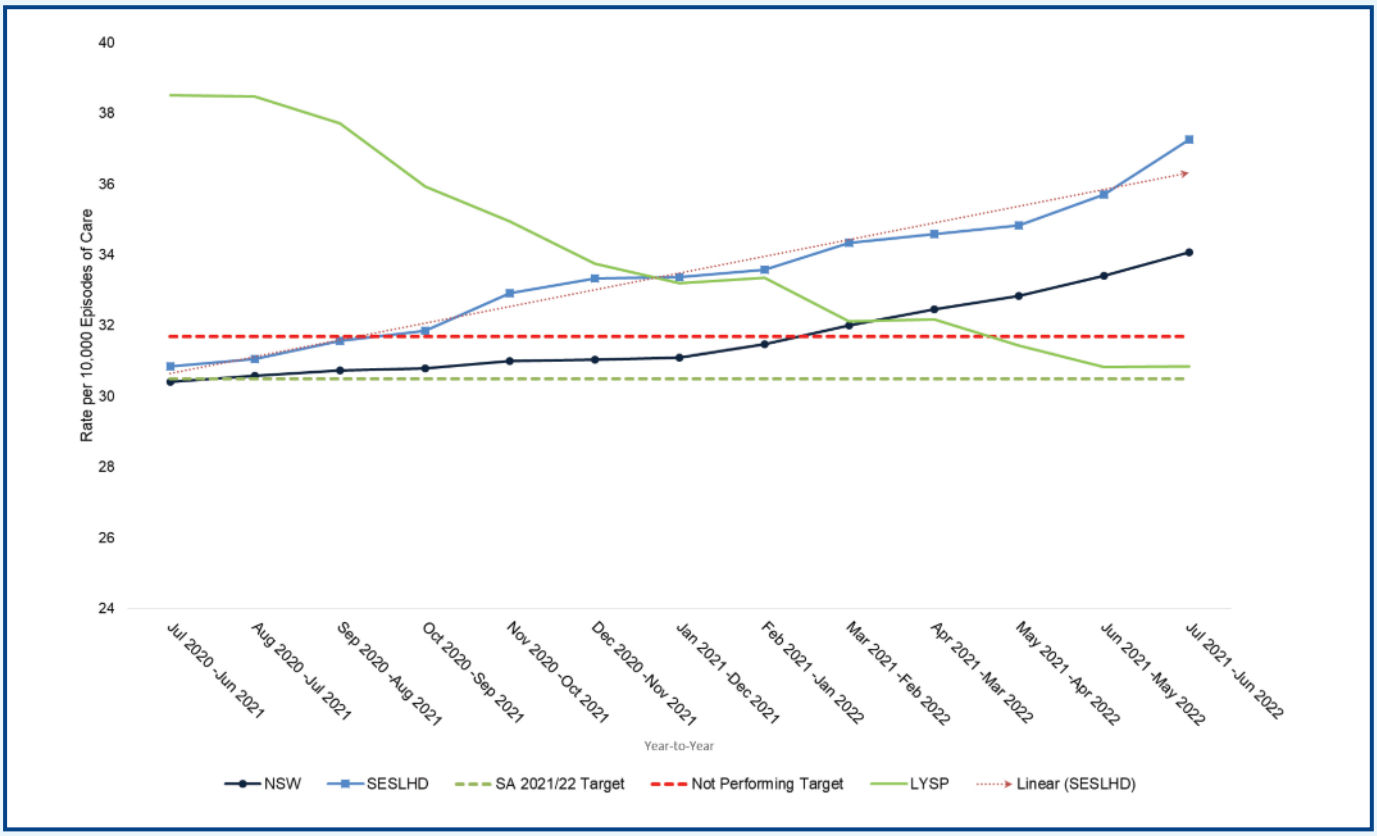
SESLHD Mental Health Service (MHS) has an action plan in place, and reports to the SESLHD Food and Hydration Committee to meet the nutritional needs of the MHS consumers across the service.

At Prince of Wales Hospital, an insulin pen pilot project on Parkes 9W, a renal ward, will be commencing in 2022/23. A Hypoglycaemic Dashboard has also been developed and implemented, to support a proactive approach to the management of inpatients with diabetes.

The Sutherland Hospital continues to work on reducing of non-medication related hypoglycaemia HACs and on monitoring rates of staff participation in Hypoglycaemia training. A detailed review of all endocrine HACs will be undertaken by the Endocrinology team in 2022/23, with an endocrine HAC review decision tool to be developed post-analysis for ongoing evaluation. The Sutherland Hospital reports a significant improvement in malnutrition HACs, with no severe malnutrition reported in last 19 month.

