SWSLHD Community Health

A Facility of South Western Sydney Local Health District

Operational Plan 2014 – 2018

Leading care, healthier communities

Health
South Western Sydney
Local Health District

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Foreword

The purpose of this plan is to set the key operational directions for SWSLHD Community Health between now and 2018. It is anticipated that Community Health in SWSLHD will experience a significant level of change during this period, providing challenges and opportunities for all of the dedicated staff working in Community Health and the population of south western Sydney. Building on foundational work that encompassed a thorough independently led review of Community Health services in SWSLHD in 2014, this plan describes a broader approach to future investment opportunities and models of care that will lead to innovation, bring services closer to where people live and engage wider groups in delivering health care and support to residents of south western Sydney.

I encourage all staff within SWSLHD to familiarise themselves with this plan, along with our partners in general practice, local government, the human services sector and residents of south western Sydney. Community Health has a proud history of working in partnership with all these groups to transition patients from acute hospital to home-based care. Equally, this history encompasses support for new mothers and families as they leave maternity units to return home to care for their new baby. It is also a recognition of our strong commitment to providing high quality nursing, medical and allied health interventions such as Speech Pathology, Occupational Therapy and Dietetics/Nutrition to children and their families unable to access private, specialised intervention services. Similarly, this plan celebrates our work with specific population groups with unique health needs including Aboriginal and Torres Strait Islander persons, culturally and linguistically diverse groups, women living with health disadvantage (including violence and trauma), young people, persons living with sexual health risks and persons living with economic disadvantage. This work has been both challenging and immensely rewarding for staff working within Community Health and the south western Sydney population accessing these services.

Building on the SWSLHD Healthcare and Strategic Services Plan - *Strategic Priorities in Health Care Delivery to 2021* and Corporate Plan 2013 – 2017 - *Directions to Better Health,* for Community Health in SWSLHD, this plan provides the blueprint for translating the SWSLHD vision and mission into locally led action. The operational priorities outlined in this plan match those set in the SWSLHD Corporate Plan, demonstrating the key action areas in which changes and improvements to services will be targeted in the four years to come. These changes and developments will be both challenging and exciting as Community Health moves forward.

This plan has been developed in consultation with all Community Health Managers. I thank them for their contributions as well as all members of the Community Health Executive Team who participated in creation of the plan. This plan would not, however, be completed to its current standard if not for the concerted effort of the Community Health Operational Plan Working Party, a small group of dedicated managers representing each of the clinical directorates. I offer my personal thanks to those working party representatives: Benjamin Neville (Psychology Team Leader); Timothy Stevenson (Quality and Safety Manager); Sonia Herrera (Nursing Unit Manager Macarthur Community Health Nursing Team); and Rana Qummouh (Women's Health Manager).

Justin Duggan

Acting General Manager

Executive Summary

The Community Health Operational Plan 2014 – 2018 has been designed to complement the SWSLHD Healthcare and Strategic Services Plan - *Strategic Priorities in Health Care Delivery to 2021* and Corporate Plan 2013 – 2017 - *Directions to Better Health**.*** This plan brings together the emerging demands for community-based care with careful consideration of the challenges and opportunities associated with delivering care that is effective, sustainable, based on sound evidence and measurable. In doing so, the plan has been constructed to address key drivers for service development. These include:

1. **Community Profile**

The plan considers the likely impact of the current and emerging community profile that SWSLHD Community Health will need to serve. This includes assessment of the unique population needs of south western Sydney in terms of both demographic characteristics and health behaviours. This analysis provides a platform for determining the types of services that need to grow and the changes that may need to be made to current models of care.

2. **Facility Profile**

The facility profile articulates the current configuration of services, facilities and workforce across south western Sydney. This section also considers the key achievements made by Community Health in areas such as research and innovation, education and training, partnerships development and activity performance. It is from this section that key achievements help to guide ongoing investment in areas of work that demonstrate great promise. Similarly, the facility profile highlights opportunities to review and redefine existing services.

3. **Future Demands & Challenges**

This section of the plan outlines the major expected changes in demand for services based on population growth, including changes for particular age and cultural groups, changes in household composition, lifestyle patterns and living with economic disadvantage. In considering the likely impact on services, this section also reflects on specific challenges for Community Health to deliver services, including: information and communication technology needs; building stock, quality and design; and changing funding patterns at both state and national levels.

4. **Priority Future Directions**

Drawing this information together, this section outlines the broad strategic priorities for future investment in community-based service models. This includes a brief description of the elements needed to underpin future models of care. This section also articulates the health conditions, settings and population groups on which Community Health will focus service enhancements between 2014 – 2018.

Introduction

In December 2013, two strategic planning documents to guide the future directions of South Western Sydney Local Health District (SWSLHD) were released:

- The Healthcare and Strategic Services Plan - *Strategic Priorities in Health Care Delivery to 2021* - which provides the healthcare services development plan for the District for the next ten years
- The South Western Sydney Corporate Plan 2013 – 2017 - *Directions to Better Health* - which outlines the actions that the District will take over the next five years to respond to community and District-wide needs and concerns and ensure that targets and strategies articulated in the national, NSW and the SWSLHD performance agreement are addressed.

The strategic directions and priority corporate actions are summarised in the *Summary of Strategic Directions*.

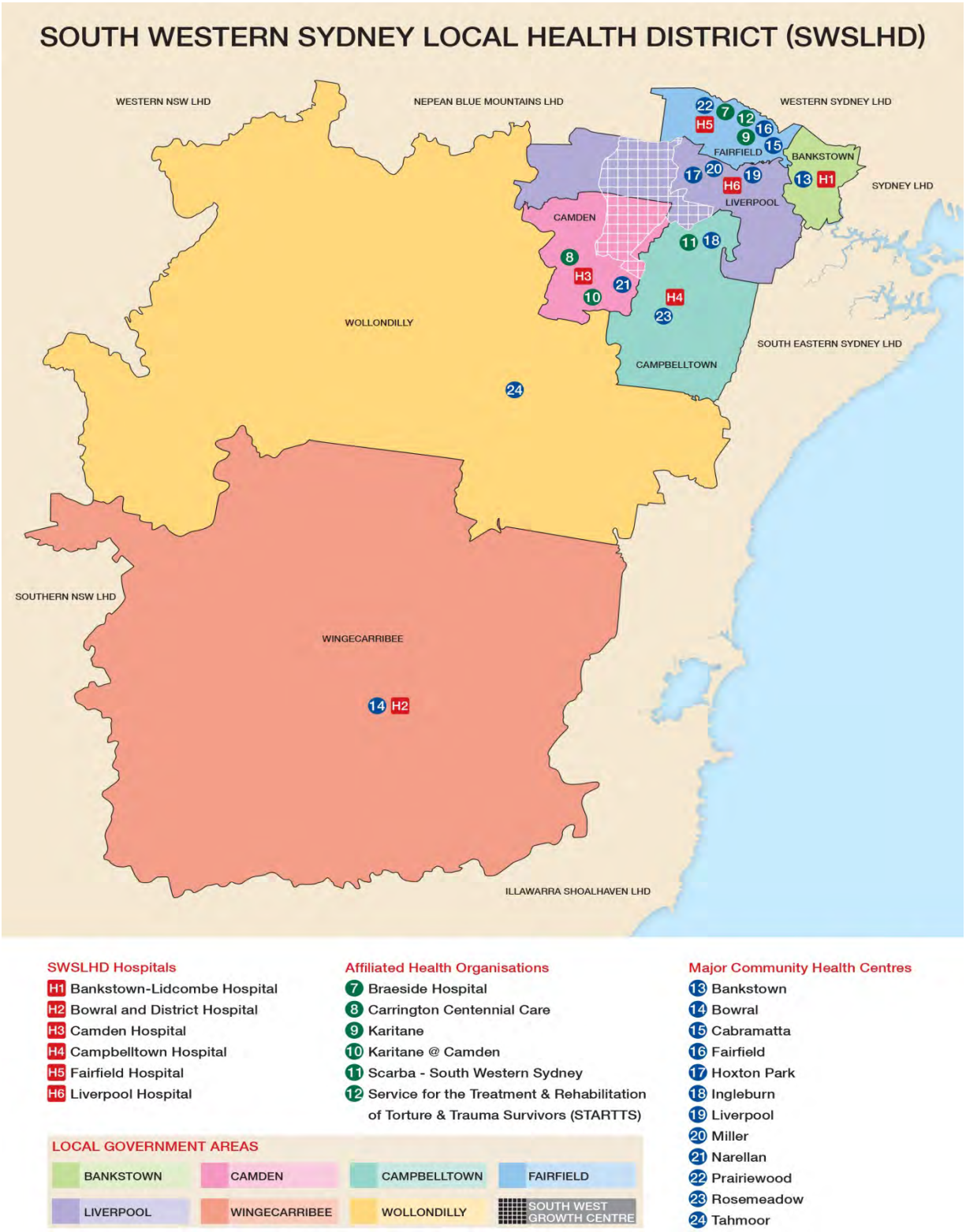
Together, these Plans form the basis of aligning all SWSLHD services to achieving the Vision of ***Leading Care, Healthier Communities***. They also provide a values framework which underpins all that we do. This includes the CORE values of Collaboration, Openness, Respect and Empowerment which are the foundation stones for building trust with our local communities; the mission statement which articulates our purpose, outlining how we will work collaboratively, innovatively and equitably to deliver better healthcare; and the core set of principles for service development (Appendix 1).

The *SWSLHD Community Health Operational Plan 2014 - 2018* provides a framework through which the corporate priorities and actions articulated in the *SWSLHD Corporate Plan* will be addressed. The Corporate Areas of Action are:

- High quality health services
- Seamless networks
- Research and innovation
- Supporting business
- Community partnerships
- Developing our staff
- Enhancing assets and resources
- Efficiency and sustainability

The Plan outlines the specific strategies that SWSLHD Community Health services will take over the next five years to realise these organisational goals and contribute to achievement of the SWSLHD Vision. The plan is designed to incorporate the findings and recommendations emerging from a thorough review of Community Health Services in SWSLHD in early 2014.

Map of South Western Sydney Local Health District



SWSLHD Hospitals

- H1 Bankstown-Lidcombe Hospital
- H2 Bowral and District Hospital
- H3 Camden Hospital
- H4 Campbelltown Hospital
- H5 Fairfield Hospital
- H6 Liverpool Hospital

Affiliated Health Organisations

- 7 Braeside Hospital
- 8 Carrington Centennial Care
- 9 Karitane
- 10 Karitane @ Camden
- 11 Scarba - South Western Sydney
- 12 Service for the Treatment & Rehabilitation of Torture & Trauma Survivors (STARTTS)

