POPULATION HEALTH DIRECTORATE PLAN 2014-2017

Working together to improve the health and wellbeing of our community

NSW GOVERNMENT Health
South Eastern Sydney Local Health District

South Eastern Sydney Local Health District

Produced by: Planning and Population Health Directorate,
South Eastern Sydney Local Health District http://www.seslhd.health.nsw.gov.au/

May 2014

Foreword

Many residents of South East Sydney Local Health District experience very good health compared with people in other parts of New South Wales and Australia. However, there are areas for improvement. For example, chronic diseases (including diabetes, heart disease and cancer) cause around 85% of premature death and disability in the District. There are also substantial differences in health status and life expectancy between different population groups, with Aboriginal, socio-economically disadvantaged, and culturally and linguistically diverse people often experiencing poorer health than the rest of the population. These challenges are placing increasing and unsustainable pressure on our health care services.

While many of the District's health services focus on the treatment of an individual's health condition, its population health services focus on addressing the range of risk and protective factors that ultimately determine the health and wellbeing of our community. Population health services aim to protect and improve health and wellbeing and prevent disease, illness and injury. South Eastern Sydney Local Health District has a wide range of population health programs and services largely located within the Directorate of Planning and Population Health.

The *Population Health Directorate Plan 2014 – 2017* outlines how our services and programs will respond to the key population health priorities and initiatives outlined in the District's overarching *Strategy 2012-17* and *Health Care Services Plan 2012-17*. The Plan builds on the direction and guidance provided by key Commonwealth and State strategies. It focuses on delivering effective population health action through an integrated approach involving partnerships with a broad range of stakeholders including other health providers, other government departments (e.g. education, local government, planning, sport and recreation, and environmental protection agencies), non-government organisations, private industry, universities and research institutions and communities.

In population health, as for a number of other areas, the legitimate need for funds is greater than the resources available. Fortunately, population health is a common target for external funding from a range of organisations and groups such as government, trusts and foundations. To this end, the Planning and Population Health Directorate has established a Grant Seeking Program that allows ready access to all available opportunities for external funding and collaborations with other groups and organisations to maximise population health efforts.

The responsibility for promoting and protecting the health and wellbeing of our community belongs to us all. There is an urgent need for preventive activity to move from the margin to the mainstream of current health practice. By working together, we will reduce preventable illness and injury, and increase the number of Australians who are healthy throughout their life course.

Ms Julie Dixon
Director, Planning and Population Health
South Eastern Sydney Local Health District

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Figures and Tables

Use of the term "Aboriginal" in this document

In accordance with NSW Health's *Communicating Positively. A guide to appropriate Aboriginal terminology*, the term "Aboriginal" is used throughout this document to include Aboriginal and Torres Strait Islander peoples. No disrespect is intended towards our Torres Strait Islander staff, patients or communities, whose contribution is gratefully acknowledged.

Section 1: Introduction

1.1 What is Population Health?

Population Health focuses on preventing disease, prolonging life, and protecting and promoting health through organised efforts and informed choices.

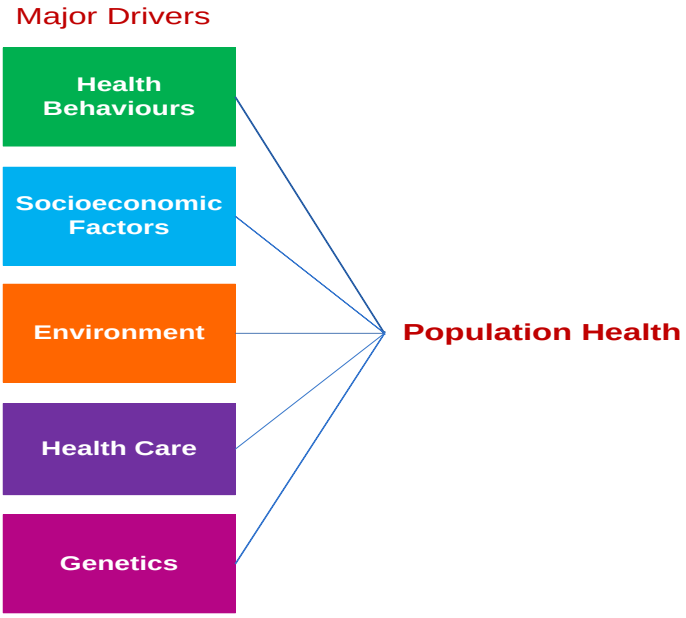

Figure 1: Major drivers of Population Health

For the purposes of this Plan, population refers both to the whole population and to particular sub-populations with specific needs requiring tailored interventions.

Population health recognises that to improve health, determinants outside health have to be tackled.[1] According to the World Health Organization, the main determinants of health include the social and economic environment, the physical environment, and the person's individual characteristics and behaviours (see Figure 1).

Population health programs and activities improve health and wellbeing through approaches that target population groups rather than individuals to reduce mortality and morbidity, particularly among vulnerable communities such as those who are socio-economically disadvantaged and Aboriginal people. These programs and activities may focus on[2]:

- Creating public policy that promotes health and wellbeing
- Promoting safe and healthy environments
- Promoting personal skills and competencies
- Promoting healthy lifestyles and behaviours
- Reducing differences in health among population groups.

It is increasingly being recognised that each life stage influences the next, and social, economic and physical environments interacting across the life course can have a profound effect on individual and community health and wellbeing. Promoting a life course approach to health is thus an important aspect of population health practice. For example being breastfed, having a healthy diet with adequate calcium intake throughout life and participating in regular weight bearing exercise promotes improved bone density and helps prevent osteoporosis and fragility fractures later in life.

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[1] David Kindig, Greg. Stoddart. What Is Population Health? American Journal of Public Health: 2003, Vol. 93

[2.] Daniel J. Friedman, PhD, and Barbara Starfield, MD, MPH. 2003. Models of Population Health: Their Value for US Public Health Practice, Policy, and Research. American Journal of Public Health 93:3, 366-369

Another important population health approach is the promotion of resilience, the capacity to recover quickly from difficulties in life. This can help offset factors that increase the risk of mental health conditions, such as lack of social support and lack of social connection. In order to build resilience, people living in the most inequitable life circumstances, e.g. those who are socially isolated, stigmatised, living with chronic health problems or in difficult economic circumstances, need targeted support. Facilities, resources, programs and services are used to support people to take part in activities that promote wellbeing and social connectedness.

Population health is considered a key priority for the NSW Government and this Local Health District.[3] Programs and services developed and delivered by this District focus on identifying and reducing or eliminating health risks, building the community's resilience to cope with life's challenges and the promotion of health and wellbeing along the life course.

1.2 The Planning and Population Health Directorate

The Planning and Population Health Directorate is one of the main providers of population health programs and services in the region and employs approximately 207 staff (many of these staff are employed on a temporary basis with enhancement funding provided by the NSW Ministry of Health). The Directorate provides a range of activities, services and programs to protect, improve and restore the health and wellbeing of individuals and vulnerable communities within South Eastern Sydney Local Health District. Programs are designed to help people stay healthy, reduce disparities in health outcomes and decrease the need for hospital care.

One example of the Directorate's activities to achieve these goals is a series of Aboriginal Wellbeing Workshops promoting smoking cessation, smoking clinics and healthy lifestyles to the La Perouse Aboriginal Community. This project was initiated by the Directorate, Prince of Wales Community Health Service, Sydney Children's Hospital, Langton Centre, Eastern Sydney Medicare Local, South East Neighbourhood Service and the Yoga Foundation.
Photo: La Perouse Aboriginal Wellbeing Workshop – staff member and volunteer from the 'Stir It Up!' program

The Directorate also comprises a small Strategy and Planning team which provides support to the SESLHD Board, Executive, clinical leaders, managers and broader organisation to make informed decisions about the strategic priorities and the most appropriate directions for change that will lead to sustainable improvement in the performance of the District. The team does this by providing technical advice and by leading and managing the development, implementation, monitoring and evaluation of strategies, population health, clinical service and business plans and local solutions that improve the effectiveness and efficiency of our services to address the health needs of the community.

[3] Population Health Priorities NSW: 2012-2017

The key operational units within the Directorate include the:

- Albion Centre (delivers HIV prevention and specialist treatment and care)
- Falls Prevention Programs and Coordination (hospital and community)
- Health Promotion Service
- HIV and Related Programs Unit
- HIV Outreach Team
- Public Health Unit
- Short Street Sexual Health Service (located in the Southern sector)
- Strategy and Planning Unit
- Sydney Sexual Health Centre (located in the Northern sector)

The Directorate also administers a range of statewide and international services and programs including:

- 'Albion International Health Services' which coordinates a program of international activities.
- Cruise Ship Surveillance Program
- Enhanced Medication Access Scheme for people living with HIV
- NSW AIDS Dementia and HIV Psychiatry Service (ADAHPS)
- NSW HIV and Sexual Health Information Lines
- NSW Sexually Transmissible Infections Unit
- NSW Sharps Management Program

1.3 Why a Population Health Plan?

The purpose of this Plan is to outline the priority areas of focus and activities that will be over the next five years to protect and improve the health and well being of our local communities.

This Plan specifically aims to:

- Improve the capacity of our services to partner and engage with local communities and stakeholders to address current and emerging health needs of local communities.
- Foster and support innovation in population health practice.
- Influence health professionals and other stakeholders within and external to the District to deliver effective population health activities.

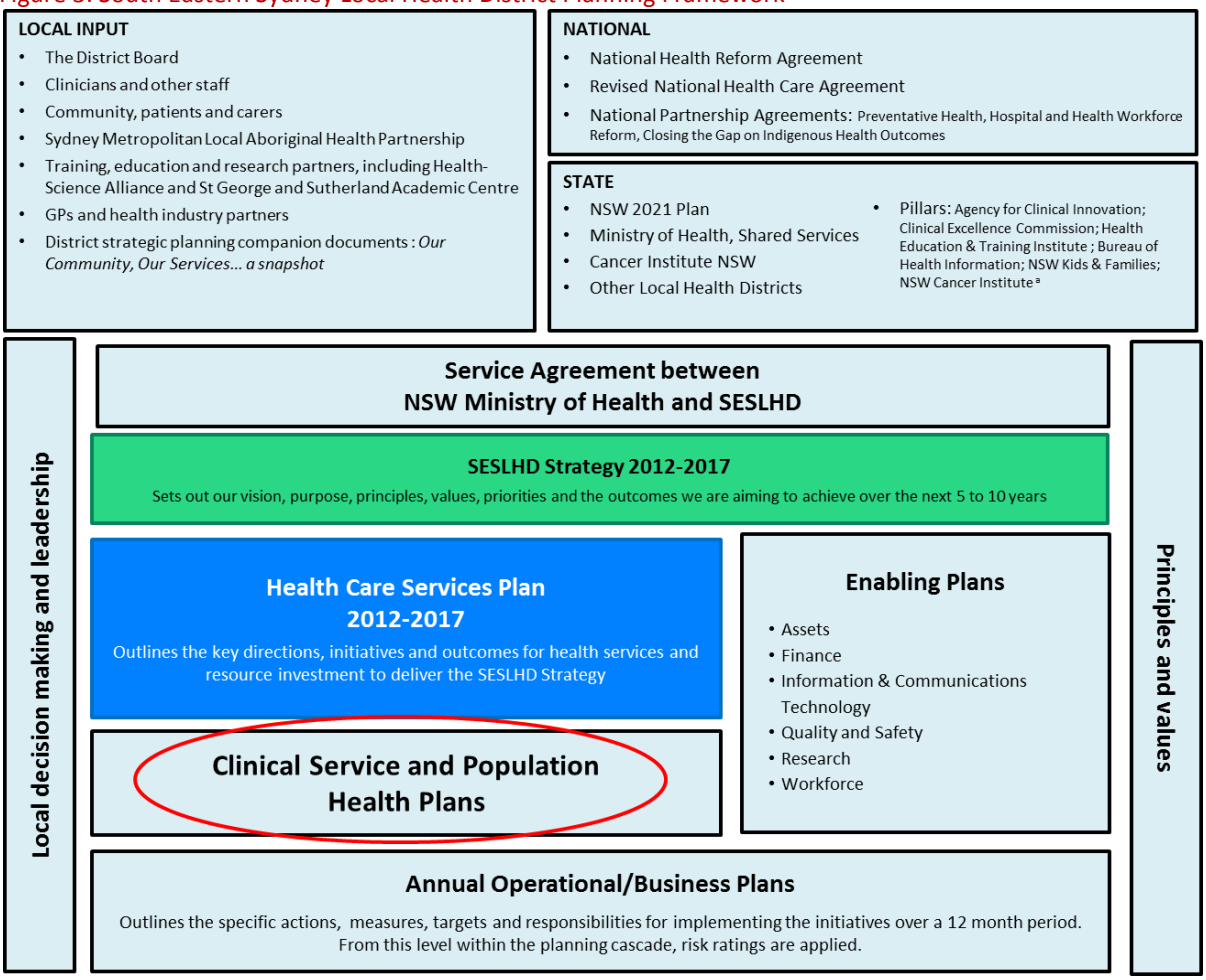
Figure 2: Benefits of Population Health planning

The Plan's development has been informed by:

- A number of State and National plans, policies and strategies, tabled in Appendix 1.
- The South Eastern Sydney Local Health District's ***Strategy 2012-2017*** and ***Health Care Services Plan 2012-2017*** www.seslhd.health.nsw.gov.au/HealthPlans.
- The South Eastern Sydney Local Health District's performance requirements as outlined in the annual Service Agreement with the NSW Ministry of Health.

The South Eastern Sydney Local Health District's Planning Framework outlined in Figure 3 illustrates where the Population Health Directorate Plan fits into the District's planning framework, the main influences on its development, and other major District plans which inform and influence each other.

Figure 3: South Eastern Sydney Local Health District Planning Framework[4]



[4] **The Pillars** are: **Agency for Clinical Innovation (ACI) , Clinical Excellence Commission (CEC), Health Education Training Institute (HETI), Bureau of Health Information (BHI), NSW Kids and Families, Cancer Institute NSW**
The **Sydney Metropolitan Local Aboriginal Health Partnership** involves the Aboriginal Medical Service Co-operative Ltd at Redfern, the SESLHD, St Vincent's Hospital Network and two other Local Health Districts (Sydney and Northern Sydney).The Partnership is to ensure that the expertise of Sydney Metropolitan Aboriginal community is brought to health care processes. With these four organisations working closely together, the Partners aim to improve Aboriginal health outcomes and service delivery.
Shared services include HealthShare NSW, eHealth NSW, NSW Health Pathology and Health Infrastructure NSW.
Other Local Health Districts closely linked with SESLHD include: geographically-defined LHDs which have services provided by the SESLHD e.g. Sexual Assault services provided to Sydney LHD residents; and functionally-defined LHDs e.g. Children's Hospitals Network (with Sydney Children's Hospital co-located and sharing services/ infrastructure with other Randwick Campus facilities), Forensic Mental Health, and St Vincent's and Mater Hospital Network (geographically located within the boundaries of SESLHD).

1.4 Effectiveness of Population Health Interventions

"Anyone with the responsibility to help individuals and communities change health risk behaviour, initiate health-promoting behaviour, change environmental factors, or manage illness must design or adapt existing effective interventions and develop plans to implement them"[5]

In general, public health systems focus more on treating the symptoms and complications of disease and other often preventable health problems rather than supporting their primary or secondary prevention. This approach is unsustainable in an environment where people are living longer, the population is ageing and growing, the burden of chronic disease is on the rise, and the community's expectations are increasing.

The increasing prevalence and cost of chronic disease means that prevention, whether primary, secondary or tertiary is important at all ages, including among the elderly, to ensure that further increases in life expectancy translate, as far as possible, into healthy years where the need for hospital and other health services is minimised. There is also an economic imperative to ensure the health of the working population is maintained as it ages.

Evidence

Overall, with the right approach and appropriate conditions and infrastructure, the delivery of population health services and interventions to individuals and communities reduces health risks and levels of morbidity and mortality in the community. Evidence also indicates that we could achieve greater improvements in health outcomes, at a much lower cost, by increasing population health activity.[6]

Cost Benefits

In percentage terms, health expenditure in Australia has risen more than the Gross Domestic Product for nine of the past 10 years.[7] Projected increases in health care costs are related to medical advancements, population growth and ageing, and the increasing prevalence of chronic disease. A continued rise in public expenditure on healthcare is projected over the next few decades if efforts are not made to tackle the causes of the projected growth, in particular the increasing burden of chronic disease.[8] Additional costs associated with preventable disease include costs to patients (travel, accommodation), the social and economic burden on carers and families, and lost wages and productivity.

The health and economic benefits of a population health approach have been identified across a range of areas. For example, it has been estimated that:

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[5] Bartholomew, L., Parcel, G., Kok, G. and Gottlieb, N. (2001) *Intervention Mapping Designing Theory- and Evidence-based Health Promotion.* Mountain View, CA: Mayfield Publishing Company.

[6] Krogsbøll LT, Jørgensen KJ, Grønhøj Larsen C, Gøtzsche PC. General health checks in adults for reducing morbidity and mortality from disease. Cochrane Database Syst Rev. 2012 Oct 17;10:CD009009.

[7] Health Spending in Australia. Health Cents at the AIHW. **Issue no. 29, March 2011**

[8] AIHW 2011. Health expenditure Australia 2009-10. Health and welfare expenditure series no. 46. Cat. no. HWE 55.

For every $1 AU spent on: [9,10]

	Direct health care saving of:
✓ Reducing **tobacco** consumption	$2
✓ Reducing **falls** in the community	$20.6
✓ Providing **needle & syringe** program	$27

Return on Investment in blood borne infection prevention programs

Our investment in HIV population health programs has returned substantial positive net benefits. The HIV transmission rate in Australia is likely to have been around 25% higher in the absence of these programs. The estimated value in 2003 of the net benefits derived from these programs was over $2.5 billion.

A study investigating the NSW Government HIV/AIDS investment program (1984 to 2005)[11] found that continued investment in preventive initiatives of the program could be expected to continue to provide benefits well into the future.[12] significant health and cost savings included:

- ✓ **45,000 HIV cases prevented**
- ✓ **863,000 quality adjusted life years saved**
- ✓ **Over $18,000 million saved through prevention**
- ✓ **2,750 HIV deaths prevented by 2010**
- ✓ **394,000 life years saved**

A key prevention program which has proven to be highly effective in preventing the transmission of HIV and other infections through injecting drug use is the NSW Needle and Syringe Program (NSP). This program improves access to sterile injecting equipment for people who inject drugs. Primary NSPs also provide a point of contact for referral to other health services. These people are often the most marginalised and of greatest public health priority. In the last decade it is estimated that there was a return of $27 dollars for every dollar invested in NSPs by Australian Governments, making it one of the most cost effective public health initiatives.[12]

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[9] Healthy people NSW: Improving the health of the population. NSW Department Of Health 2007

[10] Applied Economics (2003). Returns on investment in public health: An epidemiological and economic analysis prepared for the Department of Health and Ageing. © Copyright Department of Health and Ageing 2003, ISBN: 0 6428219 1 7

[11] Health Outcomes International in association with National Centre in HIV Epidemiology & Clinical Research. Impact of HIV-AIDS in NSW: mortality, morbidity & economic impact. Sydney: NSW Health; 2007.

[12] NSW HIV Strategy 2012 – 2015: A New Era. p. 33

Return on Investment from Immunisation

"Immunisation, even with the addition of the new, more costly vaccines, remains one of the most cost-effective health interventions".[13] Vaccine preventable diseases constitute an important cause of preventable illness, disability and death in Australia, particularly among children, the elderly and other vulnerable population groups. In Australia, investments in immunisation continue to increase and are worth making over and above the overall benefit of contributing to the world wide eradication of specific diseases such as in the case of smallpox which, according to estimates, saves around $1.3 billion a year in treatment and prevention costs.[14] Immunisation programs provide long-term health and economic benefits that far outweigh their costs.

Return on Investment from Tobacco Control

Tobacco control interventions have also proven to be an effective investment. A review of tobacco control studies concluded that 'in almost every case that tobacco control programs and policies are either cost-saving or highly cost-effective'.[15] A 2009 report[16] predicted that tobacco taxation increases, combined with additional spending on anti-smoking media promotion would achieve a smoking prevalence of 10% or less by 2020 and would avoid 248,200 premature deaths. Such a program was estimated to cost about $276 million, but would save more than $5 billion in health care costs. Other evidence based programs are further outlined in Section 5: High Priority Health Issues.

Programs owned by and responsive to Community Needs

The programs and services offered by the Directorate are both responsive to and informed by the community to ensure they are appropriate from a user's perspective and fit with the preferences of the local community. This plan builds on the strengths and resources within the community (e.g. individuals' skills, networks of relationships, local communities and groups etc.) and offers services and programs that are culturally relevant to targeted groups. All proposed interventions will be tailored to suite specific community conditions and attempt to reach all segments of the community.

Integration

The World Health Organisation[17] defines health services integration as: *"The organisation and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money"*

The Planning and Population Health Directorate collaborates with community partners to offer integrated services and programs to ensure that the community receives quality, coordinated programs and support, and that gaps, duplication and fragmentation in the provision of services are minimised.

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[13] Health Outcomes International in association with National Centre in HIV Epidemiology & Clinical Research. Impact of HIV-AIDS in NSW: mortality, morbidity & economic impact. Sydney: NSW Health; 2007.
[14] WHO, UNICEF, World Bank. *State of the world's vaccines and immunization*, 3rd ed. World Health Organization, 2009.
[15] Kahende J, Loomis B, Adhikari B and Marshall L. A review of economic evaluations of tobacco control programs. International Journal of Environmental Research and Public Health. 2009;651–68. www.mdpi.com/1660-4601/6/1/51/pdf
[16] Control VCfT. Predicted impact of proposed tobacco control strategies. Melbourne: Cancer Council Victoria, 2009. http://www.health.gov.au/internet/preventativehealth/publishing.nsf/Content/0FBE203C1C547A82CA257529000231BF/$File/commpaper-imp-tob-cont-strat.pdf
[17] World Health Organisation (2008). Technical Brief 1, Integrated Health Services. What and Why? Making Health Systems Work.

Section 2: Our District and Community

2.1 South Eastern Sydney Local Health District

The South Eastern Sydney Local Health District covers nine NSW Local Government Areas from Sydney's Central Business District to the Royal National Park in the South. The District's services include population health programs and services; ambulatory, primary health care and community health services; hospital inpatient and outpatient services, and pharmacy, imaging and pathology, among others.

The District also provides a key role in assisting residents of Lord Howe Island and Norfolk Island with access to hospital and health services, including statewide services.

South Eastern Sydney Local Health District has a complex mix of highly urbanised areas, industrialised areas and low density suburban development areas in the south. It supports a culturally and linguistically diverse population of over 847,000 people.

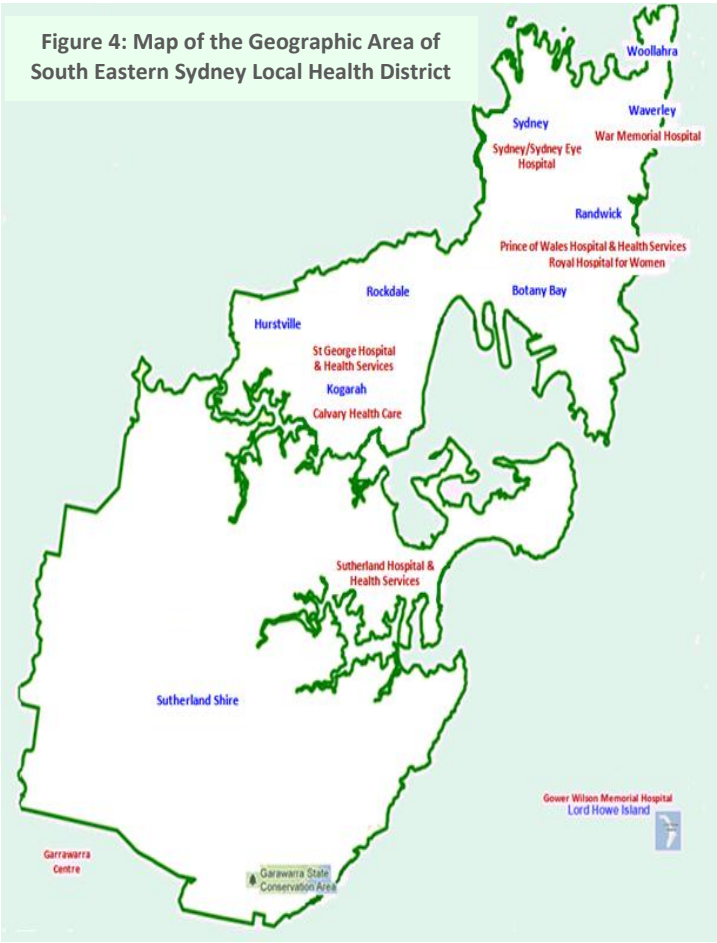


Figure 4: Map of the Geographic Area of South Eastern Sydney Local Health District

Vision

Working together to improve the health and wellbeing of our community

Purpose

The South Eastern Sydney Local Health District exists to:

- *Promote, protect and maintain the health of its community.*
- *Provide safe, quality, timely and efficient care to all who need it.*
- *Address gaps in health service access and health status.*

Facilities include six public hospitals and associated health services: Prince of Wales; Royal Hospital for Women; St George; Sutherland; Sydney / Sydney Eye; and Gower Wilson Memorial on Lord Howe Island. The District also provides one public residential aged care facility (Garrawarra Centre), and oversees two third schedule health facilities:
War Memorial Hospital (third schedule with Uniting Care) and Calvary Healthcare (third schedule with Little Company of Mary Health Care).

The District also provides one public residential aged care facility (Garrawarra Centre), and oversees two third schedule health facilities: War Memorial Hospital (third schedule with Uniting Care) and Calvary Healthcare (third schedule with Little Company of Mary Health Care).

Other public health facilities located in the South Eastern Sydney region include Sydney Children's Hospital (Randwick), St Vincent's Hospital (Darlinghurst) and Sacred Heart Hospice. Private health care facilities also provide services to our population.

Primary Health Care Organisations located in the South Eastern Sydney Region include the Eastern Sydney and South Eastern Sydney Medicare Locals.

A number of fundamental principles guide our decisions on the directions and actions to take with regard to the development and delivery of health care within the District. These are outlined in the ***South Eastern Sydney LHD Strategy 2012-2017*** and the ***Health Care Services Plan 2012-2017***[18].

2.2 Our Population

The District's population is growing and ageing.

The estimated residential population of SESLHD is over 847,000 and is projected to increase to about 890,000 by 2021 and 930,000 by 2031.

The fastest growing age groups will be the 70-84 years age group (+26%) followed by the 85 years and over age group (+18%).[19]

Population ageing creates inter-related problems for the health sector. An increase in people living with chronic diseases and disabilities, and relative decrease in carers, places a higher demand on health services and our ageing health workforce. A major challenge is to encourage healthy ageing to enable people to contribute for as long as possible and to reduce the burden on our health care system.

[18] http://www.seslhd.health.nsw.gov.au/HealthPlans/default.asp
[19] South Eastern Sydney Local Health District (May 2013). Our Population. Factsheet. Directorate of Population Health and Planning.

2.3 Disadvantaged and Vulnerable Groups

Despite great improvements in average life expectancy in recent decades, health gains have not been equally shared across all population groups. Those most likely to experience health inequities are our most vulnerable population groups.

Our population is diverse. We have significant cultural diversity, as well as sizable Aboriginal populations.

While being relatively advantaged overall compared to the rest of NSW, SESLHD is home to a large share of some of NSW's high risk populations, including homeless people, marginalised youth, and people who inject drugs.

Aboriginal people

As occurs generally across Australia, the starkest variation in health status between population groups resident in South Eastern Sydney is between Aboriginal and non-Aboriginal people. Life expectancy for Aboriginal men and women in NSW is estimated to be 70 and 75 years respectively (as compared to 79 and 83 years in the non-Aboriginal population). Aboriginal people suffer much higher morbidity across a range of conditions; including diabetes, renal, cardiovascular and respiratory diseases, and both intentional and unintentional injury.

In 2011, over 6,300 Aboriginal people lived in SESLHD, equating to 0.8% of the District's total population and 3.7% of the NSW Aboriginal population. Just over half of our Aboriginal residents live in the Northern Sector (52%, 3,284), with less than half in the Southern Sector (48%, 3,032).

While the non-Aboriginal population of SESLHD is rapidly ageing, Aboriginal people are facing increased growth in young age groups, due to higher levels of fertility, and increased mortality of those over the age of 65. In 2011, 28% of Aboriginal residents were under 15 years of age, compared with 16% of non-Aboriginal residents. Persons aged 65 years and over comprised 5.7% of the Aboriginal population, compared with 14% of the non-Aboriginal population.

Low socioeconomic status

Populations of low socioeconomic status are at higher risk of a variety of health risks and outcomes.[20] They are more likely to: be obese and develop diabetes; smoke; do insufficient physical activity; drink alcohol at high risk levels; and engage in unsafe sexual behaviours.

Within SESLHD there is a large intra District diversity in socioeconomic status, with some suburbs among the least advantaged in the state. Of the 200 State Suburbs wholly or partially within the SESLHD geographic area, 17 suburbs are, on average, more socioeconomic disadvantaged than the average (i.e. SEIFA < 1000).[21]

[20] Tucs E; Dempster B (2007) Linking Health and the Built Environment: An annotated bibliography of Canadian and other related research

[21] South Eastern Sydney Local Health District (August 2013). Geographic areas and socioeconomic disadvantage. Factsheet. Directorate of Population Health and Planning.

Culturally and linguistically diverse groups

Overseas born people, on average, experience relatively good health. However, some groups are more susceptible to specific health risks (e.g. smoking, low cancer screening rates) and chronic conditions (e.g. diabetes, heart and respiratory disease, mental illness, workplace injuries, tuberculosis) than the Australian-born.

SESLHD has a large population who were born overseas. In 2011, 26 % of the District's population (206,195 people) was born in a non-English speaking country, an increase of 5% from 2006. Almost half (42%) of these SESLHD residents live in the St George area. More than a third (37%) of our residents speak another language at home, an increase of 13% from 2006. For further information on our culturally and linguistically diverse populations, see our factsheet at http://seslhnweb/Planning_and_PopulationHealth/Factsheets.asp

Each year 7,500 people on average migrate from overseas into the SESLHD area, particularly the St George area. Most are young (18-35 years). The largest numbers come from China and India. SESLHD also receives a small but significant number (approximately 200) of new Humanitarian arrivals per year from countries such as China, Iran, Iraq, Egypt and Bangladesh. There is a significant older refugee population, particularly in the Eastern Suburbs.

Other vulnerable populations

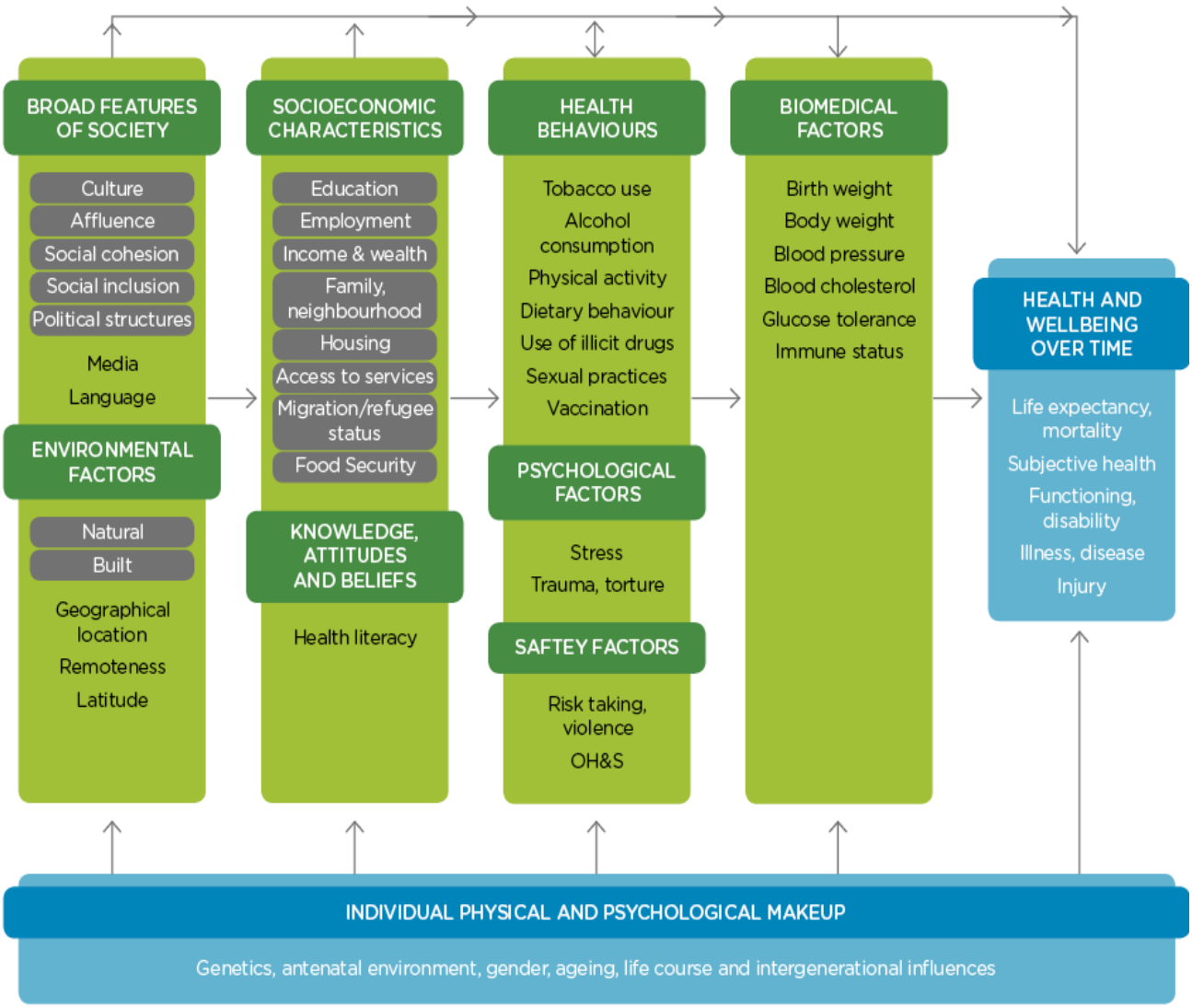
Other vulnerable populations include the homeless, people with disabilities and/ or severe mental illness, refugees, and elderly people with chronic health conditions. Their vulnerability is compounded by culture, ethnicity, English proficiency, age, gender and factors such as poor access to health care. Chronic illnesses and the impact of these illnesses are more prevalent among vulnerable populations. Their health and healthcare problems intersect with social factors, including housing, poor or no social capital and inadequate education. Social disadvantage is often exacerbated by poor health and vice versa. The numbers within some of these vulnerable populations are increasing, particularly as the population ages.

Our factsheet, Geographic Areas and Socioeconomic Disadvantage details the selected Sociodemographic indicators for South Eastern Sydney LHD resident population, by Local Government Area, 2011.

The State and District strategies and plans that inform the Directorate's work to support vulnerable populations are tabled in Appendix 2.

2.4 Risk factors and determinants of health

A large portion of the disease burden in SESLHD is preventable. The main determinants of health include the social and economic environment, the physical environment, and the person's individual characteristics and behaviours. Figure 5 provides a useful framework for understanding and informing strategies to address the key determinants of population health.



Note: Grey shading highlights selected social determinants of health

Source: Australian National Preventive Health Agency (ANPHA). *State of Preventive Health 2013*. Report to the Australian Government Minister for Health. Canberra; ANPHA, 2013.

Figure 5: A framework for the determinants of health

Individual characteristics and behaviours – which themselves are influenced by the environment - are commonly referred to as risk factors. Modifiable risk factors include excess body weight, inadequate fruit and vegetable consumption, physical inactivity, risky alcohol, smoking, unsafe sexual practices and incomplete immunisation. In general, **for every TEN people** living in the South Eastern Sydney Local Health District:

- **Nine out of 10 residents do not eat enough vegetables**
- **Four out of 10 residents do not eat enough fruit**
- **Four out of 10 residents are overweight or obese**
- **Four out of 10 residents don't achieve recommended levels of physical activity**
- **Three out of 10 residents drink alcohol at risky levels**
- **Two out of 10 residents smoke**

Many, if not all, of our common conditions, risk factors and their determinants are interlinked, as shown in Table 1. For example, increasing rates of overweight and obesity are the prime drivers behind the increasing incidence of diabetes and its complications. Obesity is also an independent risk factor for cardiovascular disease, some musculoskeletal conditions and some cancers. Reductions in risk factors such as smoking, physical inactivity and poor diet will result in a decrease in incidence of various chronic diseases, which in turn, will cause a decrease in morbidity and premature death.

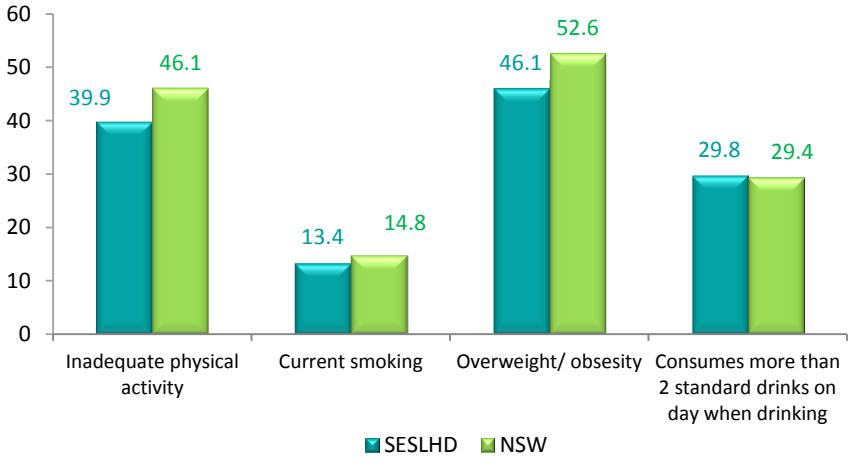
Over the last decade the prevalence of overweight and obesity among our residents has increased by about 5 percentage points, from 41% to 46%

Table 1: Links between selected conditions, risk factors and determinants

Selected Conditions	Tobacco Smoking	Physical Activity	Nutrition	Overweight/ Obesity	Alcohol misuse	Unsafe sex &/ or drug use	Chronic stress/ depression	Low SES
Cardiovascular	✓	✓	✓	✓			✓	✓
Type 2 Diabetes		✓	✓	✓	✓		?	✓
Cancer	✓	✓	✓	✓	✓	✓	?	✓
Respiratory / Asthma	✓	✓	?	✓		✓	?	✓
Mental health	+	✓	+	+	✓+	✓	✓	✓
Musculoskeletal / arthritis	✓	✓	✓	✓	✓			
Injury						✓	✓	✓
Oral Health	✓		✓					✓
Liver disease			✓	✓	✓	✓		✓

Source: Adapted from Australian institute of Health and Welfare 2012. Risk factors contributing to chronic disease. Canberra: AIHW

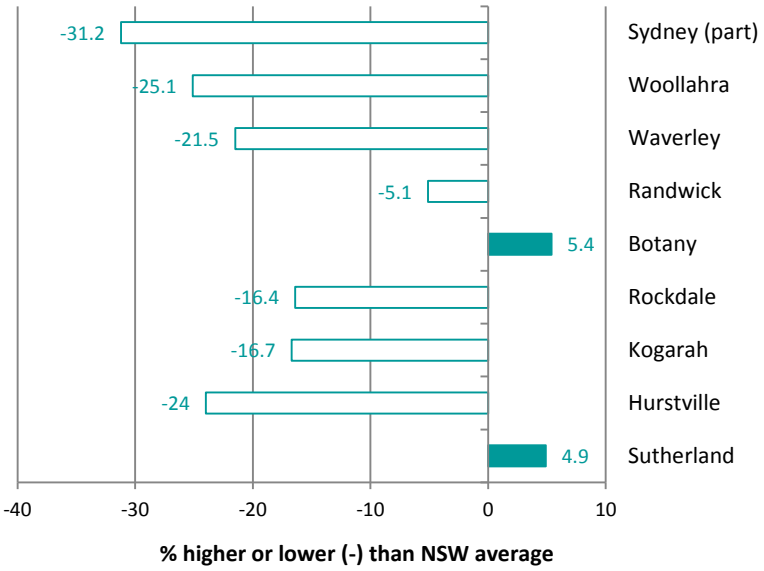
Figure 6: Common Risk Factors among South Eastern Sydney LHD and NSW residents (% population aged 16 years and over), 2011



Source: NSW Population Health Survey, accessed from Health Statistics NSW website 23 July 2012

While our population as a whole compares favourably with the NSW population as a whole, there is marked **variation** between various sub-populations resident across our District in terms of risk factors and their outcomes (Figures 8-11).

Figure 7: High BMI related hospitalisation rates (age standardised) among SESLHD residents by Local Government Area - % Difference from NSW average 2008-09 to 2009-10

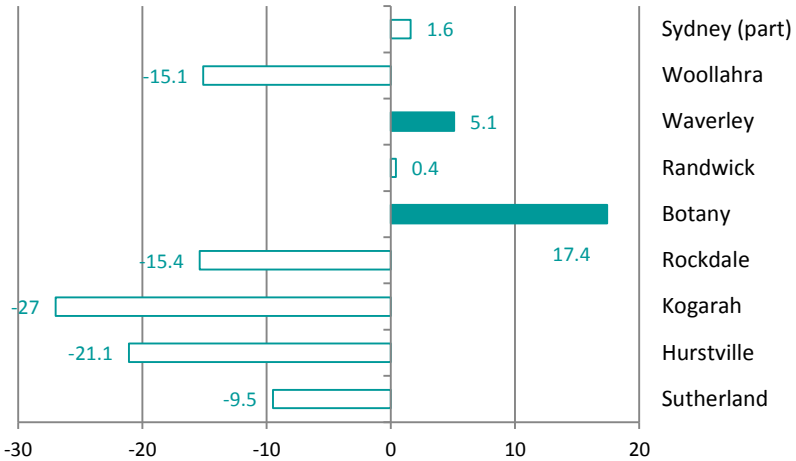


Source: NSW Admitted Patient Data Collection and ABS population estimates (HOIST). Centre for Epidemiology and Evidence, Ministry of Health. Accessed from Health Statistics NS
Notes: Directly age standardised rates, using 2001 Australian population as reference.

Sutherland and Botany Bay Local Government Area (LGA) residents are at higher risk than the average NSW resident (about 5% higher) of being hospitalised for a condition attributable to overweight/ obesity.

The opposite is true for residents of other Local Government Areas within the SESLHD geographic area.