SA 2021/22: Target set by NSW Health in the 2020/21 Service Agreement
LYSP: Last year same period

Hospital Acquired Cardiac Complications



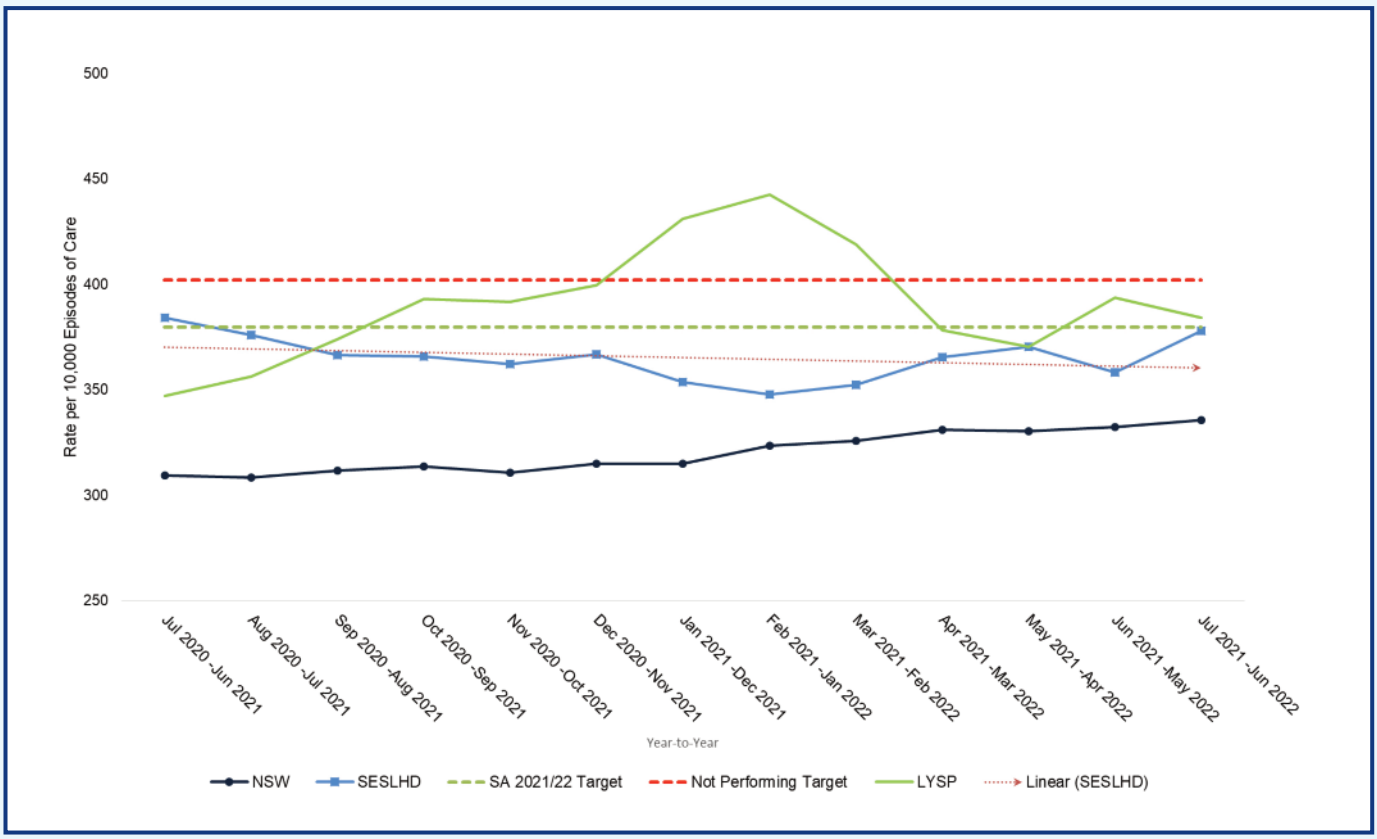
The rate of hospital acquired cardiac complications in SESLHD increased over 2021/22 and is now above the Not Performing target and the state average. Several strategies are in place with the aim of returning performance to target levels.

At Prince of Wales Hospital, cases are reviewed by the cardiology department, and all cardiopulmonary arrests are reviewed by the Clinical Emergency Response System (CERS) Clinical Nurse Consultant. Identified cases are also reviewed at Morbidity and Mortality (M&M) meetings.