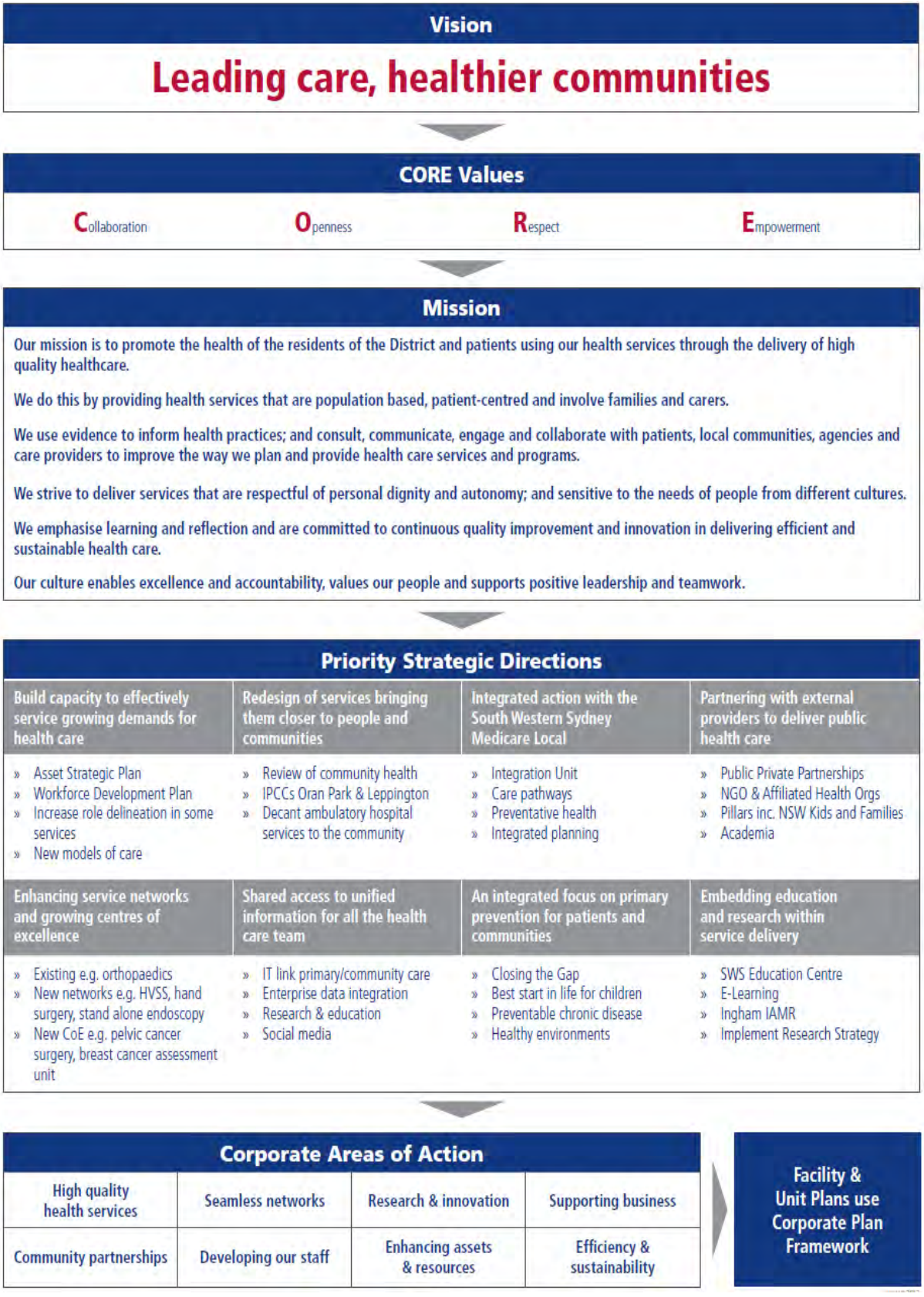
Major Community Health Centres

- 13 Bankstown
- 14 Bowral
- 15 Cabramatta
- 16 Fairfield
- 17 Hoxton Park
- 18 Ingleburn
- 19 Liverpool
- 20 Miller
- 21 Narellan
- 22 Prairiewood
- 23 Rosemeadow
- 24 Tahmoor

LOCAL GOVERNMENT AREAS

BANKSTOWN | CAMDEN | CAMPBELLTOWN | FAIRFIELD | LIVERPOOL | WINGECARRIBEE | WOLLONDILLY | SOUTH WEST GROWTH CENTRE

Values Framework



Appendix 1 outlines the Guiding Principles SWSLHD applies in service delivery.

Community Profile

South Western Sydney Local Health District covers the local government areas (LGAs) of Bankstown, Camden, Campbelltown, Fairfield, Liverpool, Wingecarribee and Wollondilly.

In 2013 the population of SWSLHD was estimated at 904,891 people, projected to increase by 18,000 people per annum over the next decade. By 2016 the population is expected to reach 966,137 people and 1.06 million by 2021.

Growth is driven in part by the high number of births associated with fertility rates (the average number of babies born to a woman through her reproductive life) which are well above the NSW rate of 2.15 births. Growth is also driven by urban development, particularly the South West Growth Centre (SWGC), which is impacting on Liverpool, Camden and Campbelltown LGAs. This mainly greenfield development will increase the population in the south-west by 300,000 people by 2025. In addition, there are significant developments planned for Wollondilly, with an additional 1,400 new dwellings and urban infill particularly in Bankstown and Fairfield LGAs.

Some key areas where South Western Sydney differs from NSW include:

- A higher rate of residents speak a language other than English at home (48.6%) than the NSW rate of 27.5% (as high as 74.1% in Fairfield LGA and low as 8.8% in Wollondilly LGA)
- 41.6% or 10,932 of all NSW Humanitarian Stream (Refugee) arrivals between 2008 and 2013 were re-settled in South Western Sydney
- A higher proportion of Aboriginal people and Torres Strait Islanders in Campbelltown LGA (3.2%) than NSW (2.5%)
- SWSLHD covers a diverse socio-economic region with ratings on the Socioeconomic Index for Advantage/Disadvantage (SEIFA) ranging from 854 to 1047 including some of the poorest communities in NSW (ABS 2011) with higher rates of unemployment and lower rates of school completion. There are also higher rates of disability
- Approximately 26,400 social housing dwellings (Community Housing and Housing NSW) with waiting lists for housing exceeding ten years in some LGAs. There are also 3,600 homeless people and almost 5,000 people living in crowded dwellings
- Higher levels of psychological distress reported (13.2%) compared to NSW (11.1%)
- SWSLHD residents were generally less likely to rate their health status as good, very good or excellent than the NSW average; report higher rates of daily and occasional smoking; lower rates of physical activity and higher rates of overweight and obesity.
- SWSLHD had a higher incidence of multiple types of cancer compared to the NSW average and mortality rates for cardiovascular disease is 5% higher in SWSLHD.
- SWSLHD has higher rates of diabetes, Hepatitis B and Hepatitis C.
- Breastfeeding rates in SWSLHD are approximately 9% lower than the NSW average.
- Babies with a low birth weight (under 2.5kg) represented 7.4% of all births in the District in 2010, 1.3% higher than the NSW average.
- In 2010, only 79% of pregnant women in the District had a first antenatal visit before 20 weeks gestation, compared to 92% in NSW. Similarly, only 54% of women had a first antenatal visit before 14 weeks gestation, compared to 79% in NSW.
- Campbelltown, Bankstown and Liverpool LGAs report higher than the NSW average in Domestic Violence Incidents with Campbelltown being more than double the NSW average to have the highest rate in the Sydney Metropolitan Area.

- Cervical screening rates, with the exception of the Wingecarribee LGA for women under 50, are between 4-6% lower than the state average.
- The number of people living alone is lower than the state average with the exception of Wingecarribee LGA.
- The NSW Office of Communities Commission of Children and Young People *41* reports that as at 30 June 2010 there were 1,955 children living in out of home care in the Metro South West Region of Community Services (11.2% of the State total). Aboriginal children are over represented in out of home care.
- South western Sydney has a higher than state average of single-parent families, the highest being within the Fairfield LGA.
- According to the Public Health Information Development Unit (PHIDU), the GP to population ratio in SWSLHD in 2012 was reported to be 1:953, indicating relative scarcity compared to the NSW ratio of 1:911 and the national ratio of 1:894. There is significant regional variation, from 1GP:606 in Wingecarribee to 1GP:2,960 in Wollondilly.
- Whilst South Western Sydney has a slightly higher rate of full-time employment than the NSW average, it has a lower level of part-time employment and higher unemployment.

Appendices 2 and 3 provide demographic and health information about the residents of South Western Sydney.

Figure 1: Fairfield Community Health Centre

Facility Profile

SWSLHD Community Health provides a range of community-based early intervention, assessment, acute/post-acute treatment, health maintenance and continuing care services designed to improve or maintain the health and wellbeing of individuals and communities. Services are provided from community health centres, early childhood health centres and other community health facilities, and in preschools, schools, non-government organisations, homes and workplaces.

The main Community Health centres are located at Bankstown, Bowral, Cabramatta, Carramar, Hoxton Park, Ingleburn, Liverpool, Miller, Moorebank, Narellan, Prairiewood, Rosemeadow and Tahmoor. In total, there are more than 60 venues including early childhood, youth health and other centres across SWSLHD used for the delivery of community health services.

Catchment Population

The catchment population of SWSLHD is diverse, encompassing areas of high density urban housing (25.64 people per hectare in Bankstown) and rural areas (0.17 people per hectare in Wollondilly). Depending on the LGA, the population can range from being culturally diverse (74.1% percent of Fairfield residents identify English as a second language) to English speaking (8.8% of Wollondilly residents identify English as a second language).

Services and Programs

Community Health provides programs and services in:

- Child and Family Health assessment and intervention for children 0-18 years and their families, including: child and family health nursing; vision screening and health promotion; audiometry; occupational therapy; speech pathology; physiotherapy; social work; psychology; orthoptics; dietetics/nutrition, medical, child protection and out of home care (OOHC)
- Specialist areas including: sexual health; women's health; sexual assault; community nutrition; community development; multicultural health and youth health
- Community Nursing Services including post-acute medical and surgical care and palliative care nursing.

Activity and Performance

In keeping with the rich and complex nature of south western Sydney, Community Health has demonstrated a strong track record in delivering a wide range of services to communities and residents with significant health needs. To address these needs, services are tailored to intervene at an early stage to reduce the risk of developing poor health. The major focus areas for these services include:

Paediatric Development

- Delivering in excess of 1000 universal health home visits per month for families with newborn babies and coordinating hearing screening for all births within SWSLHD hospitals.
- Delivering sustained health home visiting programs to vulnerable families in all regions, excepting Wingecarribee.
- Delivering specialist referred Community Paediatric medical interventions for over 1300 children living within SWSLHD boundaries per annum.

- Delivering in excess of 2900 individually tailored Speech Pathology and Occupational Therapy occasions of service for children aged between 0 – 6 years unable to access private clinical services in south western Sydney each year.
- Delivering vision screening to 4 year old children in over 500 preschools and childcare centres across south western Sydney.
- Collectively, 15% of the population serviced by this group report being from a Culturally and Linguistically Diverse (CALD) background and 3% from an Aboriginal or Torres Strait Islander (ATSI) background.

Women's Health Services

- Delivering holistic 'well women's clinics' that offer cervical screening interventions in all Local Government Areas to over 600 women annually, including 39% of which who are from a CALD background, 2% ATSI descent and, importantly, who have not received a screen within the previous 4 years.
- Delivering more than 200 specialist interventions per month for women living with violence in the Green Valley and Liverpool regions.

Youth Health Services

- Delivering counselling and nursing interventions for 700 young people living in south western Sydney annually, including 15% from a CALD background and 8% of ATSI descent.

Counselling Services

- Delivering counselling interventions to over 1800 individuals annually across all Local Government Areas (22% CALD, 5% ATSI).

Post-Acute Surgical and Medical Nursing Care

- Delivering clinic and home-based care to over 1000 new clients per month (in addition to existing clients), equating to approximately 40% of referrals for wound care, 24% for palliative care, 16% for catheter care and 5% for intravenous antibiotic administration and 9000 occasions of service per month.
- Facilitating in excess of 1 in 5 deaths at home at the request of families.

Sexual Health Services

- Delivering more than 150 clinical interventions per week through 2 sexual health clinics in Liverpool and Campbelltown, ensuring that HIV testing rates are increasing and that 80% of clients receive Chlamydia screening on first visit.

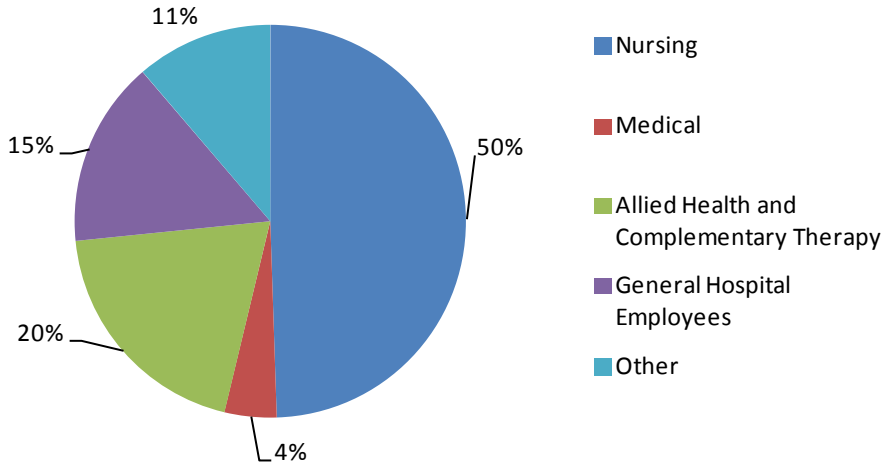
Sexual Assault Services

- Sexual Assault Services deliver over 200 individual counselling and post-incident support occasions of service per month to those who have experienced a sexual assault. These services are augmented via provision of court support and group programs.

Workforce

In 2013, 560 people or 4.7% of all SWLHD staff were employed by SWSLHD Community Health services. This includes 277 nurses, 24 doctors and a range of other clinical and non-clinical staff. Appendix 6 provides a workforce profile for Community Health by employment category.