Figure 8: Smoking attributable hospitalisation rates among SESLHD residents by Local Government Area - % Difference from NSW average, 2008/09 to 2009/10

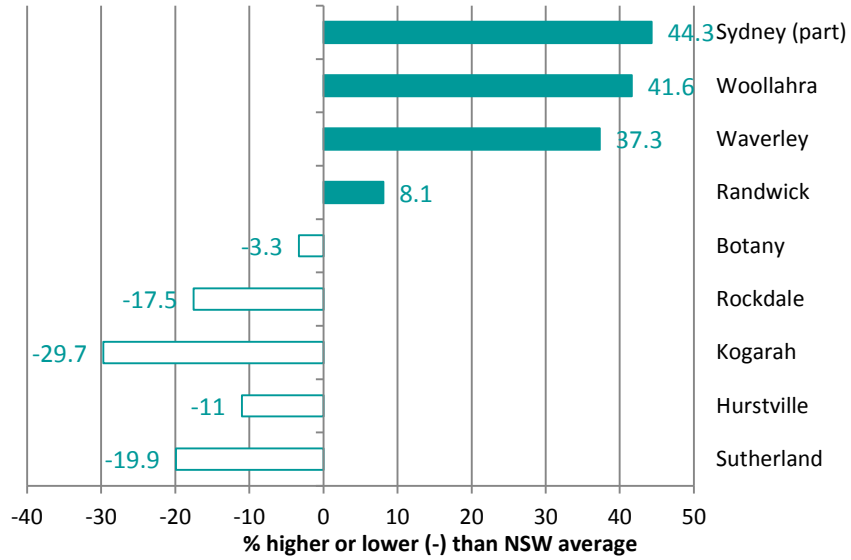


Source: NSW Admitted Patient Data Collection and ABS population estimates (HOIST). Centre for Epidemiology and Evidence, Ministry of Health. Accessed from Health Statistics NS

Botany Bay LGA residents are at much higher risk (about 17% higher) of being hospitalised for a smoking attributable condition than the average NSW resident. Waverley LGA residents are also at higher risk (5% higher).

Residents of all other LGAs within the SESLHD geographic area are at a similar risk (Sydney, Randwick LGAs) or lower risk than the NSW average

Figure 9: Alcohol related hospitalisation rates among SESLHD residents by Local Government Area - % Difference from NSW average, 2010/11 - 2011/12

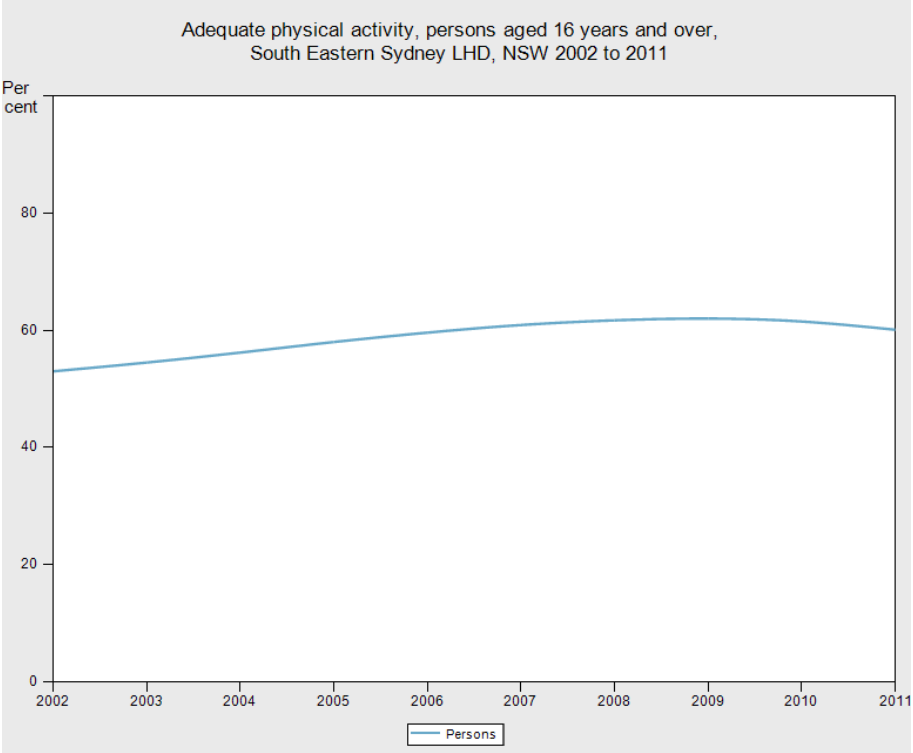


Source: NSW Admitted Patient Data Collection and ABS population estimates (HOIST). Centre for Epidemiology and Evidence, Ministry of Health. Accessed from Health Statistics NSW.
Notes: Directly age standardised rates, using 2001 Australian population as reference.

Residents of all LGAs in the northern sector of the District are at higher risk of being hospitalised for an alcohol attributable condition than the average NSW resident. North of Randwick LGA the risk is about 40% higher.

Residents in all LGAs in the southern sector are at lower risk that the NSW average.

Figure 10: Adequate Physical Activity, persons aged 16 years and over, SESLHD 2002-11



Over 40% of our residents aged over 16 are not getting enough physical activity

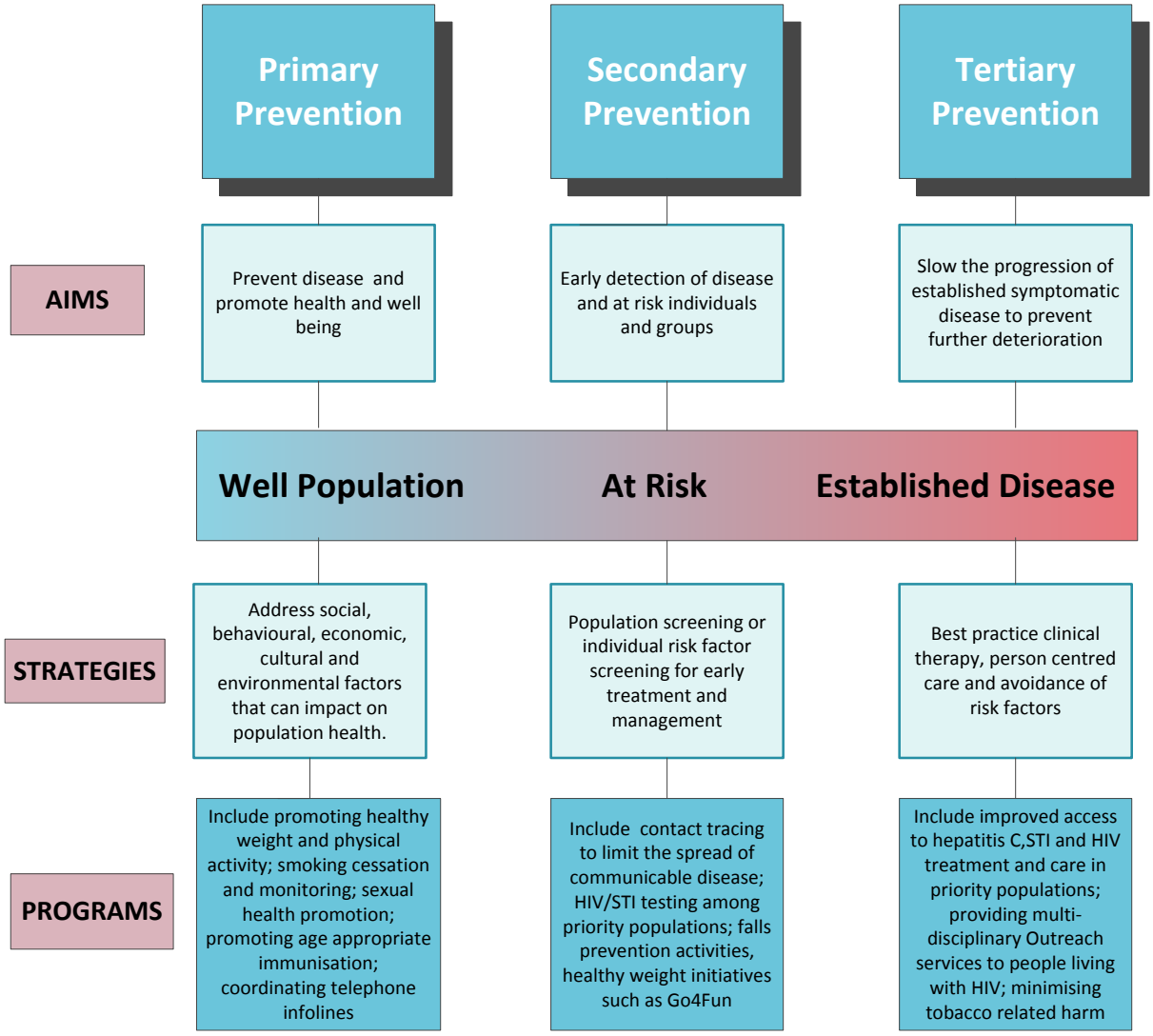
Source: NSW Adult Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.

Section 3: Our Programs and Services

3.1 Our Programs and Services

A comprehensive range of population health programs, services and activities are delivered by the Local Health District, primarily through its **Planning and Population Health Directorate** across the primary, secondary and tertiary prevention spectrum. The Directorate employs about 207 staff, who have a diverse range of backgrounds and skills.

Figure 11: Our population health activity across the preventive health continuum

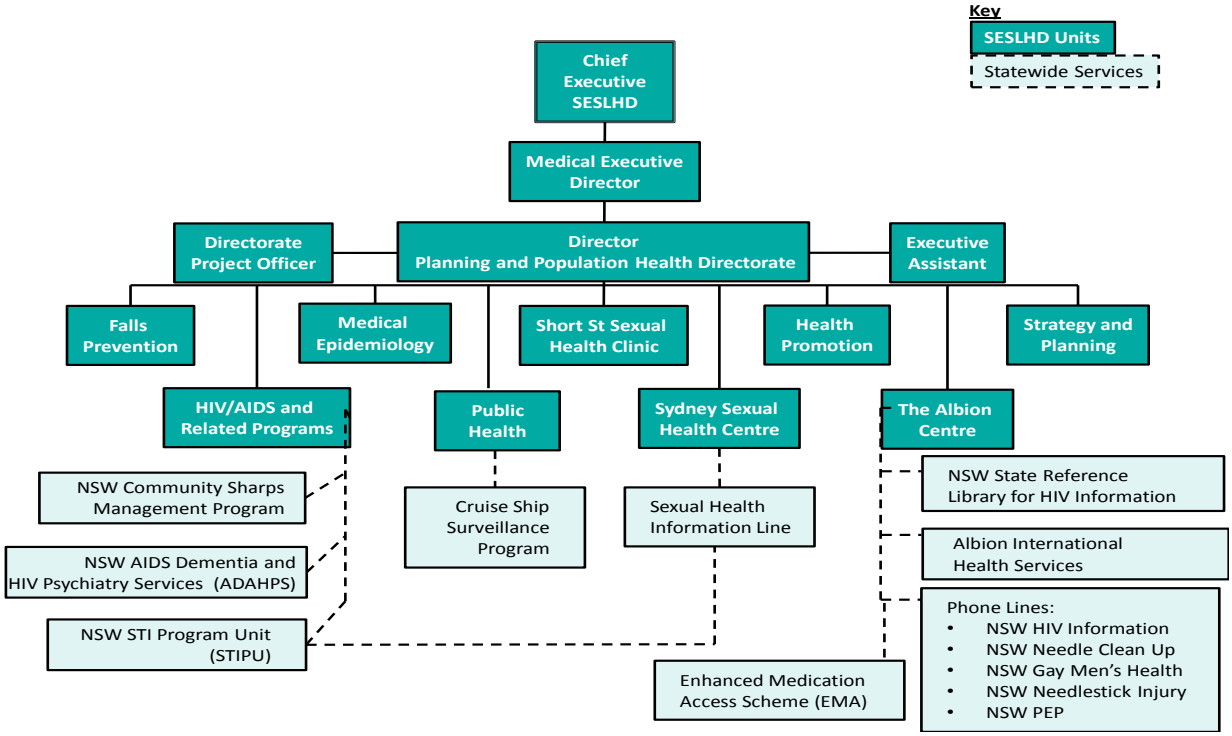


The Directorate's operational units include a Public Health Unit (health protection), Health Promotion Service, Falls Prevention Program Coordination Unit (hospital and community), HIV and Related Programs Unit and HIV and sexual health prevention, treatment and care services. The Directorate also administers a number of statewide services (see Appendix 3). Wherever possible, the operational units within the Directorate work together to prevent illness and injury, and protect and promote the health and wellbeing of the community.

The Directorate employs a number of staff who have expertise in planning, communication, epidemiology, and research and evaluation; these relate to some of our `enablers' (see *Our Population Health Framework on the following page)* to maximise the quality and effectiveness of services and programs delivered to our local community and the NSW community.

A Strategy and Planning Unit is organisationally located within the Directorate and provides support to the District's staff. The Strategy and Planning Unit assists the Directorate to integrate and undertake effective population health planning to align services and programs with new policy directions, assess emerging trends in service delivery and changing patterns of need, and to support services to identify and make best use of available resources.

Figure 12: Directorate of Planning and Population Health Organisational Chart



The Directorate's Executive Team


Julie Dixon
Director


Jamie Hallen
Falls Prevention


Colette McGrath
HARP Unit


Victoria Westley-Wise
Medical Epidemiology


Josephine Lusk
Short St Sexual Health Clinic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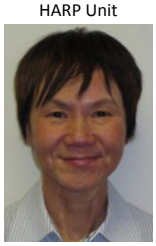

Myna Hua
Health Promotion


Julian Gold
The Albion Centre


Carla Saunders
Strategy & Planning Unit

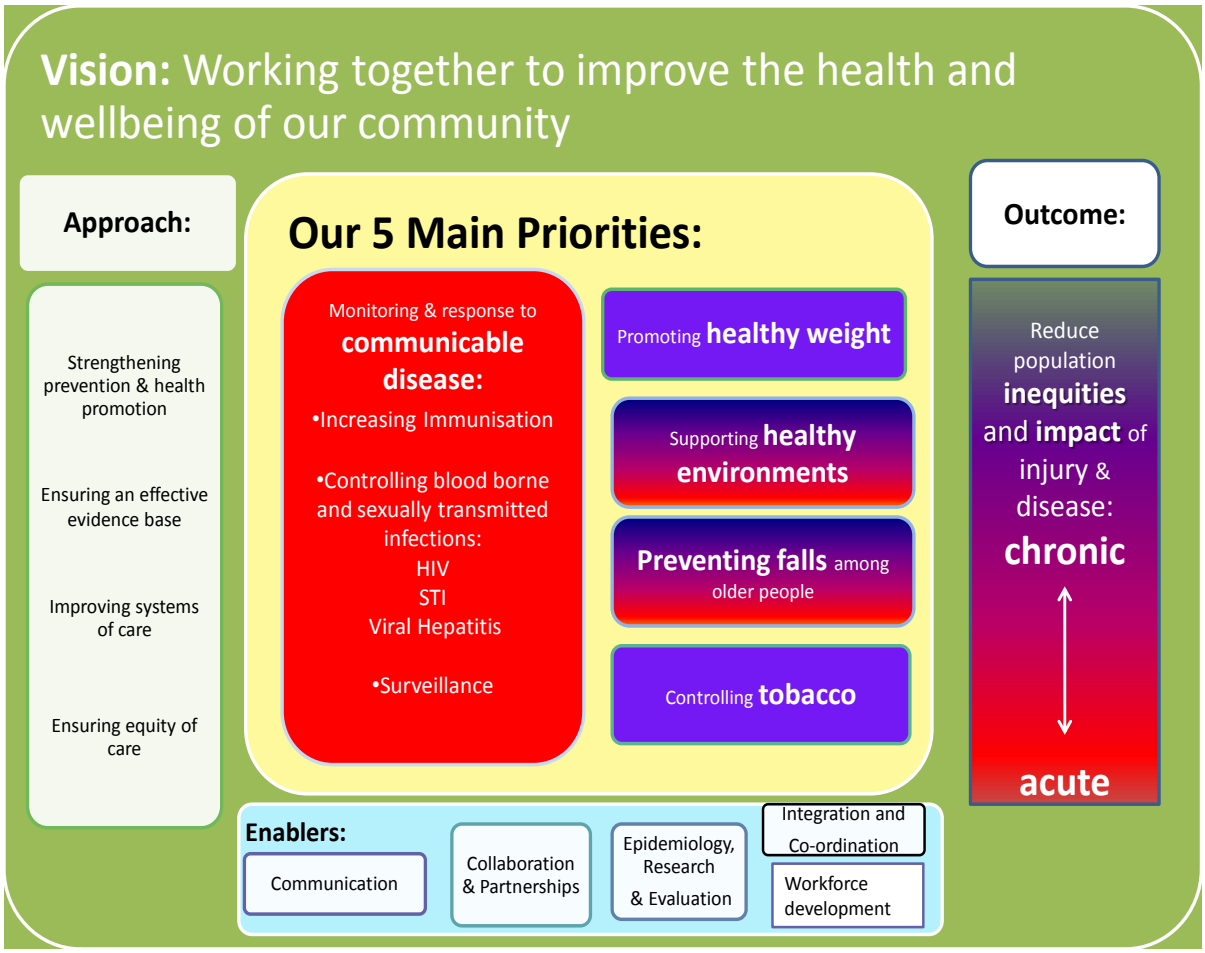
3.2 Our Population Health Framework

As shown in *Our Population Health Framework* below, the Directorate's population health efforts are built around five key domains or approaches:

- **Ensuring an effective evidence base** to guide action through systematic surveillance of population health data and the academic literature to inform program need and design.
- **Strengthening prevention and health promotion** practice through promoting and protecting health across the life course and by building sustainable partnerships.
- **Improving systems of care** through strengthening the role of prevention in the health care system.
- **Ensuring equity of care** to our most at risk populations to reduce disparities in health outcomes and service access between sub-population groups.
- **Building partnerships and inter-sectoral action** between population health and primary health care and hospitals, other government and non-government agencies, universities, private industry and the local community to promote better health outcomes; and giving priority to populations most at risk.

Population Health programs and services commonly use multi-strategic, multi-sectoral and integrated approaches to maximise population health gains. The Directorate's services and programs work across common priority areas to apply strategies for population health to a variety of population groups, risk factors, and diseases in various settings.

Our Population Health Framework



The Directorate is focusing on integrating its Unit's activities to address a range of population health needs within common priority populations. For example, priority populations at risk of and living with HIV, have higher smoking rates compared with the general population so HIV services undertake a range of smoking cessation interventions with their clients to improve their health. Similarly, HIV treatments are now more efficacious. This has enabled people living with HIV to live longer. However, the drug treatments often lead to side effects and as individuals age, they are more likely to experience a range of comorbidities. As such, healthy ageing strategies such as falls injury prevention interventions are important to protect and improve the health of this population.

3.2.1 Population Health and Health Care Integration

Health care and population health have generally been evaluated, organised and funded as two separate systems. To maximise gains in health status and expend scarce health resources most effectively,[22] health care and population health in South Eastern Sydney Local Health District is regarded as two interactive parts of a single, unified health system.

To facilitate health care and population health integration, the Directorate is strengthening its focus on developing preventive health activities to engage healthcare providers across all disciplines to support consumers to adopt healthy behaviours (e.g. modifying individual risk factors and lifestyles to improve population health, particularly tobacco use, poor diet, lack of physical activity, harmful alcohol use and safe sex behaviours). It is essential to work in partnership with clinical streams and health services in developing preventive activities to be included into routine care. The Directorate is identifying these opportunities through the clinical service planning being undertaken across the District.

HIV and AGEING FORUM

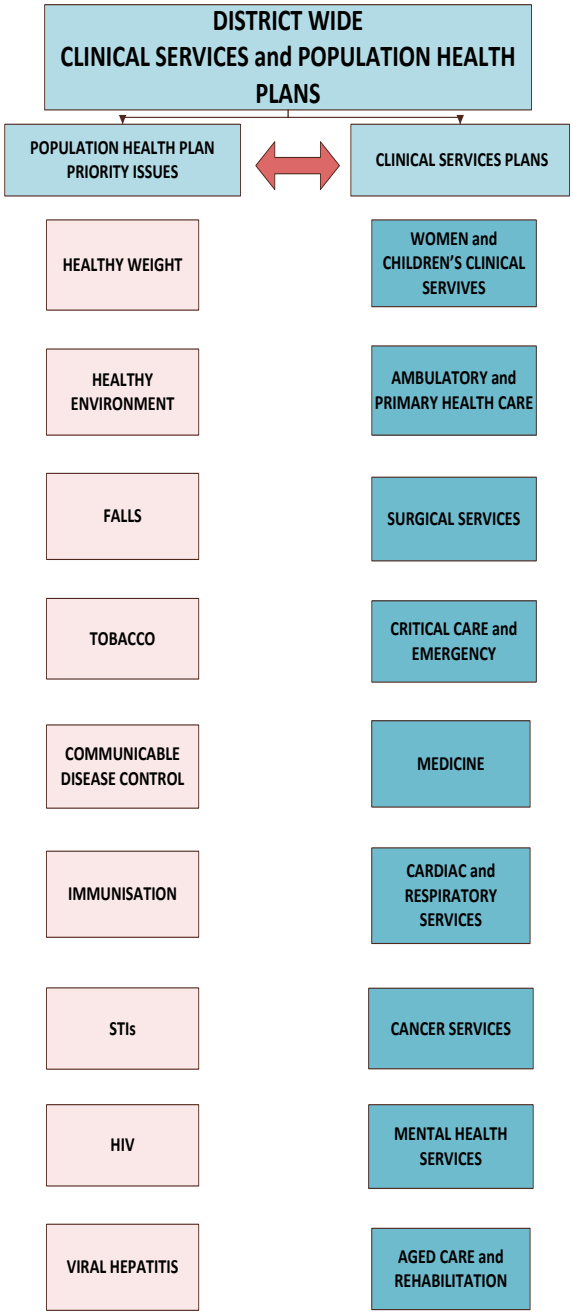
South Eastern Sydney Local Health District (SESLHD), in partnership with the Australasian Society of HIV Medicine (ASHM) NSW, hosted an 'HIV complex care and ageing' forum in August, 2013. The Forum acknowledged the key role of LHD-NGO partnerships and teamwork in the development of effective service responses in HIV.

During the last decade, clinicians and researchers have become interested in the issue of HIV, comorbidities and ageing and have tried to better understand what, if any, links might exist in the causal relationships between these issues. Research conducted into the clinical and social circumstances of people who are ageing with HIV and with co-morbidities shows that the effects of ageing may be accelerated by HIV, and that age related diseases can be made more complex by HIV treatment. However, the majority of people with HIV require only regular health monitoring (rather than specialist treatment and care).

Community organisations such as The National Association of People with HIV Australia (NAPWHA) and Positive Life NSW have tracked emerging health issues and the evolving clinical and social research. They have advocated for a multidisciplinary discussion of the issues and for future service planning. The development of the SESLHD – ASHM HIV Complex Care and Ageing Working Group and the forum are part of an ongoing involvement and commitment from the Directorate and ASHM to explore and promote discussion on this issue. The Directorate is now developing an HIV Complex Care and Ageing Action Plan.

[22] Zenzano T, Allan JD, Bigley MB, et al. The roles of healthcare professionals in implementing clinical prevention and population health. Am J Prev Med. 2011 Feb;40(2):261-7.

Figure 13: The Interrelationship between District Wide Plans



The Population Health Directorate Plan should not be viewed in strategic isolation. Figure 13 outlines the interrelationship and broader strategic context between the priority issues of Population Health and Clinical Services planning. Integrating key relevant activities of the Population Health Plan with clinical services plans presents the opportunity to embed prevention activities into everyday work practice.

Another key element of the Directorate is to achieve broad buy-in and collaboration within and outside the organisation, including with government and non-government agencies, local communities and groups, Medicare Locals, private industry, universities and others.

Integrating population health activity does not generally evolve as a natural response to having common work areas even within groups. The process needs to be purposely managed and led and have adequate levels of professional commitment and support.[23]

Improved integration efforts will provide an opportunity to generate more efficient and sustainable population health activities that contribute to meeting the expectations and wellbeing of community members, and the health performance challenges we currently face.

Information and Data Sharing

The Directorate encourages and actively participates in local community demographic and health information and data sharing with internal and external partners, such as the District's Multicultural and Aboriginal Health Units and Medicare Locals and Local Government.

Information and data sharing achieves many important goals. For example it provides more effective use of resources by avoiding unnecessary duplication of data collections and analyses between different services and organisations. Data sharing also promotes a focus on emerging areas of need and the testing of new or alternative activities and programs.

The Directorate is also supporting health care services to adopt a population health view to clinical care. For example, by identifying particular at risk individuals who may benefit from an HIV test or STI test.

[23] Nick Goodwin, Claire Perry, Anna Dixon, et al. Integrated care for patients and populations: Improving outcomes by working together. 2012. A report to the Department of Health and the NHS Future Forum

3.2.2 Partnerships and Collaboration

By its very nature, population health activity requires partnerships with stakeholder groups that operate outside the Local Health District to maximize population health gains. The Directorate is committed to ensuring external stakeholders are able to inform and/or work in partnership with the Directorate to achieve common health goals.

The Directorate has a well-established foundation of collaborative local, statewide and international partnerships that focus on improving public health and wellbeing. Building on the strengths of these existing partnerships is a major focus of this plan. Examples of current Directorate priorities where opportunities for collaboration and partnership exist include promoting healthy diet, healthy weight, tobacco control, healthy environments, falls prevention, sexual health and others. Systems to identify other opportunities on an ongoing basis and monitor progress will be developed to maximise overall population health capacity in the Local Health District.

A strengthened stakeholder engagement strategy will reflect an approach that is responsive to and inclusive of a broad range of stakeholders, and is coordinated across jurisdictions as required. Collaborative population health activity that extends beyond the Local Health District will involve one or more of the following groups depending on the activity.

Primary Health Care Partnerships and Collaboration

While the Directorate has a lead role in population health system coordination and integration and in identifying and addressing local service gaps across SESLHD, the settings and lead agencies for specific population health activities differ according to particular health issues and/or the target population and/or setting. In these cases, the Directorate often partners with primary health care agencies implementing community wide and specific initiatives, but does not necessarily lead the activities.

One of the key priorities for the national network of primary health care organisations (Medicare Locals) is to address health inequities and improve access for disadvantaged populations. One of the ways in which they will achieve this is through partnership arrangements in population health activities. Medicare Locals are required to undertake local health needs assessments and use this information to inform overall health planning for their areas of responsibility. In order for them to develop a robust understanding of their local communities, and plan and implement population health action, they need access to reliable community and other data. At the same time they will have local stakeholders with whom local data should be shared, some of whom will contribute datasets and others who may have varying levels of understanding of complex population health datasets.

The Directorate is supporting and collaborating with Medicare Locals in population health needs assessment and analyses to ensure consistency of data across the region and reduce the duplication of effort, and gain access to primary care specific information and data that is otherwise difficult to access. The Directorate and Medicare Locals can also gain efficiency benefits from collaborating on public consultations to identify and prioritise population health needs.

The Directorate and South Eastern Sydney Medicare Local have recently formed a partnership to establish a new service called **"Brake the Break"** which is an Osteoporotic Refracture Prevention Service located in the southern sector.

This Service, funded by an Innovation in Integrated Care Grant from the District, is based on an evidence-based model of care developed by the Agency of Clinical Innovation and adapted to a primary care led community setting.

The Service was developed in response to the high falls and falls hospitalisation rates in the southern sector. It aims to prevent up to 90% of osteoporotic refractures in the treatment cohort by identifying and managing the patient's osteoporosis, and integrates care between population health services, primary care, acute hospital services, allied health services and local governments.

The Directorate will continue to work closely with the Directorate of Ambulatory and Primary Health Care to facilitate integration of services and ensure cross fertilisation of ideas across all disciplines to ensure enhanced well-being for the community.

The Directorate will also continue to form and strengthen or join communities of interest (e.g. in obesity prevention, healthy environments, health inequity etc.) both locally and region-wide to share knowledge and maximise population health opportunities. Based on demographic and social information gathered through population health planning, the Directorate will continue to partner with local community groups targeting vulnerable populations to identify barriers to healthy behaviours and approaches to appropriately address them.

Stakeholder Groups in Population Health

- **Governments at all levels and across a range of portfolios provide services, initiate population health programs and policies, and have statutory and funding powers important to the District's population health work. They are also large employers that can provide leadership in supporting healthy workplaces and workforces.**
- **Consumers and local consumer and community advocacy and representative bodies to support realistic and practical program design and implementation.**
- **Academic institutions as sources of evidence, expertise and innovation.**
- **Relevant private health organisations and alliances, and a diverse range of private entities beyond the health sector.**
- **Local workplaces and employers.**
- **Primary health care organisations such as Medicare Locals and Aboriginal community-controlled health services will continue to provide important opportunities to initiate and support population health with individual patients and to be a partner in population focused-programs in the communities in which they operate.**
- **Non-Government and community-based organisations, including entities not specifically focused on health, such as sporting clubs, schools, unions, special interest groups, cultural and faith-based organisations and other groups that collectively have the potential to reach large numbers of people in their daily lives and build a culture that supports healthy living.**
- **State and Local media.**
- **Recent changes to the Local Government Act, which now includes health and wellbeing provides an opportunity to work together to address common health priorities.**

3.2.3 Communication

A **Directorate Communications Advisory Group,** led by the Directorate's Marketing and Communications Coordinator has been formed to develop, guide, monitor implement and evaluate the Directorate's Communications Plan and Media Schedule, and to ensure services adopt best practice in health communications.

Working closely with internal as well as external partners such as Local Government, Medicare Locals, community organisations and non-government organisations, the Marketing and Communications Coordinator identifies opportunities for the Directorate to promote its activities, programs and services and to foster collaborations and integration with other services providers.

3.2.4 Epidemiology, Research and Evaluation

Epidemiology is the study of the patterns and trends, causes and effects of health and disease - and related interventions - in defined populations. Epidemiology is considered a cornerstone of population health, and informs policy decisions and evidence-based practice by identifying risk factors for disease, sub-populations at risk, and effective population-based interventions. Population health practice depends on epidemiological analysis and evaluation to help us understand what makes an effective policy, program or intervention.

Epidemiology offers insight into why disease and injury affect some people more than others, and why they occur more frequently in some locations and times than in others. This understanding is necessary for finding the most effective ways to prevent and treat health problems.

The **Directorate's Research, Evaluation and Epidemiology Advisory Network (DREEAN)** provides a forum which fosters networking and collaboration among, and builds on the strengths of, Directorate staff who work and/ or have skills in:

- Research and Evaluation
- Epidemiology, including critical appraisal and communication of epidemiological & other evidence, e.g. about effectiveness and cost-effectiveness of interventions
- Data/ information collection, analysis, management and reporting and statistics

The Network aims to build a leading team of qualified health researchers in the District to enhance and sustain research across the domains of population health. Another key purpose is to encourage innovative research projects and collaborative studies to ensure the greatest possible influence on population health policy and practice.

Some examples of the Directorate's research projects include the HIV Testing project; the Point of Care Testing Project; the Tobacco Cessation Pilot Project for Chinese-speaking Male Restaurant workers, in collaboration with CATHN; the Impact of Outdoor Gyms on Park Usage and Physical Activity Levels; and the quality of private water supplies and their compliance with drinking water standards.

Population Health Research

Population health research is increasingly emphasising investigations that not only identify the relationships between health risk factors but attempt to identify and address the social processes that encourage and/or produce them.[24] The need to better focus on people with real connections with one another and their environments, and notions of agency (i.e. that situations change) is growing. Population health research is also

[24] Van Wave TW, Scutchfield FD, Honoré PA. Recent advances in public health systems research in the United States. Annu Rev Public Health. 2010;31:283-95.

focusing more on identifying how individuals and groups view their own broad socioeconomic context and their social relationships, what they identify as problematic, and how they might be helped to create their own healthy communities and environments.[25]

These new forms of research view people as having particular capacities to alter their health and social destinies. They are encouraging a move toward an environment that supports health where people live, learn, work, and play, and that makes it easier for everyone to make informed healthier choices. Population health research is also experiencing several problems currently encountered by most other health and medical research disciplines. That is, to develop the dialogue between research and practice that allows research to discriminately focus on problems that have real significance for efforts to improve population health and then for research successes to be translated into routine practice.[26]

Directorate Grant seeking Program

In population health, as for a number of other areas, the legitimate need for funds is always greater than the resources available. Accordingly, the Directorate has established a **Grant Seeking Program** to apply for external funding from a range of organisations and groups such as governments, trusts and foundations in collaboration with partners to maximise health gains that can be realised through working together to address population health issues.

A list of all grant makers interesting in funding the types of programs offered by the Directorate (and partners) will be developed to support the program. This grant maker's library will include information on all relevant funders and their timelines, application guidelines and forms, and any other information they have available to support a fully informed Grant Seeking Program.

As this Program develops, there will be further opportunities for the Directorate to form or join research networks of interest or communities of excellence across local and regional areas to share knowledge and expertise, maximise population health opportunities and foster research capacity across the District.

In addition, the Directorate will further develop or form new partnerships with universities, foundations and other research organisations to undertake relevant population health research and evaluation to:

- Enhance the quality of population health research in SESLHD.
- Pool a wealth of experience and diverse skill-sets across partners, which will increase the likelihood of obtaining competitive research grants and generating highly ranked publications.
- Strengthen the quality and impact of each partner's research by developing common research platforms for future collaboration and resource sharing.
- Provide a common research platform from which to launch and evaluate innovative multi-focus interventions.

[25] David Coburn, Keith Denny, Eric Mykhalovskiy et al Population Health in Canada: A Brief Critique. American Journal of Public Health: March 2003, Vol. 93, No. 3, pp. 392-396

[26] Debra Joy Pérez and Michelle Ann Larkin. Partnership for the Future of Public Health Services and Systems Research. Health Serv Res. 2009 October; 44(5p2): 1788–1795.

3.2.5 Workforce Development

Working in population health provides significant opportunities to contribute to reducing the causes of ill health and improving people's health and wellbeing. A number of frameworks have been developed to support an understanding of the range of specialist skills and knowledge required to work and succeed in population health areas such as public health and health promotion. These include:

- Surveillance and assessment of the population's health and wellbeing.
- Assessing the evidence of effectiveness of interventions, programs and services to improve population health and wellbeing.
- Policy and strategy development and implementation for population health and wellbeing.
- Leadership and collaborative working for population health and wellbeing.

To support specialist knowledge and skill acquisition and development, an **Extended Leadership Group** has been established with members from each unit within the Directorate. The Group provides an effective forum for piloting learning and developing programs and the identification of opportunities to implement learning and development at the team level. Members distribute relevant content covered in forum meetings and lead discussions with their teams. They also formulate structure for building learning and service development outcomes into specific programs and activities. The Extended Leadership Group provides an opportunity for greater integration and collaboration between Units and encourages innovation and idea sharing.

A number of specialist groups have also been established to support learning and development in specific areas such as research and evaluation.

It is important to have a population health workforce that can both shape and respond to the emerging and continuing needs of the population's health. The Directorate maximises its access to specialist skills and knowledge by taking full advantage of those available via partner organisations and groups, including universities, and through an investment in independent expertise as required. The Directorate will continue to develop partnerships with academic departments and schools of public health that have a key role to play in education, training, research and leadership development, and hence, in population health capacity building throughout the region.

The Directorate's Extended Leadership group and speakers at a Directorate extended leadership forum held in November 2013.

3.3 Population Health Units within the Directorate

3.3.1 Health Promotion Service

The Health Promotion Service plays a critical role in addressing identified lifestyle risk and protective factors to prevent the onset of disease such as cardiovascular and respiratory diseases, cancer, Type 2 diabetes and osteoporosis, among our local communities.

The Service addresses these risk factors by developing, delivering and evaluating evidence-based prevention and health promotion programs (predominately primary, secondary) and activities at a local level to protect and improve the health of local communities.

The Health Promotion Service delivers the following four key Programs:

- *Healthy Weight*
- *Falls Injury Prevention*
- *Tobacco Control*
- *Healthy Environments*

The Service delivers statewide prevention programs and initiatives targeted at reducing falls and falls injury, tobacco use among members of the community and overweight and obesity among children and adult residents and staff employed by the District.

To improve the effectiveness and sustainability of these programs, building partnerships with Medicare Locals, GPs, community based organisations, other government and non-government agencies, universities and research organisations and local communities is a built-in element of all prevention and health promotion programs undertaken by the Directorate. This upstream approach, which increases our communities' knowledge and skills in adopting healthy behaviours and the creation of healthier environments, contributes a healthier population, increased productivity and an overall reduction in health expenditure through reducing the demand for in-hospital care.

The Health Promotion Service's key program areas are based on priority health issues which have been informed by State and District-wide planning processes, plans and policies. Initiatives and activities developed to address these priorities have been developed by consulting with stakeholders including local communities.

The Service also supports the work of our clinicians to incorporate prevention into the clinical setting to reduce the need for further hospital care.

Key programs delivered by the Health Promotion Service include:

Healthy Weight programs promote healthy eating and physical activity for children and adults to prevent or reduce overweight and obesity in line with the *NSW Healthy Eating and Active Living Strategy 2013 – 2018*. Activities include promoting breastfeeding, developing and supporting healthy environments, especially for children and families through education and care settings. Other activities include working with local services to promote access to healthy weight initiatives and to provide education and information to enable informed healthy choices.

Falls Prevention programs and activities focus on implementing key components of the *SESLHD Falls Injury Prevention Plan 2013-2018.* Examples of programs include implementing evidence *Stepping On* and home based exercise activities for people over the age 65 years. Increasing the participation of older people to be more physically active is another key focus of the Service through promoting the NSW Health 'Active and Healthy' website and use of outdoor gyms.

Healthy Environment activities include engaging with policy makers and state and local government and the NSW Ministry of Health to advocate for and influence the design of cities and suburbs so they are supportive of healthy ways of living. Examples include working with local Government to design parks that will increase the proportion of people who engage in moderate to vigorous physical activity and developing Transport Access Guides to promote sustainable forms of transport – walking, cycling and public transport.

Tobacco Control programs and activities focus on implementing relevant components of the *NSW Tobacco Strategy 2012-2017* and *SESLHD Strategic Plan for the Prevention and harm from Smoking 2014-2017.* The Service focuses on addressing smoking among populations with high smoking rates, such as Aboriginal communities, young people, particular culturally and linguistically diverse communities and women who smoke during pregnancy.
For further information on the Service please refer to the internet website.

3.3.2 HIV and Related Programs Unit

The HIV and Related Programs (HARP) Unit plays a pivotal role in facilitating care coordination and the integration of HIV, sexual health and viral hepatitis services and programs across SESLHD, Illawarra Shoalhaven Local Health District (ISLHD) and St Vincent's Health Network (Darlinghurst). These services and programs include:

- The Albion Centre
- Central Access Service (St George NSP)
- District-wide HIV Outreach Team
- Kirketon Road Centre
- Nowra and Port Kembla Sexual Health Services
- Prince of Wales HIV Ambulatory Care Service
- Short St Sexual Health Centre
- St George HIV Ambulatory Care Service
- Sydney Sexual Health Centre
- Waratah Clinic (St George)

- *The HARP Unit plays a pivotal role in **delivering, coordinating and integrating HIV, STI and viral hepatitis health promotion and harm minimisation programs** and **services** across SESLHD and ISLHD.*
- *The HARP Unit's **Informatics and Service Development Team** provide health intelligence to identify and address emerging health needs, to report on services' activity, performance and activity based funding requirements.*
- *The HARP Unit fosters **partnerships** with community and non-government organisations, GPs, Medicare Locals and other key agencies to improve health outcomes for priority populations*
- *The Unit administers a number of **statewide services** and manages the **HIV Outreach Team.***

The HARP Unit also delivers and coordinates population based HIV, sexual health promotion and viral hepatitis harm minimisation programs to priority populations in both SESLHD and ISLHD.

The Unit's programs and activities are informed by evidence-based approaches, research, and are subject to rigorous monitoring and evaluation to maximise and protect the health and wellbeing of vulnerable communities.

Other key functions performed by the HARP Unit include:

- Supporting the District's delivery of a programmatic response to communicable diseases
- Supporting services to deliver against the strategic priorities and targets set down in relevant state, national policies and local policies and strategies
- Engaging with service providers, including general practitioners, to address the health needs of priority populations
- Designing and implementing data systems, tools and reports to enhance the capacity of services and programs to undertake robust health needs and performance analyses for the purposes of redesigning services to address emerging health needs and preferences, and improve the patient experience.
- Collecting, collating, analysing and reporting of data and information to assist HIV, sexual health and hepatitis C services to monitor their performance and improve the patient experience
- Managing the HIV Outreach Team which delivers outreach services to people living with HIV
- Monitoring and managing the performance of statewide services and locally devolved NGOs
- Managing the HARP Health Promotion Service for the ISLHD
- Providing programmatic support to St Vincent's Hospital in Darlinghurst.

Statewide services administered by the HARP Unit include the AIDS Dementia Psychiatry Service, NSW STI Programs Unit (STIPU) and the NSW Sharps Management Program.

For further information on this Unit, please refer to the HIV and Related Programs Unit Factsheet.

3.3.3 HIV Outreach team

The HIV Outreach team delivers specialist multidisciplinary outreach services to people who are living with HIV and have complex health and social needs.

HIV OUTREACH Team

The HIV Outreach Team provides a specialist multidisciplinary outreach **service to people who are living with HIV and often have complex health and social needs.** The Team operate across SESLHD and ISLHD and St Vincent's Health Network (Darlinghurst).
The Team includes nurses, social workers, an occupational therapist and dietician, who provide confidential health care services and complement existing hospital or clinic-based services. The team plays a key role in reducing inequalities in access to health care for people living with HIV, as well reducing their need for in-hospital healthcare.

People living with HIV may experience a range of acute or chronic health and social problems which require a range of services to address their health and social needs. Challenges encountered may include issues relating to medication, mental health, alcohol and other drug use, nutrition, housing and finances. The HIV Outreach Team can assist and support individuals by delivering home based care and by coordinating the delivery of multiple services. Over the last six years, the Team has provided health care and support services to over 700 clients.

The Team works closely with HIV and sexual health services and other service providers such as GPs, hospital and community health services, non-government organisations and community agencies to deliver an integrated and coordinated approach to improve the quality of care for people living with HIV with complex health and social needs.