Cardiac complications at St George Hospital are monitored by the Transcatheter Aortic Valve Implantation (TAVI) Governance committee. The Sutherland Hospital has undertaken a research project evaluating cardiac complications to identify potentially avoidable conditions with the development of a decision-making rubric for adjudication and increasing accuracy of the system to detect these complications and improve data reliability, with a target of reducing the rate of cardiac complications by in 2022/23.

SA 2021/22: Target set by NSW Health in the 2020/21 Service Agreement
LYSP: Last year same period

3rd or 4th Degree Perineal Lacerations During Delivery



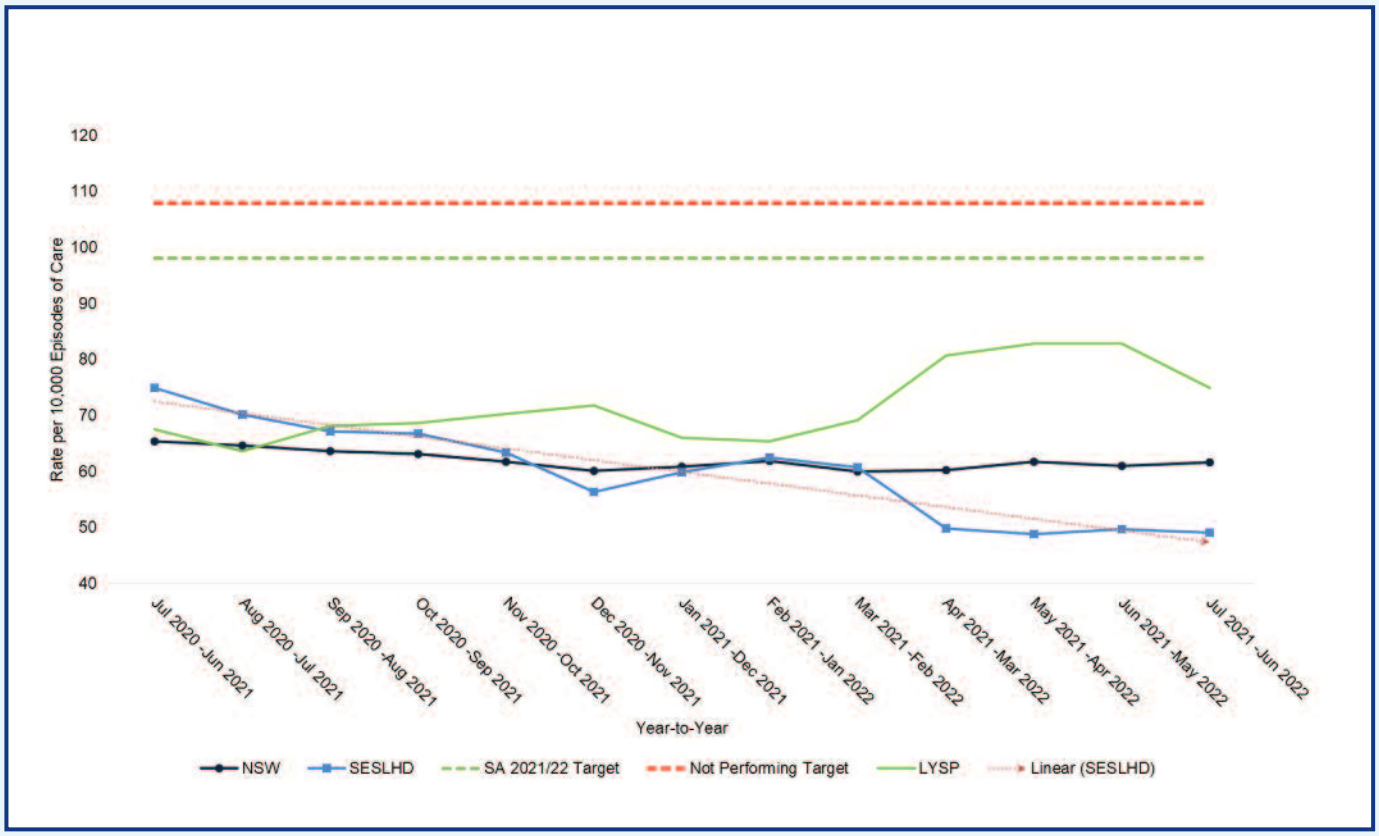
SESLHD met and exceeded the target rate for 3rd or 4th degree perineal lacerations (vaginal tears) acquired during childbirth. This performance has been achieved through numerous strategies implemented within SESLHD.