Community Health Workforce Profile, 2013



Recent Achievements

In recent years, Community Health has realised a number of significant achievements, including expansion and improvement of services available to residents of south western Sydney. These include:

- Establishment of the Triple I (Hub) as a first step in implementation of a centralised referral and care coordination service for all community-based referrals in SWSLHD.
- Increased reach of Sustained Health Home Visiting Programs to include all sectors in south Western Sydney, excepting Wingecarribee.
- Introduction of medication packages and nurse-initiated medication standing orders for Sexual Health Services
- Establishment of Women's Health clinics in areas of need and with low cervical screening rates (Narellan, Warwick Farm, Miller, Green Valley, Bankstown, Cabramatta, Claymore & Odyssey House and Prairiewood).
- Implementation of the NSW Health Domestic Violence Routine Screening (DVRS) Policy including training of approximately 80% of staff in the target services for screening e.g. Drug Health, Mental Health, Maternity and Child and Family Services.
- Development and implementation of targeted community education programs by Bilingual Community Educators, including 'Get to Know the Australian Aged Care System' and 'Planning Ahead in CALD Communities'.
- Review of school aged therapy services and reinvesting in early intervention, resulting in increased referrals for children from pre-schools.
- Establishment of an Out of Home Care (OOHC) Program with formal referral pathways and embedded partnerships to identify health risks for children in foster care.
- Establishment of strong partnerships and expanded early intervention services with Aboriginal Community Controlled Health Services in south western Sydney.
- Introduction of Community Health Nursing procedural clinics in 5 Community Health Centres within SWSLHD.
- Development and publication of 'My Very Own Book About Counselling' for children receiving counselling support.
- Successful participation in the inaugural Quality Systems Assessment Program for Community Health, demonstrating effective systems performance in wound management.

Partners

SWSLHD Community Health works in partnership with a number of government and non-government agencies, general practitioners, patients, carers and volunteers. Community engagement and support is integral to ensuring Community Health is meeting the needs of the community. Some of these partners include:

- South Western Sydney Medicare Local
- Tharawal Aboriginal Corporation
- Kari Aboriginal Resources
- Department of Family and Community Services
- Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)
- Department of Education and Communities
- Gandangarra Land Council
- South western Sydney Councils
- Universities of Western Sydney, New South Wales and Sydney
- Non-Government Partners
- SWSLHD Hospitals and Clinical Streams

Education and Teaching

In keeping with a commitment to foster best practice based on reliable evidence, Community Health has continued to develop internal capacity to deliver learning and development opportunities for Community Health staff, SWSLHD staff and external providers. This includes:

- Formalised delivery of Active Learning Modules on HIV and Sexually Transmitted Infections to General Practice
- Significant increase in student placements across Community Health over recent years
- Development of a community mental health education program specifically designed for culturally and linguistically diverse communities in partnership with government and non-government organisations
- Delivery of Domestic Violence Routine Screening (DVRS) training for screening of women in mandated services across SWSLHD
- Participation in the Performance Indicator Clinical Indicator (PICI) Group developing statewide clinical indicators, performance indicators and outcome measures for Speech Pathology services
- Increased uptake of Community Health Managers participating in postgraduate management studies through the University of Tasmania and University of Sydney
- Implementation of a new graduate program in four Community Health Nursing Teams
- Delivery of palliative Care workshops, “ABC of Palliative Care“, by Palliative Care Specialist Service 3 times per year

Research

Recognising the development of best practice is also dependent on good research and evaluation, Community Health has taken great strides over recent years to develop applied research skills. This is demonstrated by:

- Establishment of a Primary and Community Health Research Unit (PCHRU) in collaboration with the University of New South Wales and the Ingham Institute for Applied Medical Research

- Implementation of a Research Mentoring Program through PCHRU resulting in initiation of 17 research projects, generation of 6 peer reviewed journal articles, 2 peer-reviewed conference papers and 4 conference abstracts for national conferences
- Completion of a Research Capacity and Culture Review for Community Health to be used in development of a Community Health Research Strategy
- Establishment of a Community Health Research Advisory Group
- Publication of a South Western Sydney Child and Family Headline Indicators Report
- Establishment and implementation of an Early Years Research Group under the responsibility of the Community Paediatrics Unit.
- Formal research projects on: assessment of the Australian Developmental Screening Test (ADST) and Ages and Stages Questionnaire (ASQ) on diagnostic assessment for children; maternal depressive symptoms in south western Sydney; maternal predictors of vulnerability and the impact on child health; Practice Nurse use of the child Personal Health Record (PHR); normal saline in comparison to tap water; sustained home visiting services for Aboriginal and non-Aboriginal families; and service integration in a disadvantaged community of south western Sydney.

Figure 2: Ingleburn Community Health Centre

Future Demands

Activity in Community Health is measured by Non-Admitted Patient Occasions of Service (NAPOOS). This measure is also used to capture other outpatient clinical services. Based on projected population trends in south western Sydney, an assumed growth of 30% is anticipated in total non-admitted patient activity across the District between 2011 and 2021. This will result in an activity increase from 2,593,695 occasions of service (including privately referred patients) to 3,342,724 occasions of service i.e. almost 750,000 more NAPOOS. For Community Health, this is expected to equate to an increase in NAPOOS of some 50,000 between 2011 and 2017 (13%).

Population changes likely to impact on Community Health include a significant population growth to 2021 with the population projected to grow by 20% (approximately double the NSW rate over this period). This change will be particularly concentrated on the Camden Local Government Area with a population increase of 30% projected by 2018. This part of the growth corridor has limited physical infrastructure for health services and will require investment to establish integrated primary care centres as demand increases for out-of-hospital care.

Similarly, the most significant population growth increases across the District will occur in older persons with the number of people aged over 60 years expected to increase by over 30% up to 2018. Many diseases and health conditions increase with age with increased complications and co-morbidities. This in turn will impact on length of stay in hospital and demand for health care in the community.

In terms of household types, population estimates show an expected increase in lone person households up to 2018 of approximately 13%. It is likely that this change will result in increased demand for Hospital in the Home type services and challenges in achieving effective self-management of chronic and complex conditions. Community Health services will need to monitor the impact of this trend, particularly in relation to the increased risk of hospitalisations and/or social isolation with this group.

As the population ages, the proportion of individuals living in their own home with a degree of disability is increasing. While less than 40 % of the population aged between 60 and 64 are found to have some level of disability, this proportion increases to over 80% by the time the individual is aged over 84 years. This trend, again, is likely to require increasing investment in home-based health intervention services that may be provided by the public health system, non-government providers or a mix of both in coming years.

Other challenges likely to impact on Community Health in south western Sydney include:

- Ongoing lifestyle behaviour characteristics of local communities which negatively impact on health – eg. lower levels of exercise, lower consumption of healthy foods, higher rates of smoking and lower rates of antenatal visit in the first 20 weeks of gestation.
- Significant pockets of socio-economic disadvantage in the community, with some communities having lower life expectancy and considerably poorer health outcomes associated with differing capacity and ability to access health care and engage in healthy lifestyles, including those living with unemployment, locational disadvantage, poor transport options and food insecurity.
- Ensuring that people from culturally and linguistically diverse communities receive the health services they need.
- Uncertainty about the impact of changes such as: activity based funding (ABF) on local funding; increasing need to form private public partnerships to meet increasing demands; the need for better information links and systems between the community, hospital, general practice and other providers; the impact of the personally controlled electronic health record on care coordination; and planned changes to funding arrangements for Aged Care and Rehabilitation Services and implementation of the National Disability Insurance Scheme.

Challenges in Meeting Demands – Current and Future

Community Health services and facilities across SWSLHD are set to face many competing demands over the coming five years. The majority of Community Health Centres in SWSLHD are staffed to capacity and physically deteriorating. Investment will be required to ensure buildings are 'fit for purpose', meaning that they facilitate access to suitable treatment and intervention spaces for residents in south western Sydney while also providing a base for home visiting and telehealth options as clinically appropriate.

Likewise, Community Health information and communication technology systems require significant investment over this time to ensure services can effectively coordinate care, monitor and report on performance and link with internal and external care providers as needed. This will need to include introduction of electronic 'point of care' devices to manage and document patient care in 'real time'.

Recognised as an area of high need, south western Sydney is home to a high proportion of vulnerable population groups with complex social and/or health issues. These populations include Aboriginal people, non-English speaking people and people living with social and economic disadvantage. Whilst Community Health can proudly reflect on its commitment to working with these groups to improve health outcomes, the demand for such intervention is anticipated to increase. Community Health will need to develop new and innovative partnerships to ensure these needs are met.

Other specific challenges for SWSLHD Community Health include the following:

- Sustained population growth across all aged groups
- Significant increases in population growth for persons aged older than 60 years and the associated health impacts
- Increases in lone person households, particularly for older persons
- High birth rate
- Lifestyle behaviours such as smoking which contribute to disability, early death and hospitalisations
- Changes linked to funding arrangements for Aged Care and Rehabilitation Services and the National Disability Insurance Scheme, potentially affecting referral pathways, reporting relationships and service delivery models
- Reorganisation of Medicare Locals into new Primary Health Networks, potentially impacting on care delivery arrangements
- An ageing workforce

Priority Service Development Directions

Community Health Services in south western Sydney will change through the life of this plan. At the core of this change will be an understanding that, as demand for services grow, decisions need to be made as to how public resources can and should be used to greatest effect. With this in mind, SWSLHD Community Health will focus on enhancing links and interaction with general practice, other primary care providers (eg. Allied Health) and non-government providers (eg. nursing care providers) to effectively coordinate and manage complex patient care needs. This may include formation of partnerships, formalised funding agreements and shared care models with a mix of providers to ensure the right care is provided at the right time by the right service.

In keeping with this approach, Community Health will work with the SWSLHD Executive to develop, implement and monitor best practice integrated primary care centres across south western Sydney. These centres are likely to involve shared private and public investment to deliver innovation to local communities.

Greater service flexibility will be pursued including extended hours into evenings and weekends, flexible models of delivery such as outreach, increased utilisation of community health centres for clinical activity, improved transition of care from post-acute to maintenance care with appropriate providers and new and innovative models of care (eg. Ambulatory Care and Hospital in the Home Models developed in partnership with acute facilities and streams), services and facilities in areas of housing development, significant population growth or emerging health risks.

To support these directions, a SWSLHD Community Health Services Infrastructure Renewal Strategy will be developed to match infrastructure requirements to: emerging models such as Integrated Primary Care Centres (IPCC); potential outreach of ambulatory hospital services; fibre optic enabled practice and to changed and evolving population growth patterns. Specifically, there will be a focus on:

Post-acute and chronic care nursing - clarifying the role of Community Health in post-acute care, particularly in relation to increasing rates of day surgery and the shared interface between Ambulatory Care Services; increasing demands for community-based Nursing services to meet the needs of ageing communities; determining the mix of services delivered directly by the District and those manageable by non-government providers; and introduction of electronic point-of-care tools to more effectively manage demand and safe and timely transfer of care for patients in the community.

Early Years and School Aged Children - continued movement towards Sustained Home Visiting across SWSLHD, targeting the most disadvantaged families with high needs; expanded use of trans-disciplinary practice to respond to families with high needs; increasing access to early intervention therapy services for children between the ages of 0-6 years, maximising learning and development opportunities; and consolidating models of care for young people living in south western Sydney.

Violence and Neglect – enhancing services to adopt a network approach to working with some of the most vulnerable residents of south western Sydney.

Community Development and Partnerships - working with other agencies to deliver "whole of government" responses to community needs; and building partnerships in innovative

multidisciplinary primary health care to improve health outcomes for marginalised and at risk populations (e.g. homeless young people).

Service Integration and Care Coordination – building on the role of the Triple I (Hub) to facilitate care coordination of community-based referrals and positioning this service to deliver 'best in class' care coordination, monitoring, allocation and commissioning.

Figure 3: Liverpool Health Services Building

Corporate Actions

The attached action plan outlines the key actions that Community Health will be taking over the next five years. The plan is structured using the eight areas of corporate action articulated in the SWSLHD Corporate Plan 2013 – 2017, Directions to Better Health. These action areas are:

- Providing High Quality Health Services
- Community Partnerships
- Seamless Networks
- Developing Our Staff
- Research and Innovation
- Enhancing Assets and Resources
- Supporting Business
- Efficiency and Sustainability

Under each area of action, specific objectives and the associated risks of failure to make progress have been identified. Specific strategies for Community Health have been identified under each objective, together with timeframes and responsible staff. Community Health will be required to report against progress towards achievement of these strategies.

Figure 3: Narellan Community Health Centre

Corporate Action 1: Providing High Quality Health Services

The community expects and has a right to receive high quality health care. At an individual level, quality is measured by a range of factors including excellent patient outcomes, ease of access to health care, timeliness of services, good communication, strong teamwork, a seamless service and respectful treatment. At a system level it is formally measured by achievement of standards and targets and informally through media reports.

Community Health will develop and deliver quality services at a local level. Through clinical governance and corporate structures and systems, quality will be monitored and measured. Community Health will ensure that the strategies implemented enable quality health care to be fostered and strengthened.

Quality health care not only relates to the health care of people who are sick but also preventing health problems from occurring. There is considerable evidence that intervention in the early years protects children against poor longer term outcomes and that health promotion strategies will prevent premature death, reduce ill health and prevent further disability.