Outreach Services include:

- Advocacy for clients
- Counselling and mental health support
- Drug and alcohol support
- Functional assessments and interventions to improve daily living skills
- Health monitoring and education
- Help with coordinating medical and housing services
- Medication adherence and support
- Mental health and nursing assessments
- Nutritional assessment and services
- Secondary Needle and Syringe outreach program
- Water exercise group

The HIV Outreach Team's **Patient Self-Management Project** will increase health worker and General Practitioner knowledge and competency to facilitate self-management of chronic conditions, including HIV. The **Earlier Referral Project** will explore strategies to promote earlier referral of clients to the HIV Outreach Team. The Team will work with other services such as Bobby Goldsmith Foundation to promote an earlier intervention approach and empower clients to self-manage their illness.

For further information on this Service please refer to the HIV and Related Programs Unit Factsheet at: http://www.seslhd.health.nsw.gov.au/Planning_and_Population_Health/documents/factsheets/HARPUNITFactsheet51213.pdf

3.3.4 The Albion Centre

The Albion Centre is Australia's only major community-based multidisciplinary care centre with a primary focus on HIV management. It delivers HIV clinical management, counselling, research, prevention and education, and trains health care workers in the field of epidemic infectious disease management. It promotes the health and wellbeing of people affected with HIV and AIDS, viral hepatitis, sexually transmissible infections.

The Albion Centre is a specialised multidisciplinary Centre for HIV and infectious diseases providing:

- *Prevention, treatment and care*
- *Research*
- *Health worker training*
- *Collaboration with local, national and international partners*
- *Resource development*
- *Management of statewide services*

The Albion Centre is accredited by the Royal Australasian College of Physicians as a post graduate training site for infectious diseases. It has more than 130 volunteers who provide care, support and education and hosts the Ankali project, a volunteer based service supporting people with HIV.

Fifty five per cent of the Centre's clients live within the SESLHD boundaries, while forty five per cent travel from other Local Health Districts to receive this specialist care.

In recognition that HIV is a stigmatised, transmissible chronic condition and many patients living with HIV have other health and social needs, the Centre is designed to provide one stop access to prevention and a range of specialist services, to minimise the need for in hospital care, facilitate patient access to up to date therapies and clinical trials and to maximise their health and wellbeing. Comprehensive testing, early recognition, monitoring and treatment, care and support of HIV and HIV related conditions is provided by an experienced multi-disciplinary team of doctors, nurses, dieticians, pharmacists, psychologists and social workers.

Specialist services include:

- Sexual Health
- Dermatology
- Psychiatry
- Client Assistance Program
- HIV rapid testing for men who have sex with men.
- On site pharmacy access and a pharmaceutical delivery service
- Ankali project, a volunteer based service supporting people living with HIV.

The Albion Centre, through Albion Education, provides a wide range of education services to health care workers and others involved with HIV and viral hepatitis. Face to face and on-line education programs are designed to meet the needs of those working in clinical care, health promotion and the community sector. Programs offered in a range of HIV and hepatitis related areas including clinical management and treatment; nutrition; infection control; health care worker safety; and counselling and psychosocial issues.

Collaborative multi-centre research is undertaken with a wide range of stakeholders locally and internationally. The Albion Centre, through Albion International, is a partner in global health initiatives. It is a World Health Organisation Collaborating Centre for Capacity Building and Health Care Worker training in HIV/AIDS Care and is involved in a number of international partnerships including AusAID, the World Food Program and the World Bank.

For further information on this Centre, please refer to the Albion Centre Factsheet.

3.3.5 Sexual Health Services

There are two specialist sexual health services in SESLHD. These include the **Sydney Sexual Health Centre** (SSHC) which is the largest sexual health services in NSW, located at Sydney Hospital in the Central Business District; and the **Short Street Sexual Health Service**, located on the St George Hospital Campus with an outreach service at Sutherland Hospital.

The sexual health centres are specialist service providers in the key areas of:

- *STI,HIV and Viral hepatitis prevention and care*
- *Sexual health promotion*
- *Research, workforce development and education*
- *Resource development*

Both Centres provide a comprehensive service for sexual health, providing free and confidential testing, health promotion, support and management of sexually transmissible infections (STI) and HIV. The Centres also provides care to people with STI symptoms, to people who present as a contact of an STI and to priority NSW populations as outlined in the NSW Health STI and HIV strategies.

The Sydney Sexual Health and Short Street Sexual Health Centres have multidisciplinary teams comprising sexual health specialist doctors, nurses, counsellors, health promotion officers, researchers and administration staff. The Centres are committed to research, professional development and capacity building of General Practitioners, Practice Nurses, Medicare Locals and other community based organisations to work in HIV and sexual health via on-site education and training opportunities. Student placements and clinical attachments are available within the counselling, medical and nursing units and both of these clinics are accredited for training by the Royal Australasian College of Physicians.

In addition to regular clinics, the Centres provide a range of free speciality on and off site clinics, including:

- **Xpress clinic (run by SSHC)**: offers STI screening for those who are asymptomatic, with a shorter consultation than the general clinic
- **HIV services:** provide testing, treatment and care for people at risk of or living with HIV
- **Sex Worker services**: provide sexually transmissible infection testing; vaccination for hepatitis B; management of sexually transmissible infections including HIV; health education; free safe sex supplies; and counselling for sex workers. The Sydney Sexual Health Centre has a Multicultural Health Promotion Project which targets Asian sex worker, with interpreter services provided to Chinese, Korean and Thai sex workers, resources in more than 20 languages; and both centres provide outreach services to parlors throughout Sydney, including self testing kiosks at sex on premises venues
- **The M clinic (run by SSHC)**: offers screening, vaccination and management of sexually transmissible infections including HIV, hepatitis B, hepatitis C, health education, free condoms, and counselling to men who have sex with men.
- **Satellite Sexual Health Youth clinic (run by SSHC)**: for young people at Waverley Action Youth services (WAYS) Bondi Junction. It provides testing for pregnancy, sexually transmissible infections and HIV, treatment, advice and support, vaccination for hepatitis B, safe sex information, condoms and help in finding other support services.
- **a[test] clinics (run by SSHC)** held twice per week in partnership with ACON

The Sydney Sexual Health Centre also:

- Runs a project to implement fast track screening options in sexual health services across the state
- Provides a NSW Sexual Health Infoline, hosted in collaboration with the NSW STI Programs Unit
- Hosts a Committee to assess those who knowingly expose others to the risk of HIV infection
- Provides sexual health services to Justice Health, Western and Far Western Local Health Districts.

For further information, please refer to our Sexual Health Services Factsheet.

3.3.6 Public Health Unit

The role of the Public Health Unit is to protect the health of the community. That is, to identify, prevent and minimise public health risks to the community, which may be infectious, chemical, and radiological in nature and arise from other humans, from animals or from the inanimate environment. To achieve this, the key forms of activity are: surveillance and monitoring, primary prevention, enforcement and response, and education and advocacy. The Public Health Unit's regulatory responsibilities are largely defined by NSW legislation, i.e. the Public Health Act 2010, the Public Health (Tobacco) Act 2008 and the Smoke-free Environment Act 2000.

The Public Health Unit has five key program areas. Within each area there are a range of activities:

- *Infectious Diseases*
- *Immunisation*
- *Environmental Health*
- *Epidemiology research*
- *Cancer control*

Priority focus areas for the Public Health Unit are:

- Infectious diseases surveillance and response: control spread of significant infectious diseases in the community by responding to notifiable diseases, investigating outbreaks and breaches of infection control, and answering enquiries. Up-to-date summaries of public health surveillance data are provided for health practitioners and the public.
- Immunisation: provide support, in the form of technical advice, to immunisation activities undertaken in community-based and hospital settings; conduct the intensive English centres and school-based adolescent vaccination programs delivering a range of vaccines to high school students.
- Environmental health including tobacco control: enforce the NSW Public Health Act, Public Health (Tobacco) Act and Smoke-free Environment Act, and educate and inform businesses regarding their obligations under this legislation; respond to health concerns arising from the animate or inanimate environment in collaboration with local government, Environmental Protection Authority and other agencies; provide health advice in relation to contaminated sites, and to air and water quality.
- Public health emergency management: provide the public health component of emergency management at District level and participate in state-wide or multi-District responses as required by the state public health controller.
- Epidemiology and research: support investigation and surveillance of public health risks, analysis and dissemination of public health information, and operational public health research and evaluation.
- Cancer Control: address cancer prevention strategies relevant to the local community, provide advice and analysis in relation to emerging or locally identified environmental cancer hazards, and develop advice and response regarding reported cancer clusters.

  For further information, please refer to the SESLHD internet website at:
  http://www.seslhd.health.nsw.gov.au/Public_Health/

3.3.7 Falls Prevention Coordination Program

Falls are a significant cause of potentially avoidable harm. The aim of the South Eastern Sydney Local Health District Falls Prevention Program is to ensure people living in the region have a reduced risk of falls or subsequent falls, and fall related injuries. To this end, a comprehensive approach has been adopted by the Planning and Population Health Directorate to reduce falls and falls injury among our residents including:

The aim of the South Eastern Sydney Local Health District Falls Prevention Program is to ensure people living in SESLHD have a reduced risk of falls or subsequent falls, and fall related injuries.

- Delivering health promotion and secondary prevention programs and activities that support the prevention or delay of falls by increasing the period of time that older persons in our community are well, with minimal or low risk of falls and falls injury.
- Establishing a District wide governance structure to ensure access to and implementation of best practice falls prevention interventions by health care providers across the District.

The Directorate employs a Falls Prevention Program Coordinator whose role is to:

- Support and coordinate implementation of the NSW Health Policy Directive on Prevention of Falls and Harm from Falls Among Older People 2011-2015 and ACSQHC Standard 10: Preventing Falls and Harm from Falls.
- Support implementation of the *SESLHD Falls Injury Prevention Plan 2013-2018*.
- Be secretariat to the District's Steering Committees for Falls Injury Prevention in the Community and in Health Facilities.
- Liaise with the Clinical Excellence Commission and the State Falls Prevention Coordinators to ensure best practice guidelines and evidence based strategies are promoted and implemented across the District.
- Support the development of planning and reporting systems and processes to inform the SESLHD Board, Executive Team and District Clinical and Quality Council about progress made and challenges to implementation of the *District's Falls Injury Prevention Plan 2013-2018*.
- Support Local Hospital Falls Prevention Committees to design, implement and monitor implementation of strategies to reduce the incidence of falls in their facilities.
- Participate as an active member of the NSW Falls Coordinators and Falls Prevention Network.
- Collaborating and forming partnerships with local councils, Medicare Locals and non-government and other service providers to reduce the incidence of falls injury in the community setting.

The SESLHD Prevention of Falls and Harm from Falls Plan 2013-2018 can be accessed at:
http://www.seslhd.health.nsw.gov.au/HealthPlans/documents/SESLHD-FallsinjPlan-Dec2013.pdf

Section 4: Challenges & Opportunities

4.1 Challenges

A range of challenges and emerging issues impact and influence the activities of the Directorate. These include:

- The need to reduce health inequities, particularly among Aboriginal people, refugee and culturally diverse population groups, the homeless, people living with chronic illness and disability, and otherwise socioeconomically disadvantaged groups
- Responding effectively to changes in the local demography, disease patterns and the increasing burden of chronic disease as our population ages
- Detecting and responding to emerging public health threats e.g. pandemic influenza, health impacts associated with climate change, or newly emerging or re-emerging infectious diseases/ syndromes e.g. Sudden Acute Respiratory Syndrome (SARS) & `Bird flu'
- Working with a large array of stakeholders, sometimes with competing agendas
- Working with our partners to foster resilience in our most vulnerable communities, as a `primordial' population health intervention (i.e. very early primary prevention)
- Harnessing and better understanding how best to apply emerging technologies and communication methods, including social media and digital/electronic web-based platforms
- Responding effectively to the increasing range and complexity of environmental and development issues such as residential developments advancing on potentially contaminated sites and industrial areas, which increases the demand for environmental risk assessment.

Potential Health Impacts of Climate Change

There are also potential threats to population health from climate change, especially for those in the community who are already vulnerable.

Specific impacts on health include increases in disease reservoirs and vectors through altered vector migration patterns and extreme weather events/natural disasters resulting in possible re-emergence of water-borne and vector-borne infectious diseases.

Other risks to human health from climate change include injuries and fatalities related to heatwaves and other severe weather events; water and food contamination from increasing temperatures and changes in rainfall patterns; escalating respiratory allergies from increased allergens (pollens and spores) in the air; rising respiratory and heart diseases in response to increases in some air pollutants; mental health problems in those experiencing physical and economic impacts; and the health consequences of population displacement as some regions become uninhabitable.[25] A strengthened population health focus is needed to counter these emerging threats.

4.2 Opportunities

The Directorate of Planning and Population Health has a range of opportunities to ensure it delivers effective and efficient programs and services including:

- Making better use of health data and information to inform change, focus and direction
- Enhancing community input and feedback on population health services
- Fostering strategic engagement with other government, non-government and corporate agencies to deliver population health activities
- Building capacity among health care providers to embed preventive activity
- Ensuring population health staff development, training and capacity building across and within its disciplines.

Opportunity for Involvement in Urban Planning and Engagement with Local Councils

One of the District's priority initiatives within the SESLHD Health Care Services Plan 2012-2017 is to establish a cross-sectoral Healthy Environment Alliance that provides leadership and action for healthier, more livable communities. This requires engagement, coordination and advocacy across sectors with government and non government agencies, in particular Local Government. Issues to consider include land use planning; infrastructure to support physical activity, such as cycle paths, footpaths, shared paths and outdoor gyms; better public transport links that allow improved accessibility to jobs and education; equitable access to healthy food; proximity to open spaces; well designed and affordable housing; decreasing exposure to hazards in the environment; and livable urban areas that encourage community involvement in cultural, creative, sporting and recreational activities.

The Directorate has provided timely and effective responses to government urban planning/ healthy environment policies and initiatives to ensure that important contributors to health and well being and social cohesion are considered in the initial urban planning process. This includes the NSW Government draft *Metropolitan Strategy for Sydney,* which sets out a new plan for the city's future over the next two decades, (see the Planning & Infrastructure NSW > Metropolitan Strategy for Sydney for full details). This Strategy includes the development of **Urban Activation Precincts (UAP)**, with three areas determined within our District: Randwick, Anzac Parade South and Mascot Station.

The Anzac Parade South UAP will connect to the University of NSW and Randwick Hospitals Campus UAP. Centres along Anzac Parade will be developed to provide increased housing within close proximity to employment and education and good access to transport infrastructure and open space. Urban renewal will be supported by improved public transport, with the provision of light rail from Central Station to Moore Park, University of NSW and Randwick Hospitals Campus and cross regional connections to Port Botany and the airport. Mascot Station will provide opportunities to support the role of Sydney Airport.

The Randwick Education and Health Specialised Precinct will intensify the existing cluster of education and health activity around the UNSW and Randwick Hospitals Campus; provide capacity for at least 6,000 additional jobs by 2031; and improve public transport access to Sydney CBD. The Directorate has been actively involved in the consultation process for this development.

Urban renewal areas in both sectors of the District present an exciting opportunity for the Directorate to be a major supportive partner in urban design to create a built environment that protects and supports the health and wellbeing of our residents. By promoting the key factors that can influence health and well being in the built environment and creating socially inclusive communities that actively promote health and well being, we can help to keep our residents healthy and out of hospital.

Section 5: High Priority Health Issues

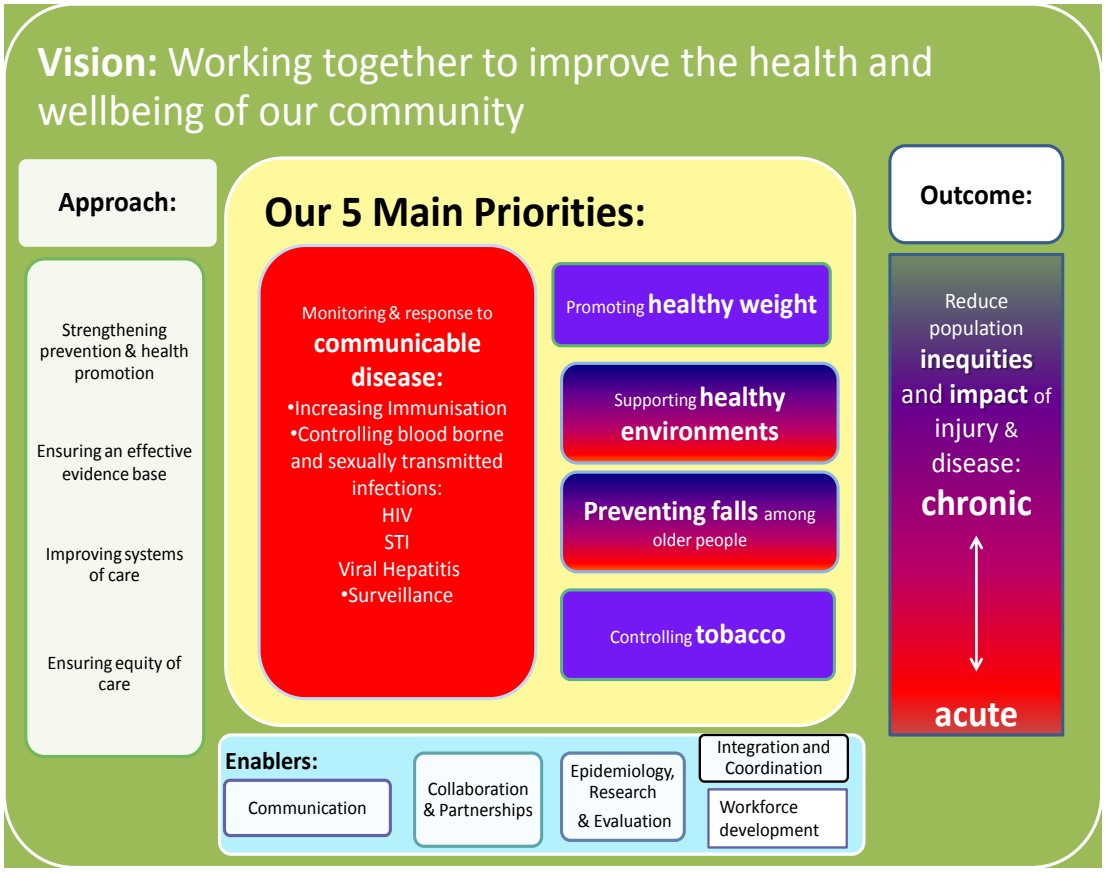
This section focuses on the Directorate's priority health issues, as a foundation for decisions on future action. The selection of priorities has been informed by State and National policies and local needs, related to both their health, social and financial cost, and their avoidability. There is evidence that significant gains in the health of the South Eastern Sydney community can be achieved through appropriate and focused attention, which includes the establishment of effective collaborations and partnerships. The active engagement of key stakeholders is a common thread throughout each of the priority areas. As shown in *Our Framework for Population Health*, 5 health issues have been selected as priorities over the next 5 years:

- **Communicable disease control**, including:
  - Immunisation
  - HIV prevention, treatment and care
  - STI prevention, treatment and care
  - Viral hepatitis prevention and access to care
  - Surveillance
- **Healthy weight**
- **Healthy environments**
- **Falls prevention**
- **Tobacco control**

In addition, five enablers have been identified (see Section 3 for further detail):

- Communication
- Collaboration and Partnerships
- Epidemiology, Research and Evaluation
- Integration and Coordination
- Workforce Development

Figure 14: Our Population Health Framework



5.1 Controlling Communicable Disease

5.1.1 Increasing immunisation coverage among our residents

Immunisation as a Population Health Focus

Immunisation is a simple, safe and effective way of protecting people against harmful diseases before they come into contact with them in the community. Immunisation not only protects individuals, but also others in the community, by reducing the spread of disease. Immunisation uses the body's natural defence mechanism - the immune response - to build resistance to specific infections.

Health Protection NSW Targets:

- 92% of Aboriginal children at one year of age are fully immunised
- 92% Aboriginal and non-Aboriginal children recorded as fully immunized at four years of age
- Increase coverage in identified geographic areas of low immunisation coverage relative to the previous year (Waverley 85.7% for 2013/14)
- 75% of year 7 students completing a course of human papillomavirus vaccine
- Maintain or increase percentage of babies born to HBsAg positive women who received hepatitis B Immunoglobulin (HBIG)) within 12 hours of birth to 100%
- Maintain or increase percentage of babies born to HBsAg positive women vaccinated with hepatitis B vaccine and tested 3 to 12 months later, with 100% of women sent a reminder letter
- 80% dTPa vaccination coverage in year 7

Many diseases prevented by immunisation are spread directly from person to person, so good food, water and hygiene do not stop infection. Despite excellent hospital care, significant illness, disability and death can still be caused by diseases which can be prevented by immunisation.

Even when all the doses of a vaccine have been given, not everyone is protected against the disease. Measles, mumps, rubella, tetanus, polio and Hib vaccines protect more than 95% of children who have completed the course. One dose of meningococcal C vaccine at 12 months protects over 90% of children. Three doses of Pertussis vaccine protects about 85% of children who have been immunised, and will reduce the severity of the disease in the other 15% if they do catch whooping cough. Booster doses are needed because immunity decreases over time.

Childhood vaccines currently save 3 million lives a year globally and are among the most successful and cost-effective public health interventions of the 20th century.[27] Rotavirus gastroenteritis, for example, is the leading cause of severe gastroenteritis in infants and young children worldwide. Prior to the introduction of the rotavirus vaccine in Australia, there were an estimated 10,000 hospitalisations annually in children under five years due to rotavirus gastroenteritis. Since the introduction of the vaccine to the National Immunisation Program in 2007, emergency department visits for acute gastroenteritis in young children have declined and hospitalisations for rotavirus gastroenteritis in the under-five-year age group have been reduced by over 70%.[28] The reduction occurred consistently across all age groups, even in children not

PERTUSSIS OUTBREAK

Despite sustained high vaccination coverage, Australia recently experienced its largest nation - wide outbreak of Pertussis (Whooping Cough) since the disease became notifiable. In NSW in 2011, 309 infants under the age of 6 months, and therefore too young to be protected by immunisation, were diagnoses with pertussis.

Source: NSW Public Health Bulletin Vol. 23(9–10)

[27] Maciosek MV, Coofield AB, Edwards NM, Flottemesch TJ,Goodman MJ, Solberg LI. Priorities among effective clinical preventive services: results of a systematic review and analysis. Am J Prev Med 2006;31:52–61

[28] Data source: National Centre for Immunisation Research and Surveillance

eligible for immunisation, suggesting an effect on herd immunity.

Immunisation can also help to prevent some cancers. Chronic infection with the Human Papillomavirus (HPV) is strongly associated with the development of cervical cancer, and chronic Hepatitis B is associated with hepatocellular carcinoma. Population programs for HPV and Hepatitis B vaccination are thus important cancer prevention strategies.

The IMMUNISE AUSTRALIA Program currently funds vaccines for the following diseases**:**

Measles	**Pneumococcal Disease**
Mumps	***Haemophilus influenzae* type B (Hib)**
Rubella	**Meningococcal group C disease**
Diphtheria	**Hepatitis B**
Pertussis (Whooping Cough)	**Rotavirus**
Tetanus	**Human Papilloma Virus (HPV)**
Poliomyelitis	**Varicella (chickenpox)**

Impact on our community

High School Program

Immunisation coverage in SESLHD High Schools has improved considerably over the last 3 years, particularly in the completion of a course of HPV vaccine among Year 7 girls, from 65% in 2010 to 75% in 2012, and diphtheria-tetanus-pertussis (dTpa) vaccination for Year 7 students increased from 63% in 2010 to 83% in 2012. Vaccine coverage in 2012 for students at schools within SESLHD boundaries also included Hepatitis B 58% in Year 7; (dTpa) 77% in Year 10 and Varicella 48% in Year 7.

Reporting coverage in school programs alone may not give a true indicator of vaccination coverage. Other factors need to be considered, including:

- The Hepatitis B program (finishes in 2013) and the Varicella program (finishes in 2015) are both “catch up” programs. Not all children will enroll in the program as they may already have been vaccinated, or for Varicella, may already have had chickenpox and vaccination is not required.
- A small percentage of students are “home schooled” and will be vaccinated by their GP, or parents may prefer to have their children vaccinated by their family GP.

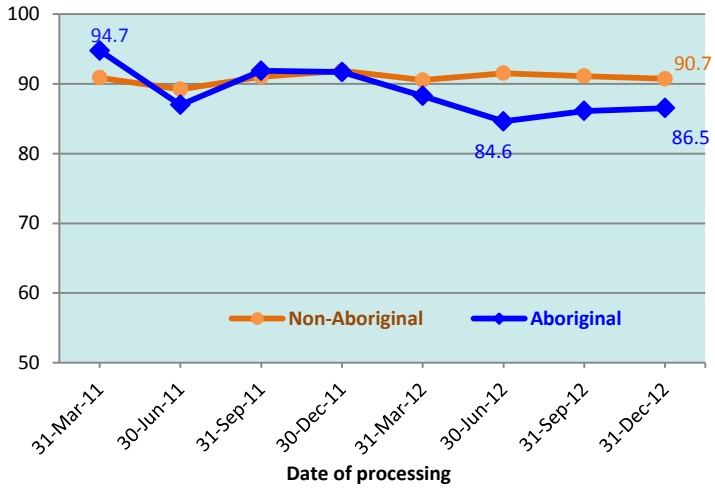
Aboriginal Children

In Australia, it is well documented that immunisation of Aboriginal infants is often delayed, catching up with other children in their second year of life.

According to data reported from the Australian Childhood Immunisation Register (31 December 2012), 86% of Aboriginal residents aged 12 to <15 months are fully immunised. This proportion is similar to the NSW average for Aboriginal children, but about 4 percentage points lower than for SESLHD non-Aboriginal children. This small apparent gap may just be a reflection of relatively small numbers in the Aboriginal cohort.

In SESLHD, the proportion of fully immunised Aboriginal children at 5 years of age is similar to the NSW average and has been fairly stable over the last year, following a marked improvement from a low of 55% in early 2011.[29]

Figure 15: Proportion of Aboriginal and non-Aboriginal children aged 12-<15 months who are fully immunised, SESLHD residents (%)



Nearly nine in 10 Aboriginal children aged 12 months who live in our District are fully immunised – similar to non-Aboriginal children

Source: Australian Childhood Immunisation Register, via SESLHD Public Health Unit

Low Coverage Areas

Over the last 3 years, in all but 3 quarters, the proportions of Waverley Local Government Area (LGA) children fully immunised at both 12 to <15 months and 60 to <63 months has been lower than the NSW average. Data from the Australian Childhood Immunisation Register (processed December 2012) shows that for Waverley LGA children aged 12 to <15 months the gap is currently five percentage points, and for those aged 60 to <63 months the gap is two percentage points.

Previous research indicates that many children may in fact be vaccinated and the lower coverage areas may reflect lower levels of reporting by GPs to the the Australian Childhood Immunisation Register in these areas.[30]

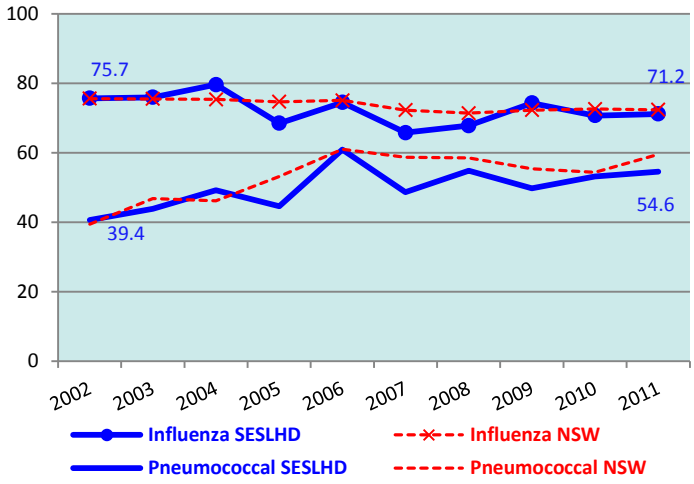
Adults

Adult influenza and pneumococcal vaccination is largely the responsibility of General Practice. In 2011 about 71% of our residents aged 65 years and over self-reported being vaccinated against influenza in the previous 12 months. Since 2002 this proportion appears to have declined by about 5 percentage points, similar to NSW-wide trends.

In 2011 about 55% of our residents aged 65 years and over self-reported being vaccinated against pneumococcal disease in the previous 5 years; this was about 5 percentage points lower than the NSW average. Since 2002 this proportion has increased considerably among SESLHD residents, by about 15 percentage points, similar to NSW-wide trends.

[29] Data source: Australian Childhood Immunisation Register - Aboriginal Coverage Reports, via SESLHD Public Health Unit
[30] Poulos R, Botham S, McFarland K, Ferson MJ. Getting it Right – The Australian Childhood Immunisation register and immunisation rates in South Eastern Sydney. Aust NZ J Public Health 2004; 28:68-71

Figure 16: Proportion of adults aged 65 years and over immunised against influenza (last 12 months) and pneumonia (last 5 years) SESLHD & NSW residents (%)



Source: NSW Population Health Survey, accessed from Health Statistics NSW

For every 10 residents aged 65 years and over:

- **7 are up-to-date for their influenza vaccination**
- **5-6 are up-to-date for their pneumococcal vaccination**

Approaches that work

A recent systemic review[31] showed that in developed countries, General Practitioners are best positioned to influence parental decisions on childhood immunization and successful strategies include parental and healthcare provider reminders. Instituting recall and reminder systems in General Practice for children due or overdue for a scheduled vaccine is an effective way to improve coverage in children less than 5 years of age.

Interventions to increase vaccination rates have a greater effect on those who are most at risk of being under-immunised. Vaccine coverage data thus needs to highlight differences in uptake rates between socioeconomic and ethnic groups, to aid the implementation and evaluation of programmes to improve immunisation rates in priority populations.

Government legislation, including The Public Health Amendment (Vaccination of Children Attending Child Care Facilities) Act 2013 which comes into force from 1 January 2014. Prior to enrolling in child care, proof of a child's vaccination status must be provided. Unvaccinated children may be excluded from child care centres in the event of an outbreak of a vaccine preventable disease for their own protection.

Public education campaigns, such as the '**Save the Date to Vaccinate'** Campaign, to improve the timeliness of vaccine coverage in children, and prevent outbreaks of serious vaccine preventable diseases. This includes a phone app that parents can upload to remind them when their child's vaccinations are due.

School based vaccination programs, which are designed to capture a large group of well children in one place to provide scheduled vaccines. Locally designed rolling mop ups over a school year enable children to be caught at each visit and contribute to improving coverage for vaccine preventable diseases.

[31] Williams, N.; Woodward, H et al.: Primary care strategies to improve childhood immunisation uptake in developed countries: systematic review J R Soc Med Sh Rep 2011;2:81. DOI 10.1258/shorts.2011.011112

Priority Actions to increase immunisation coverage of our residents

- Further develop and implement strategies to optimise immunisation coverage among our residents addressing, in particular, the non- immunised and under-immunised in subpopulations and/or geographic areas.
- Employ an Aboriginal Immunisation Officer to promote and improve coverage and timeliness of routine vaccination in Aboriginal communities.

Programs and Activities to be delivered by the Directorate from 2014-19

The Directorate **will continue** to provide advice to primary health care providers regarding immunisation; promote the uptake of age-appropriate immunisation among children; and work closely with Medicare Locals on ways to improve immunisation coverage. Priority operational areas involve:

School-based adolescent vaccination program

The Directorate's staff have conducted the vaccination of school students since the meningococcal group c vaccination program was undertaken in 2003 and 2004, to reduce the impact of this potentially devastating infection in teenagers and young adults. Since this time, the program has evolved in line with NHMRC vaccination recommendations and increasing availability of vaccines suitable for school aged children. The most recent addition to the program has been the introduction in 2013 of human papilloma virus (HPV) vaccine for boys. The school-based adolescent vaccination program currently provides HPV (3 doses), hepatitis B (2 doses) until December 2013, chickenpox (until December 2015) and diphtheria-tetanus-pertussis (DTPa) vaccine to year 7 female and male students, and catch-up HPV vaccine to boys in year 9.

In 2013, Directorate staff administered HPV vaccine in an expanded program: 10,679 doses to Year 7 girls, 10,124 doses to Year 7 boys, and 9,133 doses to Year 9 boys; in addition 9,131 doses of hepatitis B vaccine and 7309 doses of DTPa vaccine were administered to Year 7 students. In all, 46,376 doses were given in 2013, a 25.7% increase over the 2012 total of 36,885.

Intensive English Centres vaccination program

The Unit's immunisation team **will continue** to provide vaccines to students attending the two Intensive English Centres located in South Eastern Sydney Local Health District at Kogarah and Beverley Hills High schools. Because these young people come from many different countries and may not have full vaccination records extant, the program offers the full range of vaccines – meningococcal C and measles-mumps-rubella vaccines in addition to those provided routinely in the school-based adolescent vaccination program. In 2012, a total of 1655 doses of these vaccines were administered to students at the two Centres.

Promoting immunisation uptake among Aboriginal children

The Directorate **has recruited** an Aboriginal Immunisation Officer to work closely with community members and other Aboriginal Health Workers employed by South Eastern Sydney Local Health District to improve the coverage and timeliness of vaccination among Aboriginal children residing in the District and to improve Aboriginal identification reporting on the Australian Childhood Immunisation Register (ACIR).

Low Coverage Areas

The Directorate **will continue** to work closely with GPs in the Waverley LGA and with the Eastern Sydney Medicare Local to increase the reporting of immunisation encounters to the Australian Childhood Immunisation Register and to follow up children who are truly not immunised, through working with Medicare Locals to improve General Practitioners reporting to the ACIR, and improving GPs recall and reminder systems for childhood immunisations. The Directorate will provide access to the ACIR Follow-up Database for both Medicare Locals, which will allow them to produce regular reports of children that are overdue for vaccination, and work directly with practices that have a large number of children recorded as overdue.

Routine childhood vaccination

In South Eastern Sydney Local Health District, the vast majority of routine vaccinations given to children in the first 5 years of life are administered in general practice, with small numbers also administered through clinics conducted by Sydney Children's Hospital Randwick, Woollahra Council and Botany Bay City Council.

The Directorate **will continue** to support all local immunisation providers by providing information and advice about uses, precautions and contraindications around scheduled vaccines, determination of catch-up vaccinations in children who have missed previous doses, management of the cold chain and vaccine ordering.

Two new vaccines were introduced to the national schedule from July 2013 - a vaccine given at 12 months of age which combines meningococcal and *H. influenzae* b components (thus reducing injections by one) and a combined measles-mumps-rubella-varicella (MMRV) vaccine given at 18 months of age (also eliminating one injection).

Coordination

The Directorate's staff **will continue** to deliver and/or coordinate immunisation programs and services across the South Eastern Sydney Local Health District. They also contribute to immunisation planning at state and local levels, including:

- surveillance of illness in the community
- deployment of the stockpile, particularly antiviral medication and vaccines
- preparation for and participation in pandemic influenza exercises
- general advice and information on adult and childhood immunisation to both health care providers and members of the public
- following up reports of adverse reactions to vaccinations.

Partnerships

Partnerships have been a successful way of improving the Directorate's reach and impact of immunisation programs within SESLHD. Partnerships with effective communication and planning strategies are essential to achieve the most effective delivery of services. Examples of these effective partnerships include:

Medicare Locals

The Directorate **will continue** to work closely with Medicare Locals and convene the Immunisation Advisory Committee, where local providers discuss current topics and issues in childhood and adult vaccination.

General Practice

The Directorate **will continue** to act in an advisory capacity and provide regular education sessions for GPs on new vaccines, vaccine schedules and reporting requirements and undertake education programs for immunisation accredited nurses working in the public sector and in general practice.

Schools

The Directorate **will continue** to partner with local high schools to provide the Adolescent Vaccination Program and the Intensive English Centres Vaccination Program. This promotes vaccination coverage and recording. It will also answer immunisation queries from childcare services and primary schools.

The Directorate **will collect/ and report on** high quality surveillance data for vaccine preventable disease control, including vaccination rates in groups and communities.

The Directorate **will encourage** immunisation providers to report adverse events to the Adverse Event Following Immunisation (AEFI) surveillance system, particularly after the introduction of a new vaccine, to ensure the adverse event profile of the vaccine is monitored.

Mothers and babies

- **We will continue to provide education** to GPs to improve the uptake of influenza vaccine and dTpa vaccine in pregnant women.
- **We will follow up** children born to Hepatitis B _surface Ag positive mothers at 2,4 and 6 months of age to ensure that the children have received hepatitis b vaccine and reminding parents at 12 months to have the baby tested for Hepatitis B surface Abs.
- **We will continue to support** the Public Hospital Maternity Program for vaccination of postnatal women against diphtheria-tetanus-pertussis and on a monthly basis track the number of doses given to the number of women confined.

Children

- **We will support and build capacity** of immunisation providers and advisers to improve immunisation rates.
- **We will increase** vaccination coverage in identified geographical areas of low immunisation coverage (e.g. Waverley LGA as identified by ACIR), through working with Medicare Locals to improve General Practitioners reporting to the ACIR, and improving GPs recall and reminder systems for childhood immunisations.

Adolescents

- **We will deliver** the complex and ever-changing school-based adolescent vaccination program safely and effectively.
    - **We will work** with schools to improve the number of students providing an immunization history statement on enrollment.
    - **We will maintain and improve** immunization coverage in the school based program by opportunistically providing rolling “mop up” coverage into Year 8 for children whose vaccination program was delayed in Year 7.

Older people

- **We will work with** primary health care organisations and aged care facilities to identify strategies to improve influenza and pneumococcal disease vaccine uptake in people aged 65 years and over.
- **We will support** aged care facilities to develop and maintain an annual influenza vaccine register of patients who received influenza vaccine.

Aboriginal People

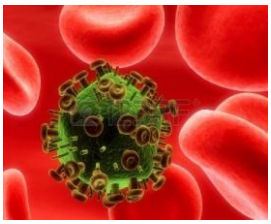
- **We will work with** communities and providers to improve vaccination coverage among Aboriginal people. Activities include:
    - Developing health system capacity to follow-up Aboriginal children due for vaccination to increase the proportion of Aboriginal children recorded as fully immunised at four years of age.
    - In collaboration with the Aboriginal Immunisation Officer, work towards improving timeliness of Aboriginal children’s immunizations and the identification of their Aboriginality on ACIR.
    - Improving the timeliness of vaccination for Aboriginal children.
    - Working with the Aboriginal Medical Service to identify further initiatives on an ongoing basis.

Photo: The Directorate’s High School Immunisation Program Nursing team

5.1.2 Controlling blood borne and sexually transmissible infections

a. HIV Prevention, Treatment and Care

HIV as a Population Health Focus



The Human Immunodeficiency Virus (HIV) continues to be a challenging communicable disease in Australia, with more people living with the disease than ever before due to population growth, longer life expectancy and improved treatments. Effective prevention and management of HIV infection involves a number of parallel and coordinated population health efforts and a programmatic response to identify and address the health needs of priority populations at risk of and people affected by HIV.

HIV snapshot

- HIV infections up 10% in 2012
- 1253 cases of HIV newly diagnosed nationally in 2012
- 25,708 people live with HIV infection in Australia
- 58% of new HIV cases in heterosexuals were in people from high-prevalence countries
- 5000–10,000 Australians are unaware of their HIV status
- HIV rapid testing now available in 32 sites in Qld, NSW and Vic.

Source: Excerpt from Hanrahan, C. HIV spike linked to rise in unsafe sex. Medical Observer 21st Oct 2013. Available at: http://www.medicalobserver.com.au/clinical-review/update

The Human Immunodeficiency Virus presents unique issues, including the associated stigma, discrimination and communicable nature of the disease; drug resistance (acquired and transmitted), and the imperative to evolve a new model of care that includes a stronger role for general practice and a more focused role for public specialist services.

Sex between men continues to account for about 80% of Human Immunodeficiency Virus (HIV) notifications in NSW. The majority of HIV diagnoses in heterosexuals are in people who have acquired HIV overseas in a country of high prevalence. HIV infection rates in NSW are on the rise, with a 24 % increase in reported cases of infection amongst NSW residents reflecting the large number of men who have sex with men that live in our district. There were 409 new diagnoses in 2012 compared to 330 in 2011. Of those 409 new diagnoses, 81 percent were homosexually active men, 14 percent heterosexuals and two percent attributed to people reporting sharing needles.
The rise may be partly explained by new innovations such as rapid HIV testing facilities and increased HIV testing, which promotes early diagnosis and treatment, however the data will need to be monitored closely and risk factor information collected.

Rates of HIV infection are much higher in the South Eastern Sydney Local Health District than elsewhere in NSW. HIV related activity (occasions of service) at publically funded sexual health and HIV services has continued to increase, for example, the District experienced a 20% increase in activity between 2010 and 2012 (from 75,411 to nearly 90,838).

Impact on our Community

HIV is a significant public health issue and source of preventable morbidity in the South Eastern Sydney Local Health District. The District has the highest concentration of people living with HIV in both NSW and Australia, and is identified as one of the highest predicted areas in terms of anticipated growth of HIV in the population. Over 10,000 people are known to have HIV in NSW.

The District delivers services to approximately 50% of all HIV clients living in NSW (once patient in-flows are considered) and nearly two thirds of all HIV-related service activities in NSW. In 2011, 330 people in NSW were newly diagnosed with HIV infection, with most infections reported among gay and homosexually active men who are residents of the South Eastern Sydney Local Health District. An estimated 20-30% of people living with HIV in NSW remain undiagnosed. The estimated lifelong cost of one HIV infection is $450,000.[32]

NSW Targets:

- Reduce the transmission of HIV among gay and other homosexually active men by 60% by 2015 and by 80% by 2020
- Reduce heterosexual transmission of HIV, and transmission of HIV among Aboriginal populations, by 50% by 2015
- Sustain the virtual elimination of mother-to-child HIV transmission
- Sustain the virtual elimination of HIV transmission in the sex industry
- Sustain the virtual elimination of HIV transmission among people who inject drugs
- Reduce the average time between HIV infection and diagnosis from 4 ½ years to 1 ½ years by 2015
- Increase to 90% the number of people living with HIV on antiretroviral treatment by 2015
- Sustain the virtual elimination of HIV related deaths.