Cases are monitored at weekly clinical review committee meetings at The Sutherland Hospital, and are audited monthly for adherence to the perineal bundle of care within Maternity services at St George Hospital.

The Sutherland Hospital (TSH) recently implemented the Lithotomy Challenge, an initiative to promote upright birth positions and to reduce the use of lithotomy and semi-recumbent positions in birth, with the goal of reducing the rate of 3rd degree perineal lacerations in TSH delivery suite. This included simulated “birth drills” with midwife and medical staff, development and display of an upright birth position poster, midwifery champions and monitoring of use of upright birth positions with monthly celebration of success. Following the challenge, there was a significant reduction in the use of lithotomy and semi-recombinant positions in birth, and rates of perineal lacerations decreased to the project's target rate of 2%.

SA 2021/22: Target set by NSW Health in the 2020/21 Service Agreement
LYSP: Last year same period

Hospital Acquired Neonatal Birth Trauma



SESLHD met the target for rates of hospital acquired neonatal birth trauma during 2021/22, and continued to improve its performance over this period. This performance has been achieved through a number of strategies across SESLHD.

Incidents are reviewed routinely, including at The Sutherland Hospital in weekly Women's and Children's clinical review meetings, and at St George Hospital in monthly Women's and Children's incident monitoring system (IMS) meetings. These regular governance meetings allow for identification of birth trauma and prevention strategies.

The Royal Hospital for Women continued fetal safety training and clinical audits to measure compliance with the 'Fetal monitoring and record keeping in labour" Guideline. Results demonstrated increased compliance with the requirements of the guideline, and a reduction in preventable neonatal brain injury caused by reduced oxygen (hypoxic-ischaemic encephalopathy) cases following commencement of the initiative. A multidisciplinary project focused on documentation and clinical coding has resulted in more accurate coding of neonatal birth trauma.

SA 2021/22: Target set by NSW Health in the 2020/21 Service Agreement
LYSP: Last year same period

2022/23 Future Priorities

2022/23 Future Priorities

Aboriginal and Torres Strait Islander Health

Building on the achievements of 2021/22, and SESLHD's ongoing commitment to Closing the Gap and improving the health outcomes and experience of Aboriginal and Torres Strait consumers, the following priorities have been identified in collaboration with SESLHD Aboriginal health services, facility Aboriginal Health working parties inclusive of Aboriginal consumer representatives, and through consumer forums and yarning circles.

2022/23 Objectives

- Embed regular accounting and reporting mechanisms in a local Aboriginal health dashboard. This will be made accessible to a broad number of stakeholders within SESLHD. These indicators align with those available across all LHDs and Specialty Health networks.
- Reporting of Aboriginal status was identified as a performance indicator to address by the Centre for Aboriginal Health. A strategy will be launched in the year 2022/23 to support improvement in this indicator.
- All facilities complete a review of the Aboriginal cultural engagement self-assessment tool in 2022/23 and continue to address needs or gaps in service delivery in Aboriginal Action Plans developed by the individual facility and across services.
- Updated Respecting the Difference face-to-face training and an online module will become available from August 2022. All staff will be required to complete these mandatory training modules.

Patient Experience

People want, and expect to receive, safe, high quality healthcare and to have a positive experience of care. Understanding a person's experience of care is a essential to providing safe, high quality, patient centred care. Evidence demonstrates positive patient experiences result in improved clinical outcomes, safer and more efficient and effective care, and higher levels of adherence to treatment. When patient-centred models of care are implemented, operational efficiencies such as reduced length of stay and readmission rates, as well as enhanced staff satisfaction are also evident.

An environmental scan of patient experience information collection at SESLHD revealed more than 26 different patient experience surveys are offered to patients across the District. While this creates a wealth of data, standardisation, aggregation and analysis are not consistent across the district and there are lost opportunities to align with strategy and improvement initiatives.

SESLHD has established a Patient Experience Working Group to develop a strategic approach to patient experience information collection, measurement, reporting, analysis and improvement. The working group to includes staff representing all SESLHD facilities and services including Aboriginal Health and Diversity Health teams, and health care consumers.