SWSLHD Objectives

1.1 Develop staff communication skills in working with patients, family and service providers

1.2 Ensure patients, carers, visitors, community and service providers are treated with dignity, respect and in an ethical manner

1.3 Improve the quality and safety of health services

1.4 Improve the patient experience

1.5 Implement early intervention and health promotion and illness prevention strategies

	Strategies	Responsible Manager	Complete By	Links to CPS
1.1	**Develop staff communication skills in working with patients, family and service providers**			
1.1.1	Implement the *Communication with Purpose Program* to improve the way in which staff and managers communicate with each other, with patients and with external care providers in primary care and the health and non-health community sector	Support Services Manager	2014	1.1.1
1.1.2	Implement the *Patient Care Challenge* to ensure patients, carers and families are included as care team members.	Director Child, Youth & Family	2015	1.1.2
1.1.3	Develop a communication and workforce development strategy which embeds the mission, vision , CORE values and principles into all aspects of service operation commencing from orientation	Support Services Manager	2015	1.1.3
1.1.4	Formalise an agreed vision, mission and objectives for Community Health	General Manager	2014	7.2.2
1.1.5	Continue to implement, monitor and provide ongoing support for Family Partnership Training across the District	Families NSW Coordinator	2015	1.2.3
1.1.6	In partnership with the District, review clinical supervision functions and structures within Community Health to develop a standardised internally driven model for clinical practice development	Director Specialist Services	2015	1.3.2
1.1.7	Introduce automatic short message service (sms) reminders for all Community Health appointments	Clinical Systems & Information Manager	2015	1.4.4
The risks of not achieving this objective are: • Increase in proportion of patients/ carer complaints arising from miscommunication/misunderstandings • Increase in proportion of appointments that are missed • Loss of faith in Community Health Services by the community				
1.2	**Ensure patients, carers, visitors, community and service providers are treated with dignity, respect and in an ethical manner**			
1.2.1	Implement the *Respecting the Difference: Aboriginal Cultural Training Framework* to provide staff with the knowledge and skills to deliver respectful, responsive and culturally sensitive services to Aboriginal people, families and communities	Support Services Manager	2015	1.2.1
1.2.2	Implement the *NSW Advance Planning for Quality Care at End of Life Strategic and Implementation Framework* to integrate advance care planning for end of life into the care of people with chronic, life-limiting illness	Chronic Care Manager	2015	1.2.2
1.2.3	Implementation of Essentials of Care across all Community Nursing Teams.	CHN Nurse Manager	2015	1.4.2
1.2.4	Implement policy in relation to grief and bereavement and ensure all staff attend related training	CHN Nurse Manager	2016	1.2.3
1.2.5	Undertake a project on implementation of strategies to ensure best practice relating to informed consent and client rights and responsibilities acknowledgement (eg. build into point of care electronic systems)	Quality & Safety Manager	2015	1.2.3

	Strategies	Responsible Manager	Complete By	Links to CPS
The risks of not achieving this objective are:	• Increase in proportion of patients/ carer complaints arising from miscommunication/misunderstandings • Loss of faith in Community Health Services by the community			
1.3	**Improve the quality and safety of health services**			
1.3.1	Meet National Patient Safety and Quality Standards through participation in external accreditation schemes and quality processes	Quality & Safety Manager	Ongoing	1.3.1
1.3.2	Implement infection prevention strategies relating to • Hand Hygiene (HH) • Health Care Associated Infections	Infection Prevention CNC	2015	1.3.3
1.3.3	Implement and evaluate the nutrition clinic service in Macarthur and finalise the needs analysis for Wingecarribee	Community Nutrition Manager	2015	1.5.3
1.3.4	Meet targets in: • Universal Health Home Visiting • Sustained Health Home Visiting • Statewide Eyesight Screening • Statewide Hearing Screening • Out of Home Care (OOHC) Health Assessment • Chlamydia Testing • Unplanned readmission to hospital rates • Planned deaths at home	Responsible Managers	Annually	1.5.3
1.3.5	Review existing Social Work and Psychology Models of Care and implement recommendations from same	Social Work & Psychology Managers	2014	1.4.1
1.3.6	Evaluate Max Clinics, including clinical indicators, patient journeys and staff surveys to evaluate outcomes and improve service	Max Service Managers	2015	1.4.1
1.3.7	Strengthen and support governance model for Community Paediatrics	Director Community Paediatrics	2014	1.3.2
1.3.8	Develop and implement rollout of statewide clinical competencies for Child, Youth and Family Allied Health staff	Allied Health Educator	2016	1.3.2
1.3.9	Review service performance in reaching targeted 'vulnerable' population groups	Heads of Department	2015	1.4.4
1.3.10	Build capacity for Clinical Coordinators at Triple I to conduct screening measures for hospital avoidance	Triple I Manager	2015	1.4.1
1.3.11	Expand the current Triple I triage process to include objective measures for acuity, including development of	Triple I Manager	2015	1.3.2

	Strategies	Responsible Manager	Complete By	Links to CPS
	a risk assessment framework and monitoring/evaluation framework for referrals not accepted and/or redirected			
1.3.12	Implement benchmarking framework against comparable care coordination models	Triple I Manager	2015	1.3.2
1.3.13	Implement the Australia-modified Karofsky Performance Scale across all Community Health Nursing services for palliative care clients	CHN Nurse Manager	2014	1.2.2
The risks of not achieving this objective are: • Failure to achieve accreditation • Increase in proportion of patients suffering an adverse event • Increase in litigation and associated costs • Increase in patients suffering poor outcomes • Increase in proportion of patients/ carer complaints arising from miscommunication/misunderstandings • Loss of faith in Community Health Services by the community • Failure to provide care in line with evidence-based best practice				
1.4	**Improve the patient experience**			
1.4.1	Monitor trends and use information from complaints and the NSW Patient Survey to implement appropriate responses to address patient concerns	Quality & Safety Manager	Annually	1.4.3
1.4.2	Embed patient/carer experience interviews into every day practice	Families NSW Coordinator	Ongoing	1.4.3
1.4.3	Increase the number and utilisation of nursing clinics available in all localities to provide choice and greater flexibility, ensuring new clinics are assessed against demand and capability to deliver	CHN Nurse Manager	2015	3.2.5
1.4.4	Embed standardised morbidity and mortality and case management review systems within all services across Community Health	CHN Nurse Manager	2014	1.3.2
1.4.5	Develop a network of consumer representatives for Community Health	Families NSW Coordinator	2015	1.4.3
1.4.6	Develop position/ process to case manage and provide integrated care model for families with a child with a newly diagnosed disability to navigate system and ensure best use of therapy resource	Responsible Managers	2016	2.3.2
1.4.7	Build on the concept of 'One stop shop' for clients through measuring demand for information (type, frequency etc) and accelerate the direct scheduling for CHN clients into outpatient procedural clinics	Triple I Manager	2015	2.1.3
1.4.8	Build capacity of clinical services to provide culturally appropriate care eg. ethno-specific cardiac rehabilitation and living with cancer programs	Multicultural Health Manager	2016	2.1.5

	Strategies	Responsible Manager	Complete By	Links to CPS
The risks of not achieving this objective are:	• Increase in proportion of patients/ carer complaints arising from miscommunication/misunderstandings • Loss of faith in Community Health Services by the community • Increase in proportion of patients suffering an adverse event • Increase in patients suffering poor outcomes			
1.5	**Implement early intervention and health promotion and illness prevention strategies**			
1.5.1	Contribute to the achievement of national, NSW and local targets to improve the health of the community through comprehensive health promotion programs implemented in collaboration with other agencies, including the South Western Sydney Medicare Local, local councils and Aboriginal Organisations, and the community including: • Closing the Gap in Aboriginal Life Expectancy • Overweight and Obesity Prevention focusing on activity and healthy eating • Falls Prevention • Mental Health Promotion • Tobacco control • Infant mortality	Directors	Ongoing	1.5.3
1.5.2	Community Nutrition to plan and implement the recommendations from the "Early Childhood Nutrition Issues: An assessment of need and options for early childhood community nutrition service development in the Macarthur region" needs assessment report	Community Nutrition Manager	2014	1.5.3
1.5.3	Review current falls prevention and pressure injury strategies in relation to reportable incidents (IIMS), including assessment of communication of strategies for patients admitted to hospital	CHN Nurse Manager	2015	1.5.3
1.5.4	Work collaboratively with Population Health Services and other government and non-government agencies to create healthy environments (eg. Claymore, Miller)	Director Specialist Services	Ongoing	1.5.6
1.5.5	Develop implementation plans to address the *NSW Refugee Health Plan 2011-2016* and the Policy and NSW Health *Implementation Plan for Healthy Culturally Diverse Communities 2012–2016*	Manager Multicultural Health Services	2014	1.5.8
1.5.6	Prevent transmission of blood borne viruses through expansion of Needle Syringe Programs, improved access to testing and treatment for HIV and Hepatitis C and comprehensive health promotion programs	Director Sexual Health Service	Ongoing	1.5.9
1.5.7	In collaboration with the South Western Sydney Medicare Local and primary health care providers, enhance the coverage and range of secondary disease prevention activities through early detection e.g. screening, and early intervention	Director Sexual Health Service	Ongoing	1.5.10
1.5.8	Increase organisational capacity to intervene effectively to reduce the incidence and impact of domestic violence presentations on clients and the health system, principally through the building of capacity within Community Health Social Work services and increased focus on community prevention of domestic violence	Director Child, Youth & Family	2015	1.5.1

	Strategies	Responsible Manager	Complete By	Links to CPS
1.5.9	Continue and refine orientation/ transition to school package for children with early learning difficulties	Allied Health Managers	2016	1.5.1
1.5.10	Work in partnership with hospitals to establish and promote Breastfeeding Friendly Facilities that ensure breastfeeding services are responsive, coordinated and streamlined to support women to continue to breastfeed.	Child & Family CNC	2016	1.5.6
1.5.11	Implement tele-health solutions through the Connecting Care service to expand program reach against a variety of individual health needs.	Chronic Care Manager	2016	7.1.7
1.5.12	Build on partnerships with the NSW Ambulance extended care paramedic program	Triple I Manager	2015	3.2.7
1.5.13	Ensure all Community Health Nursing staff receive a minimum standard of training in Chronic Disease Self-Management, including the development of a standardised management plan for this cohort of patients	CHN Nurse Manager	2015	1.3.2
1.5.14	Evidence based area health promotion and education programs to be implemented by Youth Health Services to help build resilience in young people. Health promotion and early intervention programs to continue to be implemented area wide including: • Yhunger (Nutrition and Physical activity) • Tobacco cessation (quit smoking) • Youth Friendly Resource • Hot Game (Education on health issues and opportunistic STI screening) • Same sex attracted youth program • Same Sex Attracted Survey • Love Bites (minimising domestic and sexual violence) • Schools Out! (building resilience) • Rock and Water (building resilience) • Cage the Rage (anger management)	Youth Health Services Manager	Ongoing	1.5.3

The risks of not achieving this objective are:

- Increase in proportion of Community Health clients having a preventable hospital admission
- Increase in proportion of patients suffering an adverse event
- Increase in patients suffering poor outcomes
- Loss of faith in Community Health Services by the community

Corporate Action 2: Community Partnerships

Communities have a significant role to play in the operation of health services - in service planning, in service provision through volunteering, in health research through participation in clinical trials and other forms of research, in working as businesses or local agencies with health services to meet patient needs or to provide support services, and in building physical capacity through donations and philanthropy. Different approaches will need to be developed to ensure that all members and sections of the community, including private business, can contribute.

Integral to service development and delivery will be partnerships with patients, clients, carers and the community. Services will need to draw on the expertise, experience and diversity of community members and communities to ensure that health responses are appropriate to local needs. In particular greater effort will need to be given to ensuring that communities who experience greatest disadvantage are consulted and involved in planning and development of services and programs that are tailored to meet their needs.

Health literacy plays a key role in building effective partnerships with the community. Community Health will need to ensure that the opportunities created through new social and information media are adapted so that the community and patients receive information in a way that is easily understood and enables them to make informed choices. Services will also need to consider and accept formal feedback from patients, services and the community when evaluating the effectiveness of services and programs.