Source: NSW HIV Strategy 2012-2015: A New Era

Approaches that work

HIV control applies a broad range of evidence based scientific, technological, and management systems to improve the health of at risk and affected individuals and populations. Evidence of effective HIV prevention includes a combination of testing, treatment and behaviour change. Examples of effective programs and approaches include:

- Health promotion to increase the uptake of safe sex and drug injection practices
- Increasing access to and the regular uptake of HIV and STI testing among people at risk
- Prevention programs such as the Needle and Syringe Program, which is addressed further in the viral hepatitis section
- Use of antiretroviral drugs to reduce the transmission of the virus
- Providing antiretroviral drugs to those at risk of acquiring HIV (post exposure prophylaxis)
- HIV surveillance to inform targeting of prevention measures, testing and treatment
- Integrated approaches aimed at reducing transmission that include (at least) increased testing and maximising the number of people on treatment

[32] Australian Federation of AIDS Organisations *'Cost benefit Analysis: Lifetime Costs Per Infection'* Sydney, AFAO 2006

Priority Actions for reducing and eliminating HIV infections and delivering treatment and care to those living with HIV

- Develop and implement a SESLHD HIV strategy to **increase HIV testing rates** among priority populations
- Increase HIV **awareness, testing and treatment** and care across the SESLHD
- Improve **access** to **marginalised populations** (Aboriginal people, sex workers, CALD and people who inject drugs) to **information and services**
- Develop **innovative** HIV health promotion activities including promoting **outreach** testing and treatment and care programs for priority populations
- Develop and implement a **complex needs and ageing** strategy for people living with **HIV**
- Improve **access** to sterile **injecting equipment** for people at risk of blood borne viruses
- Improve **access** to **oral health** care for at risk populations including preventive and treatment services
- Reorient service provision to encourage **early uptake** into treatment
- Focus on improving **integrated care** pathways between various community health services and hospitals and Medicare Locals
- Partnering with Medicare Locals to increase STI and HIV testing by GPs
- Identify and implement initiatives to enhance access, maximise patient flow, support the **continuum of care**, and support **integration** between emergency, other hospital and community based services
- Identify opportunities for the further development of **Centres of Excellence** for HIV and sexually transmissible infections services and to strengthen their **statewide leadership** role
- Contribute to the **evidence base** for effective population health practice through **research** and publication of results
- Strengthen **partnerships** with and routinely seek advice from relevant Non Government and other organisations to gain the benefit of informed external perspectives and the ability to test the effectiveness of proposed SESLHD approaches on specific issues with community members and groups.

Programs and Activities to be delivered by the Directorate from 2014-19

Health Promotion/Prevention

HIV health promotion programs aim to prevent the transmission of HIV by: designing and implementing prevention and early detection programs and activities that target identified priority populations. These programs are designed and delivered in partnership with at risk communities, other service providers and organisations to maximise their impact in protecting and improving the health of priority populations.

Gay men and men who have sex with men (MSM), people living with HIV (PLHIV), Aboriginal people, Sex Workers, people who inject drugs (PWID) and people from culturally and linguistically diverse (CALD) backgrounds have been identified as priority populations in the current NSW HIV Strategy. Many people from the priority populations may not seek testing, treatment or support due to the perceived and real stigma and discrimination associated with HIV. The District implements a range of health promotion programs designed to address the issues associated with stigma and discrimination.

In many cases health promotion programs include the prevention of HIV and STIs. Messages and projects implemented in this District reinforce the need to maintain safe behaviours among priority populations. Protective behaviours such as condom use, regular HIV and STI testing, commencing HIV /STI treatment and using sterile injecting equipment to reduce rates of blood borne and sexually transmissible infections are important effective preventive measures.

Emerging technologies are enhancing the mechanisms for the delivery of health promotion services and interventions. The specialist HIV services located in this District have designed websites to promote their services and most also have hyperlinks to other services for clients and health professionals to access. They also use SMS recall and reminder systems. The use of social media to disseminate health promotion messages and highlight current issues is increasingly being used. The proliferation of televisions in client waiting areas of HIV and sexual health services has also provided a medium for services to publicise certain health issues, such as the importance of smoking cessation, vaccination, and mental and sexual health in the context of HIV.

The use of antiretrovirals to prevent HIV is another important initiative implemented across the District and State. A four week course of antiretrovirals can be provided to individuals who have potentially been exposed to HIV to minimise the risk of infection taking hold (the sooner the treatment is commenced, the more likely it is to work, ideally the treatment should start within 24 hours).

In partnership with the NSW STI Programs Unit **we will promote** condom use, voluntary HIV testing and treatment through social marketing campaigns.

We will establish combination prevention initiatives that places biomedical prevention alongside conventional population based HIV prevention programs.

We will deliver a range of health promotion programs and activities for people who are HIV positive. Areas of focus include smoking cessation programs. Research shows that people are three times more likely to smoke than the general population. In an attempt to combat this, some HIV services run dedicated smoking cessation clinics with accredited tobacco treatment specialists.

NSW HIV Information Lines

The NSW HIV information Line, a statewide service, the NSWPEP (Post Exposure Prophylaxis) Hotline, a service offered in partnership with St Vincent's Hospital, and the Gay Men's Health Line are services provided by the Directorate to provide access to information about HIV transmission, risk, treatment and prevention and other issues callers associate with HIV. The lines are able to divert callers with high anxiety but low risk away from HIV specialist services.

The Needle Clean–Up Hotline responds to reports of discarded needles and syringes in public places and by doing so helps to alleviate public concern about waste generated by some users of the Needle and Syringe Program, and the Needlestick Injury Hotline provides specialist advice to people who have sustained a needlestick injury, as well as their treating clinicians. Infoline staff answer approximately 5000 calls per year.

Needle and Syringe Program

Needle and Syringe Programs are an important public health measure to reduce the spread of blood borne viral infections such as HIV, hepatitis B and hepatitis C among injecting drug users. Building an effective Needle and Syringe Program in collaboration with relevant partners is a key priority for the District. The *NSW HIV*

Strategy 2012–2015: A New Era aims to increase and diversify the number of sites and mechanisms from which sterile injecting equipment is available. This program is discussed further in the viral hepatitis section.

The Directorate and local operational NSP services **will look** for opportunities to expand the number of outlets and build on initiatives taken to maintain and further activate the current network of syringe distribution points, across both the public health sector and Pharmacy based Needle and Syringe Programs.

World AIDS Day

December 1st marks World AIDS Day. It was declared an international health day in 1988. This day focuses on raising awareness about HIV and AIDS, including the need for support and understanding of people living with HIV, the need for prevention and education initiatives and the need for action to eliminate stigma and discrimination faced by HIV positive people worldwide.

We will continue to coordinate and support World AIDS Day activities across the District in our health facilities and community settings annually. It will be used to communicate advances in HIV, including rapid testing, treatment options and promote HIV testing facilities to the community.

HIV Early Detection

HIV Testing Project

Earlier diagnosis and treatment of HIV can prevent the morbidity and mortality associated with disease progression. It also reduces the risk of secondary transmission as treatment reduces the risk of transmitting HIV to others, and if people know they are infected they can adopt risk reduction strategies.

An estimated 20% of people living with HIV in NSW remain undiagnosed. A UK study found that being diagnosed late resulted in a tenfold risk of dying within a year of diagnosis.[33] HIV diagnosis at the time of seroconversion (development of detectable specific antibodies) or very early HIV infection is a key strategy for reducing onward transmission of HIV and for improving health of those who recently acquired the virus.

To improve the early identification of people infected with HIV, the ***HIV Testing Project*** *"Could it be HIV?"* has been designed to develop the capacity of a range of hospital and community based clinical specialty services to provide targeted HIV Testing for priority populations. This includes the development of activities that allow clinical specialty services to build on existing knowledge and skills, and establish conditions that promote staff to conduct HIV Testing. The Project will aim to work with targeted speciality areas such as Alcohol and other Drug Services, Haematology/Oncology, Gastroenterology, Maternity Services, Mental Health, Neurology and Emergency Departments across the District.

[33] HIV in the United Kingdom, Public Health England, November, 2013.

Planned activities include:

- Education through antenatal services and GP Antenatal Shared Care at Royal Women's and St George Hospitals
- HIV testing as part of an integrated health promotion package to include HIV, Hep C and STIs in youth early intervention services
- Education sessions for the Inpatient Mental Health services and the HAND Clinic at Sydney Hospital.
- Ongoing follow up support with staff at the Langton Centre
- Meeting with St Vincent's Hospital to discuss how the project can support local initiatives through Drug and Alcohol services
- Development of a HIV Testing Procedure for the LHD.

Specific improvements expected from this project include greater clinical staff awareness of the factors to consider when screening people for HIV, such as which population groups to prioritise for testing, how to start the conversation about the importance of HIV testing, and appropriate steps to ensure effective follow up and support when a patient tests HIV positive.

Rapid HIV Testing Activities

To increase access to testing in the absence of licensed rapid HIV testing technology, the Directorate is piloting Rapid HIV Testing at four sites and is working in partnership with a number of non-government organisations to identify additional testing sites open at hours that are likely to be more convenient to target population groups. The trial is assessing the acceptability of rapid HIV testing use among clinicians and gay clients, as well as cost and test performance in practice.

Current HIV testing arrangements often require two visits for blood collection and results, equating to eight visits per year for high risk populations to test at the frequency recommended in guidelines. With rapid HIV testing, results are available almost immediately. All services have shown support for this initiative by adopting more flexible opening hours, not only to make testing more available for new clients but also to offer them an opportunity to access the high

Rapid Oral Testing for HIV

In response to the 24% rise in new HIV diagnoses in NSW in 2011-2012, The Albion Centre initiated the Targeted HIV Oral Rapid (THOR) study to increase access to HIV testing. THOR is a trial of rapid testing that detects HIV antibodies present in saliva. Clients provide a swab from inside their mouths, with preliminary results available in 20 minutes. Results are confirmed with standard serology.

There are currently 7 sites involved in metropolitan Sydney, including government funded services, private GP clinics and a community organisation which conducts volunteer peer-led testing.
The trial, which has performed over 500 tests in 2013, has been extremely successful in addressing some of the previous concerns with testing, such as taking blood, the lengthy wait for results and having to return to the clinic for results. Almost all clients reported they would recommend the test to peers.

The Albion Centre predicts the licensing of rapid oral HIV tests in Australia will encourage more frequent testing and thus earlier diagnosis and treatment. This will substantially reduce the risk of transmission to partners and as a result, help address the rising HIV infection rates in MSM (men who have sex with men) and others in NSW.

Albion nurse performing a rapid oral HIV test

quality expertise in HIV treatment and care provided by Directorate services. Discussions are being held with services with regard to continuing the existing trial or creating a new one that will increase the number of sites offering rapid testing such as additional sexual health clinics, general practice settings, outreach and community-based sites.

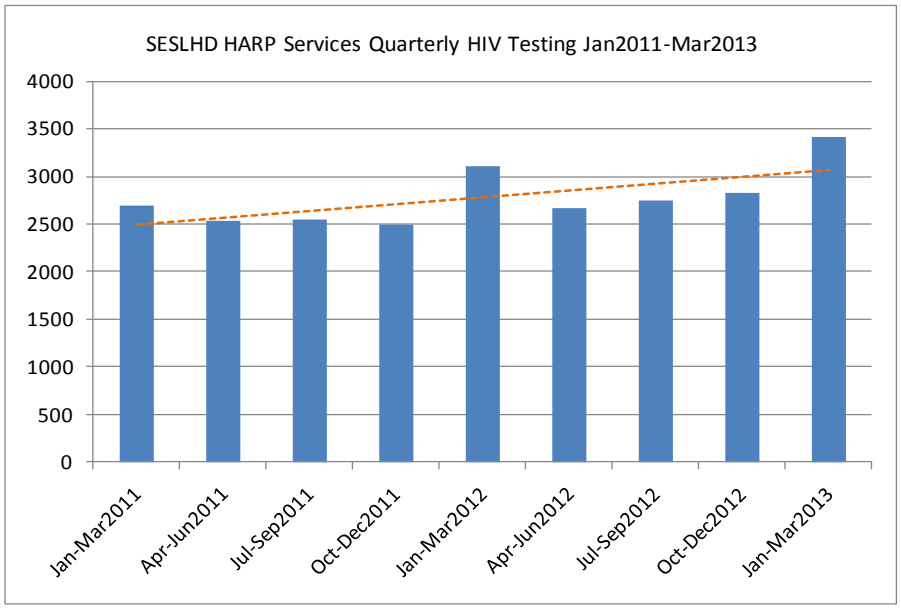
The 2011 Gay Community Periodic Survey identified that around half (47.4% in Sydney) of men who are HIV negative or unaware of their HIV status would be more likely to get tested if rapid testing were available.[34]

We will improve current HIV testing and results delivery processes and capacity for same day testing procedures.

We will collaborate and liaise with clinical services to identify and assess service needs and issues in relation to testing, with a view to increasing capacity, via innovative clinical settings and models for rapid HIV testing, for example, **we will**:

- Expand new technology to support triage and registration processes in publicly funded sexual health clinics in SESLHD through installation of 'Express Clinic' touch screen facilities as appropriate
- Develop a framework to increase capacity of Needle and Syringe services to offer testing
- Implement innovative outreach community based HIV testing models
- Support Short Street Sexual Health Clinic to provide outreach and flexible clinical services
- Investigate opportunities to enhance SESLHD hospitals outpatient and other clinical settings capacity to test priority populations for HIV
- Liaise with AIDS Council of NSW to plan for the expansion of HIV testing in the continued joint service provision targeting HIV priority populations in the District
- Support Gay Men's HIV testing project in the St George/Sutherland area to support regular HIV testing.
- We will ensure surveillance data continues to inform clinical care.

Figure 17: SESLHD HARP Services Quarterly HIV Testing Jan2011 – Mar 2013



HIV testing activity is continuing to increase

[34] Hull, P., Holt., M., Mao, L., Kao, S., Prestage, G., Zablotska, I., Triffitt, K., Edwards, B., & de Wit, J. (2011). *Gay Community Periodic Survey: Sydney February 2011*. Sydney: National Centre in HIV Social Research, The University of New South Wales. Available at http://nchsr.arts.unsw.edu.au/publications/

Treatment and Care for people living with HIV

People living with HIV are now living longer, more productive lives than in the past. However, drug treatment side effects are common, and as people affected by HIV grow older, they often experience other complex, long term health problems.

The principal medical issues for people living with HIV today have been identified as: bone loss; type 2 diabetes; body fat redistribution; cardiovascular, liver and renal health; cognitive function and mental health; malignancies; and sexual health. Many of these issues, and access to some medical treatments, are compounded by socioeconomic factors in people with HIV.[35]

HIV Services provide holistic multidisciplinary patient centred care. In addition to specialist medical and nursing services, other services are delivered by nutritionists, psychologists, social workers and other health providers. Health Promotion and research are other important activities that aid clinical care. Services regularly review their models of care to improve patient's access to evidence based prevention, treatment and care. For example, more blood and urine tests are now routinely performed in an attempt to identify co-morbidities earlier, and screening tools have been developed to identify those at greatest risk of HIV.

There is a shift towards focusing on preventative health care such as ensuring priority populations have regular HIV and STI tests. Examples include the introduction of community based testing for HIV at the AIDS Council of NSW (ACON) using peer educators to conduct rapid HIV tests and STI screening; local GPs have commenced point of contact testing (POCT) for HIV; and providing increased options for patients to collect HIV test results. Reviews are underway to reach a target of 90% of HIV positive people on antiretroviral treatment (ART) within the clinic populations.

Multiple health and social needs

The multidisciplinary services address clients' numerous and competing priorities, which may cause difficulties in attending appointments. Some **new activities** which aim to address these challenges include:

- Providing HIV positive clients who are normally stable on treatment with their routine monitoring results by SMS, thus eliminating the need for them to return for a follow up appointment
- Ensuring that HIV positive clients who are stable on treatment receive less frequent monitoring (though the number and type of tests performed per visit may increase)
- Rolling out telehealth initiatives, where clients can have a video consultation with an HIV specialist
- Using self-collected specimens and quick, self-administered risk assessments to encourage clients to regularly test for sexually transmissible infections.

HIV remains a stigmatised disease and mental health issues amongst people living with HIV are a major problem. Depression and anxiety disorders are significantly more prevalent in HIV populations as are drug and alcohol use. Economic hardship and social isolation are substantial issues as people living with HIV may have less support due to rejection from family because of sexuality, drug use and HIV status.

Cognitive impairment associated with HIV can develop earlier among people with HIV which impairs adherence to treatment and adds to morbidity and mortality. People living with HIV often need specialist skills and support to effectively manage medication adherence, to negotiate safe behaviours, to disclose status and to adjust to diagnosis.

[35] ViiV Healthcare, (2012) *HIV Life Plan Clinical Guide*

The Directorate **will continue** to provide specialist psychological services and social support programs to address the mental health needs of people living with HIV.

Adherence to HIV treatment

We will support HIV treatment uptake and adherence, through activities such as:

- Further developing the Picnic in the Park Program which aims to work with socially isolated clients
- Exploring options to develop an HIV Patient Self Management Program in partnership with Bobby Goldsmith Foundation
- Further developing triage pathways to General Practice
- Focusing on improving integrated care pathways between various community health services and hospitals and Medicare Locals.

Enhanced Medication Access Scheme

This statewide service managed by the Directorate allows people living with HIV (PLHIV) who are prescribed with anti-retroviral (ARV) S100 treatments to have their medications dispensed to them by mail, either to their homes or to a community pharmacy nominated by the patient. This negates the need for PLHIV to attend and wait at a hospital based pharmacy during working hours and increases their ease of access to medication, resulting in improved adherence and outcomes for a significant number of PLHIV.
A number of retail pharmacies around NSW have supported the scheme by allowing medications to be mailed to them on behalf of patients. These retail pharmacies hand the medications over to the patients (without re-dispensing), thus allowing delivery and collection at a more convenient time and location for the patient.

The project in its first 9 months attracted 150 participants and the numbers continue to rise. It has proven popular among those participating in the scheme, and it is predicted that enrolments will continue to increase over time.

Multidisciplinary Outreach Services

The Directorate's HIV multidisciplinary outreach service, known as the HIV Outreach team (HOT), provides health care for people living with HIV who have complex needs, across the South Eastern Sydney and Illawarra Shoalhaven Local Health Districts. Multidisciplinary services are provided within an individual case management approach and include advocacy; counselling and support; health education and monitoring; occupational therapy functional assessment and interventions; assistance with coordinating housing; medication adherence and management; drug and alcohol and mental health assessments; nutritional assessment and management; secondary needle and syringe outreach program and water based exercise classes among others.

Photo: The HIV Outreach team

A key component of the HIV multidisciplinary outreach service is to strengthen partnerships with other services such as GPs, tertiary referral hospitals, sexual health services, community health services and other agencies, by having an active representation role within their local initiatives, committees and meetings and to avoid service duplication by designing and implementing complimentary approaches to prevention and care. Over the last five years the service has provided health care and support services to over 600 clients. Client engagement and advocacy are two of the most important aspects of case management.

In partnership with key HIV service providers, a recent 12 month state-wide pilot of the HIV Complex Needs Case Management program has been implemented to provide support for sexual health staff in rural and

regional NSW to help case manage people living with HIV and complex care needs. Given the need for, and success of, this initiative it is envisaged that further capacity building activities in regional and rural areas will be implemented in the future.
The HIV Outreach team **will increase capacity** of staff to see more clients with efficiencies in technology (e.g. the use of laptops), data recording and streamlined processes.

Bobby Goldsmith Foundation (BGF) is one of the team's main referral partners and the case management services provided by the HIV Outreach Team compliments the skilled casework services that BGF staff provide to support clients in the community, such as financial and practical assistance, financial counselling, housing and employment support to the most vulnerable people living disadvantaged by HIV in New South Wales. BGF also runs a peer led workshop for clients in Patient Self-Management and The Earlier Referral Project is an example of how the HIV Outreach Team will work with services such as BGF to promote an earlier intervention approach and empower clients to self-manage their illness.

Earlier Referral Project
This project will explore strategies regarding promoting earlier referral of clients to the HIV Outreach Team, particularly at the time of treatment initiation. Much can be gained from working with clients earlier to promote skills in Self-Management and some of the ideas being developed include branding the project, developing a presentation (focussing on flags and triggers for earlier referral) for a road show with services, reviewing current referral pathways, using opportunities to present at Health and Medicare Local events, integrate into ASHM's HIV Shared Care Project and explore ways to incorporate into local Intake processes for services.

The Ankali Project

The Ankali Project is a statewide service which recruits, trains and supports volunteers who in turn provide social and emotional support to people living with HIV (PLHIV). The aims of the Project are to enhance the lives of all people living with an HIV diagnosis, but specifically more "marginalised" people; those living with mental health problems, alcohol and other drug use, severe social isolation and poverty. In doing so, the people who use the services of the Project generally maintain their medication adherence, and require less input and support from professional support services, resulting in better overall health outcomes.

At any one time the Project has approximately 130 volunteers and supports over 130 PLHIV. Over 7,500 hours of face to face support is provided annually.

"Open Your Mouth" - Oral Health Project for People Living with HIV

Poor oral health issues are a common complaint of people living with HIV. "OPEN YOUR MOUTH" is a collaborative Project between the Directorate, HIV/AIDS related clinical and health promotion services in NSW, Sydney Dental Hospital, AIDS Council of NSW, Bobby Goldsmith Foundation and Positive Life NSW, which aims to improve the oral health and wellbeing of people living with HIV.

The project working group conducted comprehensive surveys with both health care professionals and people living with HIV. The results showed that despite many clients raising oral health as a concern, most health care professionals had no access to resources or tools to educate people with HIV about oral health issues. People living with HIV also reported a need for more oral health information relating to healthy eating and drinking habits, oral hygiene and practical tips in managing symptoms of common oral health problems such as dry mouth, pain and discomfort, bad breath and taste change.

It was identified that specific training in oral health care is required to build the confidence of non dental healthcare professionals in discussing oral health issues, and that oral health care tools/resources for non dental professionals to use as part of standard HIV care and treatment need to be developed.
The working group is **currently developing** a range of oral health resources for both health care professionals and people living with HIV to address the identified gaps.

Patient Self-Management Project

The HIV Outreach Team in partnership with Sydney Local Health District is planning for the development of a new project titled, ***'Promoting Self-Management for People Living with HIV - Training for Health Workers in NSW' project***. Self-management is identified as a key strategy in the management of chronic diseases in *The National Chronic Disease Strategy* and was also emphasised as essential to future models of HIV care in the *NSW HIV and STI Clinical Services Planning Project Final Report*. Enhancing the capacity of people to self-manage their illnesses requires health care workers themselves to be informed, competent and confident in the use of practices and tools that support patient self-management.

The Patient Self-Management Project will increase health worker and General Practitioner knowledge and competency in the use of an evidenced based approach to facilitating self-management of chronic conditions, including HIV. Working in partnership with local primary health care organisations, the project supports the identification of relevant approaches to integrating self-management practices at the clinical level to enhance and complement existing approaches to case management and chronic disease care.

Case study

Thuy is a survivor of human trafficking and exploitation and suffers post traumatic stress disorder as a result of the abuse she experienced. She has been a client of the HIV Outreach Team for over 4 years after being referred following a lengthy stay in hospital. She has cognitive impairment and language barriers, and was unable to live in the community and manage her complex health conditions.

Thuy was discharged from hospital into highly supported accommodation with a full Guardianship Tribunal Order. This authorises someone (the guardian) to make decisions on behalf of her about matters such as her health care, where she should live, where she might work or receive training and/or what kind of care and support services she will need and receive.

A key focus of Thuy's care continues to be on providing opportunities to increase capacity to self manage her health and social situations. This has required much negotiation and advocacy with services including the guardian. Over time Thuy has required a decreased level of case management support in areas such as managing medications, attending a range of specialist appointments, linking her with other needed services including legal, psychological, housing and vocational as her health and in particular cognition has improved. Much advocacy with the guardian was required for Thuy to be given opportunities to live in her own unsupported accommodation and commence English classes, for example. Thuy is no longer on a guardianship order and plans are underway to remove the financial management order in place.

Thuy has had a child during this time and case management has ensured that she has been well linked with needed antenatal and early childhood services. Thuy is now able to live independently and care for herself and her daughter. Thuy continues to benefit from case management in supporting her to self manage her illnesses, to build skills and confidence in navigating the health and social welfare system, to remove barriers to her accessing needed services and in providing ongoing psychosocial support to engage in meaningful activities.

CALD Quality Improvement Project

This project is working to improve referral pathways and knowledge of Community HIV and other services for clients from culturally and linguistically diverse (CALD) backgrounds. Membership of this group has expanded to include staff from Community Teams, Multicultural HIV and Hepatitis Service, The NSW AIDS Dementia and HIV Psychiatry Service (Adahps), St George Hospital and Parramatta Sexual Health Service.

Capacity building in the primary care setting: General Practitioners and HIV care

The recent Ministry of Health *HIV and STI Clinical Services Planning Project* report placed increasing emphasis on an enhanced response by General Practitioners to the detection, treatment and management of both HIV and sexually transmissible infections in New South Wales. This report has committed to the development of an effective Shared Care model of care for both HIV and sexually transmitted infections. In implementing the report's recommendations, the Directorate provides training to local General Practitioners on a regular basis to increase skills in HIV, sexual health and hepatitis related care and increase awareness of HIV, sexual health and hepatitis issues among priority populations. The training also aims to strengthen relationships between General Practitioners and HIV specialists, hepatitis and sexual health services, including improving referral protocols and ongoing communication.

We will continue to participate in the HIV Shared Care Project which aims to improve the medical management of clients by General Practitioners and Specialist Physicians through the development and trial of a revised GP Management Plan.

We will convene a group specifically aimed at giving greater focus to increasing opportunities for the management of people living with HIV within the general practice setting. This group would include high HIV case load GPs to identify effective approaches to gaining buy-in from other General Practitioners in the relevant communities.

NSW AIDS Dementia and HIV Psychiatry Service

The NSW AIDS Dementia and HIV Psychiatry Service (Adahps) is a statewide public health service supported by the Directorate for residents of NSW who have HIV and complex needs, such as HIV associated dementia and/or HIV and mental illness.

Adahp's specialist HIV case managers and clinical psychologists work in partnership with clients, their families and carers, health professionals and non-government organisations to provide a number of assessment, diagnosis, education, partnerships and consultancy services. The service also co-ordinates the NSW HIV Supported Accommodation Program.

To be eligible for Adahp's services, an individual must be HIV positive and either:

- have a suspected or confirmed diagnosis of HIV Associated Dementia and/or a HIV related psychiatric illness, or
- exhibit signs of cognitive impairment or behavioural disturbance that cannot be managed by local services, or
- require specialist assessment and management that is not available in the local area, or
- have complex needs that require added assistance from Adahps.

Workforce Development Grants Program

The HARP Workforce Development Grants Program aims to support the development of staff currently working in hepatitis, HIV or sexual health. Two funding schemes are currently available, one providing support for study grants and the second for conference attendance.

Education Programs

The Directorate provides education and training for health and community workers involved in the response to HIV and STIs, from both within SESLHD and across the state. Training ranges from introductory courses on HIV to specialist training in counselling associated with HIV testing. An online training program was initiated to allow participants to complete some of its courses without needing to attend face to face sessions. In 2014, a number of hybrid courses will be introduced, allowing a combination of face to face and online learning.

The Directorate hosts the state-wide HIV Library, which specialises in the medical, psychological, nutritional and treatment aspects of HIV and AIDS, viral hepatitis, sexually transmissible infections and healthcare worker safety. The Information Management Service provides access to journals and on-line information services, including international conference proceedings.

Photo: **Organisers of the one-day workshop 'HIV in the New Era'.** From left: Ruth Hennessy (Psychologist, Albion Centre), Diane (Positive Life), Sarah Smith (WAD Coordinator, HARP), Nicholas Bates (Acting Education Manager, Albion Centre), Jeffrey Dabbhadatta (Health Promotion, HARP)

We will continue to improve the capacity of our workforce to care for people affected by HIV by:

- Promoting the Confidentiality Checklist and seeking opportunities to roll this out to mainstream services through orientation and other learning programs, including focusing on reducing stigma and discrimination against people with HIV within the health system
- Addressing the impact that stigma and discrimination has on priority populations accessing mainstream health care services
- Providing staff orientation programs and training workshops
- Exploring funding for nurse practitioner training and support at three sexual health clinical services
- Diversifying the sites from which treatment is available, and maximising opportunities to assess and initiate treatment
- Capturing numbers of individuals presenting for first time HIV testing can be used to benchmark and to monitor future trends.

We will contribute to the evidence via publications in peer reviewed journals.

Care coordination and Integration

The Directorate provides a programmatic response to HIV prevention, treatment and care. The services and programs delivered by the Directorate are integrated across the care continuum. A range of committees support the integration and coordination of prevention, treatment and care delivered by Directorate's services and other service providers such as St Vincent's Hospital and services delivered in the ISLHD. Multidisciplinary committees provide broad oversight of the services and programs delivered to priority populations and address emerging issues and challenges presented by this complex discipline. These structures also support the active collaboration of clinicians, managers and non-government organisations, which share the responsibility of HIV prevention, treatment and care to maximise the impact of these services and to reduce duplication of effort.

Communication and referral between services is a critical component of patient centred care. In the past, HIV services have tended to be well linked with services for people experiencing health problems such as viral hepatitis and alcohol and other drug use; however clients now increasingly require other specialist referral because of co-morbidities related to areas such as renal, cardiovascular and neuro-cognitive dysfunction. The continued stigmatisation of HIV means that many clients remain unwilling to see health care professionals from non-HIV services. Multi-disciplinary care is also required for the coordination of care for people with long term and complex medical and social needs.

An increase in the number of people with HIV choosing to have children has also meant that HIV services are increasingly liaising with obstetric services. Improved knowledge, increased efficacy of new treatments and the sensitivity of modern viral load tests (a blood test measuring the amount of HIV virus in the client's blood) mean that, with appropriate support, clients can almost eliminate the risk of HIV being transmitted to their baby.

The NSW Paediatric HIV Service at Sydney Children's Hospital, Randwick provides care for children, families and pregnant women living with HIV. It is the only service of its kind in Australia and provides medical management, psycho-social support, research, consultation and education.

We will explore and implement effective approaches, in relation to the ageing HIV population and associated increases in complex care needs of people living with HIV, including:

- Work with and educate aged care facilities and ensure our acute care services are up to date and able to ensure that those affected do not suffer any stigma and discrimination
- Develop the Action Plan for HIV Clinical and Community Services with key partners and clinicians to explore the health care needs of people living with HIV living with chronic co-morbid diseases, focussing on developing effective and sustainable models of integrated care
- Investigate and support the implementation of models of care in the community setting that adequately provide for needs of people living with HIV and complex care and ageing issues
- Participate in the evaluation of a one year pilot of the HIV Complex Needs Case Management Program (providing care, support and advice to sexual health staff and GPs in rural and regional NSW) in partnership with Sydney LHD and the statewide Adahps service.

We will continue to improve cross sectoral coordination between HIV and mainstream clinical and community based services, and we will strengthen case management opportunities for those in need.

We will continue to provide clinical advice and support to sexual health services and GPs in Southern and Murrumbidgee LHDs as part of the statewide HIV Complex Needs Case Management Project.

NSW Health Panel for Management of People with HIV Infection who Risk Infecting Others

This panel has significant input from the Directorate and SESLHD, with the Chair a clinician from SESLHD. The role of the Panel is to provide advice to clinicians managing clients with HIV who may be abrogating their public health responsibilities and liaise closely with clinicians of those individuals considered to be placing partners at risk of HIV infection. The Panel advises the Chief Health Officer on actions needed to reduce the public health risk they might pose.

Partnerships

Service partnerships have been a productive way of improving the Directorate's reach and impact of programs within SESLHD. Partnerships with effective communication and planning strategies between government, non-

government and community organisations and the affected community are essential to achieve the most effective mix and range of services. Examples of effective partnerships include:

- Consumers and carers
- Non-government organisations and local government and other government agencies
- Medicare Locals
- General Practitioners and Nursing and Allied Health practitioners
- Research Partners, such as the Kirby Institute

Partnership with Marie Stopes International Timor-Leste

The Albion Centre has formed a partnership with Marie Stopes International for the Timor-Leste Australia collaboration for HIV Testing and Counselling Project (TAC-TAC). TAC-TAC is part of the AusAID funded regional HIV/AIDS capacity building program linking Australian organisations with counterparts in Asia-Pacific to strengthen HIV/AIDS responses.

Marie Stopes International Timor Leste (MSITL) works in partnership with the Ministry of Health to provide sexual and reproductive health services in Timor-Leste in eight districts. Other stakeholders include Estrela+, WHO and the National Reference Laboratory along with civil society groups and individuals.

Although Timor-Leste has a low prevalence of HIV, it is experiencing higher rates of HIV transmission than epidemiological modelling projected in 2005. STI prevalence rates are also increasing, and HIV sentinel surveillance has reported an HIV prevalence of 2.58% in the STI population group. Providing HIV testing and counselling through sexual and reproductive health services addresses this heightened risk group and the issue that some people may be unwilling to attend a service specifically for HIV, but may be willing to be tested in the context of STI service provision.

TAC-TAC will mentor health workers to provide HIV Testing and Counselling (TAC) through Marie Stopes International Timor Leste sexual and reproductive health clinic, develop and implement outreach models in selected Districts and strengthen quality assurance processes for HIV testing and counselling.

b. Sexually Transmissible Infections Prevention, Treatment & Care

Sexually Transmissible Infections as a Population Health Focus

STI snapshot

- Highest rates of STIs are found among young people
- Chlamydia is the most commonly notified sexually transmissible infection
- Highest rates of Chlamydia recorded in 15-19 year old females
- Highest rates of gonorrhoea recorded in 20-24 year old males
- Highest rates of infectious syphilis recorded in 20-24 year old males
- Important to develop preventative interventions tailored to a young, newly sexually active population

Source: Middleton, M and McDonald, A. Sexually transmissible infections among young people in Australia: An overview (online). HIV Australia, Vol 11, No. 1, Mar 2013: 9-10. Availability: http://search.informit.com.au/documentSummary;dn=226150928175649;res=IELHEA>ISSN:1446-0319 (cited 30 Oct 2013)

Sexually Transmissible Infections (STIs) including chlamydia, syphilis and gonorrhea are controllable communicable diseases that pose a major public health risk throughout Australia and particularly in South Eastern Sydney.

Chlamydia is the most commonly notified disease across Australia and a significant contributor to pelvic inflammatory disease (which occurs when an infection spreads from the vagina to the cervix, the endometrium and the fallopian tubes); ectopic pregnancy (a pregnancy that occurs outside the womb); epididymitis (inflammation of the epididymis, the tube that connects the testicle with the vas deferens); and infertility in both men and women. It is estimated that in NSW, 75% of chlamydia infections are not diagnosed.[36]

Chlamydia affects people of all sexual orientations in high numbers, predominantly in the 15 to 29 years age group. Although up to 80% of chlamydia infections are found in people under the age of 29, it is estimated that as few as 9% get a chlamydia test, despite 86% of females and 65% of males in the 16-29 year group attending a GP at least once a year.[37]

Chlamydia infection is very often asymptomatic, so in populations where there is not a strong culture of regularly testing for STIs, chlamydia infections are frequently undiagnosed and untreated.

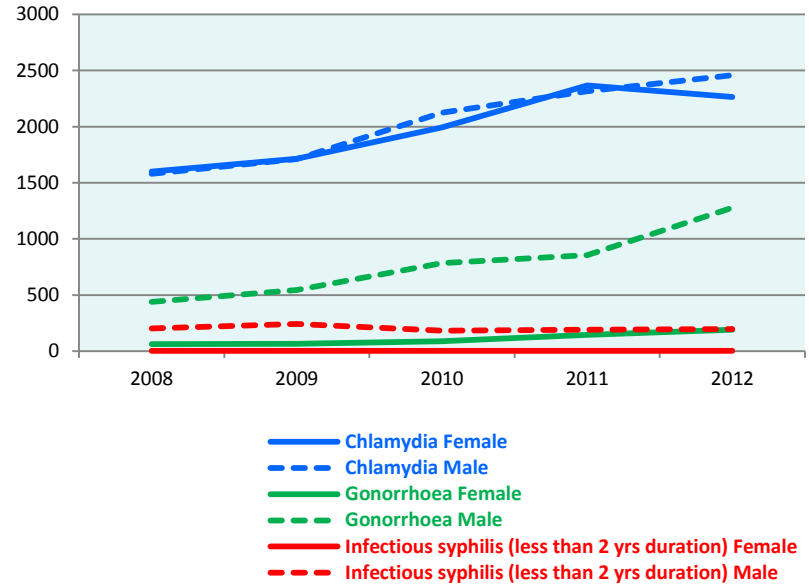
Without effective prevention and treatment, the transmission of STIs can escalate quickly and create a significant burden of illness throughout a community. There is also a correlation between HIV and STI infection rates, partly because of similarities in the ways in which they are transmitted, but also because immune responses which are present when someone has an STI increase the likelihood of HIV being passed on. Lack of condom use during sex makes the transmission of HIV and other infections more likely. This synergy between the presence of an STI and HIV transmission is often neglected, especially with many STIs being asymptomatic and undiagnosed. The Directorate has made a significant investment in improving surveillance of infectious syphilis and gonorrhoea in order to improve the understanding of risk factors for these diseases and thus to better craft and target prevention activities.[38] [39]

[36] Guy RJ, Ali H, Liu B, et.al. Genital chlamydia infection in young people: a review of the evidence. A report to the NSW Health Department. Kirby Institute University of NSW. November 2011.
[37] Kong et al, **Med J Aust 2011**; 194: 249-252.
[38] Botham SJ, Ressler K-A, Maywood P, Hope KG, Bourne CP, Conaty SJ, Ferson MJ, Mayne DJ. Men who have sex with men, infectious syphilis and HIV co-infection in inner Sydney: results of enhanced surveillance. Sexual health 2013; 10:291-298

Impact on our Community

This District continues to have a high rate of chlamydia, which can be partly explained by the high rates of testing. Rates are highest in the Local Government Areas of Sydney, Waverley, Woollahra, Randwick and Botany. Gonorrhoea infections are also on the rise among residents within the District, particularly among males aged 20-44 years within inner metropolitan areas. Between 2010 and 2012, occasions of service for testing/ treatment/management of STIs (excluding HIV) at non-inpatient services across the District increased by 37% from 4,182 to 5,790.

Figure 18: Notifications of sexually transmitted infections, SESLHD residents, by gender, 2008-2012



Chlamydia and gonorrhoea notifications are increasing among our residents

Source: Notifiable Diseases Report, 2012 SAPHaRI NSW Health.

Gonorrhoea infections in the District are found predominantly in men who have sex with men, but increases are also occurring in the heterosexual population. This can be explained partly by the sexual behaviours that people in this population group engage in: most cases of genital gonorrhoea are symptomatic (meaning that people seek early treatment before exposing future partners) whereas most cases of anal and pharyngeal gonorrhoea are not (meaning that people with infections in these sites are normally unaware they are infected).

NSW Targets:

- Increase consistent condom use with casual sex partners
- Increase STI testing, particularly among priority populations.

Approaches that work

Features of effective interventions to reduce STI's include those that use/adopt:[40]

- Programs that promoting safe sex behaviours
- Behavioural skills training, including improving people's ability to act with self confidence
- Targeted and tailored, client-focussed interventions (in terms of age, gender, culture, etc.), that make use of needs assessment and/or formative research.

[39] Ressler K-A, Ferson MJ, Smedley EJ. Gonorrhoea infection, re-infection and co-infection in inner Sydney men: a population based study. Med J Aust 2014; 200:in press

[40] Jennifer Downing, Lisa Jones, Penny A. Cook, and Mark A. Bellis. Prevention of STIs: a review of reviews into the effectiveness of non-clinical interventions. Evidence briefing update. 2006. http://www.nice.org.uk/media/ABC/87/STI.EvidenceBriefingFinal.pdf

Priority Actions for controlling sexually transmissible infections

Our goal is to reduce the transmission of sexually transmissible infections by:

- Improving access to **sexually transmissible infections prevention, screening and treatment** and **care** for priority populations
- Developing innovative **health promotion** activities to promote safe behaviours and STI testing
- Promoting **sexual health online risk assessment tools** to encourage early and appropriate care seeking behavior
- Developing new and innovative **models of care** provision for people affected by sexually transmissible infections
- Identifying and implementing activities to enhance access to and enhance the **continuum of care**, and support **integration** between emergency and other hospital and community based services
- Identifying opportunities for the development of **Centres of Excellence** and strengthen their statewide leadership role
- Contributing to the **evidence base** for effective population health practice through surveillance, research and publication of results to inform our response
- Strengthening **partnerships** with and routinely seeking advice from relevant Non-Government and other organisations to gain the benefit of informed external perspectives and the ready ability to test the effectiveness of proposed SESLHD approaches on specific issues with community members and groups.

Programs and Activities to be delivered by the Directorate from 2014-19

Sexual Health Promotion

Sexual health promotion programs aim to reduce STIs by:

- Strengthening prevention, early detection and health promotion programs targeting identified priority populations through partnerships with community and non-government sectors to maximise outcomes.
- Building the capacity of the sexual health workforce to undertake planning, evaluation and health promotion.

Young people have been identified as a priority group for STIs by the NSW Ministry of Health and Local Health District, particularly those in other identified priority populations including Aboriginal, Culturally and Linguistically Diverse (CALD), gay and men having sex with men, people who inject drugs and sex workers. Young people are infrequent users of mainstream health services and require strategies that take into consideration the places where young people gather and the types of communication and media they favour.

The Directorate provides annual funding and best practice training and support to local youth health services to deliver youth based, peer education and sexual health promotion outreach projects. These programs target young people aged 14-24 who live in and/or frequent the local areas.

Projects focusing on Young People

The Directorate funds, sets performance targets, coordinates training and chairs an advisory committee which oversees the management of programs for the three SESLHD based youth services.

We will expand the number of sexual health activities and clinical services in youth service settings.

Peer Education outreach project

Targeted outreach occurs at local beaches, youth events, festivals, TAFE Colleges and youth services. The **Safe Summer Survival** Peer Education Sexual Health program recruits young people to train and work as sexual health peer educators, with 36 young people already trained. Peer educators may provide young people with information about sexual health and drugs and alcohol, and health packs (condoms, lubricant and written information about sexual health and drugs and alcohol). Peer educators also promote and encourage access to youth specific sexual health services and drug and alcohol services. The '*Like, Dislike'* sticker was developed by WAYS Youth Services to use as a tool for outreach and is popular with young people.

The NSW Festivals initiative

The Directorate, in partnership with other LHDs and Family Planning NSW and led by the NSW STI Programs Unit (STIPU), provides a statewide social marketing/outreach campaign to promote sexual health messages to sexually active young people attending events across the state. This aims to increase young people's awareness of issues relating to STI testing, treatment and prevention, by providing a range of interactive activities, including sexual health quizzes that promote discussion about condom use, sexual health knowledge and where to go for STI testing. There is also a social media campaign which promotes condom use and provides information about STI testing.

Youth Week partnership

Working in collaboration with STIPU as part of a state wide initiative, the Directorate has a three year partnership with the Office of Communities to include sexual health as the main component of Youth Week. STIPU chairs a committee that oversees the development of a strategy to engage with young people and promote sexual health promotion messages. In 2012 a state wide forum was held at NSW Parliament House entitled '*Addressing the rise in STIs',* was attended by 80 young people representing LGAs from around NSW.