2022-23 Future Priorities

- Establish governance for Patient Experience across SESLHD (including oversight, reporting and standardisation)
- Identify appropriate data/information governance and use, including visibility, aggregation, key indicators)
- Embed the use of patient experience measures to inform and improve care and service delivery
- Create feedback opportunities that are equitable and accessible, and consider individual's needs
- Develop a shared vision for human experience at SESLHD, supporting the Elevating the Human Experience Framework

Reducing Hospital Acquired Complications across SESLHD

Goal

To minimise clinical harm resulting from preventable hospital acquired complications (HACs) to an agreed, acceptable level via an embedded governance system, including a single agreed set of key performance indicators (KPIs) and targets, which describes responsibility across all relevant levels of the organisation and results in continuous improvement in performance and identifies predictive, risk based approaches to their management.

Hospital acquired complications (HACs) are patient complications for which risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. HACs can affect the patient's recovery and increase the patient's length of stay, with an associated increased cost of care.

2022-23 Future Priorities

- Review clinical data in relation to identified high burden HACs to identify common patterns of incidence, likely preventable thresholds and potential improvement strategies.
- Establish an agreed HAC performance reporting dataset and strengthen and embed accountability and responsibility of HACs at all levels of the organisation
- Provide clinical and operational data analytics to departments and teams to inform quality improvement
- Implement and evaluate evidence-based continuous improvement strategies to reduce HACs
- Review financial data with the aim to understand impacts and improve financial stewardship.

Appendix 1

SESLHD Governing Body Attestation Statement 2022

Health
South Eastern Sydney
Local Health District

This attestation statement is made by	**Michael Still**
	Name of office holder/member of Governing Body
Holding the position/office on the Governing Body	**Board Chair**
	Title of officeholder/member of Governing Body
For and on behalf of the governing body titled	**South Eastern Sydney Local Health District Board**
	Governing body's title (the Governing Body)
	South Eastern Sydney Local Health District
	Health service organisation name (the Organisation)

1. The Governing Body has fully complied with, and acquitted, any Actions in the National Safety and Quality Health Service (NSQHS) Standards, or parts thereof, relating to the responsibilities of governing bodies generally for Governance, Leadership and Culture. In particular I attest that during the past 12 months the Governing Body:

   a. has provided leadership to develop a culture of safety and quality improvement within the Organisation, and has satisfied itself that such a culture exists within the Organisation

   b. has provided leadership to ensure partnering by the Organisation with patients, carers and consumers

   c. has set priorities and strategic directions for safe and high-quality clinical care, and ensured that these are communicated effectively to the Organisation's workforce and the community

   d. has endorsed the Organisation's current clinical governance framework

   e. has ensured that roles and responsibilities for safety and quality in health care provided for and on behalf of the Organisation, or within its facilities and/or services, are clearly defined for the Governing Body and workforce, including management and clinicians

   f. has monitored the action taken as a result of analyses of clinical incidents occurring within the Organisation's facilities and/or services

   g. has routinely and regularly reviewed reports relating to, and monitored the Organisation's progress on, safety and quality performance in health care.

2. The Governing Body has, ensured that the Organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people.

Appendix 1 (continued)

3. I have the full authority of the Governing Body to make this statement.

4. All other members of the Governing Body support the making of this attestation statement on its behalf *(delete if there is only one member/director of the governing body)*.

I understand and acknowledge, for and on behalf of the Governing Body, that:

- submission of this attestation statement is a pre-requisite to accreditation of the Organisation using NSQHS Standards under the Scheme
- specific Actions in the NSQHS Standards concerning Governance, Leadership and Culture will be further reviewed at any onsite accreditation visit/s.

Signed 

Position **SESLHD Board Chair**

Date 24/08/2022

Counter signed by the Health Service Organisation's Chief Executive Officer (however titled)

Signed 

Position **SESLHD Chief Executive**

Name **Tobi Wilson**

Date 23.8.22

Appendix 1 (continued)

Schedule of health service organisations covered by this attestation statement

Name of health service organisation	Address
150025 SESLHD Mental Health Service	Level 2, 11 South St KOGARAH 2217
110748 The Sutherland Hospital	The Kingsway CARINGBAH 2229
110141 St George Hospital	Gray St KOGARAH 2217
110333 Royal Hospital for Women	Barker St RANDWICK 2031
116366 SESLHD Northern Sector	
Prince of Wales Hospital	Barker St RANDWICK 2031
Sydney/Sydney Eye Hospital	8 Macquarie Street, SYDNEY 2000
117366 Population and Community Health	8 Macquarie Street, SYDNEY 2000

SESLHD Safety & Quality Account 2022

2021-22 Report
2022-23 Future Priorities

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Produced by:
SESLHD Clinical Governance Unit
South Eastern Sydney Local Health District


NSW
GOVERNMENT