SWSLHD Objectives

2.1 Engage and involve stakeholders in planning, service development and delivery

2.2 Raise the profile of the District locally through timely and accurate information

2.3 Empower individuals and local communities to make informed health choices

	Strategies	Responsible Manager	Compete by	Links to CPS
2.1	Engage and involve stakeholders in planning, service development and delivery			
2.1.1	Increase the number and range of people involved in Community Health Meetings, local networks and consultation processes, to reflect the diversity of communities across the District	Families NSW Coordinator	2015	2.1.2
2.1.2	Develop new approaches to consult with people of all ages from diverse backgrounds and facilitate their collaboration in service development	Multicultural Health Manager	2015	2.1.5
2.1.3	Increase the number of volunteers and community representatives contributing to and supporting Community Health services, including recognition and support of existing volunteer programs (eg. Palliative Care)		2016	2.1.6
2.1.4	Strengthen and build on partnerships with the Tharawal Aboriginal Medical Service and Gandangara Land Council Medical Services to improve the health of Aboriginal people and their access to health services.	Director Child, Youth & Family	Ongoing	2.1.8
2.1.5	Implement standard contract of care for all Community and Post Acute clients.	CHN Nurse Manager	2015	2.3.2
2.1.6	Establish an Integration and Partnerships Directorate to improve integration, commissioning capability and engage with external stakeholders in service planning (eg. Violence and neglect network)		2014	2.1.3
2.1.7	Triple I (Hub) to explore partnerships with the aged care gateway to minimise gaps to services for clients post reform	Triple I Manager	2015	2.3.1
2.1.8	Utilise social media as a strategic communication option for appropriate consumer groups (eg. Facebook)	Families NSW Coordinator	2015	2.3.1

The risks of not achieving this objective are:

- Disengagement from the community
- Failure to meet the needs and expectations of the community
- Loss of faith in Community Health Services by the community

2.2	Raise the profile of the District locally through timely and accurate information			
2.2.1	Meet reporting Key Performance Indicators and timeframes for all externally funded programs	Program Managers	Ongoing	8.1.9
2.2.2	Raise profile of Community and Post Acute Nursing through Roadshows and Nursing Grand Rounds	CHN Nurse Manager	2015	2.3.1
2.2.3	Inclusion of Community Health events and achievements in District newsletters, local media and social media	Support Services Manager	Ongoing	2.2.1
2.2.4	Conduct a comprehensive review and update of the Community Health website	Support Services Manager	2015	2.2.1
2.2.5	Develop a branding strategy for Triple I (Hub) to appeal to other organisations as a 'best in class' service	Triple I Manager	2015	2.2.1

The risk of not achieving this objective is:

- Loss of faith in Community Health Services by the community

	Strategies	Responsible Manager	Compete by	Links to CPS
2.3	Empower individuals and local communities to make informed health choices			
2.3.1	Establish and trial a 'leg club' in one Community Health Centre	CHN Nurse Manager	2015	2.1.5
2.3.2	Distribute results of the social media scoping survey and develop recommendations for wider implementation across Community Health	Families NSW Coordinator	2015	2.3.1
2.3.3	Provide soft entry access to health services through activities and participation in community events including Aboriginal Supported Playgroups across the District, parenting groups and others	Families NSW Coordinator	2015	2.3.2
2.3.4	Foster localised relationships with practice nurses to build capacity in community based care provision – this may include rotational model of PNs through Triple I and Connecting Care services	Triple I Manager	2015	2.1.3
2.3.5	Strengthen self-management principles in care to Indigenous clients through the Aboriginal Connecting Care Program.	Chronic Care Manager	2015	3.4.1

The risks of not achieving this objective are:

- Increase in adverse patient outcomes through poor health literacy
- Increase in patients suffering poor outcomes

Corporate Action 3: Seamless Networks

The health of individuals and communities is not only dependent on quality of health care and how and where health services and programs are delivered but also on individual factors including the social and environmental determinants of health such as education, employment and income and food security. Improving health can as a result be extremely difficult, requiring excellent communication, coordination and collaboration within and across health facilities and services, with other health providers such as general practitioners, with community services and across levels of government.

Health improvement will require input from medical, nursing, allied health, prevention and other health practitioners across hospitals, community health centres and primary health care settings. It will also require close collaboration and coordination with other government agencies and community based services which provide ongoing support to individuals, families and communities.

Community Health staff will work in partnership with the District and at local and regional levels to plan for future needs, develop services and programs, improve access and build knowledge about factors which contribute to health and wellbeing which will influence the work of other agencies.

There will also be a focus on building an integrated health care system for local residents and other people using and working with health services. This will mean that irrespective of where help is sought, the right service can be accessed. Networks will be developed within clinical and service streams to build skills and expertise. Where required, centres of excellence will be developed to ensure that health care is provided at the most appropriately equipped facility.

SWSLHD Objectives

3.1 Actively participate in regional and local forums to build capacity to respond to emerging needs

3.2 Foster coordinated planning and service delivery in health care

3.3 Improve transfer of care and patient access to services

3.4 Strengthen access and support for high needs groups

	Strategies	Responsible Manager	Complete by	Links to CPS
3.1	**Actively participate in regional and local forums to build capacity to respond to emerging needs**			
3.1.1	Participate in NSW Government Community Renewal activities including at Claymore, Rosemeadow/Ambarvale, Bradbury/Airds and Bonnyrigg.	Director Specialist Services	Ongoing	3.1.2
3.1.2	Participate in and contribute to local council and interagency planning, coordination and implementation forums addressing human services, multicultural communities, Aboriginal people and People with Disabilities (PWD)		Ongoing	3.1.4
3.1.3	Work collaboratively with the South Western Sydney Medicare Local (SWSML) on: targeted integration strategies; collaborative planning and community consultation approaches; responses to local health needs; common KPIs; shared representation on appropriate corporate governance entities; and efficient coordination and communication.	Triple I Manager	Ongoing	3.1.5
3.1.4	Contribute to the development of a SWSLHD Child Health Plan	Director Child, Youth & Family	2015	3.2.6
3.1.5	Expand Triple I (Hub) to enable performance as a regional processing service for internal and external partners	Triple I Manager	2016	3.1.6
3.1.6	Provide training and support to all clinicians in Community Health regarding trauma informed practice for working with clients who have experienced trauma		2016	3.1.3
The risks of not achieving this objective are: • Increase in demand for specialised Community Health based services • Fragmentation of health care and service provision • Increase in proportion of patients suffering an adverse event • Increase in patients suffering poor outcomes				
3.2	**Foster coordinated planning and service delivery in health care**			
3.2.1	Develop models for integrated networks of care, consistent with the principles for clinical network development (S8.2 Strategic Plan) and clearly identifying the benefits of the network for all stakeholders	Directors	2015	3.2.1
3.2.2	Develop and implement collaborative service models involving clinical streams and primary health care providers such as SWSML and Aboriginal Health Services which: • strengthen coordination and integration • target potentially preventable hospitalisations • work towards implementation of an Integrated Primary and Community Care (IPCC) model of care in community settings, including the establishment of IPCC Centres in the South West Growth Centre	Directors	Ongoing	3.2.7
3.2.3	Develop a coordinated and integrated feeding service between Hospital and Community Health at key sites within the District	Speech Pathology Manager	2015	3.3.1

	Strategies	Responsible Manager	Complete by	Links to CPS
3.2.4	Continue to review and improve processes for Safe Start Perinatal Intake Meetings and Postnatal Vulnerable Families Case Review Meetings	Nurse Managers	Annually	3.2.2
3.2.5	Review referral and service delivery pathways for young people with Mental Health Services, Drug Health Services and Inpatient Services to enhance coordinated planning and service delivery	Youth Health Services Manager	2015	3.2.7
3.2.6	Work with Integrated Partnership Directorate to review referral pathways for clients to a range of government and NGO services as well as Medicare local	Director Integration & Partnerships	2015	3.1.4
3.2.7	Expand partnerships with maternity and mental health around care pathways for vulnerable families antenatally	Nurse Managers	2016	3.2.7
3.2.8	Facilitate greater involvement of the General Practice in Triple I to support its role in coordinating and integrating care in the primary care setting	Triple I Manager	2014	3.1.5
The risks of not achieving this objective are: • Fragmentation of health care and service provision • Failure to support effective seamless transition between the acute care setting and the community				
3.3	**Improve transfer of care and patient access to services**			
3.3.1	Develop strategies in partnership with acute and primary health care providers to improve clinical handover and transfer of care between professionals, teams, facilities and services with patient and carer involvement (eg. Introduction of point-of-care eMR system to coordinate care).	Triple I Manager	2015	3.3.1
3.3.2	Develop web-based information about available services, entry criteria and referral processes	Quality & Safety Manager	2015	3.3.2
3.3.3	Increase the number of community-based clinical service referrals coordinated via Triple I (Hub)	Triple I Manager	2015	3.2.5
3.3.4	Continue expand capacity of Triple I (Hub) to deliver care coordination functions for community-based services	Triple I Manager	2015	3.3.1
3.3.5	Youth Health Services to work in partnership with inpatient, community health and other service providers to develop Transition Plans for young people: - in early stages of adolescence (11-13yrs) and late stages (18-24yrs) - with chronic illnesses or disabilities - on the Out of Home Care Pathway to appropriate services after the age of 16 years	Youth Health Services Manager	2016	3.3.1
3.3.6	Implement a model of care for coordination with inpatient units to support multidisciplinary care and transfer to the community	Triple I Manager	2015	3.3.1
3.3.7	Review current model of Community and Post Acute Nursing Care in relation to Ambulatory Care Models across SWSLHD in consultation with local facilities and relevant specialties	CHN Nurse Manager	2014	3.2.7

	Strategies	Responsible Manager	Complete by	Links to CPS
3.3.8	Review all clinical handover processes to ensure transition of care between Community Health, acute and sub-acute facilities, primary care and other external providers is safe and effective	Nurse Managers	2015	3.3.1
The risks of not achieving this objective are: • Failure to support effective seamless transition between the acute care setting and the community • Increase in proportion of patients suffering an adverse event • Increase in patients suffering poor outcomes				
3.4	**Strengthen access and support for high needs groups**			
3.4.1	Guided by the 10 year NSW Aboriginal Health Plan, work with the District to initiate a process to develop a SWSLHD Aboriginal Health Plan to apply from 2015 onwards.	Director Specialist Services	2015	3.4.1
3.4.2	In collaboration with Primary Health Care providers, implement Chronic Disease programs including Connecting Care and the 48 Follow up Program for Aboriginal people to reduce the number of potentially avoidable hospitalisations.	Chronic Care Manager	2015	3.4.3
3.4.3	In collaboration with SWSML and other service provider agencies, identify a best practice framework for meeting the diverse needs of local multicultural communities across all aspects of healthcare provision within SWSLHD	Director Multicultural Health	2015	3.4.4
3.4.4	Implement a SWSLHD Disability and Carers Action Plan which incorporates NSW Government interagency initiatives, the Carer's Recognition Act and the SWSLHD Carers Model of Care Framework and Disability Guidelines	Business Manager	2015	3.4.6
3.4.5	Expand access to health care for residents in rural fringe areas and geographically isolated areas through service outreach, practical support and use of new technologies such as tele-health (eg. Wollondilly Integrated Primary Care Centre)	Directors	2015	3.4.9
3.4.6	Improve local responses to the Ministry of Health Guidelines, Policies and Procedures for the Protection of Children and Young People including assessment of children in ED and paediatric services and in Out of Home Care.	Responsible Managers	Ongoing	3.4.10
3.4.7	Consolidate Youth Health services with Child and Family Clinical Services and conduct a review of the current operating model	Director Child, Youth & Family	2014	3.4.10
3.4.8	Establish a Violence and Neglect (VAN) Network to implement joint planning and referral pathways with internal and external stakeholders	Director Specialist Services	2015	3.4.12
3.4.9	Expand and embed the Strong Fathers Strong Families Project across the District	Strong Fathers Strong Families Coordinator	2014	3.4.2
3.4.10	Develop a sustainable implementation strategy to transition clinical elements of the Women's Health Service to NGO operators	Women's Health	2015	3.4.4

	Strategies	Responsible Manager	Complete by	Links to CPS
		Manager		
3.4.11	Explore options to transition management of The Hub (Miller) to external providers	The Hub Manager	2015	3.4.4
3.4.12	Develop integrated referral pathways to social support services at Triple I (Hub)	Triple I Manager	2015	3.3.1

The risks of not achieving this objective are:

- Disempowerment of the patient/consumer and their families/carers
- Isolation of marginalised groups from access to healthcare
- Increase in proportion of patients suffering an adverse event
- Increase in proportion of patients/ carer complaints arising from miscommunication/misunderstandings
- Loss of faith in Community Health Services by the community

Corporate Action 4: Developing Our Staff

Over the next ten years, there will be further development of health services in South West Sydney. Quality health services and care relies on having sufficient staff with the necessary knowledge and skills to provide effective care and to provide it in the right location.

Community Health will need to attract and retain skilled staff across all health professions and support services. It will also need to ensure that the skills and knowledge of existing staff are developed and that staff has the capacity and adaptability to adopt new practice, and skills needed to support innovation and change. Community Health will value its workforce and ensure that staff are encouraged, rewarded and treated fairly and with respect.

Building on the work of the Centre for Education and Workforce Development and existing and developing relationships with local universities and NSW Technical and Further Education, Community Health will work with the District to develop the skills and qualifications needed by its workforce. These relationships will also be important in developing relationships with potential employees.