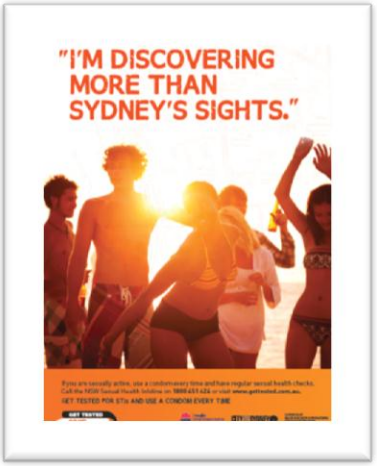
We will continue to support the following health promotion activities:

- Peer Education Outreach Project
- Participate in the NSW Festivals initiative
- Youth Week, a 3 year statewide partnership

Backpackers Project

The Directorate, in collaboration with the Sexual Health Infoline, City of Sydney Council and the Backpacker Operators Association of NSW surveyed backpackers across Sydney to determine rates of testing, perceived risk levels, STI knowledge and knowledge of available services.

Backpackers in general were found to have higher rates of chlamydial infection than comparison populations of the same age and reported higher rates of previous chlamydia infection; had more sexual partners; and were twice as likely to drink to hazardous levels than the rest of the population. The study also found only 22% of backpackers regularly used condoms during sex, increasing their risk of contracting STIs.



In response, the partner organisations developed and supported the implementation of an information campaign targeting the more than 400,000 backpackers who visit Sydney each year. Campaign resources included: a poster encouraging backpackers to get tested and use a condom, with the NSW Sexual Health Infoline phone number and the Get Tested Play Safe (GTPS) website address; a booklet containing essential information relating to STIs and suitable sexual health services available to backpackers while staying in Sydney; and a condom tin, including a condom, lubricant sachet, instructions on how to use condoms and contact details for the NSW Sexual Health Infoline.

A recent evaluation of the project recommended that:

- Campaign resources be redistributed throughout spring and summer in 2013/14
- Alternative campaign dissemination strategies be explored, including mobile smart phone application
- Data continues to be collected and monitored from the GTPS website and NSW SHIL.

Health Promotion staff have visited and engaged with over 60 backpacker establishments in the LHD to encourage support for this program and to ensure engagement strategies are developed at a local level. Over 7,000 booklets and 10,000 safe sex tins have been distributed.

We will continue to implement the backpackers project and explore further campaign dissemination options.

Aboriginal Health Programs

Aboriginal Sexual Health Promotion Officers work with young Aboriginal people in a range of settings that build strong relationships and trust and enable a supportive environment to discuss sexual health and issues associated with accessing sexual health services and GPs.

Using sport and sporting events has proved a popular way to engage and maintain relationships with young Aboriginal people. Programs have been developed that are gender specific and include a holistic approach to addressing sexual health issues, viral hepatitis and other associated health issues, such as domestic violence, mental health and reproductive health. A holistic approach reduces the likelihood of young people suffering stigma and discrimination associated with sexual health and hepatitis C.

Examples of our programs include:

- Working with the La Perouse Youth Haven and providing sexual health education and support around sexual health and hepatitis C issues to young people who attend the weekly youth groups, the Lapa Lads, the Lapa Divas and the Lapa Deadlys leadership program
- The "Strong Brother" program with young Aboriginal males at Endeavour High School. In this program the focus on a cultural context and use of traditional approaches was the basis for educating the young men about sexual health and hepatitis C
- "Sista's are doing it for themselves", a young women's project that provides self-defense training and different workshops in sexual and reproductive health, mental health and domestic violence
- *"Staying Strong",* a project led by AH&MRC in collaboration with the Directorate, Matraville High school and La Perouse Youth Haven to build young Aboriginal people's resilience around drug use, and to raise awareness of prevention of blood borne viruses
- "*Healthy bodies, Healthy minds",* an annual camp in partnership with Malabar Midwives, where Aboriginal young women can explore a combination of confidence building skills and interactive workshops and programs addressing puberty, and sexual health.

We will support Aboriginal sexual health workers to conduct targeted awareness raising initiatives among community members and **we will strengthen** partnerships with Aboriginal communities and youth organisations to incorporate sexual health programs in service provision.

Other activities include:

We will improve accessibility to STI testing through multifactoral interventions including:

- Expanding the number of sexual health clinical services in youth service settings
- Strengthening community and school- based STI prevention programs with priority populations
- Implementing models of testing that include an outreach dimension
- Promoting contact tracing of sexual partners who may have been exposed to an STI
- **www.stitest.org.au**, an STI/HIV screening website that contains a computer assisted self interview (CASI) risk assessment, pathology request form and location details, patient education and information, and referral pathways.

We will develop and evaluate education programs – including via social marketing and new technologies to enhance:

- Prevention and early detection of STIs through increased safe sex practices and regular STI testing, particularly among youth
- Education of people with HIV about health benefits of treatment.

We will maintain and increase condom use among priority populations by improving condom distribution procedures, including access to condoms for priority population groups.

We will use other new technology to disseminate information and improve service provision by:

- Implement touch screen express clinic technology in all sexual health services
- Promote an online risk assessment tool to encourage early and appropriate care seeking behavior.

We will use, develop and evaluate social marketing and new technologies to prevent and detect STIs through increased safe sex practices and regular STI testing, particularly among young people.

We will develop strategies to support youth peer education work targeting Gay, Lesbian, Bisexual & Transgender (GLBT) young people.

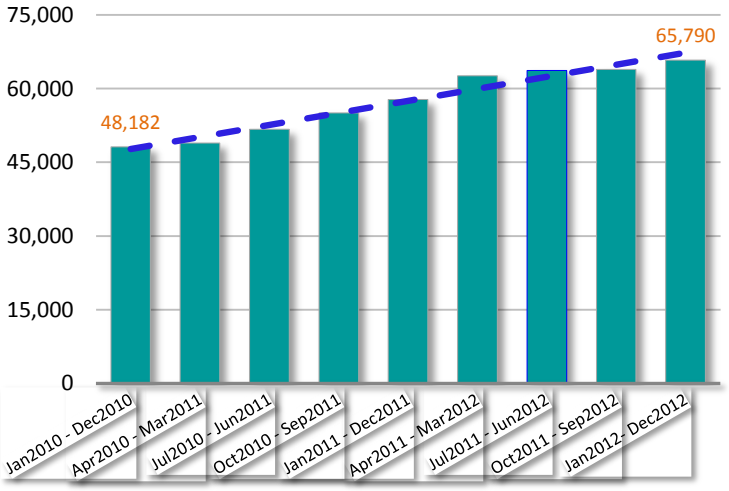
We will contribute to reliable evidence development and validation via publications in peer reviewed journals.

Diagnosis, Treatment and Care

Publically funded Sexual Health Services provide a network of expert, free clinics for the diagnosis and management of STIs and HIV, providing services to patients and consultancy to primary care providers and hospital specialists. The clinics provide a range of multidisciplinary services that include diagnosis and treatment, partner notification services, prevention and health promotion services to those most at risk of acquiring STIs, including a variety of targeted programs to sex workers and men having sex with men (including the provision of client-specific clinics). Sexual health clinics also provide HIV testing, treatment and care and a variety of counselling and support programs.

There has been a significant increase in the total number of non admitted patient occasions of service (NAPOOS) and the total number of clients accessing sexual health services in 2012, increasing by 11.5% compared to 2011. Occasions of service in the January to March quarter of 2013 increased by 25% when compared to the same quarter in 2011. This is largely explained by the increase in access to and promotion of testing. Sexual Health Clinics have reviewed their models of care to improve access and streamline the patient journey. They have responded to the demand for their services by revising their hours of operation, developing Xpress style services that can be used within clinics and in community based and outreach settings. The introduction of electronic registration and self-administered risk assessments has enabled “fast tracking” for sexual health / HIV screening, resulting in an increase in capacity for clients to test at a centre.

Figure 19: STI testing, treatment and care activity Jan 2010-Dec 2010 to Jan2012-Dec2012



Source: SESLHD HARP Unit minimum dataset

The NSW STI Programs Unit

This is a state wide service administered through the Directorate which assists publically funded sexual health services to orientate service delivery toward priority populations; strengthens the capacity of general practitioners to manage STIs within the primary care setting; and promotes community awareness through statewide STI social

Local Primary Care Provider Training

The Directorate organises regular training for local General Practitioners in the identification and management of people with STIs to enhance their knowledge of testing and treatment. This initiative is undertaken in partnership with the Australasian Society for HIV Medicine and local Sexual Health Clinic staff. Training is also provided to GP Practice nurses in STI/HIV screening.

The Directorate supports the delivery of a range of local activities led by the NSW STI Programs Unit. Examples of projects include:

- **NSW General Practice Project** which aims to increase the amount c targeted STI and HIV testing; and to support the capacity of genera

within the primary care setting by improving access to STI information, training and resources and strengthening links to publicly funded sexual health services.

- **Supporting Primary Health Care Nurses** with access to resources, training and competency standards.
- **HIV/STI Health Promotion Resource Project** to promote community awareness of sexual health care through statewide STI social marketing and information campaigns.

The NSW Sexual Health Infoline

The Directorate provides a confidential and anonymous statewide sexual health telephone information and referral service staffed by experienced sexual health nurses, with strategic support from STIPU.

The aims of this service are to educate and promote the sexual health of the community and to facilitate efficient use of the publicly funded sexual health centres across NSW. A total of 7442 calls were answered in the year up to June 2013, with the numbers of calls increasing steadily over the last 5 years.

The majority of calls were consistently about HIV and STI risk assessment and testing and most callers were identified as belonging to one or more STI priority populations. About 10% of callers were health care workers using the line as an advice/education resource.

We will promote The Sexual Health Infoline use of social media (blogs, messages via other providers such as Ticketek and music festivals) and other technologies to provide messages to the priority populations as an alternative to phone calls or emails.

'Play Safe' website

The STI prevention 'Play Safe' website has been redeveloped and managed as a hub for young people in NSW, for:

- HIV and STI information and education.
- undertaking risk assessments for STIs and HIV.
- prevention messages, condom information and access to general practice and publically funded sexual health services.

Coordination and Integration

The Directorate coordinates a range of initiatives that support the active engagement and collaboration of multi-disciplinary clinicians, state wide services managers, staff and key non-government organisations which share the responsibility of STI prevention, treatment and care across the District.

Key committees include:

- **Priority Populations Reference Group** which aims to ensure there is a coordinated approach to addressing the needs of priority populations and improving access to services. It includes representation from across the Directorate and NGOs. It allows for the development of joint programs between STI and HIV services and the

Effective outcomes of the **Priority Populations Reference group** include:

A **Confidentiality Checklist**, developed as a quality assurance tool to enhance client confidentiality of people affected by and/or living with HIV, blood borne infections (BBIs) or STIs who present at health services

Gap Analyses, extensive population-based research that sought to gather data about the needs of particular disadvantaged populations, including:

- CALD communities requiring HIV/AIDS/ STI Services to inform the planning and delivery of STI services across the District
- People who inject drugs who require HIV/AIDS and STI services
- Aboriginal people who are at increased risk of HIV/AIDS and are not accessing HIV/AIDS/STI services across the District
- "At risk "sex workers within the district who are not in contact with sexual health services.

sharing of resources to develop programs targeting populations that are at high risk and difficult to engage.

- **Planning, Performance and Services Development (PPSD) Committee,** which provides strategic direction and project governance and coordinates an LHD wide approach to implement: planning and performance; service development; treatment; care and support; and prevention and health promotion.
- **Clinical Services Committee** which focuses primarily on the key policy, program, service development and evaluation issues in HIV and STI service provision.

We will continue the coordination of programs, services and activities through a robust and effective governance structure that enables health promotion and treatment and care services to deliver effective interventions and health care to our local communities.

Partnerships

Service partnerships have been a productive way of improving the Directorate's reach and impact of programs within SESLHD.

Partnerships with effective communication and planning strategies between government, non-government and community organisations and the affected community are essential to achieve the most effective mix and range of services. Examples of **effective partnerships** include:

- A partnership with the NSW STI Programs Unit to host the NSW General Practice Program
- The STIs in Gay Men Action Group (STIGMA), a collaboration between primary care and community partners, in its work with STI Service Directors, and in engaging non-HIV services in reaching their clients with safe sex and sexual health promotion messages
- The allocation of resources to the youth sector to draw on the expertise of youth organisations and their staff to reach vulnerable young people with resources and programs designed specifically to meet their sexual health needs
- Sexual health clinics providing training and advice to the health sector, including local General Practitioners and practice nurses, Medicare Locals and other government and non-government organisations.
- A partnership between Short St Sexual Health Service, HARP and ACON to explore ways to access at risk MSM in the local area who are non-Gay identifying and not community connected.

We will improve staff training and liaison between services by:

- Supporting General Practice to enhance the provision of STI services by coordinating the SESLHD GP partnership project with Medicare Locals, NSW STI Programs Unit and the Australasian Society of HIV Medicine
- Further developing triage pathways to General Practice
- Exploring funding opportunities for nurse practitioner training and support at sexual health services
- Developing strategies to support youth peer education work targeting gay, lesbian, bisexual and transgender young people.

Timmy Lockwood, a Clinical Nurse Specialist at Sydney Sexual Health Centre, was awarded the best oral presentation by a nurse at the 2013 Australian Sexual Health Conference in Darwin. He presented on the first testing service in Australia to utilise peer educators in testing for HIV and STIs in a community venue. The program commenced in July 2013 and is operating at 90 per cent capacity, with plans to soon extend its locations.

c. Viral Hepatitis Prevention and Improving Access to Care

Viral Hepatitis as a Population Health Focus

Hepatitis means inflammation of the liver. Hepatitis can be idiopathic (have an unknown cause), but some known causes include alcohol, chemicals and drugs (both prescribed and non-prescribed) as well as autoimmune disease. Hepatitis can also be caused by a number of different viruses including hepatitis A, B, C, D, E and G. All have different transmission routes and consequences.

Hepatitis B and C are preventable communicable diseases that have a high burden of morbidity and reduced quality of life. Hepatitis B can lead to acute liver failure and both hepatitis B and C are important risk factors for liver cancer and cirrhosis. Together they account for almost 5% of all cancers.[41]

Hepatitis C Snapshot

- An estimated 224,000 people in Australia live with chronic hepatitis C.
- An estimated 9,700 new hepatitis C infections occur annually.
- Of these new infections:
  - 89% occur through blood-to-blood contact between people sharing equipment used for injecting illicit drugs
  - 7% occur among immigrants (through medical procedures and other transmission routes in their countries of origin)
  - 4% involve other blood-to-blood contact such as unsterile tattooing and body piercing.
- A large number of Australians with hepatitis C are yet to be diagnosed and are unaware of their condition
- The District has the 4th highest rate of hepatitis B in NSW.

Source: Hepatitis C factsheet: Australian snapshot published by Hepatitis NSW Nov 2013.

Specific populations can be targeted in hepatitis B and C interventions. There is a safe, inexpensive vaccination for hepatitis B, which is on the National Immunisation Program Schedule. More than 80% of people living with chronic Hepatitis B were infected at birth or in early childhood, normally because they contracted the disease before hepatitis vaccination was included in the program, or more commonly, because they were born overseas in countries where hepatitis B vaccination is often not universally offered.[42]Many older men having sex with men have been infected with hepatitis B because they became sexually active before vaccination was widely available, and hepatitis B shares many transmission routes with HIV. However, people who contract hepatitis B as adults are at significantly lower risk of remaining chronically infected than those who contract the disease in infancy.

Past or current sharing of injecting equipment accounts for approximately 90% of new Hepatitis C infections (where the risk factor is known).[36] There is currently no vaccine available for hepatitis C. However, research into the development of a vaccine is underway.

In Australia it is estimated that around 13% of people with HIV also have hepatitis C.[43] HIV shares some major routes of transmission with hepatitis C and B. People who inject drugs are at particularly high risk for hepatitis C and HIV co-infection, as are those who engage in certain esoteric sexual practices where blood can be readily exchanged between partners. It is also important to note that, whilst hepatitis C is not generally considered a sexually transmissible infection, in people who are co-infected with HIV, for reasons not yet entirely clear, Hepatitis C becomes easier to transmit sexually.

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[41] Bosch FX, Ribes J, et al. Epidemiology of hepatocellular carcinoma. Clin Liver Dis. 2005 May;9(2):191-211, Review.

[42] The Australian Immunisation Handbook,10th Edition 2013 http://www.health.gov.au/internet/immunise/publishing.nsf/Content/handbook10-4-5

[43] National Needle and Syringe Programs Strategic Framework 2010-2014.Commonwealth of Australia 2010 http://www.health.gov.au/internet/main/publishing.nsf/Content/needle-frame

Impact on our Community

The District has the 3rd highest rate of hepatitis C notifications (reflecting high levels of injecting drug use) and the 4th highest rate of hepatitis B notifications (reflecting a large population from East Asian countries, and men who have sex with men). While hepatitis C notifications are declining generally across the Local Health District, the demand for services continues to be elevated.

Currently the majority of people are treated in tertiary care within models of care that are mostly at full capacity or with waiting lists.

Future demand created by the increasing morbidity and the need to prevent further complications means that building the required infrastructure for shared care arrangements with community based services is required; both to best serve the needs of the client group, and to alleviate the increasing burden on tertiary services.

Liver Disease

Hepatitis C and B have the second and third highest prevalence rate of liver disease in Australia (after non-alcoholic fatty liver disease). In 2012 it is estimated that there were 307,040 people diagnosed with hepatitis C, and 211,089 people with hepatitis B. This is projected to increase to 414,278 and 262,842 people respectively by 2030. About 75 % of those with hepatitis C will develop chronic infection. In 2012, the estimated years of healthy life lost to disability (YLDs) for hepatitis was 145,536; and 2,550 deaths were attributed to Hepatitis C. [44]

Table 2: HCV Notifications by Local Government Area, SESLHD residents, 2009-2012

LGA/Year	2009	2010	2011	2012
Botany Bay	18	19	23	16
Randwick	61	57	42	44
Sydney	211	159	126	105
Waverley	20	15	19	10
Woollahra	23	21	24	12
Hurstville	28	38	17	15
Kogarah	15	14	13	9
Rockdale	25	42	24	19
Sutherland	53	46	40	28
Total	**454**	**411**	**328**	**258**
Annual decrease %		9.5%	20.2%	21.3%

Approaches that work

Prevention

Evidence based and publically funded hepatitis B prevention interventions include:

- The vaccination of infants at birth and 2, 4 and 6 months of age
- The school-based adolescent vaccination program for hepatitis B

NSW Targets:

- Reduce the proportion of people that report injecting equipment by 25%
- Increase the number of people accessing hepatitis C treatment by 100%
- Reduce the proportion of people with chronic hepatitis B whose infection is undiagnosed

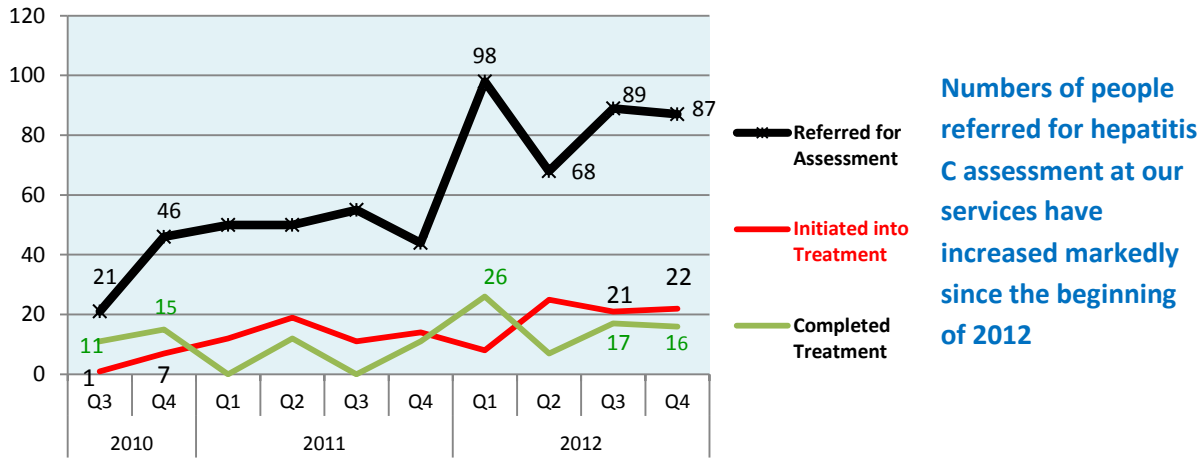
[44]The economic cost and health burden of liver diseases in Australia. The Gastroenterological Society of Australia/Australian Liver Association January 2013 pps ii,iii,6-9, 59-60

- Screening and vaccination of populations at higher risk. In Australia, groups with a higher prevalence of chronic hepatitis B infection include people who inject drugs, men who have sex with men, Aboriginal people, correctional facility inmates and immigrants from endemic regions[45]
- Needle and syringe distribution through a range of modalities and in varied settings to reach key populations[46]
- Monitoring, treatment and long term support for people living with chronic hepatitis B.

Evidence based hepatitis C prevention interventions include:

- Needle and syringe distribution through a range of modalities and in varied settings to reach key populations
- Models of care that result in increased treatment capacity for priority populations
- Expanded shared care arrangements with specialists, GPs and nursing support.

Figure 20: Hepatitis C assessment and treatment by publicly-funded services, July 2010-December 2012 (Persons)



Numbers of people referred for hepatitis C assessment at our services have increased markedly since the beginning of 2012

Source:SESLHD HARP Unit - HCV Ambulatory Care minimum dataset

Treatment and Care

The Directorate's target priority populations include people with hepatitis B and C; people who inject drugs; Aboriginal people; young injectors and new injectors; and people in custodial settings.
Evidence based interventions for hepatitis B and C include:

- Assessment of disease status to identify patients with progressive disease. Earlier diagnosis of chronic infection assists in halting development of more advanced illness
- Regular monitoring, care and support for people living with chronic disease
- Longer term chronic illness management including expanded shared care arrangements with primary care clinicians, nursing support and relevant specialists, including infectious diseases specialists.

[45] Hepatitis B vaccines for Australians | NCIRS Fact sheet: June 2012
[46] Dolan, K. MacDonald, M., Silins, E. & Topp, L. 2005. *Needle and syringe programs: A review of the evidence.* Canberra: Australian Government Department of Health and Ageing.

Priority Actions for preventing the transmission of Viral Hepatitis and improving treatment uptake

- Improve **access** to **marginalised populations** (Aboriginal people, sex workers, CALD, people who have recently been in custodial settings, young people who are new injectors or at risk of injecting, unvaccinated adults at risk of hepatitis B and injecting drug users) to **information and services** provided by HIV and Related Programs (HARP)
- Improve access to **Hepatitis B and C prevention, screening and treatment** and care among priority populations
- Improve **access** to sterile **injecting equipment** for people at risk of blood borne viruses
- Identify and implement initiatives to enhance access to services, support the **continuum of care**, and support **integration** between emergency, critical care and other hospital and community based services
- Develop new and innovative **models of care** provision for people living with viral hepatitis, including through nurse-led and primary care models.
- Identify opportunities for development of **Centres of Excellence** for viral hepatitis
- Contribute to the evidence base for effective population health practice through **research** and publication of results
- Strengthen **partnerships** with General Practitioners, Non-Government and other organisations to implement and evaluate health promotion activities and to support people to effectively manage their condition
- Enhance hepatitis C surveillance.

Programs and Activities to be delivered by the Directorate from 2014-19

HIV and hepatitis B and C infections continue to present unique challenges, including the stigma and discrimination associated with these diseases, the sensitive and contentious nature of prevention initiatives such as the Needle & Syringe Program and the imperative to develop new models of care that include a stronger role for general practice and a more focused role for public specialist services provided within the District.

Needle and Syringe Program

Needle and Syringe Programs are a public health measure to reduce the spread of blood borne viral infections such as HIV and hepatitis B and hepatitis C among injecting drug users. Building an effective Needle and Syringe Program in collaboration with relevant partners is a key priority for the District. The distribution of syringes is continually increasing across the South Eastern Local Health District which currently has eight automatic dispensing machines and three primary outlets. The District also manages a number of secondary outlets. Almost 240,000 syringes are now distributed across the District each quarter.

At a Glance

South Eastern Sydney Local Health District Needle and Syringe Programs:

- ✓ 3 primary Needle and Syringe Programs
- ✓ 13 secondary Needle and Syringe Programs
- ✓ 9 automatic dispensing machines
- ✓ 58 pharmacy Needle and Syringe Programs
- ✓ Around 960,000 syringes are distributed across the District each year
- ✓ 20% of syringes distributed annually are through Automatic Dispensing Machines

Injecting drug use is the primary mode of transmission for hepatitis C. It is estimated that between 2000 and 2009 across Australia, Needle and Syringe Programs (NSP) directly averted 32,050 new HIV infections and

96,667 new hepatitis C infections, with healthcare costs saved of around $1.28 billion.[47] Over the last decade it has been estimated that for every one dollar invested in NSPs, $27 dollars have been returned.

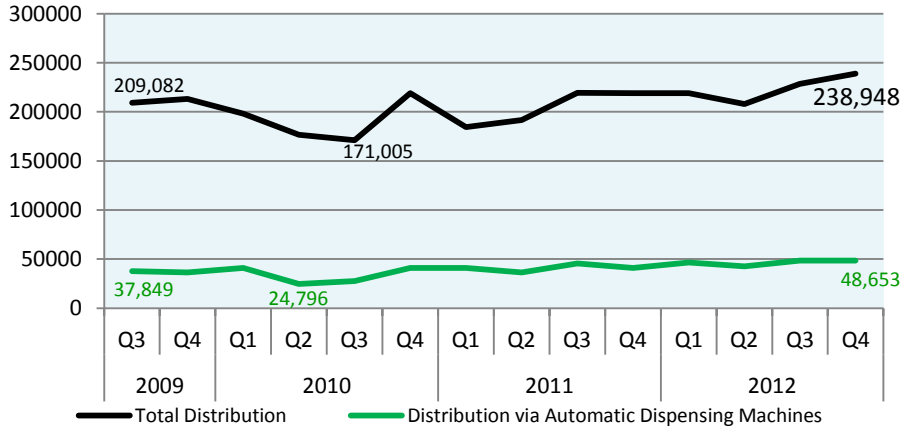
The Directorate is responsible for the program co-ordination and strategic support of Needle and Syringe Programs delivered by a range of services across the SESLHD and Illawarra Shoalhaven Local Health District. Distributing sufficient injecting equipment to prevent hepatitis C will require an escalation of existing efforts and flexible, innovative approaches to service provision that further strengthen the program. The key principles that underpin the strategic priorities for the Districts' Needle and Syringe Programs are:

- diversifying the range of mechanisms through which equipment is dispensed
- increasing the number and types of sites from which equipment is dispensed
- developing planning and support systems that make NSPs more effective.

Innovative service improvements over the past 2 years have included:

- A dedicated hepatitis C prevention senior project officer to coordinate NSP service development programs
- Provision of 24 hour automatic dispensing machines in all public hospitals
- New secondary outlets, with a particular focus on diversification of the number and type of outlets
- Development and integration of evidenced based hepatitis C prevention programs across existing NSP services (primary and secondary outlets)
- Strengthening the relationship and support between publically funded NSP services and the pharmacy sector
- Broadening the scope of health promotion and primary health care interventions available through primary NSP sites
- Strategic partnership development through the co-location of services, development of innovative outreach models and relationship building between the NSP sector and the broader health and non-government sector
- Continuing applications for additional NSP services, e.g. St Vincent's Hospital and Bobby Goldsmith Foundation.

Figure 21: Syringes distributed by SESLHD HIV and Related Programs (HARP), 1 July 2009- 31 December 2012



Distribution of syringes by SESLHD services is continually increasing

About 240,000 syringes are now being distributed across the District each quarter

Source: HARP Unit NSP database

[47] Wilson, D. (2009). *Return on investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia.* Available from: http://www.kirby.unsw.edu.au/sites/default/files/hiv/attachment/RO-2ReportLQ.pdf

We will continue to support, coordinate, and identify opportunities to expand an effective Needle and Syringe Program, with the aim of increasing volume of equipment via public and pharmacy programs by >= 8.8% p.a. (40% over 4 years). Activities to achieve this include:

- Commissioning the design of methodologies to estimate the size and location of people who inject drugs across the District to assist in framing an appropriate Needle and syringe Program response
- Providing needle and syringe programs in all of our public hospitals and community health facilities to enhance distribution by 40% (in line with NSW strategies)
- Diversifying the range of sites and models via which needle and syringe equipment is provided (e.g. Aboriginal Community Controlled Health Services, youth and community health services and others)
- Reviewing service models in established primary and secondary needle and syringe outlets to identify opportunities for increased distribution
- Piloting innovative models for expanding access, including through extended distribution and community pharmacies.

We will commission a viral hepatitis health impact assessment to assist in framing an appropriate District service response.

We will map services involved in hepatitis C prevention/health promotion.

We will increase access to information regarding hepatitis C among priority populations including identifying strategies to engage intravenous drug user peer networks.

We will develop models for supporting viral hepatitis prevention capacity within youth sector partners.

We will continue to support the state wide rollout of "Going Viral" (3-part project for youth workers aimed at preventing new hepatitis C infections among young people).

We will develop additional health promotion programs for viral hepatitis in priority populations such as gay men, MSM, Aboriginal people, people who inject drugs and culturally and linguistically diverse populations:

- Support localised responses to hepatitis C prevention within Aboriginal communities including Aboriginal cultural awareness training to LHD-based NSP services
- Increase awareness of hepatitis C among Aboriginal people through targeted information/education and participation in Aboriginal community events.

We will increase access to treatment programs and services for people who inject drugs who are most marginalized and of greatest public health priority, including those who are:

- Aboriginal
- Street based
- HIV positive and have complex needs
- Young injectors who do not yet have a blood borne virus, and/ or who do not access the public system
- People from culturally and linguistically diverse communities
- Support treatment uptake and adherence in priority populations, including via:
- Pilot a program providing peer support for treatment decisions in one or more hepatitis C treatment services to increase the number of people with hepatitis C in treatment.
- Manage and evaluate the Aboriginal hepatitis C Treatment Access project
- Further build the capacity of high caseload General Practitioners, other primary care providers and other private physicians to assess and treat people with viral hepatitis
- Pilot the provision of nurse-led clinics in selected Aboriginal Community Controlled Organisations
- Expand access to hepatitis C treatment via GPs, alcohol and other drug services and other services.

We will increase the capacity of GPs and health care workers to address hepatitis C via targeted training and information, and awareness raising to reduce stigma and discrimination related to hepatitis C.

Viral Hepatitis Health Promotion programs and activities

The Directorate coordinates and delivers Health promotion programs and activities, such as social marketing campaigns, education programmes and capacity building initiatives focussing on youth, Aboriginal, culturally and linguistically diverse and other target population groups impacted by viral hepatitis. These activities increase the capacity of local viral hepatitis prevention services to reduce viral hepatitis transmission among vulnerable communities.

The Directorate brings together representatives from across a diverse range of local services, including NGOs, research bodies, NSW Ministry of Health, multicultural, Aboriginal and youth health. A key focus of the group is generating targeted projects and identifying areas of potential collaboration between its members. The sharing of knowledge and the practice skills of the varied membership has allowed the development of a wide range of innovative health promotion and prevention activities.

Achievements include:

- **Going Viral** - a capacity building program for youth workers aimed at preventing new hepatitis C infections among young people. Over the course of three months, youth workers participating in the initiative have access to a one-day intensive hepatitis workshop, site visits to experience local hepatitis C prevention services first-hand and support with planning a hepatitis prevention project with up to $750 funding. This program is now being taken up by other LHDs to support a statewide roll out
- Development of an Aboriginal Community Engagement Plan for harm minimisation services
- Culturally and Linguistically Diverse training and action planning for all NSP services
- Youth audits in NSP and Drug and Alcohol services
- Workforce development activities, including cross agency workplace visits and joint projects
- During the annual Hepatitis Awareness Week, South Eastern Sydney Local Health District partners with Hepatitis NSW to raise awareness of hepatitis through numerous events to showcase the range of initiatives which target young people who may be at risk of viral hepatitis
- Joint planning with mental health services to implement an integrated package of care for the Bondi Junction youth mental health program, to incorporate prevention, screening and management of HIV, viral hepatitis and STIs
- Development of the "Youth at Risk" training package, for youth services working with young people at risk of transitioning or recently transitioned to injecting drugs.

Gary Gahan, Harm Minimisation and Hepatitis C Program Manager from the HARP Unit, won the inaugural Hepatitis NSW Cheryl Burman Award. Gary received this award for showing exceptional leadership in his work, which is at the cutting edge of viral hepatitis health promotion

We will develop, implement and evaluate the Hepatitis C Health Promotion Action Plan, and explore the level of response needed to address the upcoming NSW hepatitis B Strategy within the District.

Aboriginal Hepatitis C Treatment Access Project

This project was originally a component of a statewide initiative funded by the NSW Department of Health under the National Partnership Agreement - Indigenous Health, hepatitis C Project. The statewide program comprised:

- Recruitment of a network of treatment access coordinators
- Development of a hepatitis C training program aimed at Aboriginal Health Workers and delivered through the Aboriginal Health College
- Development of a hepatitis C training program aimed at medical, nursing and allied health and delivered through ASHM
- The Aboriginal Health and Medical Research Council (AH&MRC) was commissioned to implement a state-wide Hep C Campaign in partnership with the Deadlys Award winning band 'The Last Kinection'.

> ***"It is estimated that between 13, 000 and 22, 000 Aboriginal and Torres Strait Islander peoples are living with hepatitis C in Australia, representing 4% of all Indigenous Australians, compared with 1% of non-indigenous Australians."*** Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy: 2010-2013.

The South Eastern Sydney Illawarra Health Aboriginal Treatment Access Program commenced in October 2010 with the primary role identified as increasing the number of Aboriginal people accessing culturally appropriate hepatitis C treatment services. Important outcomes of the project to date include:

- Culturally sensitive community awareness training through a series of community focused arts and music creative projects
- Two residential retreats were hosted for Aboriginal people who were considering hepatitis C treatment
- HCV capacity building activities across a range of Aboriginal community controlled health organisations.

The HepCheck 123 Project

People subject to homelessness demonstrate inequities in health status and poor access to health services, with high rates of hepatitis C, alcohol dependence, injecting drug use and outbreaks of Hepatitis A. The strategic priorities for homeless health include the need to develop partnerships between health and homelessness services; building an evidence base; the creation of care pathways for clients; and a commitment to developing intersectoral care planning approaches.

While there are a large number of existing health, community based and local government services working across this geographical area, there is a lack of coordination in relation to viral hepatitis screening, assessment, vaccination, management and care for at risk individuals. In line with current NSW Health strategies, opportunities exist for enhancing current service provision within established services and for the development of innovative responses to address the viral hepatitis needs of this vulnerable population.
In response, the Directorate has formed an Inner City Homeless and Hepatitis Planning Group to develop the *Hep Check 123* project, a partnership between health and homeless services to develop an integrated

approach to health promotion, client education, screening and assessment tools, referral pathways and workforce development.

Key focus areas will include the development of a client education and health promotion program; development of standardised viral hepatitis screening and assessment tools; mapping and promoting of referral pathways; workforce development; and supporting effective vaccination programs in sexual health service settings.

As part of this initiative, a visit was made to Matthew Talbot Hostel to provide Hepatitis B vaccine to the non-immune men residing in the hostel. The hostel is now registered to order free hepatitis B vaccine from the NSW State Vaccine Centre. Within the centre two accredited nurse immunisers can opportunistically initiate vaccination of the men. Along with other programmes this initiative will help reduce liver disease in the homeless population in the inner city.

Community Sharps Management

The Directorate is responsible for the program management of the community sharps disposal program in SESLHD and administers the NSW Community Sharps Management Program (CSMP). This is a state-wide program aimed at advocating for, and promoting, a coordinated response to community sharps management. The project applies a partnership approach and supports councils and other stakeholders to implement best practice community sharps management policies and practices across NSW.

The NSW Community Sharps Management Program is a state wide program aimed at advocating for and promoting a coordinated response to community sharps management. The Program supports key stakeholders to implement best practice community sharps management policies and practices.

The Program manages a dedicated website (http://www.communitysharps.org.au), a grants program and offers policy and practice guidance for health and local government agencies.

Community sharps are sharps that have been generated by non-clinical activities such as insulin pen needles, syringes and lancets used by people in the self-management of diabetes and other medical conditions, syringes used by people who inject drugs, and injecting equipment used by owners to treat pets and livestock. Under NSW environment legislation, community sharps generated at residential premises or in public places are defined as solid waste and are generally the responsibility of local councils.

Hepatitis B and C Treatment and Care

Facilities across the District deliver treatment and care for patients who have viral hepatitis.
The Directorate delivers education, screening and routine monitoring for people who are co-infected with HIV and viral hepatitis, because the disease progresses more rapidly in patients who are co-infected.

Coordination and Integration

Key activities of the Directorate include coordinating, developing and supporting a wide range of prevention and health promotion initiatives being undertaken by the Directorate and District's services to reduce the transmission of hepatitis B and C. Cordination of activities and services ensures the optimum use of resources and enables an immediate response to occur to reach populations at risk. Coordination also supports the

overall capacity of services and programs and encourages collaboration and the sharing of information and resources.

The Directorate also has a secretariat role to the **Hepatitis C Clinical Advisory and Liaison Committee** which provides an opportunity for the Directorate and facilities delivering treatment and care, within the District and St Vincent's Hospital and hospitals located in the Illawarra Shoalhaven Local Health District.

Coordination of hepatitis C health promotion and prevention activities occurs through the District wide **Hepatitis C Health Promotion and Prevention Advisory Group** and **Informatics Steering Committee.** These committees ensure implementation and alignment with relevant state policies and strategies occurs and that local population needs are identified and addressed. The Informatics Steering Committee provides advice and recommends improvements to informatics related projects, processes and activities to ensure continuous improvement in data collection quality and better use of data in business decisions occurs. The Committee also provides custom built systems data and technical information related to the development of projects, processes and policies and works closely with services to ensure integrity of data and to be ready for the introduction of Activity Based Funding.

Working in partnership with clinicians and other partners, the Directorate **will continue to refine and enhance** the **Hepatitis Minimum Data Set** (MDS). The MDS is designed to continually improve the collection and reporting of viral hepatitis activity across Ambulatory Care, outpatient and Community Health Services.

Partnerships

Partnering with other agencies and service providers provides the opportunity for the Directorate to build healthier communities through focusing efforts on coordinated and targeted primary prevention and early detection strategies. Partners include:

- Medicare Locals , General practitioners, practice nurses and allied health practitioners
- Local Government and other government agencies
- NGOs and community based organisations such as Hepatitis NSW
- Consumers and carers

Hepatitis C advocates receive media training

C me Community Advocates are people with lived experience of hepatitis C who are trained to advocate on behalf of themselves and other members of the community affected by hepatitis C. In February 2013, **c me** community advocates from across NSW received coaching from experienced journalists on how to deliver their hepatitis c advocacy message effectively and with confidence.

Dealing with media is a vital but sometimes frightening part of advocacy, but after training the advocates felt more confident to appear in the media. Advocates practiced being interviewed for radio and TV and received individual feedback on their performance in a safe and supportive environment. They learnt how to use their personal experience as an advocacy tool to advocate for things such as access to new drugs, and break down barriers such as stigma and discrimination against people living with hepatitis C.

5.1.3 Communicable Disease Surveillance

Communicable Disease Surveillance as a Population Health Focus

Communicable diseases are a significant public health priority in Australia. These diseases arise from a variety of sources such as food borne diseases; the emergence of antimicrobial resistant bacteria; blood borne and sexually transmitted diseases; vector borne diseases; and vaccine preventable diseases. (The control of sexually transmissible, blood borne and vaccine preventable diseases have been discussed in detail in previous sections).

Population health activities aim to reduce the incidence and impact of communicable disease. This requires close collaboration with other agencies such as the Australian Quarantine Inspection Service, the Department of Agriculture, Fisheries and Forestries - Australia and the Food Standards Australia New Zealand.

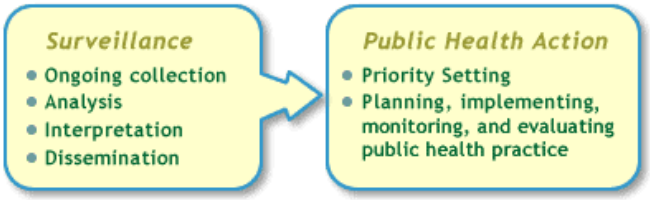
Surveillance is fundamental to the prevention and control of communicable diseases. The Office of Health Protection (OHP) is the Commonwealth's primary data collection and coordination centre for many communicable diseases. The OHP also coordinates and contracts other agencies to collect data and/or conduct research on communicable diseases. Two such centres are the Kirby Institute for infection and immunity in society and the National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases (NCIRS).

Impact on our Community

Communicable disease prevention, control and management are an important focus of the Directorate. In recent years, new cases of vaccine preventable communicable diseases acquired in Australia such as measles and meningococcal have been rare among our residents, however sexually transmitted infections are increasing in South Eastern Sydney. Cases of gonorrhoea have increased by 65%, from 832 in 2010 to 1374 in 2012 and Chlamydia rates are the highest in NSW. The District has the 3rd highest rate of Hepatitis C infections (reflecting high levels of injecting drug use) and the 4th highest rate of Hepatitis B infections.

Approaches that Work

- Routine surveillance to monitor the occurrence of disease outbreaks and inform acute response and management strategies.
- Primary and secondary health promotion activities to prevent the spread of disease and encourage early detection and treatment



Priority Actions to Monitor and Respond to Communicable Disease

- Further develop and **embed** prevention, early detection and intervention initiatives across the **continuum of prevention and care** within clinical (inpatient, ambulatory, primary care) and non-clinical settings.
- Further develop **disaster/emergency** management planning, preparation and response arrangements and capacity within the SESLHD
- Collaborate with the Environmental Protection Authority, local government and others on **health protection** issues of local and regional importance, including reduction of community exposures to **environmental hazards, communicable disease outbreaks** and other relevant issues.

Programs and Activities to be delivered by the Directorate from 2014-19

- **We will strengthen** surveillance systems through enhanced data collection, analysis and reporting and more efficient notification of disease
- **We will ensure** timely follow up of outbreaks of communicable disease
- **We will improve** identification of indigenous status in notifications and ensure culturally appropriate responses
- **We will support** the implementation of the public health recommendations from the pandemic influenza evaluation for population health
- **We will improve** the participation of district GPs in the Electronic General Practice Surveillance (eGPS) for influenza
- **We will enhance** preparedness and operational capacity to respond to new and emerging diseases and public health emergencies, including assisting in rapid response to outbreaks in the community to prevent population exposure
- **We will strengthen** public health action to control notifiable diseases according to impact and in line with national and state protocols
- **We will work** in partnership with local government to ensure collaborative and effective polices and operating procedures are in place for public health priorities
- **We will maintain** Cruise ship surveillance
- **We will continue** the Enhanced Surveillance of Gonorrhoea Program with support of local GPs
- **We will provide** timely recommendations to the community about prevention of disease, i.e. health alerts
- **We will monitor** cases of tuberculosis and provide expert advice to services where required.

Programs and Activities to be delivered by the Directorate from 2014-19

Infectious Disease Responses

The Directorate carries out a wide range of activities related to the surveillance, investigation and control of infectious diseases. The incidence of diseases which are notifiable under the Public Health Act 1991 are monitored, and suspected cases and outbreaks are followed up, such as suspected food borne disease; gastrointestinal outbreaks in institutions; and cases of measles. These reports allow staff to work with health care providers to ensure appropriate public health measures are taken to prevent further spread of disease, to identify a disease source and provide information to doctors, childcare centres, schools and members of the community on public health aspects of infectious diseases, guidelines for exclusion from childcare, school or work and prophylactic measures when necessary.
We will continue to carry out activities related to the surveillance, investigation and control of infectious diseases.

Reporting

The Directorate provides up-to-date summaries of public health surveillance data on the residents within South Eastern Sydney to individuals, families, GPs and other medical practitioners. These include reports on:

- Numbers of locally acquired cases of notifiable diseases

- High quality surveillance data for vaccine preventable disease control
- Influenza Update
- Sexually transmissible infections
- Laboratory surveillance reports for Campylobacter, RSV and Rotavirus
- Cruise Ship Surveillance Program
- Arbovirus surveillance

Monthly Surveillance Report

This monthly report summarises the numbers of notifiable conditions in residents living within South Eastern Sydney Local Health District. These include Chlamydia, Cryptosporidiosis, Influenza, Giardiasis, Hepatitis A,B,C and E, Pneumococcal Disease (Invasive), Legionellosis, LGV, Listeriosis, Mumps, Pertussis, Ross River, Rotavirus, Salmonellosis, Shigellosis, Syphyllis – infectious, Tuberculosis and Typhoid. Some rare notifiable conditions are not reported here.

Figure 22: South Eastern Sydney Public Health Unit NCIMS Notifiable Diseases Report Jan – Sep 2013

Onset Year 2013

	Onset Month									Total (ALL)
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	N
Chlamydia	260	275	233	246	307	223	286	274	230	2334
Cryptosporidiosis	20	31	27	29	15	<3	4	6	<3	134
Influenza	26	21	30	28	31	35	166	545	334	1216
Giardiasis	21	52	37	46	42	20	32	33	33	316
Gonorrhoea	124	103	106	116	95	117	134	116	99	1010
Hepatitis A	<3	<3	.	.	<3	<3	.	.	.	7
Hepatitis B - Unspecified	38	17	26	22	33	24	33	48	31	272
Hepatitis B - Newly Acquired	.	<3	.	.	<3	.	.	.	.	3
Hepatitis C - Unspecified	20	25	20	19	28	24	25	30	29	220
Hepatitis C - Newly Acquired	.	<3	.	<3	<3	.	.	.	.	4
Hepatitis E	<3	.	.	<3	.	<3	.	.	.	<6
Pneumococcal Disease (Invasive)	<3	<3	.	3	7	7	6	8	4	38
Legionellosis	.	.	.	<3	.	.	.	.	.	<3
LGV	.	<3	<3	<3	<3	<3	<3	<3	.	10
Listeriosis	<3	.	.	.	.	<3	.	<3	.	4
Measles	.	.	.	.	.	.	.	.	<3	<3
Meningococcal Disease	.	.	.	.	.	.	<3	<3	.	<6
Mumps	.	.	4	.	<3	.	.	.	.	<7
Pertussis	32	21	28	31	11	4	13	19	19	178
Ross River	<3	<3	<3	<3	.	.	.	.	.	5
Rotavirus	3	4	<3	5	<3	7	8	11	12	54
Salmonellosis	74	35	39	43	32	28	20	25	26	322
Shigellosis	.	3	3	3	<3	<3	3	3	<3	20
Syphilis - Infectious	17	25	26	13	21	11	14	12	4	143
Tuberculosis	6	<3	6	<3	4	<3	3	3	<3	27
Typhoid	.	.	<3	<3	<3	.	.	.	.	5

Seasonal Influenza Surveillance

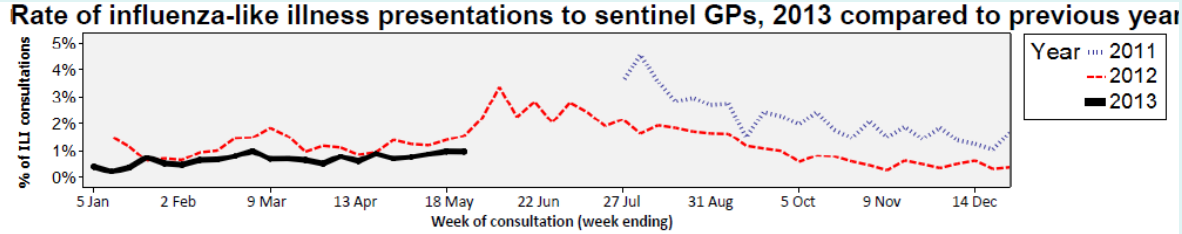
The Directorate supplies a report that provides an analysis of the numbers and types of influenza virus that are circulating within the South Eastern Sydney Local Health District, based on laboratory confirmed cases of influenza virus and the number of people presenting to the emergency department with influenza-like-illnesses. It also compares this data with the rest of NSW and Australia to provide a summary of the implications for the area.

Electronic General Practice Surveillance (eGPS) for influenza

The Directorate extracts and collates data using a standardised program from the clinical management software of participating district GP practices, and issues weekly reports from the start of the “influenza season”.

Figure 23: Seasonal Influenza Surveillance

This report provides an analysis of the numbers and types of influenza virus that are circulating within the South Eastern Sydney Local Health District, based on laboratory confirmed cases of influenza virus and the number of people presenting to the emergency department with influenza-like-illnesses. It also compares this data with the rest of NSW and Australia to provide a summary of the implications for the area, with a weekly report issued in the influenza "season".



Note: This data is collected from practices participating in the SESLHD electronic GP surveillance program, located in the eastern and southern suburbs of Sydney. It may not be representational of the whole area.

Issuing Health Alerts

Public health issues may arise which have either a current actual impact on the community or the potential for impact on the community. Public health alerts issued by the Directorate most commonly involve communicable or other infectious diseases, or may involve environmental health threats. These alerts are written to both inform members of the public and to assist General Practitioners and other healthcare workers based in the community or in hospitals. Recent examples include: warning local residents of the trapping of very high counts of mosquitoes, identified as *Aedes vigilax*, which have the potential to spread Ross River virus and Barmah Forest virus infection, at the Georges River sites of Alfords Point and Illawong; Radiance of the Seas cruise ship alert for potential spread of Hepatitis A in February 2013; and information nights for Sutherland Council residents to provide expert information regarding the Kareela flying fox population.

Cruise Ship Surveillance

The Directorate conducts two programs for cruise ships visiting the Port of Sydney: the **Cruise Ship Health Surveillance Program** and the **Vessel Inspection Program**. The programs are designed to:

- Provide public health response to outbreaks and advice on preventative measures and health related issues
- Conduct environmental health inspections of cruise ships
- Collect data on the incidence of infectious diseases on board cruise ships arriving in Sydney ports. Under Australian quarantine laws, ships are required to report gastroenteritis outbreaks to AQIS/DAFF Biosecurity before entering each port. For ships entering the Port of Sydney, this information is also provided to the Public Health Unit of South Eastern Sydney Local Health District and reports are posted on their website.

Enhanced Surveillance of Gonorrhoea Pilot Program

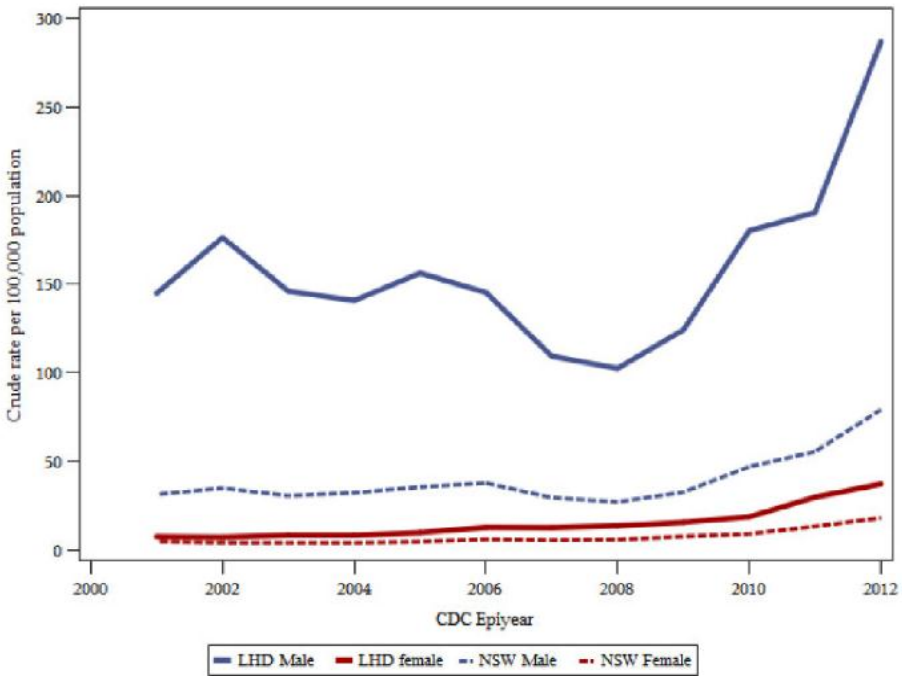
In response to a rapid increase in notification of cases of gonorrhoea in South Eastern Sydney and as routine notification data from laboratories has limited information, the Directorate commenced short term enhanced surveillance of gonorrhoea cases with specimen collection dates in January and February 2013. A letter and short questionnaire were sent to the requesting doctor seeking additional information including indigenous status, sexual exposure and likely source of infection, onset date of symptoms and initiation of treatment. The

data collected was entered on to the NSW Notifiable Diseases Information Management System (NCIMS) and analysed.

These are the first data which directly report men having sex with men (MSM) status among gonorrhoea cases at a population level in Sydney. For men, the infection is occurring mainly in MSM population, and for women, the infection is occurring in sex workers and those with casual sex partners. Enhanced surveillance enabled the report the Aboriginal status of people notified with gonorrhoea and to describe risk factors for infection. The data reflects notifications over a seven week period and thus may not reflect the situation if collected over a longer time frame.

It is essential that the data collection continue over a longer time frame and at a state-wide level to accurately inform public health and health promotion activities that aim to interrupt the transmission of gonorrhoea or promote its early detection and treatment. Ongoing support has been sought from local GPs in the collection of important information on cases of gonorrhoea infection.

Figure 24: Annual Gonorrhoea Rates by Sex, NSW and SESLHD, 2001 – 2012



Research

An important aspect of the work of the Directorate is ongoing research in infectious disease related areas. Research projects include: enhanced surveillance to determine the incidence of and risk factors for new cases of hepatitis C; ongoing investigation of cases of salmonella; seasonal influenza surveillance; investigation of gastroenteritis in child-care centres, development of improved guidelines for the public health management of meningococcal infection; costs to the community of hepatitis A; follow up of cases of antenatal syphilis to exclude congenital syphilis; assessing the accuracy of the ACIR Register data; and the follow up of provision of influenza vaccine to the homeless. The Unit often collaborates with other agencies in research aimed at improving our knowledge of how relevant diseases can be prevented, and how preventative services can be best delivered.

We will continue to participate in ongoing research initiatives.

Partnerships

We will continue to work closely with general practitioners, community nurses and hospital-based clinicians, pathology laboratories, schools and childcare centres, with local councils and with other government agencies to protect the public health.

Food poisoning outbreaks **will continue** to be investigated jointly by the Public Health Unit and the NSW Food Authority.

Coordination

We will continue to protect, detect, investigate and coordinate a response to new and re-emerging communicable disease threats in South Eastern Sydney and facilitate best practice in their control, by providing professional, high quality public health services, education, research, information and interventions.

The Directorate supports the NSW Health Protection Agency, including the implementation of public health recommendations from the pandemic influenza evaluation for population health; acts in an advisory role on public health issues in the community; and responds to complaints from the public concerning significant risks to public health**.**

Photo: The Public Health Unit team

5.2 Promoting healthy weight

Healthy Weight as a Population Health Focus

NSW Target:

- Reduce overweight and obesity rates of children and young people (5–16 years) to 21% by 2015
- Stabilise overweight and obesity rates in adults by 2015, and then reduce by 5% by 2020

Source: NSW 2021 A Plan to Make NSW Number 1

The prevalence of overweight and obesity in Australia is high and continues to increase, affecting more than 60% of adults and nearly 25% of children and adolescents, which is double what it was 20 years ago. Higher rates are reported in the most disadvantaged socioeconomic groups, Aboriginal people and many people born overseas. Socioeconomic inequalities in obesity are widening throughout developed countries. [48,49]

Increasing early childhood obesity is a particular concern, because it increases the risk of poor health both during childhood, adolescence and later in life. Studies show that obese children are more likely to stay obese into adulthood and have an increased risk of health problems into the future. A recent Australian study showed that young adults (aged 25-34 years) had the greatest increases in weight and waist circumference of all age groups.[50]

Being overweight or obese is strongly associated with a high risk of morbidity and mortality, and several chronic diseases including type 2 diabetes, cardiovascular disease, some cancers, and mental health problems such as depression.[51] Many interconnected factors have been identified that contribute to weight gain over the lifespan of an individual – from genetic background to early nutrition, education and exposure to environments considered to be 'obesogenic' – environments that encourage over consumption of food and make it easier to be sedentary rather than physically active.

At the population level, evidence is mounting of increased food consumption, particularly of energy-dense/nutrient poor foods, and a shift to more sedentary work and leisure activities.

Health problems related to excess weight impose substantial economic burdens on individuals, families and communities. Data from the Australian Diabetes, Obesity and Lifestyle (AusDiab) study indicate that the total direct cost for overweight and obesity in 2005 was $21 billion ($6.5 billion for overweight and $14.5 billion for obesity).[52] The same study estimated indirect costs of $35.6 billion per year, resulting in an overall total annual cost of $56.6 billion. The impacts of overweight and obesity on the health of our population and on our health system will be felt for many years to come.

Impact on our Community

In recent years, the prevalence of overweight and obesity among SESLHD residents has increased markedly.[53] Since 1997, the proportion of overweight or obese residents aged 16 years and over has increased by about a third, from 35% to 46%. While this is lower than national and state levels, it is still significant that nearly half of our residents are above a healthy weight.

[48] NHMRC, Obesity Guidelines 2013, http://www.nhmrc.gov.au/guidelines/publications/n57
[49] National Preventative Health Taskforce, Australia: the healthiest country by 2020. Technical Report No 1 Obesity in Australia: a need for urgent action,2009
[50] AUSDIAB The Australian Diabetes, Obesity and Lifestyle Study 2012
[51] NHMRC, Obesity Guidelines 2013, http://www.nhmrc.gov.au/guidelines/publications/n57
[52] Colagiuri S et al, The cost of overweight and obesity in Australia Med J Aust 2010; 192 (5): 260-264.
[53] SESLHD Directorate of Planning and Population Health, Population Health Report Card. Baseline report March 2013

Obesity related chronic disease risk factors are also prevalent among SESLHD residents. For example, in 2011, of SESLHD residents aged 16 years and over:

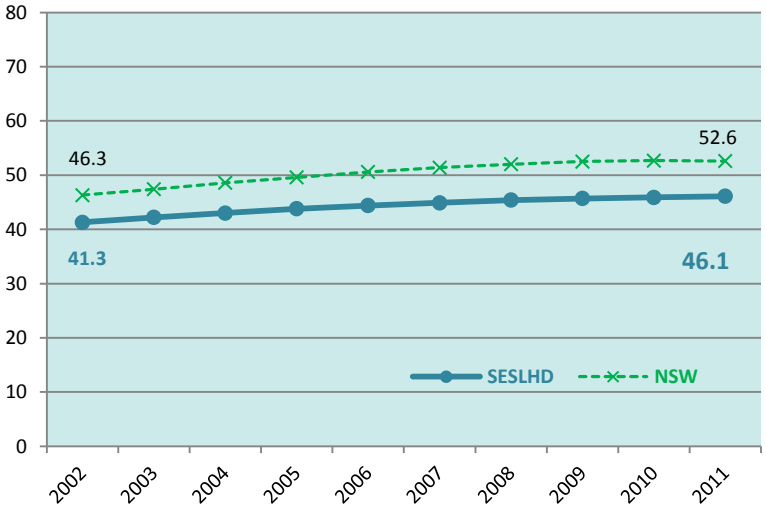
- 40% were not sufficiently active
- 42% had inadequate fruit intake
- Over 90% had inadequate vegetable intake

These patterns for SESLHD residents are similar to NSW trends with vegetable consumption being slightly lower in SESLHD residents than the NSW average. Furthermore we know that people are also likely to underestimate physical activity levels.[54]

In 2010/2011, 3800 hospital admissions of SESLHD residents were attributable to overweight/ obesity. Residents of Sutherland and Botany Bay LGAs are at higher risk than NSW residents (about 5% higher) of being hospitalised due to a high body mass index (BMI). Increasing hospitalisations for diabetes and kidney disease in SESLHD may also be related to the high levels of overweight and obesity.

See: http://www.healthykids.nsw.gov.au

Figure 25: Prevalence of overweight and obesity, % of residents aged 16 years and over, SESLHD and NSW



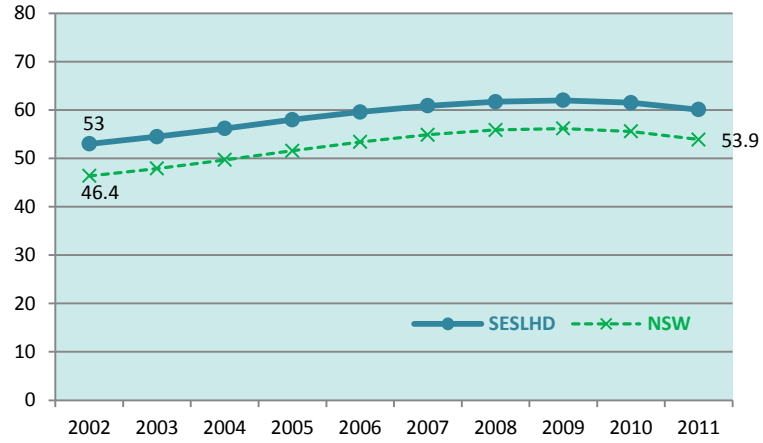
Source: NSW Population Health Survey, NSW Ministry of Health, accessed via Health Statistics NSW. Note: Overweight or obesity is defined here as Body Mass Index of at least 25kg/m^2 Weight/(Height)2).

Nearly half of our residents are overweight or obese.

Over the last decade the prevalence of overweight/ obesity among our residents has increased by about 5%.

[54] AUSDIAB The Australian Diabetes, Obesity and Lifestyle Study 2012

Figure 26: Prevalence of adequate physical activity, % of residents aged 16 years and over, SESLHD and NSW



Source: NSW Population Health Survey, NSW Ministry of Health, accessed from Health Statistics NSW. Note: Adequate physical activity is defined as at least 150 minutes per week over 5 separate occasions

Only six out of 10 of our residents do adequate physical activity.

While specific information is not available for SESLHD children, data from the 2010 NSW Schools Physical Activity Nutrition Survey (SPANS) indicated several areas of concern[55]:

- higher levels of overweight and obesity in children from lower socioeconomic backgrounds
- higher levels of obesity risk factors in children of Asian and Middle Eastern backgrounds
- 50% of primary school children exceeded the recommended 2 hours/day small screen recreation(SSR)
- 28% of primary school children were unfit, increasing to 33% of high school children.

An estimated 15,000 SESLHD children aged 7-13 years are overweight/obese (based on prevalence of 8% in this population in NSW).

Type 2 Diabetes

The most common modifiable risk factors for type 2 diabetes are obesity, lack of physical activity and poor diet.

An estimated 40,000 South Eastern Sydney Local Health District residents have diabetes. Of the 33,600 SESLHD residents diagnosed and registered with the National Diabetes Services Scheme, over 80% have type 2 diabetes.

Diabetes is a major health concern because of the seriousness of its complications.

Undiagnosed or poorly managed diabetes can affect almost every system in the body, leading to a range of renal, cardiovascular, neurological and other complications.

Approaches that work

Prevention is considered to be the most efficient and cost-effective approach for tackling overweight and obesity in children, adolescents and adults[43,46] and should have a positive impact on other chronic diseases due to common risk factors. Preventing unhealthy weight gain is considered the most appropriate population target rather than weight loss,[56] with short and medium term outcome measures including changes in diet,

[55] SPANS NSW Schools Physical Activity and Nutrition Survey Executive Summary. Hardy L, University of Sydney 2010
[56] National Preventative Health Taskforce, Australia: the healthiest country by 2020. Technical Report No 1 Obesity in Australia: a need for urgent action, 2009

physical activity or sedentary behaviours, as well as measured changes in policies, services and professional practices.[57]

Recent reviews have identified promising approaches to address the complex array of interrelated social, environmental, behavioural, genetic and physiological factors influencing energy balance .[58,59,60] There is agreement that a 'whole of system' approach is required that:

- Involves multiple sectors and engages multiple agencies
- Includes multiple strategies, programs and policies
- Targets multiple population groups and intervenes at multiple stages of life.[53,54,55]

Generally an approach is needed which creates living environments that support healthy eating and physical activity as well as encouraging people to adopt healthier lifestyles. A portfolio of prevention interventions[61] is recommended, including approaches that:

- Are settings-based (e.g. pre-schools, schools, workplaces), encouraging work with stakeholders and partners to support change in the social contexts of everyday lives
- Are long term, to facilitate continuous or repeated exposure
- Have a mixture of:
    - Universal strategies to improve knowledge and reduce exposure to obesity promoting factors in the whole population, e.g. influence the built environment
    - Targeted strategies aimed at groups considered to be at higher risk of developing obesity, e.g. people who are already overweight, socially disadvantaged communities, Aboriginal communities and some ethnic groups
- Have a strong emphasis on early childhood (with a focus on families and care-givers) to increase the likelihood of behaviour changes. Other life stages identified as important opportunities for prevention include adolescence, early adulthood, pregnancy and menopause
- Include use of the media and communication strategies
- Address a range of known risk factors including consumption of sugar sweetened drinks, sedentary lifestyles and breastfeeding.[62]

While some approaches impact overweight and obesity directly, others are considered enablers that can reinforce or amplify change, or indirectly support behaviour change. The National Preventative Health Taskforce identified action areas for Australia[63] including a mixture of approaches to:

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[57] Gill T et al, A "state of the knowledge" assessment of comprehensive interventions that address the drivers of obesity: a Rapid Assessment Prepared for the NHMRC by the Boden Institute of Obesity, Nutrition, Exercise and Eating Disorders, University of Sydney, 2010

[58] Hector D et al, Evidence update on obesity prevention; Across the life-course. Prepared for NSW Ministry of Health. Sydney; Physical Activity Nutrition Obesity Research Group, 2012

[59] Gill T et al, A "state of the knowledge" assessment of comprehensive interventions that address the drivers of obesity: a Rapid Assessment Prepared for the NHMRC by the Boden Institute of Obesity, Nutrition, Exercise and Eating Disorders, University of Sydney, 2010

[60] Vandenbroeck IP, Goossens J, Clemens M. Tackling obesities: future choices—building the obesity system map [internet]. Government Office for Science, UK Government's Foresight Programme; 2007. Available from: http://www.foresight.gov.uk/Obesity/12.pdf

[61] Gill T et al, A "state of the knowledge" assessment of comprehensive interventions that address the drivers of obesity: a Rapid Assessment Prepared for the NHMRC by the Boden Institute of Obesity, Nutrition, Exercise and Eating Disorders, University of Sydney, 2010

[62] World Health Organization (WHO). Expert report on diet, nutrition and the prevention of chronic diseases: report of a joint WHO/FAO expert consultation. Geneva: WHO; 2003. Technical report series 916.

[63] National Preventative Health Taskforce Australia: the healthiest country by 2020. Technical Report No 1 Obesity in Australia: a need for urgent action. 2009

- promote environmental changes in the community that increase physical activity and reduce sedentary behaviours
- change the food supply to increase the availability and demand for healthier foods and decrease the availability and demand for unhealthy foods
- embed physical activity and healthy eating in everyday life.

Interventions to improve built environments can also address inequalities in opportunities to eat well and be physically active.

Priority Actions to promote healthy weight

- **Implement** the NSW Strategy for Healthy Eating and Active Living Strategy: Preventing overweight and obesity in New South Wales 2013-2018
- **Implement** Healthy Children and related child obesity **prevention initiatives**
- **Develop** community based **prevention strategies** promoting healthy lifestyle interventions
- **Promote** the free NSW Get Healthy Information and Coaching Service to residents of SESLHD
- Social **marketing** of healthy lifestyle initiatives
- **Develop** and **implement** targeted healthy weight **programs** for disadvantaged communities
- **Promote** the uptake of risk factor management programs delivered in the primary care setting
- **Build** effective **partnerships** and referral pathways with general practice, Medicare Locals, external service providers and community groups and facilitate successful network arrangements within SESLHD
- **Establish** processes to **engage** effectively with patients, clinicians, Local Lead Clinicians groups, Medicare Locals and other stakeholders to optimise outcomes and service integration and coordination.

Programs and Activities to be delivered by the Directorate from 2014-19

The majority of the Directorate's work to promote healthy weight relates to implementation of the National Partnership Agreement on Preventive Health. [64] This includes:

- Working closely with the NSW Ministry of Health, NSW Office of Preventive Health, other LHDs and key stakeholders to address relevant state and national overweight and obesity targets
- Ensuring relevance of broader prevention initiatives through application of research and evidence to improve the planning, implementation and evaluation of local initiatives
- Contributing to building evidence on best practice approaches to community-based obesity prevention by publishing and communicating through scientific conferences, journals and the media and participating in professional networks and forums.

NSW Healthy Eating and Active Living Strategy

We will continue to implement the relevant components of the ***NSW Healthy Eating and Active Living Strategy: Preventing overweight and obesity in New South Wales 2013-2018*** [65] to tackle the impact of lifestyle-related chronic disease. This includes programs that promote healthy weight in children and adults, information campaigns and strategies that create supportive environments for healthy eating and active living. The Strategy outlines four priority areas to promote healthy eating and active living for the whole community:

[64] "Council of Australian Governments (COAG). National Partnership Agreement on Preventive Health, 2008" http:www.health.gov.au/internet/main/publishing.nsf/Content/phd-prevention-np
[65] www.health.gov.nsw.au/obesity

1. Environments to support healthy eating and active living
2. Statewide healthy eating and active living support programs
3. Healthy eating and active living advice as part of routine service delivery
4. Education and information to enable informed, healthy choices.

Promoting Healthy Weight in Children

Breastfeeding

The Directorate is involved in the development of local policies and practices that support implementation of the ***NSW Health Policy Directive, Breastfeeding in NSW: Promotion, Protection and Support***. The policy, which aims to improve breastfeeding practices in NSW, is to be implemented by the Ministry of Health and Local Health Districts between 2011 and 2015.

We will implement the policy as a member of the SESLHD Lactation Group which also includes SESLHD staff of maternity facilities, Child and Family services, Families NSW[66] as well as Medicare Locals and the Australian Breastfeeding Association.

NSW Healthy Children Initiative (HCI)

The Directorate will continue to implement the statewide ***NSW Healthy Children Initiative*** (HCI) which promotes healthy weight in children, young people and families through a range of interventions to encourage healthy eating and physical activity, and reduce small screen recreation (e.g. watching television, using electronic media such as DVDs, computer and other electronic games) in early childhood education and care services, schools, and community and recreation settings. The HCI also includes programs focusing on communication with families and social marketing to young people. Funded under the National Partnership Agreement on Preventive Health (NPAPH) to June 2018, the progressive rollout and combination of statewide and local strategies with a focus on the sociocultural and environmental determinants of obesity allows for greater reach and relevance to facilitate change and sustainable outcomes.

We will work with a range of stakeholders to build the capacity of services to promote healthy weight by:

- providing training and professional development
- providing support and advice for new and ongoing community-based projects
- developing and disseminating local resources
- participating in statewide planning and evaluation to ensure programs are appropriate and relevant to local communities.

We will continue to implement and coordinate primary prevention programs in education settings: *Munch & Move* and *Live Life Well @ School;* and a community secondary prevention program: *Go4Fun.* Future programs which will be supported include *Healthy Playgroups* (for children 0-5 years) and *yHunger* (training workshops for youth workers).

Munch and Move

Munch & Move supports the healthy development of children 0-5 years in over 400 early childhood education and care services in SESLHD. The program links to national health and early childcare quality frameworks to assist educators implement a fun, play-based approach to support that promotes and encourages

[66] NSW Government's overarching strategy to enhance the health and wellbeing of children up to 8 years and their families. From http://www.families.nsw.gov.au/about.htm

physical activity, healthy eating and reduced small screen time in young children. The Directorate will continue to support local services to implement the program and develop specific initiatives to address local needs.

Live Life Well@ School

Live Life Well @ School works to engage students aged 5-12 years, teachers and families in the promotion of healthy eating and physical activity in over 200 primary schools from Department of Education and Communities, Catholic and Independent sectors in SESLHD. The Directorate will continue to support schools to implement the program and develop a 'whole of school approach' linked to Australian Dietary and Physical Activity guidelines and tailored to the needs of their school culture and community.

Go4Fun®

Go4Fun is a secondary prevention service which assists children aged 7-13 years who are above their healthy weight, and their families, to adopt a healthy lifestyle and a long lasting and healthy approach to living. The Directorate will continue to manage the program, which is conducted at various locations across SESLHD with at least three programs running each school term. Go4Fun is based on the UK MEND (Mind, Exercise, Nutrition, Do it!) Program.[67]

Early evaluation of data from the NSW program has shown positive outcomes in physical and behavioural measures including: waist circumference, BMI, sedentary behaviour and physical activity.

Promoting Healthy Weight in Adults and our Community

NSW "Get Healthy" Information and Coaching Service

The Directorate will continue to support the *Get Healthy Information and Coaching Service* through promotion to SESLHD staff, residents, organisations and community as an accessible option for people wanting information and who would benefit from individualised support.

This service provides free, confidential telephone and web-based support and information for people wanting to make healthy changes to their lifestyle for healthy eating and physical activity and weight control. Participants can also take part in an ongoing coaching

get healthy®
Information & Coaching Service
A joint Australian, State and Territory initiative under the National Partnership Agreement on Preventive Health

Key findings of NSW program:

Participants who have completed the 6 month coaching program have reported significant improvements, including:

Increases:

- Physical activity levels
- Vegetables & fruit consumed daily

Decreases:

- 4kg average weight loss
- 4.9 cm average off waist circumference
- Take away meals consumed per week
- Sweetened drinks consumed daily

[67] Sacher PM, Kolotourou M, Chadwick PM, Cole TJ, Lawson MS, Lucas A, Singhal A. Randomised controlled trial of the MEND program: a family-based community intervention for childhood obesity. Obesity.2010:18(S1):S62-8

process to assist them with behaviour change.

Initial evaluation results of the Service are promising and future enhancements will improve support for Aboriginal people, culturally and linguistically diverse people, pregnant women and those at high risk of type 2 diabetes.

NSW Healthy Workers Initiative

The NSW Healthy Workers Initiative, which is being rolled out under the National Partnership Agreement on Preventive Health from 2013, aims to improve the health of working adults and decrease their risk of diabetes and cardiovascular disease, by focussing on healthy weight, physical activity, healthy eating, smoking and harmful alcohol consumption. The Initiative will:

- support changes in workplace environment and culture and individual behaviour change
- address modifiable risk factors such as physical activity and diet
- target workers in industry sectors and communities which have a high prevalence of chronic disease risk factors
- coordinate a screening and assessment service for potential referral to diabetes prevention programs.

We will support implementation of NSW Healthy Workers Initiative as relevant to SESLHD workers and options to promote a healthy workforce, e.g. provision of healthy food to staff and visitors in line with NSW Health policy (Live Life Well@ Health: Healthier Food and Drink Choices – Staff and Visitors in NSW Health facilities. PD 2009_081 http://www0.health.nsw.gov.au/policies/pd/2009_081.html).

We will establish a comprehensive and integrated approach for identifying and referring likely candidates for existing healthy weight initiatives (such as Go4Fun, Get Healthy Service).

We will further develop collaborative relationships – including with local councils, Medicare Locals, health and other service providers and community organisations - to promote healthy eating and active living by:

- developing or enhancing existing community based initiatives
- enhancing local support for healthy weight
- building capacity to and promote healthy environments e.g. walkable suburbs, outdoor gyms, accessible and affordable fresh food, access to public transport.

We will implement relevant components of the SESLHD Sustainability Strategy such as promoting active transport through assisting the development of transport access guides for local hospitals.

We will establish a social marketing and communication plan for promoting healthy weight messages, programs and options to service providers and the community.

We will contribute to the evidence base by fostering ongoing research and evaluation disseminating the results of SESLHD program evaluations and participating in broader research strategies as appropriate.

We will support cross-government initiatives as appropriate and will work to strengthen community capacity and social inclusion as part of all work in health promotion, and particularly to support disadvantaged communities and vulnerable populations.

Capacity Building and Coordination

Healthy Built Environments

Obesity prevention requires a whole of community approach, including effective community infrastructure, public transport as well as urban design and development that promote health. Key activities of the Directorate will continue to be the coordination, development and support of a wide range of initiatives that build organisational capacity for promoting healthy weight and contribute to a healthy environment. Activities include: providing training and resources to the community; providing comments on various planning documents e.g. through use of the *Healthy Urban Development Checklist* to advocate for opportunities to improve access to healthy food and active living; increasing active travel e.g. assisting SESLHD facilities to develop transport access guides.

Shape Up Australia[68]

We will support relevant state and federal government marketing campaigns promoting healthy weight, e.g. *Measure Up, Swap It Don't Stop It*, and explore options to provide a coordinated approach with other agencies, e.g. *Shape Up Australia*. This is a new evidence based initiative which will provide credible information on healthy weight, diet and physical activity as part of an integrated approach from existing obesity prevention and healthy lifestyle efforts across government and non-government sectors.[69].

Partnerships

Partnerships with key stakeholders from different sectors are crucial to support the Directorate's healthy weight activities. The Directorate will engage with providers such as:

- Aboriginal Health and Multicultural Health Services and agencies
- Medicare Locals
- Sydney Children's Hospitals Network
- St Vincent's Hospital, Darlinghurst
- Non-government organisations including youth services, neighbourhood centres, Cancer Council NSW, Heart Foundation
- Local councils
- Physical activity providers
- Academic and research groups such as PANORG (Physical Activity, Nutrition Obesity Research Group/Sydney University) to identify and disseminate evidence-based guidelines and advice to inform policy and practice. [For further information, see Healthy Environments priority health issues]

[68] http://www.shapeup.gov.au/
[69] http://anpha.gov.au/internet/anpha/publishing.nsf/Content/shape-up

Case Study: Healthy Eating and Active Play @ Playgroup

This innovative project is aimed at children up to 5 years of age and their families in the supported playgroup setting was implemented between 2005 and 2012. Supported playgroups directly reach children from disadvantaged populations and their parents/carers so provide an opportunity to influence the food and physical activity environments these children are exposed to at playgroup as well as at home. The project was developed in response to identified local needs and was implemented in two stages with input from key stakeholders including playgroup staff, health and education professionals and parents/carers.

Target groups were playgroup staff and also parents/carers. Strategies included:

- Development and provision of resources providing activities and information in line with Australian dietary and physical activity guidelines
- Training workshops and ongoing support from the project team.

Healthy Eating and Active Play at Playgroup reached over **80 individual playgroups,** servicing more than **1500 disadvantaged children and their families.** Sustainable improvements found in practices and service provision included:

- Increased opportunities for healthy food and active play
- Staff confidence in communicating and disseminating information to parents/carers
- Statistically significant increases in supervised active play sessions.

The Active Play component completed in 2011 include statistically significant increases between pre and post implementation data in the following areas:

- Supported playgroup provision of structured games indoors (58.8%-92.9%) and outdoors (47.1%-100%)
- Supported playgroup staff aware of active play messages (62.1%-96.4%) and resourcing parents/carers (57.6%-88.9%)
- Parents/carers walking to/from the park (58.0%-67%) and giving babies floor play-time (78.0%-91.3%).

Changes reported by parents /carers suggested that desired flow on effects to families had also occurred. Partnerships with early childhood support agencies and approaches to build the sector's capacity to continue implementing obesity prevention initiatives into the future enhance sustainability of these positive outcomes. A statewide program informed by the SESLHD work has been integrated into the NSW Healthy Children Initiative.[70]

The Directorate's project **Active Play at Playgroup: Addressing Child Obesity in 0-5 year olds,** won the *Keeping People Healthy to Avoid Unnecessary Hospitalisation* Category in the **2012 NSW Health Awards.**

[70] Commonwealth of Australia. Implementation Plan for the Healthy Children Initiative, National Partnership Agreement on Preventive health, 2010
http://www.federalfinancialrelations.gov.au/content/npa/health_preventive/healthy_children/nsw_ip.pdf

5.3 Promoting healthy environments

Healthy Environments as a Population Health Focus

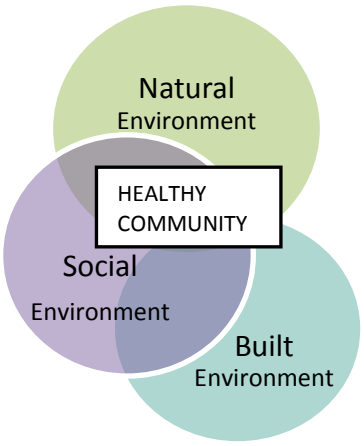
A healthy environment is one where all sectors contribute to create social and physical environments that foster health. The impact of environments on health outcomes are becoming increasingly well understood[71], and can include factors such as how urban and building design can influence health behaviours or how policy and action can impact or modify environmental health hazards. Environments can thus play a key role in determining population health outcomes.

The Built Environment

The built environment structures our lives and influences our health. It is the design of a community's physical structures including housing, businesses, transport systems, and recreational facilities which affect patterns of living that in turn, influence health.[72]

The built environment has a direct influence on people's health and well-being by:

- Encouraging or inhibiting physical activity
- Determining access to healthy food
- Promoting social interaction and participation
- Enhancing sense of community
- Influencing people's perceptions of safety
- Offering the opportunity to participate in civic life



"As Australia faces increasing health costs from rising rates of obesity, diabetes and other lifestyle diseases, health workers are seeking to influence the design of cities to make them more supportive of healthy ways of living."[73] New alliances will be forged with other sectors such as local government and built environment professionals to provide an impetus for health action in this area.[74]

Environmental Hazards

Environmental health addresses all the physical, chemical, and biological factors external to a person, and all the related factors that can potentially affect health. It is targeted at preventing disease and creating health-supportive environments[75].

The Directorate manages environmental health issues relating to: safe drinking water supplies, recreational use of water (public swimming pools), sewage management, toxicology (chemicals, poisons and toxins in soil, food, water and air), microbial control, skin penetration industries, funeral industries, arbovirus control, air quality, waste management and basic hygiene.

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[71] Rydin, Y, Bleahu, A, Davies, M, Davila, JD, De Grandis, G, Groce, N, Hallal, PC, Hamilton, I, Howden-Chapman, P, Lai, K, Lim, CJ, Martins, J, Orsin, D, Ridley, D, Scott, I, Taylor, M and Wilkinson, P (2012). Shaping cities for health: complexity and the planning of urban environments in the 21st century. *The Lancet* 379:2079-2108.
[72] Northern Sydney Central Coast Health Promotion Service (2009). The Urban Planning 4 Health Guide
[73] UNSW Healthy Built Environments Available from: http://www.be.unsw.edu.au/programmes/healthy-built-environments-program/about
[74] World Health Organisation (2009). Milestones in Health Promotion Statements from Global Conferences.
[75] Australian Government Department of Health and Ageing. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strate.g.-envhlth-index.htm

Impact on our Community

A healthy built environment is particularly important for residents of SESLHD, where rates of obesity, diabetes, physical inactivity and falls related hospitalisations have increased significantly over the last decade.

Populations of low socioeconomic status are frequently those most strongly impacted and at higher risk for a variety of health outcomes[76]. Within SESLHD there is a relatively large intra District diversity in socioeconomic status, with some suburbs among the least advantaged in the state.

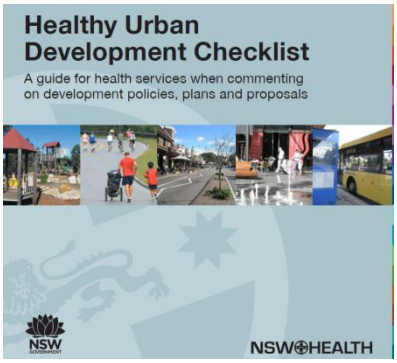
Building and maintaining healthy environments has been identified as a priority for the DPPH with key actions to:

- Facilitate collaborative public policy planning and implementation to influence the design of urban areas to make them more supportive of healthy ways of living
- Implement and ensure compliance with relevant legislation and healthy public policies to promote environmental health; for example environmental tobacco smoke, chemical exposure, infectious agents, sharps and provision of safe drinking water supply.

The NSW Government initiative to develop Urban Activation Precincts will have a large impact on the community, with three areas determined within our District. These include Randwick, Anzac Parade South and Mascot Station. These urban renewal projects will improve services, facilities and public spaces and provide opportunities for the development of new housing close to retail, employment, education and transport. Working in consultation with state and local governments, the Directorate will be a major partner in their urban design for the future benefits of our residents, in helping to keep them healthy and out of hospital and to plan for their future health needs.

Approaches that work

- Partnerships with other health protection agencies, and local and state governments
- Legislation, regular surveillance, monitoring and health alerts
- The built environment policy and design to support and promote: physical activity, access to healthy food options, strong and connected communities[77]



Community garden at Matraville Estate

[76] Tucs E; Dempster B (2007) Linking Health and the Built Environment: An annotated bibliography of Canadian and other related research

[77] Kent J; Thompson SM and Jalaludin B (2011). Healthy Built Environments: A review of the literature, Sydney. Healthy Built Environment Program, City Futures Research Centre, UNSW.