SWSLHD Objectives

4.1 Develop a sustainable workforce that reflects and has the skills required to address community needs

4.2 Create an organisation that people want to work in

4.3 Develop relationships with future employees

	Strategies	Responsible Manager	Complete by	Links to CPS
4.1	**Develop a sustainable workforce that reflects and has the skills required to address community needs**			
4.1.1	Implement the District Workforce Plan with a focus on initiatives to enhance staff capacity in primary prevention work, to achieve the Strategic Plan's priority strategic direction of an integrated focus on primary prevention for patients and communities	Directors	2015	4.1.1
4.1.2	Consistent with the Aboriginal Employment Implementation Plan informed by the *NSW Health Aboriginal Workforce Strategic Framework 2011-2015:* increase representation of Aboriginal people across clinical and non-clinical settings and levels; increase Aboriginal traineeships; and develop career pathways and skills including support and mentoring programs	Directors	2014	4.1.3
4.1.3	Strengthen succession planning by linking performance management processes to post graduate management, management trainee and mentoring programs for clinical and non-clinical staff.	Directors	2015	4.1.8
4.1.4	Increase utilisation of the performance management system, ensuring the processes are clearly linked to individual performance and service goals and priorities	All Managers	2014	4.1.11
4.1.5	Develop career pathways in Nursing	Nursing Managers	2015	4.2.4
4.1.6	Develop a training/retraining strategy for use of point of care and emerging information technology and communication tools used for client care	Business Manager	2015	4.1.1
4.1.7	Develop strategies to focus on ageing in the workplace with specific emphasis on the nursing workforce	Nurse Managers	2016	4.1.1
4.1.8	Increase utilisation of Allied Health Assistants across Community Health services	Allied Health Managers	2015	4.1.1
4.1.9	Develop a strategy to support changes to work practice for Administrative staff as clinical service uptake of the eMR increases	Administration Managers	2015	4.1.1
4.1.10	Develop a framework to Identify and evaluate skill shortages and emerging skill needs in Triple I (Hub)	Triple I Manager	2015	4.1.6
4.1.11	Increase utilisation of Enrolled Nurses across Community Health	Nurse Managers	2015	4.1.6

The risks of not achieving this objective are:

- Inability to recruit and retain a competent workforce
- Failure to provide care in line with evidence-based best practice
- Increase in proportion of patients suffering an adverse event
- Failure to achieve accreditation
- Loss of faith in Community Health Services by the community

	Strategies	Responsible Manager	Complete by	Links to CPS
4.2	**Create an organisation that people want to work in**			
4.2.1	Create a respectful, effective and innovative Work Health Safety environment through implementation of the *NSW Public Sector Workplace Health and Safety and Injury Management Strategy 2010-12*	Workplace Health & Safety Manager	2014 & ongoing	4.2.2
4.2.2	Implement programs which improve the health and wellbeing of staff. This includes healthy worker initiatives which focus on issues such as vaccination, healthier eating, active transport, smoke free workplaces and staff amenities	Workplace Health & Safety Manager	2014 & ongoing	4.2.3
4.2.3	Support career and study pathways through recognised training programs	CH Executive	Ongoing	4.2.4
4.2.4	Identify and promote options to increase work place flexibility and address workload management	CH Executive	2015	4.2.5
4.2.5	Develop and implement strategies informed by the *NSW Health Your Say* and NSW Public Sector Workplace surveys and the *NSW Health Workplace Culture Framework* Characteristics	CH Executive	Annually	4.2.6
4.2.7	Increase awareness and uptake of salary packaging opportunities	Business Manager	Ongoing	4.2.3
4.2.8	Establish a staff recognition program in Community Health	Business Manager	2015	4.2.3
4.2.9	Develop a business case for creation of a Human Resource Officer position dedicated to supporting Community Health	CH Executive	2014	4.2.2
The risks of not achieving this objective are: • Inability to recruit and retain a competent workforce • Increase in ongoing education and professional training costs • Inefficient service provision				
4.3	**Develop relationships with potential future employees**			
4.3.1	Work collaboratively with universities and other educational agencies to grow clinical placement capacity, ensure clinical training meets future District service requirements and ensure quality clinical education placements (including education of staff providing clinical supervision)	CH Executive	Ongoing	4.3.1
4.3.2	Develop a targeted recruitment framework to attract skilled staff to work at Triple I (Hub)	Triple I Manager	2015	4.1.1
The risks of not achieving this objective are: • Inability to recruit and retain a competent workforce • Inefficient service provision				

Corporate Action 5: Research and Innovation

Health services and practices are constantly evolving and changing with new evidence about better methods to respond to emerging needs and improve health care. There are also changes led by national and state governments that require flexibility and new ways of working including new partnerships.

The District has considerable clinical and research expertise and experience that can be leveraged to support the development of the District's healthcare services. Clinicians and health services will be encouraged and supported to assume leadership roles and identify where they can contribute to health improvement. In collaboration with Ministry of Health agencies and other agencies, local services will use new health practice and contribute to new evidence through innovation and research which leads to better health outcomes for local communities. Community Health will be an active partner in this endeavour.

SWSLHD Objectives

5.1 Foster an innovative culture and research capability

5.2 Support innovation and best practice in prevention and clinical settings

	Strategies	Responsible Manager	Complete by	Links to CPS
5.1	**Foster an innovative culture and research capability**			
5.1.1	Develop and implement a Community Health Research Strategy based on the outcomes of the Research Capacity and Culture Review, ensuring academic capacity is built within Community Health by fostering partnerships with the Ingham Institute and relevant Universities	CH Executive	2015	5.1.1
5.1.2	Incorporate research into new service developments and initiatives, align new research with District and NSW priorities and develop new collaborations with the University sector	CH Executive	Ongoing	5.1.3
5.1.3	Increase participation in translational research, strengthening the application of evidence in new models of service delivery	CH Executive	Ongoing	5.1.5
5.1.4	Develop research infrastructure including facilities, videoconferencing capacity, teaching links and funding	Business Manager	Ongoing	5.1.7
5.1.5	Review and develop the partnership with Early Years Research Program	Director Community Paediatrics	2015	5.1.8
5.1.6	Promote development and utilisation of subject matter experts/resource nurse roles in research and development within Community Health	CHN Nurse Manager	2015	5.1.8
The risks of not achieving this objective are: • Failure to provide care in line with evidence-based best practice • Failure to contribute to the knowledge base of best practice • Inability to recruit and retain a competent workforce • Inefficient service provision				
5.2	**Support innovation and best practice in prevention and clinical settings**			
5.2.1	Develop a program to acknowledge, showcase and celebrate the work of individual staff and teams within Community Health and SWSLHD	Support Services Manager	Ongoing	5.2.1
5.2.2	Increase participation in quality and innovation award programs	CH Executive	Ongoing	5.2.3
5.2.3	Utilise a framework linked to the Quality and Safety Committee to assess, plan for, implement and evaluate new models of care, innovations in practice and emerging health technology	Committee Co-Chairs	2015	5.2.5
5.2.4	Enhance infrastructure to support innovation in wound management, including trial of a wound consultation model (eg. Use of electronic point of care multimedia devices)	CHN Nurse Manager	2015	5.2.4
5.2.5	Develop a learning, development and research prioritisation framework	Triple I Manager	2015	5.2.2
5.2.6	Explore options to expand the role of the Nurse Practitioner in Community Health	CHN Nurse Manager	2015	5.2.4
5.2.7	Collect and analyse data on service utilization by CALD background people to monitor and review services	Multicultural Health Manager	2015	8.4.1
5.2.8	Complete research into the OOHC pathway in SWSLHD, reviewing the pathway and timing of allied health intervention for children placed in interim OOHC	OOHC Coordinator	2016	5.2.7

Strategies	Responsible Manager	Complete by	Links to CPS
The risks of not achieving this objective are: • Failure to provide care in line with evidence-based best practice • Inability to recruit and retain a competent workforce			

Corporate Action 6: Enhancing Assets and Resources

Community Health will continue to work with SWSLHD to ensure that health service infrastructure has capacity to meet the growing and complex healthcare needs arising from demographic change. Additional investment will be required in public and private health services to meet this demand.

Community Health, through SWSLHD, will continue to identify and invest in capital infrastructure programs and new technology. Information technology will also require further development to ensure that communication supports clinical services, health service structures and needs. Improving utilisation and management of existing resources will also ensure that new and existing resources are efficiently used.

Community Health will also investigate and be open to new opportunities to develop health services for local communities.

SWSLHD Objectives

6.1 Provide physical capacity to address emerging health needs and population increases

6.2. Respond to changes in the operating environment

6.3 Ensure good stewardship of existing resources

	Strategies	Responsible Manager	Complete by	Links to CPS
6.1	**Provide physical capacity to address emerging health needs and population increases**			
6.1.1	Participate in implementation of the SWSLHD Asset Strategic Plan to ensure that facility development reflects need and progress projects including land purchase and construction of new Integrated Primary and Community Care Centres in the South West Growth Centre	Business Manager	2016	6.1.2
6.1.2	Participate in development of a Community Health Infrastructure Strategy which includes new models of care for integrated primary, community health and specialist service delivery	Business Manager	2015	6.1.6
6.1.3	Undertake information system hardware expansion and refresh for eMR, and core network and communication systems including tele-health	Senior Analyst	Ongoing	6.1.7
6.1.4	In consultation with all clinician groups, identify technology requirements and innovative funding opportunities and mechanisms for Community Health	Senior Analyst	Ongoing	6.1.8
6.1.5	Contribute to the Bankstown masterplan and Campbelltown Hospital redevelopment	Community Health Executive	2014	6.1.4
6.1.6	Undertake redesign of Community Health Centres to accommodate maximum capacity to deliver clinic-based care	Facilities Manager	2015	6.1.6
6.1.7	Implement a strategy to reduce production of paper-based records	Senior Analyst	2015	6.1.6
6.1.8	Expand Triple I physical location to accommodate future growth of the service	Triple I Manager	2015	6.1.6
The risks of not achieving this objective are: • Inefficient service provision • Failure to comply with Work health & safety requirements • Failure to comply with Infection Prevention & Control requirements • Inability to recruit and retain a competent workforce				
6.2	**Respond to changes in the operating environment**			
6.2.1	Evaluate implementation of recommendations from the Community Health Review to determine whether service changes meet expected outcomes	CH Executive	2014	6.1.6
6.2.2	Participate in organisation-wide capacity building strategies to meet service demand changes relating to the NDIS, Aged Care Reforms and Activity Based Funding	CH Executive	2015	6.1.6
6.2.3	Establish a robust commissioning capability within Community Health to ensure organisational readiness to respond to service delivery reforms	Director Integration & Partnerships	2015	3.1.5
6.2.4	Consider creation of an Integration and Partnerships Directorate to build upon the successes of Triple I as a key element of integrated care and to ensure quality commissioning processes when engaging external providers	Director Integration & Partnerships	2014	6.1.6
6.2.5	Review utilisation of all Community Health Centres to ensure that clinical spaces are accessible for clients	Facilities Manager	2015	6.1.6
6.2.6	Youth Health Services to continue to identify opportunities to increase outreach service delivery and flexible	Youth Health Services	2015	6.1.6

	Strategies	Responsible Manager	Complete by	Links to CPS
	locations for mobile services in response to shifts in community needs and resources	Manager		
6.2.7	Ongoing review of service capacity and resource utilisation for weekend services	CHN Nurse Manager	Ongoing	6.1.6
6.2.8	Conduct annual review of skill mix across all departments to identify efficiencies	Directors	Annually	4.1.6
6.2.9	Develop a strategy to manage physical resource implications resulting from the Community Health Review	Facilities Manager	2014	6.1.6
The risks of not achieving this objective are: • Failure to comply with Work health & safety requirements • Failure to comply with Infection Prevention & Control requirements • Inefficient service provision • Inability to sustain service provision as planned				
6.3	**Ensure good stewardship of existing resources**			
6.3.1	Develop and monitor use of a standardised list of clinical products	Nurse Practitioner	2014	8.4.1
6.3.2	Establish centrally accessible electronic booking systems for workplace health and safety (environmental) assessment, fleet booking and management and room bookings	Administration Managers	2015	6.3.2
6.3.3	Establish systems for electronic resource tracking and monitoring of point of care devices	Senior Analyst	2015	6.3.2
6.3.4	Introduce electronic swipe card access to all Community Health Centres	Administration Managers	2015	6.3.2
The risks of not achieving this objective are: • Loss of faith in Community Health Services by the community • Inefficient service provision • Inability to recruit and retain a competent workforce				

Corporate Action 7: Supporting Business

In an environment of rapid change, clinicians and managers require access to appropriate and up-to-date information and data to support informed choices, monitor progress and develop new ways of care. Information management and technology (IM& IT) provides potential for developing efficiencies, promoting innovation and improving patient care.