Priority Actions to promote healthy environments

- Establish a cross-sector **healthy built environment** alliance that provides leadership and action for healthier, more livable communities by influencing environmental factors such as access to affordable fresh food and opportunities for people to engage in active lifestyles (e.g. improving walkability of suburbs, safety, access to outdoor free gym equipment etc).
- Continue to monitor compliance with **tobacco legislation** to protect SESLHD residents from unnecessary exposure to **tobacco smoke** (see section on Tobacco control).
- Further develop **disaster/emergency** management planning, preparation and response arrangements and capacity within the SESLHD
- Collaborate with the Environmental Protection Authority, local government and others on **health protection issues** of local and regional importance, including reduction of community exposures to environmental hazards, communicable disease outbreaks and other relevant issues.
- Develop and implement initiatives to **promote the health of staff** and a positive and supportive workplace, for example implement the Healthy Workers Initiative.

Programs and Activities to be delivered by the Directorate from 2014-19

Collaborating and forging partnerships with State and Local Government is critical to promoting Healthy Environments and active lifestyles for our residents. The Directorate will continue to build effective and sustainable collaborative partnerships to promote active lifestyles and healthy eating such as walkability of suburbs, installation of outdoor gyms, access to public transport and access to affordable fresh food. Other examples include

- Submitting responses to state/ regional plans, e.g. *NSW Government Green Paper – A New Planning System*, and *NSW Planning and Infrastructure – Sydney over the next 20 years Discussion Paper*.
- Developing responses to Local Government plans and development applications, including the *Health and Education Precinct* within Randwick LGA.
- Providing advice to Local Councils with respect to Local Environmental Planning under the Planning and Assessment Act 1979
- Providing advice to councils on the need for Human Health Risk Assessment in the redevelopment of contaminated land for human habitation and liaising with the EPA and councils in the management of contaminated land.

We will continue to lead and coordinate the District's receipt of requests from the Department of Planning, Local Government and NSW Ministry of Health regarding the review of new planning documents and plans.

We will continue to collaborate with the NSW Ministry of Health to implement the liquor licensing program which aims to protect the health and safety of the community.

We will develop transport access guides for local hospitals and exploring funding opportunities and continue collaborating with local councils to promote active transport.

We will maintain links with the UNSW Healthy Built Environment Program to improve knowledge and skills and enhance use of relevant healthy built environment planning tools will remain a key focus of the Directorate.

SESLHD Community Sharps Management Program

The Directorate is responsible for the program management of the community sharps disposal program in SESLHD and administers the state wide NSW Community Sharps Management Program, which advocates and promotes a coordinated response to community sharps management. The program supports key stakeholders to implement best practice community sharps management policies and practices across NSW. The Directorate also provides Safe Handling and Harm Reduction Training to government and non-government agencies across the District.

Community sharps are sharps that have been generated by non-clinical activities such as insulin pen needles, syringes and lancets used by people in the self-management of diabetes and other medical conditions, syringes used by people who inject drugs, and injecting equipment used by owners to treat pets and livestock. Under NSW environment legislation, community sharps generated at residential premises or in public places are defined as solid waste and are generally the responsibility of local councils.

The unsafe disposal of all community sharps poses ongoing waste and community safety issues. It also impacts on the acceptability of and tolerance for public health services such as needle and syringe programs in the community.

Smoke-free Environments

The Directorate follows up complaints regarding commercial premises which allow smoking in enclosed areas, in contravention of the Smoke-Free Environment Act 2000 and monitors new provisions of the Smoke-Free Environment Act, which prohibit outdoor smoking in certain public areas

To protect staff, patients and visitors from second-hand smoke, the SESLHD has developed a Smoke - free Health Care Policy, which aims to:

Case Study: The Impact of Outdoor Gyms and Physical Activity Levels

Environmental health is being increasingly recognised as an important part of a comprehensive population health approach to increasing physical activity. Park improvements such as outdoor gyms have the potential to increase park patronage and physical activity.

The Directorate advised Randwick City Council on the design and installation of an outdoor gym suitable for older people. A time series research study is being conducted to determine if the installation of outdoor gyms have the potential to increase park usage and physical activity.

The study will determine:

- The number and demographics of park and outdoor gym users
- Whether outdoor gyms can increase park use and physical activity levels of park users
- Whether outdoor gym equipment is used correctly
- Which are the most popular pieces of outdoor gym equipment
- The facilitators and barriers to park use and outdoor gym use

Preliminary results show that of 219 post outdoor gym interviews with people over 50 years, 32% of females and 43% of males had used the outdoor gym. Focus groups with older people have been conducted to ensure quality of usage and a 'How to Use an Outdoor Gym' guide has been developed, and posted at: http://www.seslhd.health.nsw.gov.au/Planning_and_Population_Health/Health_Promotion/docs/OutdoorGym_V7.pdf

Outdoor gym at Maroubra

- Reduce the number of smokers in smoke-free areas (staff/visitors/patients)
- Increase the number of SESLHD staff accessing smoking cessation services and Nicotine Replacement Therapy (NRT)
- Increase the number of patients offered nurse initiated NRT.

Health risks from contaminated sites

Regulation of contaminated sites is the responsibility of the NSW Environment Protection Authority and of relevant local councils. The Directorate and Health Protection NSW provide advice to these agencies and to the general public regarding health risks attributed to contamination. The Directorate staff may also facilitate referral to clinical toxicology services where there is concern that members of the public may be suffering symptoms of poisoning. The Directorate's Cancer Control Program has specific expertise in relation to chemicals which may cause cancer.

Monitoring of facilities

The Directorate is responsible for the monitoring of cases or outbreaks of infectious diseases from an environmental source, and for regular surveillance to ensure certain facilities comply with the Public Health Regulation 2012. Inspections are also undertaken in response to complaints from the public and/ or outbreaks e.g. Legionnaire's disease outbreak in the community. Activities include regular inspections of:

- Publicly used swimming pools and spas to test the water for bacterial infection and to ensure they are registered with their local council.
- Hospital cooling towers within the District to sample and monitor the presence of Legionellosis (the cause of Legionnaire's disease, a severe form of Pneumonia).
- Skin Penetration registered businesses, such as Tattoo Parlors, manicurists and ear piercing premises, to check that businesses are registered with Council and comply with legislation regarding hygiene and infection control.

Case Study: Orica Botany mercury contamination and site remediation

The Directorate's Public Health Unit is represented on the **Orica Community Liaison Committee**, which provides a forum for community members to raise concerns and hear Orica and agency reports on a range of issues associated with the long history of chemical production on the Banksmeadow site. The Committee was initially established a decade ago as a forum for discussion of the chemical contamination of the groundwater under Botany. In the past 1-2 years, the Committee has also been a venue for discussion of mercury contamination around a former chlorine production plant and the efforts used to rid the site of this mercury contamination.

Following its review of community input and assessment of Orica's Remediation Action Plan, the EPA issued a new Management Order in early August 2013 and added legally enforceable conditions to Orica's Environment Protection Licence to allow the remediation project to proceed. A comprehensive set of regulatory requirements will ensure a high standard of environmental management during the project. The remediation will include removal of mercury-contaminated soil and free mercury to the extent practicable followed by installation of a capping and containment system to manage the remaining mercury contamination by January 2015.
This result is a considerable achievement for the work of the Directorate in the community, in assessing the health risks for residents of the District and ensuring a healthy environment.

The Public Health Unit has produced a detailed fact sheet 'Mercury exposure and health', posted at:
http://www.seslhd.health.nsw.gov.au/Public_Health/environmental_health.asp

Other activities to be undertaken by the Directorate to address the priority initiatives:

We will base Public Health Unit responses around the Incident Control System.

We will continue to monitor environmental hazards to reduce the risk of disease.

We will detect, investigate and respond to:

- outbreaks of communicable disease
- new and re-emerging disease threats
- potential health effects from contaminated sites, disposal of hazardous chemicals and materials, air pollution.

We will develop a process for structured debriefs following significant events.

We will revise and develop policies, guidelines and standard operating procedures promoting an evidence-based, best practice and consistent response to communicable diseases.

We will promote/ensure compliance and monitoring of legislation and standards to minimise population risks associated with:

- cooling towers swimming pools
- skin penetration (e.g. tattoo)
- drinking and recreational water quality.

We will gather complete accurate data on notifiable disease according to protocols and agreed data quality indicators.

We will develop and implement a plan for evaluating surveillance systems.

We will continue to strengthen strategic research links with the University of Sydney, University of New South Wales (UNSW), and NSW research centres, including work with PANORG (Physical Activity, Nutrition, Obesity Research Group).

We will promote our staff use and access to active transport options for travel to and from work.

We will increase the evidence and facilitate development, review and implementation of built environment healthy public policy.

We will influence the design of urban areas to make them more supportive of sustainability and healthy ways of living.

Photo: Staff from the Public Health Unit at the Orica site.

5.4 Preventing falls and falls injury among our community

Falls Injury prevention as a Population Health Focus

Injuries from falls are a leading cause of morbidity and mortality in older people. At least 1 in 4 people aged 65 years and over fall at least once per year, with substantially higher rates in those aged over 85. Whilst not all falls result in injury, the consequences of those that do can be severe. As many as one-third of those hospitalised due to a fall injury such as a hip fracture do not survive beyond one year later.[78] For those that do, the period of hospitalisation and rehabilitation can be substantial and expensive, and many will require assistance from community based services or transfer into long-term residential aged care.[79]

SESLHD Target
In the next five years we will decrease the number of falls related hospitalisations for persons over 55, in spite of increasing numbers in this age group, with no increase in SESLHD falls injury hospitalisation rates (age standardised, overnight) above SESLHD 2011/12 baseline.
Source: SESLHD *Falls Injury Prevention Plan 2013-18*

Falls and their associated injuries can also have long term effects on older people. They can cause a restriction of activity, increased fear of falling, reduced quality of life and loss of independence.[80]

No other injury cause (including road trauma) has a greater impact on the NSW Health system. And this impact is growing as the population ages. This is being driven not only by the increasing total number of people over 65, but also by the increasing proportion of those who will reach the age of eighty or ninety, for whom the risk and consequences are much greater.

There is a case to be made for a whole-of life approach to building healthy bones and preventing injuries later in life. Reducing falls is important, but reducing falls injuries is more so, and for that we must consider ways in which to build a more resilient future population. This requires focus on calcium, Vitamin D and physical activity across all ages. This should include health promotion, opportunities for early intervention, and service planning wherever there are opportunities to identify and intervene with those who are at risk.

Impact on our Community

The number of falls resulting in hospitalisation among elderly people living in South Eastern Sydney is high, with some residents (particularly those living in the Rockdale and Randwick Local Government Areas) having a greater likelihood of a falls injury requiring hospitalisation than residents of other South Eastern Sydney suburbs.

On a typical day, 24 adults residing in SESLHD are hospitalised due to a fall. For many, the consequences will be life-changing, or even fatal.

Residents aged 65 years and over in six of the remaining nine local government areas within the District also have an increased risk of falls related hospitalisations compared to other NSW residents on average.

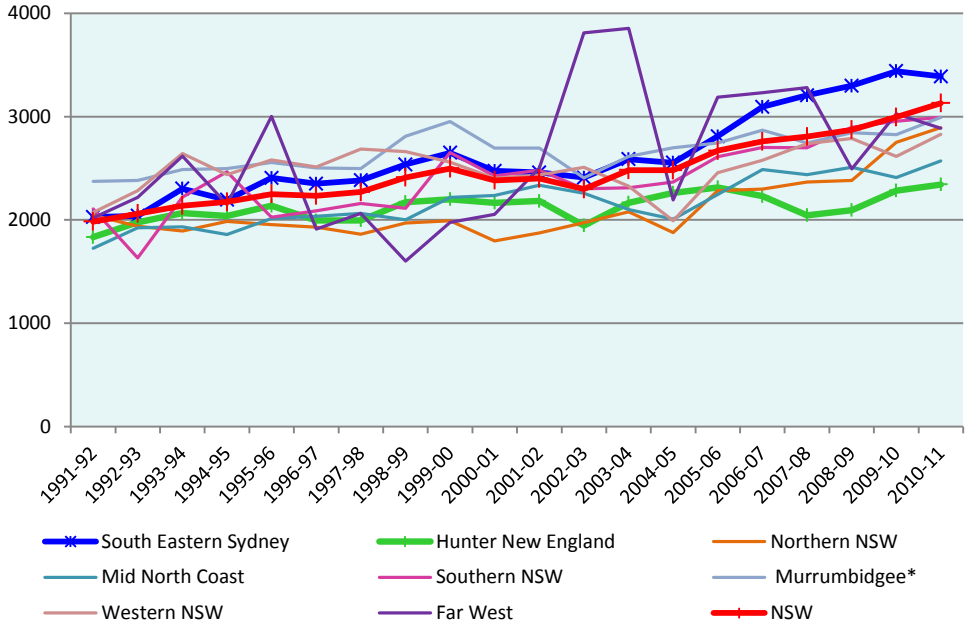
[78] SESLHD Falls and Falls Injury Prevention Plan 2013 - 2018
[79] Preventing Falls and Harm from Falls in Older People Best Practice guidelines for Australian community Care, 2009
[80] Ibid

Consistent with the pattern for NSW as a whole, between 2011 and 2021, the fastest growing age group in SESLHD will be the 70-84 years age group (+26%). Over the following decade, the largest increase will be seen in those aged 85 and over. The most substantial burden of illness and the highest risk group for multiple falls has been observed in the 85+ age group. In preparation for this ageing population, *SESLHD Health Care Services Plan 2012-2017* has identified the reduction of falls injuries in older adults as a priority Strategic Direction.[81]

Falls Injury

No other single cause of injury, including road trauma, costs the health system more than falls-related injury. **Falls injury** is expected to be second only to **diabetes** in its future impact on NSW hospitals. South Eastern Sydney Local Health District residents aged 65 years and over have a higher risk of a falls-related hospitalisation than the NSW average (since 2006/07 South Eastern Sydney Local Health District rates have averaged around 10% higher than the NSW average). Over the last decade, hospitalisations for falls injury among residents aged 65 years and over have increased by around one third. This increase has been greatest among the very old. Among those aged 85 years and over, rates have increased by 57%, while among those aged 75-84 years, rates have increased by 45%. The increase has been lower among those aged less than 75 years, with those aged 70-74 years and those 65-69 years experiencing a 25% and 22% increase respectively. If current trends continue, without concerted preventative action, health system costs from falls injury will escalate dramatically, due to the projected large increases in number of older residents.

Figure 27: Falls related injury overnight hospitalisation rates per 100,000 persons aged 65 years and over, SESLHD, Non-Metropolitan LHDs and NSW average, 1991-92 to 2010-11



Source: NSW Admitted Patient Data Collection and ABS population estimates (SAPHaRI). Accessed from Health Statist 30 January 2013. Notes: Directly age standardised rates, using Australian 2001 standard population as reference. Includes fall in the first external code field. Records relating to same day stays, statistical discharge and hospital transf (based on source of referral) were excluded.

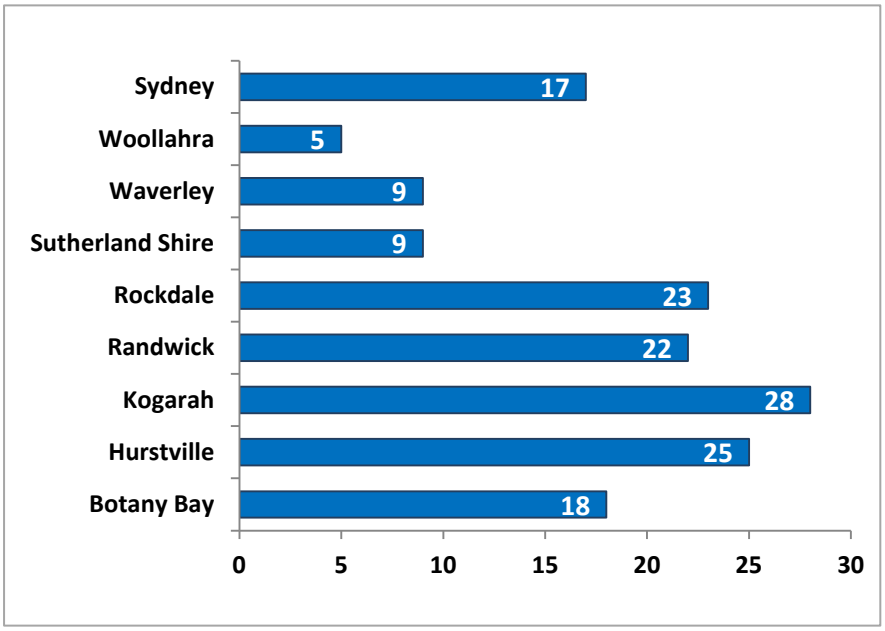
[81] SESLHD Health Care Services Plan 2012-2017, p.21 Available at: *http://www.seslhd.health.nsw.gov.au/HealthPlans/documents/FinalSESLHDHCSP2012-withrevisedcover.pdf*

Approaches that work

The two main focus areas recommended in Prevention *of Falls and Harm from Falls among older people 2011-2015* (NSW Health)[82] are:

- To support the provision of appropriate exercise programs for older people at risk of falls and promote the uptake of these programs
- To work with stakeholders to incorporate best practice falls prevention strategies into work practices.

Figure 28: Falls related hospitalisations among SESLHD residents 65 years and over by Local Government Area of residence -- % difference between SESLHD LGA and NSW state average rates per 100,000 population,2010-11 to 2011-12



Our residents aged 65 years and over living in all LGAs are 5-28% more likely to be hospitalised for a falls injury than other NSW residents

The risks are highest among those resident in Kogarah, Hurstville and Rockdale LGAs

Source: NSW Admitted Patient Data Collection and ABS population estimates (SAPHaRI).

A number of effective falls prevention interventions are available for older people living in the community. These include strategies for:

- an individual older person
- subgroups of older people who are at risk of falls
- the older population living in the community as a whole.

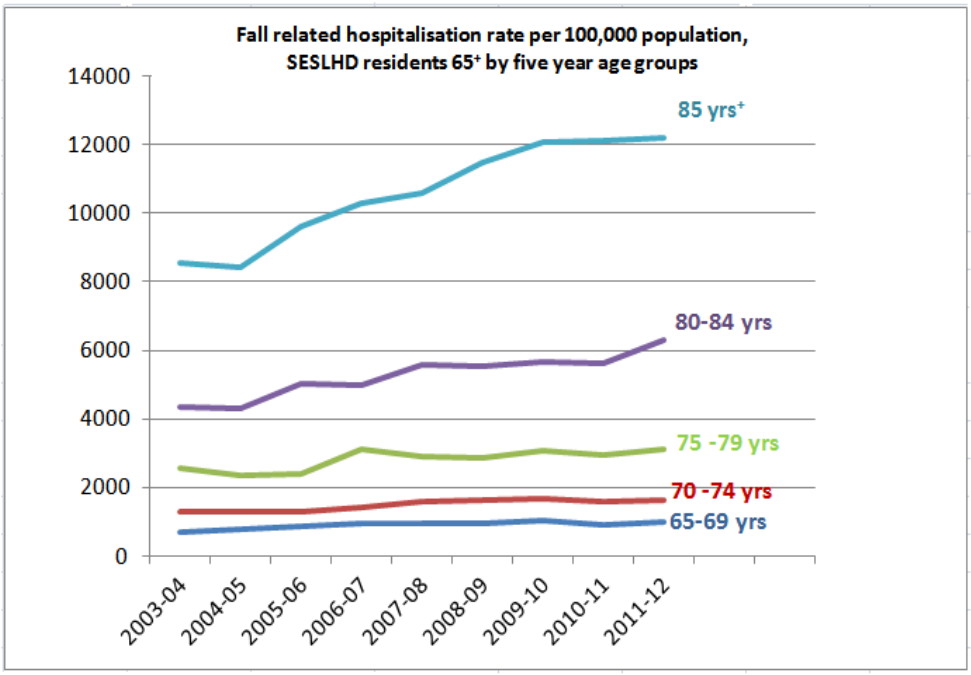
The Prevention of Falls Network Europe (ProFaNE) has classified falls prevention interventions into three categories: single, multiple and multifactorial.

Single interventions that are effective in reducing falls include exercise (particularly exercise programs that include balance training), vitamin D supplementation (although only in people with low vitamin D levels) and home safety interventions (again, only in high-risk subgroups of older people).

Multiple interventions tested in Australia that have been shown to be were effective in reducing the rate of falls (e.g. the Stepping On Program) includes: exercise, participant education and home safety.

[82] Available at: http://www.health.nsw.gov.au/policies/pd/2011/pdf/PD2011_029.pdf

Figure 29: Falls related hospitalisation rate per 100,000 population, SESLHD residents 65+ by 5 year age group.



Source: NSW Admitted Patient Data Collection and ABS population estimates (SAPHaRI).

A Cochrane systematic review of controlled (not randomised) trials concluded that a multiple intervention as a population-based approach to preventing falls-related injury is effective and can form the basis of public health practice.

- For older people who live in the community, the success of interventions can be limited by adherence. Education and involvement in decision making is essential for encouraging older people (and their carers) to adopt and adhere to falls prevention interventions.[83]

- The role of the built environment in promoting healthy lifestyles, including self-directed physical activity, is being increasingly recognised as an important priority for population health[84] and specifically for healthy ageing.[85] This includes urban planning to improve the local environment, from the provision of physical activity amenities and appealing parks and public spaces to practical risk reduction such as footpath maintenance and hazard reduction. The built environment plays an important role in facilitating healthy and active ageing and maintaining confidence in older people.[86]

[83] Preventing Falls and Harm From Falls in Older People Best Practice Guidelines for Australian Community Care 2009
[84] Rydin Y, Bleahu A, Davi.e.s M, Davila JD, Friel S, De Grandis G, et al. Shaping cities for health: complexity and the planning of urban environments in the 21st century. Lancet. 2012 Jun 2;379(9831):2079-108. PubMed PMID: 22651973. Pubmed Central PMCID: 3428861.
[85] Kerr J RD, and Frank L. The role of the built environment in healthy ageing: Community design, physical activity, and health among older adults. Journal of Planning Literature. 20125;27(1):43-60.
[86] Hunter RH, Sykes K, Lowman SG, Duncan R, Satariano WA, Belza B. Environmental and policy change to support healthy aging. J Aging Soc Policy. 2011 Oct;23(4):354-71. PubMed PMID: 21985064.

Priority Actions to Prevent Falls and Falls-Related Injury

- **Reduce the incidence, morbidity and mortality** of falls in SESLHD residents through partnerships with community groups offering a range of health promotion initiatives, including home based strength/balance courses; vision assessments; and peer education
- Further develop and embed **prevention, early detection and intervention** initiatives across the continuum of prevention and care within clinical (inpatient, ambulatory, primary care) and non-clinical settings.

Programs and Activities to be delivered by the Directorate from 2014-19

Addressing falls injury prevention in Health Care Facilities and Services

We will coordinate a strategic and consistent approach across facilities and services for multifactorial interventions such as falls risk assessment and tailored risk-reduction strategies - to reduce falls and harm from falls.

We will build the capacity of our staff to address falls risk prevention with clients, including by improving patient, family and carer awareness of the risks of falls and how to prevent their occurrence.

We will promote effective referrals to ***Stepping On*** programs for all people over 65years attending healthcare facilities as the result of a fall.

We will increase health service provider awareness of, and access to, falls prevention and physical activity opportunities.

Addressing falls injury prevention in our community

We will promote physical activity to key stakeholders and the community in the broader context of healthy ageing.

Creating an Environment that Supports Active Living

The Directorate has a role to work in partnership with local government and other organisations to ensure that the built environment promotes and supports healthy lifestyles, including self-directed physical activity. This includes actions such as supporting local government in their promotion of outdoor gymnasiums, commenting on regional plans and local government development applications as detailed in the Healthy Environments section of this plan.

Supporting Partners to incorporate Falls Prevention Strategies into policy and practice

A wide range of partner organisations and providers, who are involved in the care of older people, can assist falls prevention. The Directorate has a role to support aged care providers to help reduce the incidence of falls, by supporting the development of sustainable skills, knowledge and commitment and incorporate best practice falls prevention strategies into their work policy and practices. In addition, supporting the public and private providers of optometry, dietetic, podiatry and services who address risk factors for falls is important.

We will increase community awareness of, and access to, falls prevention and physical activity opportunities.

We will develop and offer a range of evidence-based, multifactorial falls prevention Interventions (assessment and tailored strategies) in partnership with community groups and members, including:

- home based strength/balance courses
- vision assessments
- peer education activities.

Specialist Falls Injury Prevention Programs

Stepping On Program

Stepping On is a seven week community group program designed to build strength, balance, knowledge and confidence among older people so that they can remain independent at home. In conjunction with an exercise program to build strength and balance, participants discuss and learn about aspects of falls prevention, including vision, medication and how to identify and modify hazards.

The program offers seniors a way of reducing falls and at the same time increasing self confidence in situations where they are at risk of falling. Expert presenters such as Physiotherapists, Occupational Therapists and Vision experts support the implementation of the program.

31 Stepping On programs were completed in SESLHD for the 2012/2013 financial year. Five programs were for Culturally and Linguistically Diverse communities.

BEST at Home

BEST (Balance, Exercise and Strength Training) at Home is a pilot 12 week, home-based exercise program that targets people over 65. The aim of the program is to increase strength, balance and physical activity in participants to reduce their risk of falling. The program consists of training in strength and balance exercises that participants complete three times a week in their own home along with additional physical activity options. Results and recommendations from delivering Best@Home Programs will be published in peer reviewed journals. Programs have been initiated with both the Chinese and Spanish speaking communities.

Activities to increase Physical Activity

We will promote the NSW Health Active and Healthy Website, a State-wide, publically-accessible database which allows both older people and health professionals to search for classes by postcode/suburb. This website also provides valuable information about falls prevention risk factors and how to address them. The site is maintained by the NSW Falls Prevention Program.

We will Support organisations to offer appropriate falls preventive exercise programs. Professional development opportunities for fitness leaders, to enable them to increase the strength and balance exercises they offer to older people, are a priority. Increasing the capacity of some organisations, through grant funding, to enable them to offer exercise programs to targeted communities is being undertaken.

We will foster partnerships with Medicare Locals, Local Government and other relevant agencies and groups to reduce falls risk in our community.

We will build the capacity of relevant service providers - including health care providers, NGOs, physical activity providers and other organisations/ services) - to implement evidence-based interventions in a sustainable manner. These include:

- Falls risk assessment and multifactorial interventions, including through incorporating falls prevention within usual work practices
- Physical activity programs focussed on balance and strength.

We will assess epidemiological and other information to better understand the above NSW state average for falls in people over 65 years in our community.

We will recognise that people living with HIV may experience some effects of ageing at a faster rate and may require clinical assessment and intervention at a younger age.

We will contribute to the evidence base for falls prevention in community settings.

Partners

Within SESLHD:

- Ambulatory and Primary Health Care Directorate, notably including Aboriginal Health and Multicultural Health
- A range of clinical, community, allied and rehabilitation health services

External Partners:

- Medicare Locals
- General Practitioners and Practice Nurses
- Local Governments, particularly those with the highest rate of falls (e.g. Rockdale)
- Physical activity coordinators and providers, including but not limited to *SHARE, AIM for Fitness, Strengthening for Over 60s, Stepping On*
- The NSW Falls Prevention Program (Clinical Excellence Commission)
- Centre for Population Health (NSW Ministry of Health)

A CONSUMER REPRESENTATIVE'S STORY

Jan Denniss is a member of the district's Consumer Advisory Group and has been a volunteer at St George Hospital for more than 13 years. Jan volunteered to be the Consumer Representative for the SESLHD Health Services Falls Prevention Advisory Committee as she had previous experience in the Falls Prevention Volunteer Program at St George Hospital and had been on the St George Hospital Falls Prevention and Management Committee.

The role of a Consumer Representative is an important way to give a voice to the patient's perspective. Jan said that her views were always listened to, and she appreciated that she was "allowed to ask anything, say what she wanted to say and was given honest answers." She valued the district wide representation on the committee, where ideas and actions from all over the LHD were shared. She also gained a greater appreciation of the difficulties faced in changing practices, the budgetary and workforce constraints that prevent change, and that there are no easy answers to falls prevention.

Some of her ideas for falls injury prevention include increasing the number of Lo Lo beds on aged care wards, so that the impact of a fall from bed is reduced; and the development of a NSW wide Volunteer Falls Prevention Program to provide trained volunteers to help supervise and observe high risk falls patients in hospitals.

The District is fortunate to have committed people like Jan who give their time to promote the consumer's cause and give us a better understanding of their needs. Working together with people like Jan will allow us to improve the planning and delivery of healthcare services to the community.

5.5 Controlling tobacco

Tobacco Control as a Population Health Focus

The prevalence of smoking across NSW has gradually declined over the last decade, from approximately 21.8% in 2002 to 14.8% in 2011.[87] Despite this, tobacco smoking remains the leading cause of Australia's preventable mortality and morbidity. It kills over 15,500 people annually and continues to contribute to years of debilitating illnesses and substantial costs to the public healthcare system. Mounting evidence has been collected to demonstrate the harmful impact that smoking has on developing a range of conditions and diseases including:[88]

SESLHD Targets

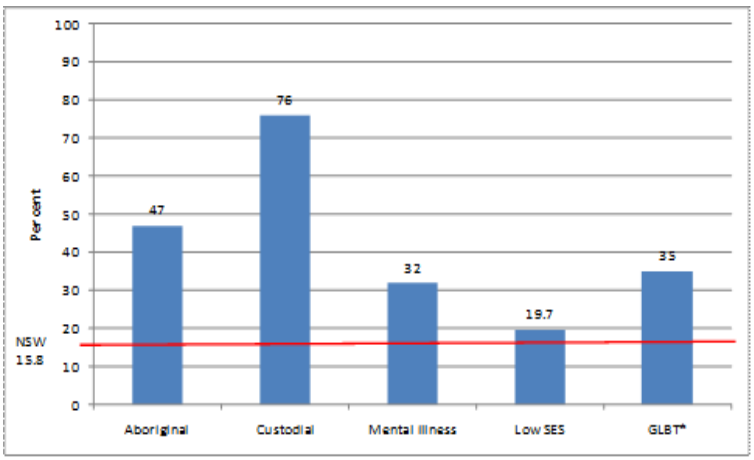
1. Reduce smoking rates by 3% by 2015 for non-Aboriginal people and by 4% by 2015 for Aboriginal people.

2. Reduce the rate of smoking by pregnant Aboriginal women by 2% per year and reduce the rate of smoking by pregnant non-Aboriginal women by 0.5% per year.

Source: Target from *NSW 2021* (the NSW State Plan)

- Various cancers, e.g. lung, esophagus, mouth, stomach
- Cardiovascular disease
- Chronic obstructive pulmonary disease
- Other respiratory diseases – emphysema, bronchitis
- Peripheral vascular diseases
- Other serious medical conditions, e.g. diabetes

Exposure to environmental tobacco smoke, known as 'second-hand smoking', is also associated with a range of serious illnesses [89] including Sudden Infant Death Syndrome (SIDS) in babies; asthma, ear and respiratory infections in children; lung cancer and coronary heart disease in adults.



Although smoking rates have declined significantly in Australia in the general population since the 1990s (16.8 %),[90] the smoking rates remain high in a range of disadvantaged population groups.

Figure 30: Tobacco smoking by at risk population groups compared to general population in NSW

[87] Centre for Epidemiology and Evidence. Health Statistics NSW: NSW Ministry of Health; 2011 [cited 2013 21/5/2013]. Available from: http://www.healthstats.nsw.gov.au/.
[88] US Department of Health and Human Services. The Health Consequences of Smoking: A Report of the Surgeon General. Atlanta, GA: Centers for Disease Control and Prevention, Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2004.
[89] US Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Atlanta, GA: Centers for Disease Control and Prevention, Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2006.
[90] Intergovernmental Committee on Drugs, National Tobacco Strategy 2012-2018. Commonwealth of Australia,2012

Respiratory Disease

Respiratory conditions affect the airways and can be chronic or acute and cause ill health, disability and death. Chronic respiratory diseases include asthma, emphysema, chronic obstructive pulmonary disease and bronchiectasis. According to the Australian Health Survey, an estimated 6.3 million Australians suffered from a chronic respiratory condition in 2010–11 (ABS 2012). In 2011, there were 12,529 deaths where a respiratory condition was the underlying cause (ABS 2013). This was the third most common cause group following cancer and diseases of the circulatory system[91].

Smoking is one of the major contributors to chronic lung disease. 'Second hand' smoke can also cause asthma in children. Compared with non-smokers, smoking is estimated to increase the risk of:

- Men developing lung cancer by 23 times
- Women developing lung cancer by 13 times
- Dying from chronic obstructive lung diseases (such as chronic bronchitis and emphysema) by 12 to 13 times
- An estimated 90% of all lung cancer deaths in men and 80% of all lung cancer deaths in women are attributed to smoking.[92]

Although smoking rates have declined significantly in Australia in the general population since the 1990s (16.8 %),[93] the smoking rates remain high in a range of disadvantaged population groups.

People of low Socio-Economic Status (SES), with mental illness, homeless, incarcerated, vulnerable youth and Aboriginal people have reported smoking rates between 20% and 80%.

Smoking substantially contributes to social disadvantage; not only due to the cost of tobacco products or medical treatment, but also that smoking in society is seen "as a marker of low educational aspirations, low socio-economic status and unemployment."[94]

Impact on our Community

SESLHD ranks positively within the NSW context, having been consistently lower than the NSW average over this period and having amongst the lowest smoking rates of any District. The prevalence of smoking in SESLHD has decreased over time from approximately 20.1% in 2002 to 13.4% in 2011[95]. There is a marked difference though between the smoking rates of populations with the lowest and highest socio economic status. Although SESLHD overall has a relatively advantaged population, there are pockets of distinct disadvantage within the District, including communities within Botany Bay, Inner Sydney and Rockdale. The smoking rate in Botany LGA is one of the highest in SESLHD-over 17%.[96]

In 2011, SESLHD's total Aboriginal resident population was just over 6300 people. Smoking is a major threat to the health of Aboriginal people. Almost half of all Aboriginal Australians aged 15 years and over smoke, which

[91] Australian Institute of Health and Welfare 2013. Available from: http://www.aihw.gov.au/chronic-respiratory-conditions/

[92] US Department of Health and Human Services. The Health Consequences of Smoking: A Report of the Surgeon General. Atlanta, GA: Centers for Disease Control and Prevention, Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2004.

[93] Intergovernmental Committee on Drugs, National Tobacco Strategy 2012-2018. Commonwealth of Australia,2012

[94] White & Hayman, 2006; The Cancer Council NSW, 2006

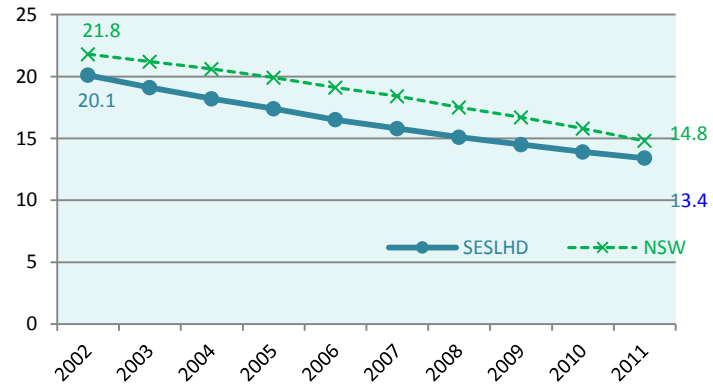
[95] Centre for Epidemiology and Evidence. Health Statistics NSW: NSW Ministry of Health; 2011 [cited 2013 21/5/2013]. Available from: http://www.healthstats.nsw.gov.au/.

[96] Closing the Gap Prime Ministers report, February 2012

equates to more than double the rate for the wider Australian population. In SESLHD, 28% of Aboriginal pregnant women still smoke in the second half of their pregnancy.[97]

SESLHD has 26% of its population born overseas and over a third (37%) speaking a language other than English at home. People born in China make up by far the largest culturally and linguistically diverse (CALD) population groups residing in SESLHD. Some CALD groups including those residing in SESLHD have substantially higher smoking rates than the State average (14.8%), some as high as 50%. These include men from Chinese and Arabic backgrounds. [98]

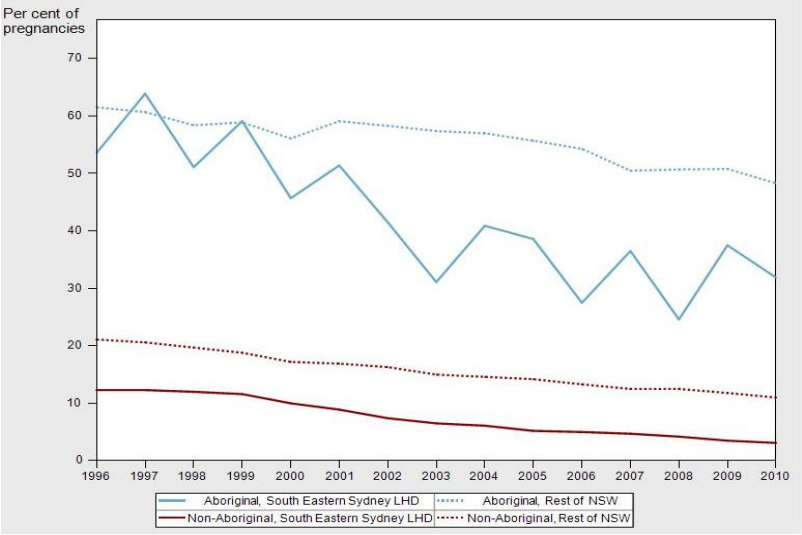
Figure 31: Prevalence of smoking (current daily or occasional), % of residents aged 16 years and over, SESLHD and NSW



While smoking rates have declined considerably in recent years, around 13% of our residents still smoke

Source: NSW Population Health Survey, NSW Ministry of Health, accessed from Health Statistics N

Figure 32: Smoking at all during pregnancy by Aboriginality, NSW & SESLHD residents, 1996-2010



Between 1996 and 2010 smoking in pregnancy decreased by approximately 30 % among Aboriginal women.

More than 1 in 5 Aboriginal women still smoke during pregnancy.

Source: NSW Perinatal Data Collection (SAPHaRI). NSW Ministry of Health.
Reproduced from Health Statistics NSW Note: Any smoking during pregnancy is included. All mothers giving birth (stillbirths and live births) in NSW are included. Due to under-reporting of Aboriginality to the PDC, it is likely that the true number of Aboriginal mothers in NSW is at least one-and-a-half times higher than that used to calculate these figures.

[97] SESLHD: About our District: a Snapshot/Health equity –are we achieving it? Available from: http://www.seslhd.health.nsw.gov.au/HealthPlans/documents/Snapshot/HealthEquity.pdf
[98] Intergovernmental Committee on Drugs. National Tobacco Strategy 2012-2018. Commonwealth of Australia; 2012.

Approaches that work

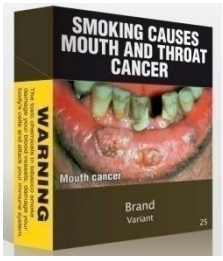
The death toll in Australia from smoking will pass the one million mark within this decade. Tobacco use remains unacceptably high when one half of all long-term smokers will die as a result of their smoking.

A broad range of evidence-based strategies have been applied to prevent and or reduce tobacco smoking in the community. These include:

- Public education campaigns which help to personalise the health risks of smoking and increase people's sense of urgency about quitting.[99]
- Complementing anti-tobacco public education campaign strategies with cessation support services to help smokers to quit. These cessation services include the NSW Quitline, including Multilingual (Chinese, Arabic and Korean) Quitline service, Cancer Institute NSW 'iCanQuit' website, Tobacco cessation mobile phone Apps, specialised cessation services, tobacco cessation brief interventions provided by health professionals and workplace programs.

Quitline 13 7848

- Increasing smokers' awareness and understanding of pharmacotherapies, particularly for highly dependent smokers. Evidence suggests that there are considerable benefits in enhancing tobacco cessation brief interventions by GPs and other health professionals.[100]
- Smoke-free environments which reduce non smokers' exposure to second-hand smoke and contribute to the de-normalisation of tobacco smoking. Smoke-free environments support efforts to quit and reduce the consumption of cigarettes, as smoke-free environments provide fewer opportunities to smoke.
- Sustained and systemic efforts for interventions targeting young people.[101]
- Involvement of Aboriginal community-controlled health organisations in providing leadership, policy development, program implementation of tobacco control strategies in partnership with governments, health services and non-government organisations is critical to achieve further reductions in the prevalence of smoking among Aboriginal people. This includes the specific adoption of accepted strategies such as the "Kick the Habit" social marketing campaign.
- Prohibition of displays of tobacco which can influence children's perceptions about the availability and accessibility of cigarettes in their community,[102] and make it harder for intending quitters to quit smoking.[103]



- Plain packaging of tobacco products, as recently mandated by the Tobacco Plain Paper Packaging Act 2011. Evidence of the effectiveness of plain packaging is extensively set out in the reports of the Preventative Health Taskforce.[104]

[99] National Preventative Health Taskforce. Australia: The Healthiest Country by 2020. Commonwealth of Australia; 2009
[100] Stead LF, Perera R, Bullen C, et al Nicotine replacement therapy for smoking cessation. Cochrane Database Systemic Review 2012, Issue 11. Art. No.:CD000146. DOI:10.1002/14651858.CD000146.pub4.
[101] 19. Scollo M and Winstanley M. Tobacco in Australia: Facts & Issues. Melbourne: Cancer Council Victoria; 2008.
[102] Wakefield M, Germain D, Durkin S, Henriksen L. An experimental study of effects on schoolchildren of exposure to point-of-sale cigarette advertising and pack displays. Health education research. 2006 Jun;21(3):338-47.
[103] Wakefield M, Germain D, Henriksen L. The effect of retail cigarette pack displays on impulse purchase. Addiction. 2008 Feb;103(2):322-8. PubMed PMID: 18042190.
[104] Available from: www.preventativehealth.org.au

Priority Actions to prevent and control tobacco use

- Drive an increase in **smoking** cessation and reduce uptake rates among our residents.
- Continue to monitor compliance with **tobacco legislation** to protect our residents from unnecessary exposure to **tobacco smoke**.
- Further develop, implement and evaluate effective and sustainable programs with and for **Aboriginal** people, including culturally appropriate and effective health promotion and primary care programs specifically targeting smoking cessation among pregnant women.
- Implement targeted programs for **disadvantaged** communities.
- Establish processes to **engage** effectively with patients, clinicians, local lead Clinicians groups, Medicare Locals and other stakeholders to optimise outcomes and service integration and coordination.