A patient-centred Electronic Medical Record (eMR) informed by privacy considerations will provide a comprehensive view of each patient. All team members will share access to the EMR, strengthening decision making and improving communication.

Community Health will develop point of care technology and use of applications to promote work practice innovation, and provide specialist support required for optimal client care. Business planning capabilities will be developed to ensure that existing and new services are viable from a service and financial perspective

SWSLHD Objectives

7.1 Develop integrated and appropriate technology to meet the needs of clinicians, managers and patients

7.2 Develop business intelligence and decision support capability

	Strategies	Responsible Manager	Complete by	Links to CPS
7.1	**Develop integrated and appropriate technology to meet the needs of clinicians, managers and patients**	**Responsible Manager**	**Completed By**	**Links to CPS**
7.1.1	Develop an Information Management and Technology Strategy for Community Health in consultation with the District, including Information Management and Technology	Business Manager	2015	7.1.1
7.1.2	Extend and enhance the patient-centred Electronic Medical Record (eMR) functionality across Community Health	Director of Nursing	2015	7.1.2
7.1.3	Where possible, develop single points of contact for clients and the community to facilitate access to information and services and improve service coordination for clients	General Manager	2015	7.1.6
7.1.4	Expand teleconferencing, telehealth and access to web-based technologies to improve clinical care, management and networking arrangements.	Business Manager	2016	7.1.7
7.1.5	Ongoing review and monitoring of the eMR to ensure forms are appropriate and collection of data is accurate as it is used for mandatory reporting as well as informing practice development	Director of Nursing	Annually	7.1.2
7.1.6	Implement Tririga System into Community Health	Facility/WH&S Manager	2015	7.1.8
7.1.7	Finalise development and implementation of single electronic referral form for utilisation by hospital and general practice referrers	Triple I Manager	2014	7.1.2
7.1.8	Explore options to introduce interactive online service/appointment booking systems	Director Child, Youth & Family	2016	7.1.6

The risk of not achieving this objective is:

- Failure to adequately analyse and identify inefficiencies in service provision
- Inappropriate allocation and use of resources – poor stewardship

7.2	Develop business intelligence and decision support capability	Responsible Manager	Completed By	Links to CPS
7.2.1	Establish a commissioning capability within Community Health to manage community-based clinical services commissioned to the non-government sector	Director Integration & Partnerships	2015	7.2.1
7.2.2	Development and implementation of activity dashboards for all services to monitor service key performance indicators	Directors	2015	7.2.3
7.2.3	Investigate options to introduce a community-based information and communication technology solution to support changes in funding arrangements/requirements	Director of Nursing	2015	7.2.1
7.2.4	Explore options to introduce automatic payment system for appropriate vendors		2016	7.2.4
7.2.5	Increase utilisation of smartphone technology to aid clinical practice	Senior Analyst	2015	7.1.1

The risk of not achieving this objective is:

- Failure to adequately analyse and identify inefficiencies in service provision
- Inappropriate allocation and use of resources – poor stewardship
- Sub-optimal monitoring of service provision

Corporate Action 8: Efficiency and Sustainability

Recent changes to funding models created by the National Health and Hospitals Reform Agreement will drive considerable change in how services are funded, provided, organised and measured. There will be a growing emphasis on monitoring performance and identifying opportunities to improve efficiency and effectiveness in care and service delivery. All services will need to ensure that the necessary processes and systems are used to drive improvement.

With a complex health environment, responding to new challenges will also create new risks. Systems will need to be developed to ensure that the risks are clearly identified and strategies are in place to ensure that these risks are managed. These systems will need to be supported by effective governance.

The threats posed by climate change on the environment and on individuals and communities are increasingly recognised. Community Health will reduce and manage use of resources so that the impact on the environment is minimised.

SWSLHD Objectives

8.1 Strengthen the financial sustainability of the District

8.2 Minimise risk

8.3 Contribute to environmental sustainability

8.4 Ensure efficiency of services

8.5 Strengthen governance

	Strategies	Responsible Manager	Complete by	Links to CPS
8.1	**Strengthen the financial sustainability of the SWSLHD Community Health**			
8.1.1	Develop capability, understanding and responsiveness to Activity Based Funding	Business Manager	2015	8.1.2
8.1.2	Develop and implement a Community Health Efficiency and Revenue Plan	Business Manager	2015	8.1.4
8.1.3	Develop financial capability in managers and staff to ensure effective financial management	Business Manager	2015	8.1.6
8.1.4	Meet identified annual targets for services including expenditure, revenue and payment of creditors	Business Manager	Annually	8.1.9
8.1.5	Develop improved care pathways that reduce costs in health care delivery (eg. wound care)	Nurse Practitioner	2015	8.1.9
8.1.6	Reduce inappropriate use of negative pressure bandages for wound management	CHN Nurse Manager	Ongoing	8.1.9
	The risk of not achieving this objective is: • Inappropriate allocation and use of resources – poor stewardship • Loss of faith in Community Health Services by the community			
8.2	**Minimise risk**			
8.2.1	Develop a framework for managing risk across Community Health which includes strategies to: • embed governance structures and arrangements into day to day operation • develop and maintain risk registers • establish formal processes for identifying and analysing risks • develop risk management plans • ensure disaster recovery and continuity	CH Executive	2015	8.2.1
8.2.2	Implement and participate in a comprehensive rolling program of audit and implement the recommendations	CH Executive	2015	8.2.2
	The risks of not achieving this objective are: • Inefficient and ineffectual Enterprise Risk Management systems and processes • Inability for the organisation to monitor and manage effectiveness of service provision • Failure to meet the needs and expectations of the community			
8.3	**Contribute to environmental sustainability**			
8.3.1	Implement a Community Health Sustainability Plan that is consistent with the District Sustainability Plan	Business Manager	2014	8.3.1
8.3.2	Reduce Community Health reliance on fleet	Business Manager	Ongoing	6.3.2
8.3.3	Reduce Community Health generation of paper	Senior Analyst	Ongoing	8.3.1
	The risk of not achieving this objective is: • Inappropriate allocation and use of resources – poor stewardship • Failure to meet the needs and expectations of the community			
8.4	**Ensure efficiency of services**			

	Strategies	Responsible Manager	Complete by	Links to CPS
8.4.1	Review the efficiency and effectiveness of services and models of care and identify strategies for reengineering and disinvestment	CH Executive	Ongoing	8.4.1
8.4.2	Develop a performance monitoring system as part of the commissioning arm of Community Health with the ability to monitor ongoing performance of externally commissioned services	Director Integration & Partnerships	2015	3.1.5
The risks of not achieving this objective are: • Inefficient service provision • Fragmentation of health care and service provision • Loss of faith in Community Health Services by the community				
8.5	**Strengthen Governance**			
8.5.1	Develop the management and decision making skills of the Community Health Executive and Clinical Directors	CH Executive	2014 & ongoing	8.5.2
8.5.2	Embed actions from the annual performance agreement, SWSLHD *Strategic Priorities in Health Care Delivery to 2021* Healthcare Services Strategic Plan and *Directions to Better Health for South Western Sydney – Corporate Plan 2012 – 2017* into service business plans	CH Executive	2014	8.5.3
8.5.3	Implement strategies to increase staff awareness of statutory and related reporting requirements	CH Executive	2014 & ongoing	8.5.4
8.5.4	Review governance arrangements for Community Health as part of the implementation phase for the Community Health Review	CH Executive	2014	6.1.6
The risk of not achieving this objective is: • Inefficient service provision • Fragmentation of health care and service provision • Loss of faith in Community Health Services by the community				
8.6	**Ensure work health safety**			
8.6.1	Develop a framework to implement the NSW Ministry of Health Policy Directive 2013_005 *Work Health and Safety: Better Practice Procedures*	Workplace Health & Safety Manager	2014	8.6.1
8.6.2	Establish an effective work health safety management system that aligns with the NSW *Work Health and Safety Act 2011*	Workplace Health & Safety Manager	2015	8.6.2
8.6.3	Develop a business case for creation of a Return To Work Coordinator with direct responsibility for Community Health staff	CH Executive	2014	8.6.3
The risks of not achieving this objective are: • Failure to comply with Work health & safety requirements • Inability to recruit and retain a competent workforce				

Implementation

This Plan identifies the key strategies that will be implemented by SWSLHD Community Health services over the next five years. Against each key strategy the person(s) responsible for ensuring that the operational aspects of the strategy are progressed and the completion status have been identified.

The SWSLHD Community Health Management Team will monitor, on a monthly basis, progress against this Plan. It is expected that all services will contribute to achieving the objectives of the Plan and will report progress to the Executive. The review process will include consideration of:

- The performance reports prepared for the *South Western Sydney Local Health District Annual Strategic Priorities and Performance Agreement* with the NSW Ministry
- Local priorities from this Plan for inclusion in the Annual *SWSLHD Strategic Priorities and Performance Agreement* for the subsequent financial year
- New and emerging NSW Government priorities and whether they are adequately reflected within this Plan
- Reports on progress against strategies which may not be in the annual performance agreement. This may include strategies which have a longer timeframe or have been prioritised to respond to the operating environment

Progress on strategies within this Plan will be used to inform the South Western Sydney Local Health District Annual Report and reporting to the NSW Ministry of Health.

Image 1: Rosemeadow Community Health Centre

Appendices

Appendix 1: SWSLHD Guiding Principles

The **Principles** which guide how services are managed and developed into the future are:

1. All residents have equity in access to health care services. People who are disadvantaged will be provided with assistance to access services where necessary.

2. Health services across the District will be of high quality.

3. Patients, communities, staff and service providers will be treated with courtesy, dignity and respect.

4. Health care will be patient and family centred and responsive to the needs of individuals, families and communities.

5. Individuals and communities will be actively engaged in health care and programs. They will be provided with information and supported to make informed choices about their health. Autonomy in decision making will be respected.

6. Population health programs and strategies will be developed with communities and other agencies to improve the health of local communities. Strategies will be multifaceted to increase effectiveness and sustainability.

7. Services will be provided as close to home as possible and integrated across hospitals, community and primary health settings. Networks to centres of excellence and tertiary services will increase access to expertise when required and support timely care.

8. Teamwork will occur within all health services, and involves patients, community members and service partners. New partnerships and opportunities to improve health and health care will be explored and developed.

9. The workforce is valued and will be consulted and included in the development and implementation of initiatives. Personal and professional development opportunities will be provided to enable staff to meet ongoing changes in the health system.

10. Services will be provided in a safe and healthy environment.

11. New models of care, health care practices and technology based on evidence will be used to ensure that patients and communities receive the best and most appropriate service available. Innovation and research will be encouraged to ensure safe and appropriate interventions.

12. Services will be provided in an efficient and cost effective manner and will be evaluated and remodelled as required.

13. Environmental sustainability will be fundamental to the design and delivery of clinical and non-clinical services and infrastructure.