Programs and Activities to be delivered by the Directorate from 2014-19

SESLHD Smoke-free Health Care Program

From January 2013, the Tobacco Legislation Amendment Act (2012) enabled Local Health Districts and statutory health corporations to make a new by-law to issue penalty infringement notices to those smoking on designated smoke-free outdoor areas at public hospitals, health institutions and health services and provided the legislative framework for enforcement. Smoking inside all NSW Health buildings, vehicles and all outside areas is banned. Those who wish to smoke may do so in designated smoking areas, or if they are not available, must smoke off-campus.

Achieving implementation of this policy is a substantial undertaking. In SESLHD, this is overseen by the Smoke-Free Health Facilities Steering Committee with the engagement and participation of personnel throughout the District.

The Directorate will **lead and monitor** implementation of the SESLHD Smoke-free Health Care Program, including a strong focus on by-law implementation, designated smoking areas, public awareness, compliance monitoring and access to smoking cessation services by patients and staff, to provide:

- a smoke-free environment across all SESLHD facilities
- appropriate education and support to staff, patients and visitors to quit smoking.

As an integral part of the SESLHD Smoke-free Health Care plan, the Directorate provides leadership to support staff who are ready to quit by developing a range of resources and products related to offering free nicotine replacement therapy (NRT), free 4 weeks NRT for staff and promoting referral to the Quitline. Implementation of the nurse initiated NRT practice across SESLHD facilities provides patients with tobacco cessation brief intervention advice, access to NRT products and on discharge, referral to a smoking cessation service or the Quitline.

Tobacco Control Programs for special needs groups

The Directorate tailors its programs and activities for communities with a higher rate of smoking. It collaborates with service providers who service these vulnerable groups in the community and implements a range of smoking awareness and cessation activities. Successful partnerships have been developed with a diverse range of community-based organisations across South Eastern Sydney servicing socially disadvantaged clients.

These include those subject to homelessness, vulnerable youth, people who inject illicit drug users and people living with HIV/AIDS and other communicable and non-communicable diseases.

We will continue to facilitate training, provides resources and support to ensure staff are confident to discuss tobacco related topics and supports smoking cessation of their clients and works with organisations to develop a Smoke- free policy.

Tobacco awareness and cessation in the Aboriginal community

A key population health priority of the District is to build awareness among Aboriginal health workers and other health professionals regarding tobacco and second-hand smoking harm, particularly among pregnant women and their household members, families with children and people with chronic health conditions.

Quit For New Life is a new project which will be implemented in SESLHD and coordinated by the Directorate from 2014 onwards. The aim of this program is to reduce the smoking rate among Aboriginal pregnant women and exposure to second-hand smoking during the pre-natal and postnatal periods. The project works in collaboration with the Aboriginal Maternal Infant Health Services and Child and Family Health Services at Malabar and Narrangy-Booris Maternal, Child and Family Health Services based at Menai, Aboriginal health workers and the Health Promotion Service to change clinical practice and include smoking cessation advice into routine care.

We will continue to build the capacity of services within SESLHD and external to health to develop and deliver smoking prevention and cessation programs and actions.

Reducing tobacco smoking in Culturally and Linguistically Diverse communities

Due to a high prevalence of smoking in the Chinese and Arabic communities, these culturally and linguistically diverse (CALD) communities are a focus of the Directorate's work. Key projects being delivered by the Directorate include:

Tobacco retailer education project

In partnership with the Media and Communications Unit and Multicultural Health Unit, the Directorate has developed the **"Selling tobacco? Have You Asked for ID?"** project.

An education kit printed in English and simplified Chinese, Korean and Arabic will be posted to retailers in SESLHD who are known to have a high concentration of retailers from these CALD backgrounds. The kit will also be widely distributed through relevant small business and cultural associations and events as identified by the Multicultural Health Unit and the Directorate.
The initiative will be evaluated and if successful recommended for regional or State-wide use.

Tobacco Control project in the Arabic-speaking community

To address the high smoking rate among the Arabic community, the project aims to raise awareness about second-hand smoking and de-normalise water pipe smoking. Progresses to-date included consultations with Arabic-speaking community members and service providers, scoping literature for good practice models in smoking cessation in Arabic-speaking community and integrated evidence-based strategies to develop

culturally appropriate and effective intervention. An Advisory project group will be formed with support of the Arabic-speaking community members and workers to guide development and implementation of the project.

Tobacco Cessation Pilot Project for Chinese-speaking Male Restaurant workers

The Directorate has continued to work with the Chinese Australian Tobacco and Health Network (CATHN) to address smoking rates in the Chinese community. Due to the higher smoking rates found among restaurant male workers following consultations with owners and managers in Chinese restaurants, CATHN piloted a study with male Chinese restaurant workers in metropolitan Sydney in late 2012. The study explored smoking behaviours and knowledge of smoking related harm including Environmental Tobacco Smoke (ETS) and the benefits of quitting. In 2013, a grant from the Cancer Institute NSW was received to implement smoking cessation activities with this population group.

Case Study: A Partnership in Tobacco Control

The Chinese Australian Tobacco and Health Network (CATHN) was formed in 2001 by representatives from South Eastern Sydney, Sydney, Western and Northern Sydney Local Health Districts and the Cancer Council NSW, to reduce smoking prevalence and environmental tobacco smoke among the Chinese community. It has since been awarded NSW Multicultural Health Communication Service Awards in 2005, 2007 and 2009, demonstrating that pooling resources from a number of LHDs strengthens the effect of tobacco control initiatives among the Chinese community.

With the rapid increase of Chinese immigrants moving to NSW, there has been a correlation of higher smoking rates, particularly among Chinese males. In 2012, CATHN conducted a survey among 382 male Chinese restaurant workers in 54 Chinese restaurants in Haymarket, Chatswood, Hurstville and Parramatta to determine their smoking prevalence, and knowledge and attitudes towards their tobacco use and quitting. Preliminary results of the survey show that 30.8% of the workers smoked daily across metropolitan Sydney and 40% in Hurstville and Haymarket areas were either daily or occasional smokers.

In 2013, CATHN received a Cancer Institute NSW Evidence to Practice Grant in Tobacco Control to implement a pilot project among 40 male workers in two Chinese restaurants in metropolitan Sydney. In 2014, the project will implement a range of strategies including tobacco cessation training, a support group and a Chinese media campaign targeting the restaurant workers. Questionnaires at different phases will also be used to assess the effectiveness of the project.

The results of the project will be used to guide future development and implementation of smoking cessation programs targeting the workers in the greater metropolitan Sydney.

Addressing Tobacco Smoking in Young People

Reduction of tobacco smoking and uptake in young people remain a high priority for the Directorate. We have been working with a range of organisations that service young people to address these issues.

Randwick College: Towards a Smoke-Free Campus (TAFE) – is a collaborative project between Randwick College of TAFE, Cancer Council NSW and the South Eastern Sydney Local Health District Health Promotion

Service has been developed with the aim of protecting students and staff at Randwick TAFE from exposure to tobacco and assist the organization to move to a smoke-free campus.
Student and staff baseline surveys were conducted to evaluate current knowledge and attitudes towards tobacco as well as an observation study to gather information about smoking on the campus.

Based on recommendations from an environmental audit an alternative designated smoking area has been identified and will be built and ready for students and staff to use as of Term 1, 2014. Furthermore, smokers willing to quit will be able to access on-site trained counsellors and free nicotine replacement therapy (NRT) from Term 1, 2014.

Teachers from courses such as Dentistry, Early Child Care and Fitness are also encouraged to incorporate tobacco related content into their lesson plans and will be provided with the necessary information and resources.

Youth Project Graphic Design Competition

In partnership with St George Youth Services (STGYS) and graphic design students from St George TAFE, a competition was conducted with the aim of developing posters with anti-smoking messages, targeting 12-25 year olds. There were twenty-three artwork submissions, with over 270 votes collected from young people who chose the final three winning posters.

The posters that were developed will be used for future marketing and promotional purposes (i.e. websites, brochures, posters etc.) to engage young people and to encourage them to think about quitting smoking or prevent the uptake of smoking at a range of settings young people access.

Tobacco Control Project for Community Service Organisations (CSO) servicing disadvantaged Young People (WAYS, Botany Youth Program)

Working in partnership with youth-specific non-government organisations in Waverley and Botany local government areas, the Directorate has developed strategies to raise awareness of tobacco smoking harm and support these organisations to make a positive move towards addressing smoking with their staff and clients. The partnership started by engaging organizations in World No Tobacco Day 2013 activities and through collaborative development of a work plan. Planned strategies include: training staff in smoking brief intervention and cessation to assist their clients and staff in quitting smoking, provide resources and referrals to other smoking cessation services, undertake a review of existing smoking policies. Evaluation will include pre and post staff and client surveys about their knowledge and attitudes towards tobacco smoking and cessation as well as an amendment of an organisational smoke-free policy.

We will continue providing assistance to organisations to train their staff to support clients to quit tobacco smoking and develop smoke free policies.

Tobacco Compliance Programs

The Directorate will continue to deliver a range of Activities to monitor compliance with tobacco legislation in our community. These include meeting the obligations determined by the NSW Ministry of Health regarding tobacco control legislation (tobacco advertising, Sales to Minors, smoke-free environments), including:

- complaints investigations
- retailer inspections

- maintenance of a tobacco retailer database
- issue of warning letters
- preparation for prosecutions and consultation with the Ministry's Legal Branch on court appearance procedures.

The Directorate will also build the capacity of health professionals, local government officers and/ or others with responsibilities related to monitoring compliance.

We will continue to maintain a tobacco retailer database and an annual program of retail inspections to monitor and enforce compliance by tobacco retailers with Public Health (Tobacco) Act 2008 provisions which prohibit the sale of tobacco to minors and restricts retail advertising of tobacco products at point of sale.

A recent investigation revealed 56 tobacco retailers in SESLHD were in breach of the Act and were issued notifications (to be further investigated by the Directorate) for in-store breach of compliance or for not registering on the Tobacco Retailers Notification (TRN) list. In 2012, 40 breach of compliance notices were issued, with 38 successfully prosecuted.
The Directorate also follows up complaints regarding commercial premises which allow smoking in enclosed areas and people smoking in certain outdoor public areas in contravention of the amended Smoke-free Environment Act 2000, which make the following settings smoke-free:

- In public playgrounds within 10 metres of children's play equipment
- In open areas of public swimming pools
- In major sporting facilities and at public sports grounds
- At public transport stops and stations
- Within 4 metres of the pedestrian access point to public buildings
    - Commercial outdoor dining areas (from 2015)

Case Study: Partnership with Pole Depot Community Centre

Pole Depot Community Centre was awarded an **Anti-Tobacco Multicultural Community Grant** for priority culturally and linguistically diverse (CALD) communities from the Cancer Institute NSW in 2012-2013 to address high smoking rates in the Chinese community. The Directorate's Health Promotion Service worked in partnership with Pole Depot to achieve a range of important outcomes, including:

- **Capacity building**
  The Directorate held two training workshops for centre staff, community workers and Chinese-speaking volunteers to raise awareness about tobacco and second-hand smoking harm and quit smoking support. Training packs (both in English and Chinese) were provided to all participants.
- **Resource Development**
  The "*Smoking & Passive Smoking English Class Workbook*" was developed and used as a teaching resource for new arrivals who attended English classes at Pole Depot. It contained information on smoking/passive smoking and its harmful effects, NRT products in simple English and Chinese. The workbook was translated into simplified Chinese, trialled by English language teachers and recommended for use in the class. In 2013 the workbook won the Multicultural Health Communication Service Award for the best Non-Government Organisation Resource (under $5,000).
- **Organisational Development**
  A Smoke-free Workplace Policy Committee was formed to review and revise the Pole Depot's existing smoking policy to reflect the new Tobacco Legislation Amendment 2012.

Smoke Free Environments: Monitoring and Targeted Education Project

This project was instigated by the Directorate in March and April 2013 to identify levels of compliance and provide cautionary notices and information to community members with the aim of encouraging community compliance with recently amended tobacco legislation. Activities included: community education and awareness, with the provision of information to the public through media, fact sheets, and the Tobacco Information Line; the issuing of no smoking cautionary notices in community settings to provide individuals with targeted education and advice about their prohibited behaviour; supporting community compliance through scheduled and visible compliance monitoring; and investigation of community referrals, complaints monitoring and enforcement, with penalties associated with non-compliance. A total of 124 monitoring site visits were undertaken in a variety of public places in the District over the two month project period. No Smoking Cautionary Notices were issued to 28 people: ten for breaching smoking less than 4 metres from a pedestrian access point to a public building; and eighteen for smoking at a public transport stop or station. No smokers were observed within 10 metres of a children's playground or within a spectator area at a community sporting ground during an organised sporting event during this period. Overall, the large majority of observations of monitoring sites found no smokers in public places.

Other activities to be undertaken by the Directorate to address the priority initiatives:

We will implement local activities to support ***World No Tobacco Day*** each year.

We will develop a systematic approach to the introduction or update of smoke-free policies at organisations servicing young people.

We will ensure tobacco control actions involving young people are delivered in settings and through communication channels which will reach them.

We will implement tobacco control actions to support smoking cessation in people living with HIV and other priority populations accessed by the Directorate.

We will review and develop a systematic approach to developing and implementing sustainable tobacco control strategies for organisations servicing high risk population groups.

Photo: Health Promotion and Sydney Medically Supervised Injecting Centre, Kings Cross staff engage a client about smoking issues.

We will establish an effective governance structure to oversee the development, implementation and monitoring of the SESLHD Strategic Plan for the Prevention of Smoking and Harm from Smoking 2014-2019.

We will promote services to include patient referrals to Quitline and the Get Healthy Telephone Information and Coaching service.

We will promote state-wide campaigns about cessation services to/through partnerships with local organisations such as Medicare Locals, community-based organisations, partner agencies and community networks.

We will ensure that all programs have appropriate evaluation design, including indicators that are routinely tracked and reported, and contribute to the evidence base by disseminating the results of SESLHD program evaluations and participating in broader research strategies as appropriate.

Section 6: Monitoring and Evaluation

Our Directorate's Population Health Units measure their performance against targets and indicators set down in the NSW State Plan, the annual NSW Ministry of Health Service Agreement with the District, and a number of local District relevant indicators.

6.1 State Plan

The State Plan - *NSW 2021: A plan to make NSW number one* - sets the NSW Government's improvement agenda over the next 10 years, including in terms of various population health targets indicators, as shown in Table 3 below.

Table 3: NSW State Plan Targets and Measures related to Directorate's Population Health programs

Targets	Measures
Reduce smoking rates	
• Reduce smoking rates by 3% by 2015 for non–Aboriginal people and by 4% for Aboriginal people • Reduce the rate of smoking by non–Aboriginal pregnant women by 0.5% per year and by 2% per year for pregnant Aboriginal women	• Proportion of adults aged 16 and over who are current smokers • Proportion of women who smoked at any time during pregnancy
Reduce overweight and obesity rates	
• Reduce overweight and obesity rates of children and young people (5–16 years) to 21% by 2015 • Stabilise overweight and obesity rates in adults by 2015, and then reduce by 5% by 2020	• Proportion of children (5-16 years) who are overweight or obese • Proportion of overweight or obese, adults aged 16 years+
Close the gap in Aboriginal infant mortality	
• Halve the gap between Aboriginal and non–Aboriginal infant mortality rates by 2018	• Deaths in Aboriginal children aged up to 1 year per 1,000 live births

6.2 Population Health Directorate Plan 2014 -2019

The monitoring and evaluation system for this Population Health Plan can be summarised as follows:

Table 4: NSW Ministry of Health – SESLHD Service Agreement Measures related to Population Health as per SESLHD Health Care Services Plan 2012-2017

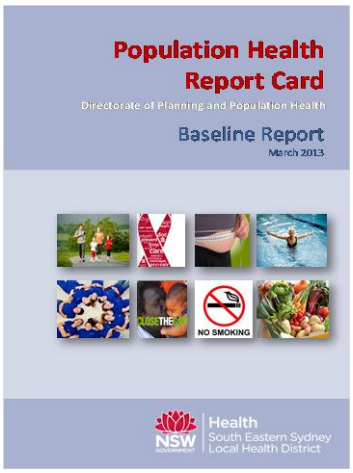
Monitoring & evaluation of progress in terms of:	Timing	Reporting	To:
1. Qualitative assessment of timely implementation of Plan initiatives/ actions	Six monthly	Nominated lead Unit within Directorate, with Directorate-wide coordination/ collation of report.	Directorate Executive
2. Quantitative assessment against:			

Monitoring & evaluation of progress in terms of:	Timing	Reporting	To:
a) Measures in the SESLHD/ NSW Ministry of Health Service Agreement	As per SESLHD/ MOH Service Agreement	Health System Performance Report SESLHD Population Health Report Card on SPaRC	Board, District Executive (routinely available)
b) Other local measures and targets (including those established in other Agreements)	As per relevant agreements & Report Card schedule (3-12 monthly, depending on measure)	SESLHD Population Health Report Card on SPaRC	
3. Qualitative and quantitative assessment	Annual Mid- term	Hard copy report (& electronic version) which brings together 1 & 2, & clearly identifies: • Successes and shortfalls • Reasons for shortfalls and actions taken or required • Recommendations to revise initiatives/ actions and measures/ targets as appropriate	Board, District Executive

When there are shortfalls in performance in terms of the measures and targets which are the same as (or closely relate to) those in the Service Agreement, responses will proceed as per the District's Performance Management Framework.

Population Health Report Card

A range of Population Health measures and targets – including those set down in the NSW State Plan and Ministry of Health's Service Agreement with the District - have been bought together in a newly developed *Population Health Report Card* which supports close monitoring and surveillance, and allows an examination against progress towards local health priorities in South East Sydney.



It is appropriate that this Directorate's *Population Health Report Card* and schedule will be the primary vehicle for monitoring and reporting of the implementation and outcomes of the Population Health Directorate Plan 2013-2018. An overview of this system is provided in Table 5.

Measures and targets included in the Report Card comprise:

- Those referred to in the District Service Agreements with the Ministry of Health.
- Other measures which provide complementary and contextual information to the Service Agreement measures and/or are related to other key Population Health programs.

It should be noted that for most, if not all, of these measures, both program/ implementation and outcome measures, while progress is intended to reflect the performance of our services, it depends on many other factors. These include:

- Approaches and actions taken by other services within and outside SESLHD and the broader health sector; and
- A range of social, economic, organisational, political, legislative and environmental factors which can potentially be influenced by population health services, but are generally out of our direct control.

It is intended to increase the number and range of measures and targets monitored via the Report Card to address performance domains that are currently not, or are inadequately, monitored.
Ongoing monitoring of these indicators is being facilitated by their incorporation - and, as far as possible, automated updating and reporting of data - into the Standard Performance and Reporting Collaboration (SPaRC) on the SESLHD intranet. This is currently being developed by the SESLHD Business Intelligence and Efficiency Unit.

Table 5: Population Health Performance Indicator/Service and Monitoring Measures identified in the annual SESLHD Service Agreement (SA) with NSW Ministry of Health (MoH) and Directorate's Population Health Report Card

Source	Service Name	Service Volume	Notes	Data Available
Increasing Immunisation Coverage				
NSW MoH	Public Health Unit	≥ 71%	Number of adults aged 65 years and over immunised against influenza	NSW Population Health Survey (from Health Statistics NSW)
NSW MoH	Public Health Unit	≥ 55%	Number of adults aged 65 years and over immunised against pneumococcal disease	NSW Population Health Survey (from Health Statistics NSW)
NSW MoH	Public Health Unit	< 11 cases Measles, < 5 cases meningococcal disease, < 1 Influenza type B	Number of vaccine preventable diseases - measles, Hib disease and meningococcal disease	Annual Statewide Health Protection Work Plan Indicators
SA Schedule D,E; NSW MoH	Childhood Immunisation Program	92%	Immunisation coverage: Aboriginal children fully immunised at 1 and 4 years of age	MoH Centre for Population Health
SA Schedule D,E; NSW MoH	Childhood Immunisation Program	92%	Immunisation coverage: Non Aboriginal children fully immunised at 1 and 4 years of age	Annual Statewide Health Protection Work Plan Indicators
SA Schedule D,E; NSW MoH	School based immunisation program	75%	Immunisation coverage: Year 7 students receiving 3rd dose of human papillomavirus (HPV) vaccine	MoH Centre for Population Health
Controlling blood borne and sexually transmissible infection				
SA Schedule D	STI Programs Unit	100%	Proportion of sites implementing the updated NSW Standard Operating Procedures manual (SOP) all publically funded Sexual Health Services. Hosted by SESLHD	Harp Unit Minimum dataset

SA Schedule D	Publicly funded HIV/sexual health services	To be advised	Antiretroviral dispensing data from hospital pharmacies per quarter - number of patients dispensed at least one ART regimen; number of patients dispensed Hep C ART, number of patients initiating HIV ART; number of patients initiating Hep C ART, number of patients who interrupted HIV ART	Health Share NSW
SA Schedule D. NSW MoH	Publicly funded HIV/sexual health services	To be advised	Total number of HIV tests and positive results by age and sex	Harp Unit Minimum dataset
NSW MoH	Publicly funded HIV/sexual health services	To be advised	Total number of HIV tests and positive results by sexual contact risk -Aboriginal people - gay and homosexually active men	To be advised
NSW MoH	Publicly funded HIV/sexual health services	To be advised	Total number of HIV tests and positive results by sex work risk	To be advised
	Publicly funded HIV/sexual health services	To be advised	Total number of HIV tests and positive results by injecting drug risk	To be advised
	Publicly funded HIV/sexual health services	To be advised	Number of HIV notifications	SEALS
	Publicly funded HIV/sexual health services	To be advised	Number of STI notifications	HARP Minimum Dataset
	Publicly funded HIV/sexual health services	To be advised	CD4 count by antiretroviral treatment status	To be advised
SA Schedule D,E	Needle and Syringe Program		Number of needles and syringes distributed in the last 12 months. Numbers are to be maintained or increased from levels of activity in the 2011/12 period	HARP unit NSP database
NSW MoH	Publicly funded HIV/sexual health services	40,650	Number of HIV testing/treatment/management OOS provided and proportion provided to specific priority populations • gay men and other homosexually active men • Aboriginal people • Total	MoH Centre for Population Health
SA Schedule D,E	Publicly funded HIV/sexual health services	Numbers are to be maintained or increased from activity in the 2011/12 period.	Number of STI testing/treatment/ management OOS provided and proportion provided to specific priority populations • Aboriginal people • Sex workers • Gay men and other homosexually active men • Total	MoH Centre for Population Health
SA Schedule D	Publicly funded HIV/sexual health services	1.26% % HIV testing (Aboriginal)	HIV testing proportion provided to Aboriginal people. Numbers are to be maintained or increased from activity in the 2011/12 period.	Harp Unit Minimum dataset
SA Schedule D	Publicly funded HIV/sexual health	42.09% % HIV testing	HIV testing proportion provided to gay men and other homosexually	Harp Unit Minimum dataset

	services	(homosexual)	active men. Numbers are to be maintained or increased from activity in the 2011/12 period.	
SA Schedule D	Publicly funded HIV/sexual health services	36,314 HIV treat/mgmt OOS	HIV treatment/ management OOS provided (monitoring proportion provided to gay men and other homosexually active men; and Aboriginal people). Numbers are to be maintained or increased from activity in the 2011/12 period.	Harp Unit Minimum dataset
SA Schedule D	Publicly funded HIV/sexual health services	SS Adahps Supported Accommodation Intake and Coordination Program	Proportion of referred clients who meet the priority 1 criteria under the original NSW HIV Supported Accommodation Program are accommodated appropriately. Hosted by SESLHD	Harp Unit Minimum dataset
SA Schedule D; MoH	Publicly funded hepatitis C related services	265	Number of clients in publicly funded services that are assessed for hepatitis C treatment	Harp Unit HCV Ambulatory Care Minimum dataset
SA Schedule D; MoH	Publicly funded hepatitis C related services	58	Number of clients in publicly funded services that are initiated onto hepatitis C treatment	Harp Unit HCV Ambulatory Care Minimum dataset
SA Schedule D	The Albion Centre Enhanced Medication Access Project	≥ 205 total enrolments per quarter	Number of patients actively enrolled in the EMA Scheme. Hosted by SESLHD	Albion Centre Pharmacy
Monitoring and response to communicable disease				
SA Schedule D; MoH	Public Health Unit	>85%	Food borne disease outbreaks where investigation commenced within 24 hours of report	Annual Statewide Health Protection Work Plan Indicators
Promoting healthy weight				
SA Schedule D, E NSW MoH KPI	Healthy Children Initiative (Tier 2 KPI)	50% cumulative	Proportion of Centre-based children's service sites adopting the Children's Healthy Eating and Physical Activity Program in Early Childhood to agreed standard (%)	MoH Centre for Population Health
SA Schedule D,E; NSW MoH KPI	Healthy Children Initiative (Tier 2 KPI)	50% cumulative	Proportion of Primary school sites adopting the Children's Healthy Eating and Physical Activity Program in Primary School to agreed standard (%)	MoH Centre for Population Health
SA Schedule D,E; NSW MoH KPI	Healthy Children Initiative (Tier 2 KPI)	432	Number of Children 7-13 years who enrol in the Targeted Family Healthy Eating and Physical Activity Program	MoH Centre for Population Health
SA Schedule D,E; NSW MoH KPI	Healthy Children Initiative (Tier 2 KPI)	85%	Proportion of children 7-13 years who complete the Targeted Family Healthy Eating and Physical Activity Program	MoH Centre for Population Health
NSW Healthy Eating and Active Living Strategy 2013 - 2018	Health Promotion services	≥ 52% fruit and 9% vegetables	Number of residents over 16 years consuming adequate number of serves of fruit and vegetables	NSW Population Health Survey (from Health Statistics NSW)
NSW Healthy Eating and Active Living Strategy 2013	Health Promotion Service	Sutherland and Botany Bay LGA residents to have < 5%	Number of hospitalisations for conditions attributable to overweight/obesity	NSW admitted patient data collection and ABS population

- 2018		greater high BMI related hospitalisations compared to NSW average		estimates (HOIST). (from Health Statistics NSW)
NSW MoH	Health Promotion Service	1,911	Number of Get Healthy Service participants	Office of Preventive Health
Preventing falls among older people				
SESLHD Falls and Falls Injury Prevention Plan 2013- 18	Health Promotion Service	< 3500 per 100,000	Number of falls related hospitalisations among residents aged 65 years and over	NSW admitted patient data collection and ABS population estimates (HOIST).
SA Schedule D; NSW MoH	Stepping On Program	30	Multi-faceted falls prevention groups are to be delivered to community-dwelling older adults who have either had a fall, or who have a fear of falling	SESLHD Stepping On Program, DPPH
Controlling tobacco				
SESLHD Strategic Plan for the Prevention of Smoking and Harm from Smoking 2013-2018; NSW MoH	Health Promotion Service	< 32%	Aboriginal women who smoked during pregnancy	NSW Perinatal Data Collection (SAPHaRI)
SESLHD Strategic Plan for the Prevention of Smoking and Harm from Smoking 2013-2018	Health Promotion Service	< 3%	Non-Aboriginal women who smoked during pregnancy	NSW Perinatal Data Collection (SAPHaRI) NSW Population
SESLHD Strategic Plan for the Prevention of Smoking and Harm from Smoking 2013-2018	Health Promotion Service	< 14%	Prevalence of smoking of residents aged 16 years and over	Health Survey (from Health Statistics NSW)
SESLHD Strategic Plan for the Prevention of Smoking and Harm from Smoking 2013-2018	Health Promotion Service	To be advised	Proportion of pregnant Aboriginal women (smokers) attending Quit for New Life Program that are referred to Quitline	Health Promotion
SESLHD Strategic Plan for the Prevention of Smoking and Harm from Smoking 2013-2018; NSW MoH	Health Promotion Service	To be advised	Proportion of pregnant Aboriginal women (smokers) attending Quit for New Life Program that are booked in for a follow-up appointment for smoking cessation care	Health Promotion
SESLHD Strategic Plan for the Prevention of Smoking and Harm from Smoking 2013-2018; NSW MoH	Health Promotion Service	To be advised	Proportion of pregnant Aboriginal women (smokers) attending Quit for New Life Program that are provided NRT	Health Promotion
NSW MoH	Public Health Unit	To be advised	Number of inspections of premises for compliance with tobacco control legislation	SESLHD Public Health Unit

Appendices

Appendix 1
Key Organisations, Policies and Resources Informing Population Health Activity

National
• National Partnership Agreement on Preventive Health • Australia: the healthiest country by 2020, National Preventative Health Strategy - the roadmap for action, National Preventive Health Agency • Australian Dietary Guidelines (2013) • Australian Physical Activity Recommendations for Children 0-5 Years • Second National Sexually Transmissible Infections Strategy 2010–2013 • Third National Hepatitis C Strategy 2010–2013 • National Hepatitis B Strategy • Sixth National HIV Strategy 2010–2013 • Third National Hepatitis C Strategy 2010–2013 • National Disability Strategy 2010-2020 • National Immunisation Program Schedule • National Injury Prevention and Safety Promotion Plan 2004–2014 • National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013 • National Tobacco Strategy • National Environmental Health Strategy • National service improvement framework for diabetes • National Safety and Quality Commission Standards • Implementation Plan for the Healthy Children Initiative. National Partnership Agreement on Preventive Health, 2010 • NMHRC Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Adolescents and Children in Australia (2013) • ANPHA National Preventative Health Research Strategy 2013 -2018
State
• NSW 2021 (State Plan) • Population Health Priorities NSW: 2012-2017 • NSW Aboriginal Health Plan 2013-2023 • NSW Healthy Eating and Active Living Strategy 2013-2018 • NSW Cancer Plan 2011-2015 • The NSW Refugee Health Plan 2011-2016 • NSW Tobacco Strategy 2012 – 2017 • NSW Immunisation Program • Environmental Sustainability Strategy 2012 - 2015 • Healthy Culturally Diverse Communities 2012-2016 • Keep Them Safe Guidelines • Influenza - NSW Health Influenza Pandemic Plan • Breastfeeding in NSW: Promotion, Protection and Support • Falls - Prevention of Falls and Harm from Falls among Older People: 2011-2015 • Women's Health Plan 2009-2011 • Healthy Urban Development Checklist • Youth Health Policy 2011-2016: Healthy bodies, healthy minds, vibrant futures • NSW HIV Strategy

- NSW STI Strategy
- HIV - Management of People with HIV Infection Who Risk Infecting Others
- NSW Sexual Health Promotion Guidelines
- NSW Hepatitis C Strategy
- Skin Penetration Guidelines
- Sexually Transmitted Infection Testing Guidelines for Men who have Sex with Men - STIGMA (Sexually Transmitted Infections in Gay Men Action Group)
- HIV/AIDS Care and Treatment Services Needs Assessment
- Tuberculosis and Human Immunodeficiency Virus (HIV) Infection
- HIV/AIDS, STI & Hepatitis C Strategies: Implementation Plan for Aboriginal People 2006-2009
- Pandemic Management - Governance Arrangements - Escalation of Health System Response
- Men's Health Plan 2009-2012
- Culturally & Linguistically Diverse Carer Framework: Strategies to Meet the Needs of Carers
- Population Health Surveillance Strategy NSW 2011-2020
- Notification of Infectious Diseases under the Public Health Act 2010
- HIV/AIDS, STI & Hepatitis C Strategies: Implementation Plan for Aboriginal People 2006-2009
- Pandemic Management - Governance Arrangements - Escalation of Health System Response
- Men's Health Plan 2009-2012
- Culturally & Linguistically Diverse Carer Framework: Strategies to Meet the Needs of Carers
- Population Health Surveillance Strategy NSW 2011-2020
- Notification of Infectious Diseases under the Public Health Act 2010

Appendix 2:
State and District strategies/plans supporting vulnerable populations

	NSW	SESLHD
Aboriginal Health	Aboriginal Chronic Conditions Area Health Service Standards www.health.nsw.gov.au/pubs/2005/accahss_report.html NSW Aboriginal Health Plan 2013 – 2023 National Aboriginal and Torres Strait Islander Health Plan 2013-2023 The Health of Aboriginal People of NSW: Report of the Chief Health Officer	Aboriginal Health Implementation Plan
Aged	Prevention of Falls and Harm from Falls among Older People: 2011-2015 www.health.nsw.gov.au/policies/gl/2011/GL2011_004.html Implementation Plan for NSW Dementia Services Framework 2010-2015	Falls Prevention Implementation Plan)
Carers	NSW Carers (Recognition) Act 2010 Implementation Plan 2011 – 2014 NSW Carers Action Plan 2007 - 2012 Working with Carers NSW	Carer Action Plan 2011-2012
Disability	A NSW National Disability Strategy Implementation Plan (NSW Government's initial priorities and actions) is under development. Service Framework : to improve the health care of people with intellectual disability Access to therapy services for people with an intellectual disability and their families in NSW Policy	SESLHD Disability Action Plan 2010-2015
Homeless	NSW Homelessness Action Plan 2009-2014 www.housing.nsw.gov.au/NR/rdonlyres/070B5937-55E1-4948-A98F-ABB9774EB420/0/ActionPlan2.pdf	Regional Homeless Action Plan 2010-2014 - Coastal Sydney (2010)
HIV affected	NSW HIV Strategy Sexually Transmitted Infection Testing Guidelines for Men who have Sex with Men - STIGMA (Sexually Transmitted Infections in Gay Men Action Group) HIV/AIDS Care and Treatment Services Needs Assessment Tuberculosis and Human Immunodeficiency Virus (HIV) Infection	
Multicultural Health	NSW Health Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012-2016. www.health.nsw.gov.au/policies/pd/2012/PD2012_020.html	Multicultural Health Service Strategic Plan 2010 – 2012
Refugee Health	Refugee Health Plan 2011-2016 Asylum Seekers - Medicare Ineligible - Provision of Specified Public Health Services Policy	SESLHD Refugee Health Implementation Plan
Youth Health	Youth Health Policy 2011-2016: Healthy bodies, healthy minds, vibrant futures	Youth Health
Children	Implementation Plan for the Healthy Children Initiative. National Partnership Agreement on Preventive Health, 2010	

Appendix 3:
Statewide Services administered by the Directorate

The Directorate administers a number of statewide services/units. These services and units have common priority populations and strategic collaborations with the Directorate of Planning and Population Health, and provide an opportunity to work closely together to address the current and future needs of the community.

These services include:

- Albion Centre :
    - Phone Lines
        - NSW HIV Information Line
        - NSW Needle Clean-Up Hotline
        - NSW Gay Men's Health Line
        - NSW Needlestick Injury Hotline
        - NSW PEP (Post Exposure Prophylaxis) Hotline
    - Albion Centre Library, the NSW State Reference Centre for HIV information, and a UNAIDS Information Support Centre, specialising in the medical, psychological, nutritional and treatment aspects of HIV.
    - '*Albion International Health Services*' which coordinates a program of international activities.

- NSW Community Sharps Management Program, which supports key stakeholders to implement best practice community sharps management policies and practices across NSW.

- NSW AIDS Dementia and HIV Psychiatry Service (ADAHPS), assists in the care and management of people with HIV and complex needs. Typically, clients may have a diagnosis of AIDS Dementia or a psychiatric illness complicating their HIV infection.

- NSW STI Program Unit (STIPU), which assists publically funded sexual health services to orientate service delivery toward priority populations; strengthens the capacity of general practitioners to manage STIs within the primary care setting; and promotes community awareness through statewide STI social marketing and information campaigns.

- Public Health Risk Panel to assess those who knowingly expose others to the risk of HIV infection, and provide advice to health care workers and LHDs regarding management to reduce public health risk.

- Sexual Health Information Line, a sexual health telephone information service run by Sydney Sexual Health Centre.

Appendix 4:
Aboriginal Health Impact Statement

Introduction

This Aboriginal Health Impact Statement has been produced to accompany the SESLHD Population Health Plan 2014-2019.

This Impact Statement is based on the NSW Aboriginal Health Impact Statement and Guidelines and aims to document the health needs and interests of Aboriginal people have been imbedded into the development, implementation and evaluation of the Plan.

Declaration

Title of Initiative

SESHLD Population Health Directorate Plan 2014 – 2019

☑ The health needs and interests of Aboriginal people have been considered and appropriately addressed in the development of this initiative.

☑ Appropriate engagement and collaboration with Aboriginal people has occurred in the development and implementation of this initiative.

☑ Complete checklist is attached.

Name of Manager: Gail Daylight
Title: Manager
Unit Name: Aboriginal Health
Local Health District: South Eastern Sydney

Signature: G Daylight Date: 20/2/14

Checklist

DEVELOPMENT OF THE POLICY, PROGRAM OR STRATEGY

1. Has there been appropriate representation of Aboriginal stakeholders in the development of the policy, program or strategy? ***Yes***

2. Have Aboriginal stakeholders been involved from the early stages of policy, program or strategy development? Please provide a brief description ***Yes***

Discussions were held with SESLHD's Manager, Aboriginal Health prior to the commencement of the planning process for the Population Health Plan to identify priority issues for Aboriginal people in the District. Since then advice has been sought from the Manager as required. In addition, as part of the consultation process the draft Plan has been provided to the Manager for broad distribution and comment.

3. Have consultation/negotiation processes occurred with Aboriginal stakeholders? ***Yes***

4. Have these processes been effective? Explain ***Yes***

The input from the Manager, Aboriginal Health has been highly valued. The Manager has given a broader perspective to the Plan in terms of examples of services, identification of Aboriginal people, as well as highlighting some key documents. All suggestions have been incorporated into the Plan.

5. Have links been made with relevant existing mainstream and/or Aboriginal-specific policies, programs and/or strategies? Explain ***Yes***

This Plan has been informed by a number of key documents informing population health policy, including the NSW Aboriginal Health Plan 2013-2023, Aboriginal Chronic Conditions Area Health Service Standards, National Aboriginal and Torres Strait Islander Health Plan 2013-2023, The Health of Aboriginal People of NSW: Report of the Chief Health Officer and the SESLHD Aboriginal Health Implementation Plan.

CONTENTS OF THE POLICY, PROGRAM OR STRATEGY

6. Does the policy, program or strategy clearly identify the effects it will have on Aboriginal health outcomes and health services? Comments ***Yes***

This Plan acknowledges that the needs of Aboriginal people be considered, and recognises that Aboriginal people are a priority population for population health services initiatives and programs in the District. The Population Health Plan identifies the need for health promotion and risk management initiatives for Aboriginal people, and outlines priority initiatives to achieve this.

7. Have these effects been adequately addressed in the policy, program or strategy? Explain ***Yes***

Consideration of the needs of Aboriginal people, engagement of Aboriginal staff and community members, the appropriateness of interventions, and better data and indicators to track progress are described across the Plan. These include primary prevention strategies for Aboriginal people in community settings, risk triage, and referral into prevention strategies as appropriate.

Examples of specific initiatives to address Aboriginal health outcomes in the Population Health Plan include:

- employing an Aboriginal Immunisation Officer to improve coverage and timeliness of vaccination among Aboriginal children in the District and to improve Aboriginal identification on the Australian Childhood Immunisation register.
- Aboriginal Sexual Health Promotion Officers working with young Aboriginal people to provide

education and support for sexual health issues.

- Aboriginal people have been identified as a priority population to gain access to treatment programs and services for people who inject drugs, particularly through the Aboriginal hepatitis C Treatment Access Project.
- Working in partnership with the La Perouse Aboriginal Health Service to promote health and wellbeing, with tobacco control and healthy eating programs.
- Tobacco control programs to build awareness among Aboriginal Health Workers regarding tobacco and second hand smoking, including a new project, 'Quit for New Life', to reduce the smoking rate and exposure to second hand smoke amongst pregnant Aboriginal women.
- A commitment to improving Aboriginal status in notifications of communicable diseases and ensuring culturally sensitive responses.

8. Are the identified effects on Aboriginal health outcomes and health services sufficiently different for Aboriginal people (compared to the general population) to warrant the development of a separate policy, program or strategy? Explain

Yes

Initiatives for Aboriginal people have been included in the Plan as a whole to ensure that all aspects of the Plan routinely and systematically consider the needs of Aboriginal people. This will ensure access to the most appropriate prevention evidence, intervention tools, infrastructure support and local resources.

Programs have been initiated to target areas of need within the SESLHD Aboriginal population, including Immunisation, sexual health, hepatitis C and tobacco control, and will be reviewed on a regular basis.

Underreporting of Aboriginality makes it difficult to measure the effectiveness of health services and achieve equitable outcomes for Aboriginal people. Improved recording remains a significant factor for improving equitable health outcomes for Aboriginal people.

IMPLEMENTATION AND EVALUATION OF THE POLICY, PROGRAM OR STRATEGY

9. Will implementation of the policy, program or strategy be supported by an adequate allocation of resources specifically for its Aboriginal health aspects? Describe

Yes

One of the District's key priorities is to adequately resource the health needs of Aboriginal people to reduce inequities of health service access and outcomes. Implementation of actions outlined in this Plan will be prioritised by the overarching committees responsible for implementation and monitoring implementation. All actions which require additional resources will be carried out subject to availability of funding provided by the District, State or Commonwealth.

10. Will the initiative build the capacity of Aboriginal people/organisations through participation? In what way will capacity be built?

Yes

Capacity building for Aboriginal communities is an important aspect of this Plan, with specific programs and initiatives targeting Aboriginal people and communities. Directorate staff will continue to work closely with Aboriginal Health workers and community members to improve the health outcomes of Aboriginal people.

The development of this Plan will allow all stakeholders, Aboriginal and non- Aboriginal, to learn more about these priority health issues and build personal and professional capacity through the development and implementation of this Plan.

11. Will the policy, program or strategy be implemented in partnership with Aboriginal stakeholders? Briefly describe the intended implementation process

Yes

The implementation of the Population Health Plan will be dependent on a range of important partnerships, including Aboriginal Health. SESLHD Aboriginal Health will continue to provide input and leadership to ensure this occurs.

12. Does an evaluation plan exist for this policy, program or strategy? *Yes*

13. Has it been developed in conjunction with Aboriginal stakeholders? Briefly describe Aboriginal stakeholder involvement in the evaluation plan

The evaluation of the Population Health Plan will occur throughout the Plan's life (ie 2014 – 2019). This evaluation will include:

- evaluation of improvements in identification of Aboriginal people
- specific performance indicators for Aboriginal people, including:
    - reduced smoking rates for Aboriginal people and reduced rate of smoking for pregnant Aboriginal women
    - number of pregnant Aboriginal women who attend Quit for New Life Program referred to Quitline, are booked in for follow up smoking cessation care, and are provided with NRT.
    - Aboriginal children fully immunised at 1 and 4 years of age.
    - HIV testing/treatment/management occasions of service for Aboriginal people. Numbers are to be maintained or increased from 2011/12 perod.

  These results will be reported to the Chief Executive through the District Executive Team and the District Clinical and Quality Council as well as the Manager, Aboriginal Health.

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NSW GOVERNMENT Health
South Eastern Sydney
Local Health District