Appendix 2: Demographic profile of South Western Sydney

Population Characteristics	Bankstown	Camden	Campbelltown	Fairfield	Liverpool	Wingecarribee	Wollondilly	SWSML	NSW
Total persons (Estimated Resident Population) [1]	190,637	58,376	151,221	196,622	188,083	46,042	44,403	875,384	7,211,468
	21.8%	6.7%	17.3%	22.5%	21.5%	5.3%	5.1%	12.1%	
Population Profile (Source: ABS Census 2011)									
Aboriginal people and Torres Strait Islanders	1,388	1,117	4,729	1,322	2,676	802	1,036	13,070	172,621
	0.8%	2.0%	3.2%	0.7%	1.5%	1.8%	2.4%	1.6%	2.5%
Aboriginal people: Median Age	24	18	18	21	20	20	20	N.A.	21
Aboriginal people: Median Household Income	1089	1796	1006	988	988	1064	1381	N.A.	941
Aboriginal people: Median Weekly Rent	240	360	225	260	235	270	278	N.A.	200
Persons born overseas	68,721	9,007	41,133	98,652	71,715	6,734	5,374	301,336	1,778,548
	37.7%	15.9%	28.2%	52.5%	39.8%	15.2%	12.4%	35.8%	25.7%
Language spoken at home – English only	72,426	48,973	101,863	48,620	80,046	40,564	39,455	431,947	5,013,343
	39.7%	86.3%	69.8%	25.9%	44.4%	91.4%	91.2%	51.4%	72.5%
1st most common language other than English spoken at home	Arabic	Italian	Arabic	Vietnamese	Arabic	Italian	Italian	Arabic	Arabic
	38,640 (21.2%)	873 (1.5%)	4,004 (2.7%)	35,840 (19.1%)	17,194 (9.5%)	276 (0.6%)	348 (0.8%)	74,296 (8.8%)	184,252 (2.7%)
2nd most common language other than English spoken at home	Vietnamese	Spanish	Samoan	Arabic	Hindi	German	Arabic	Chinese	Mandarin
	16,594 (9.1%)	531 (0.9%)	3,047 (2.1%)	13,745(7.3%)	8,043 (4.5%)	192 (0.4%)	196 (0.5%)	35,780 (4.3%)	139,825 (2.0%)
3rd most common language other than English spoken at home	Greek	Arabic	Hindi	Assyrian	Vietnamese	Greek	Maltese	Vietnamese	Cantonese
	6,565 (3.6%)	471 (0.8%)	3,044 (2.1%)	10,582(5.6%)	7,843 (4.4%)	161 (0.4%)	180 (0.4%)	61,313 (7.3%)	136,374 (2.0%)
4th most common language other than English spoken at home	Cantonese	Cantonese	Bengali	Cantonese	Italian	Spanish	Greek	Italian	Vietnamese
	5843 (3.2%)	324(0.6%)	2563 (1.8%)	9,334 (5.0%)	5,108 (2.8%)	105 (0.2%)	145 (0.3%)	12,090 (2.0%)	87,499 (1.3%)
Humanitarian Stream, number of settlers arriving from 2005 to 2011	985	7	196	6,547	3,197	0	0	10,932	26,239
Disability: need for assistance with core activities	11,279	2,218	7,717	13,180	9,643	2,328	1,624	47,989	338,362
	6.2%	3.9%	5.3%	7.0%	5.4%	5.2%	3.8%	5.7%	4.9%
Carers: Unpaid assistance to a person with a disability	17,268	4,672	13,554	17,519	15,484	4,596	4,002	77,095	638,614
	9.5%	8.2%	9.3%	9.3%	8.6%	10.4%	9.3%	9.2%	9.2%
Education [2,3]									
Total persons 15 years and over, no longer attending primary or secondary school	135,830	40,672	108,230	141,451	130,534	34,012	31,646	622,375	5,344,114
Education: Completed Year 12 or equivalent	65,318	17,484	46,128	64,273	63,884	14,965	11,497	283,549	2,631,287
	48.1%	43.0%	42.6%	45.4%	48.9%	44.0%	36.3%	45.6%	49.2%
Education: Completed Year 10 or equivalent	28,859	13,403	31,059	25,070	28,009	10,140	11,869	148,409	1,278,047
	21.2%	33.0%	28.7%	17.7%	21.5%	29.8%	37.5%	23.8%	23.9%
Education: Completed Year 10 or below	51,696	18,403	46,525	58,922	47,990	14,210	16,177	253,923	1,983,205
	38.1%	45.2%	43.0%	41.7%	36.8%	41.8%	51.1%	40.8%	37.1%

Employment [2,3]									
Total labour force	75,608	29,969	70,235	75,950	80,188	20,106	22,224	374,280	3,334,857
Employed full time	44,906	19,295	43,968	44,627	50,804	11,367	13,886	228,853	2,007,925
	59.4%	64.4%	62.6%	58.8%	63.4%	56.5%	62.5%	61.1%	60.2%
Employed part-time	20,162	7,762	16,987	18,934	18,696	6,731	6,096	95,368	939,465
	26.7%	25.9%	24.2%	24.9%	23.3%	33.5%	27.4%	25.5%	28.2%
Unemployed	5,739	1,209	5,182	7,341	5,620	846	936	26,873	196,526
	7.6%	4.0%	7.4%	9.7%	7.0%	4.2%	4.2%	7.2%	5.9%
Income [2]									
Income: Median individual ($/weekly)	428	690	549	369	510	548	617	N.A.	561
Income: Median family ($/weekly)	1,228	1,865	1,390	1,065	1,401	1,348	1,661	N.A.	1,477
Income: Median household ($/weekly)	1,091	1,727	1,251	1,022	2,199	1,094	1,478	N.A.	1,237
Family households with incomes <$600/wk	15.1%	7.3%	12.5%	17.8%	12.3%	11.7%	9.0%	13.6%	12.3%
Family households with incomes > $2500/wk	16.8%	27.8%	17.1%	12.9%	18.9%	17.2%	24.1%	17.7%	23.3%
Family characteristics [2]									
Families	47,029	15,462	39,123	49,714	46,563	12,271	11,877	222,039	1,829,553
Couple families with children	24,715	8,494	19,016	25,853	26,421	4,777	6,247	115,523	831,850
	52.6%	54.9%	48.6%	52.0%	56.7%	38.9%	52.6%	52.0%	45.5%
Couple families without children	12,411	4,635	10,769	11,569	11,058	5,539	3,906	59,887	669,019
	26.4%	30.0%	27.5%	23.3%	23.7%	45.1%	32.9%	27.0%	36.6%
One parent families	9,069	2,182	8,718	11,227	8,478	1,832	1,613	43,119	297,904
	19.3%	14.1%	22.3%	22.6%	18.2%	14.9%	13.6%	19.4%	16.3%
Other families	834	151	620	1,065	606	123	111	3,510	30,780
	1.8%	1.0%	1.6%	2.1%	1.3%	1.0%	0.9%	1.6%	1.7%
Household composition: private dwellings [2]									
Households	57,238	17,875	47,286	55,835	53,595	16,694	13,953	262,476	2,471,296
Family household	44,620	14,963	37,380	45,959	44,019	12,053	11,472	210,466	1,777,398
	78.0%	83.7%	79.1%	82.3%	82.1%	72.2%	82.2%	80.2%	71.9%
Lone person household	11,454	2,589	8,854	8,737	8,596	4,324	2,245	46,799	599,148
	20.0%	14.5%	18.7%	15.6%	16.0%	25.9%	16.1%	17.8%	24.2%
Other households	1,164	323	1,052	1,139	980	317	236	5,211	94,750
	2.0%	1.8%	2.2%	2.0%	1.8%	1.9%	1.7%	2.0%	3.8%

Dwelling characteristics [2]									
Total private dwellings	60,236	18,806	49,486	58,369	55,958	19,656	15,038	277,549	2,736,637
Median rent ($/weekly) (occupied private)	310	360	260	280	295	260	270	N.A.	300
Median housing loan repayment ($/monthly) (occupied private)	2,002	2,167	1,800	1,800	2,167	1,873	2,167	N.A.	1,993
Occupied private dwellings - fully owned	19,467	4,648	11,435	18,139	12,908	6,945	4,298	77,840	820,006
	32.3%	24.7%	23.1%	31.1%	23.1%	35.3%	28.6%	28.0%	30.0%
Occupied private dwellings - rented including rent-free	16,549	3,347	14,373	17,181	16,301	3,564	2,276	73,591	743,050
	27.5%	17.8%	29.0%	29.4%	29.1%	18.1%	15.1%	26.5%	27.2%
Number of Public Housing Dwellings [4]	6,282	367	6,438	4,634	4,879	9	18	22,627	
Proportion of dwellings rented from Housing NSW	9.3%	1.8%	11.2%	7.4%	7.9%	2.3%	1.0%	7.5%	4.4%
Travel [2,3]									
Proportion travelled by car only	66.4%	73.6%	65.8%	70.4%	69.8%	68.6%	72.7%	68.9%	62.6%
Proportion travelled by public transport only	13.5%	3.3%	13.2%	10.5%	8.9%	1.8%	2.1%	9.6%	11.7%
Proportion travelled by bicycle or walking only	2.1%	1.4%	1.6%	2.0%	2.6%	4.1%	1.7%	2.1%	4.8%
Internet Connection at Home									
Proportion of private dwellings with no internet connection	23.2%	13.5%	19.3%	25.3%	19.2%	19.7%	16.5%	20.9%	20.1%
Socio-Economic Indexes for Areas - Index of Relative Socio-Economic Disadvantage (IRSD) (2006) [5]									
IRDS Score	945	1,057	955	876	966	1,032	1,044	N.A.	N.A.
Rank in NSW	39	133	46	4	28	124	127	N.A.	N.A.
Most Disadvantaged Suburb & IRDS Score	Villawood (718)	Leppington (971)	Claymore (574)	Villawood (718)	Cartwright (735)	Welby (921)	Warragamba (952)	Claymore (574)	Murrin Bridge (497)
2nd most Disadvantaged Suburb & IRDS Score	Chester Hill (900)	Narellan (1015)	Airds (602)	Cabramatta (739)	Miller (738)	New Berrima (975)	Tahmoor (968)	Airds (602)	Claymore (574)

Source:

1. Total persons data from ABS Estimated Resident Population (ERP) (ABS 3218.0 Regional Population Growth, Australia - released 31 July 2012) - includes an allowance for census net undercount and estimated number of Australian residents temporarily overseas at the time of the 2011 census

2. All other data is from the Australian Bureau of Statistics 2011 Census of Population and Housing; percentages apply to census count data, not ERP data

3. Proportion is applying to people aged 15 years and over in the census

4. Number of Public Housing Dwellings, Housing NSW 2010 (accessed June 2012)

5. SEIFA ranks areas in Australia according to relative socio-economic advantage and disadvantage. A lower IRDS score indicates that an area is relatively disadvantaged compared to an area with a higher score. There are 153 LGAs in NSW. All areas within a State are ordered from lowest to highest score, with the area with the lowest score given a rank of 1.

6. Humanitarian data sourced from the Department of Immigration and Citizenship Settlement Database (2012)

Appendix 3: Health Status of South Western Sydney Residents

Although high level health indicator measures such as life expectancy at birth and deaths from all causes for SWSLHD residents mirror the NSW average, on a range of health indicators local residents have poorer outcomes than the average for NSW. SWSLHD residents on average have elevated rates of behaviours which have been linked to poorer health status and chronic disease including cardiovascular and respiratory diseases, cancer, and other conditions that account for much of the burden of morbidity and mortality in later life.

Health Behaviours

- SWSLHD residents were generally less likely to rate their health status as good, very good or excellent than the NSW average
- Current daily and occasional smoking at 19.2% (higher than the NSW average)
- Adequate physical activity at 47.8% (7% worse than the NSW average)
- Overweight at 34.1% (slightly higher than NSW average)
- Obesity at 21.8% (2% higher than NSW average)
- Consuming vegetables in recommended quantities at 7% (3% worse than the NSW average)
- First antenatal visit before 14 weeks gestation for Aboriginal mothers at 54% (17.3% worse than the NSW average) and for non-Aboriginal mothers at 53.8% (25.8% worse than the NSW average)
- 15.3% of women smoked during pregnancy (4% higher than the NSW rate)

Health Status

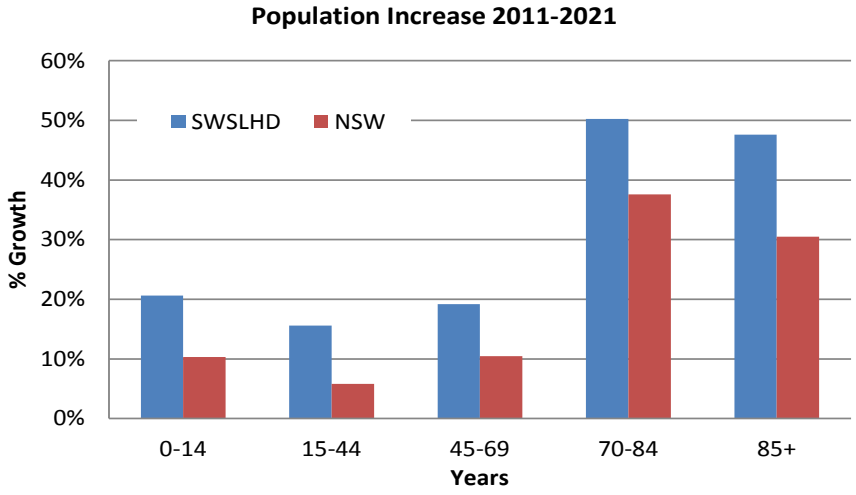
- Higher standardised mortality ratios (SMRs) than NSW for deaths from all causes in Campbelltown (107.4), Liverpool (105.8) and Camden (102)
- In 2004- 2008, SWSLHD had higher incidence of lung, kidney, head and neck, pancreas, thyroid, stomach, bladder, uterus and liver cancer than NSW
- Cardiovascular disease was the most common cause of death in NSW in 2007, accounting for 35.1% (16,260) of all deaths. Mortality rates in SWSLHD for cardiovascular disease at 83.9 per 100,000 are 5% higher than the NSW average of 100 and are significantly higher in Liverpool LGA (111.4) (2005/06)
- Higher rates of diabetes are reported for residents of Bankstown, Liverpool, Campbelltown and Fairfield LGAs than for NSW
- Rates of Hepatitis B in SWSLHD were almost double the NSW rate, and were particularly high in Fairfield
- Rates of Hepatitis C in SWSLHD are higher than the NSW rate, particularly in Campbelltown and Fairfield
- The prevalence of dementia is expected to substantially increase over the next ten years as the population ages

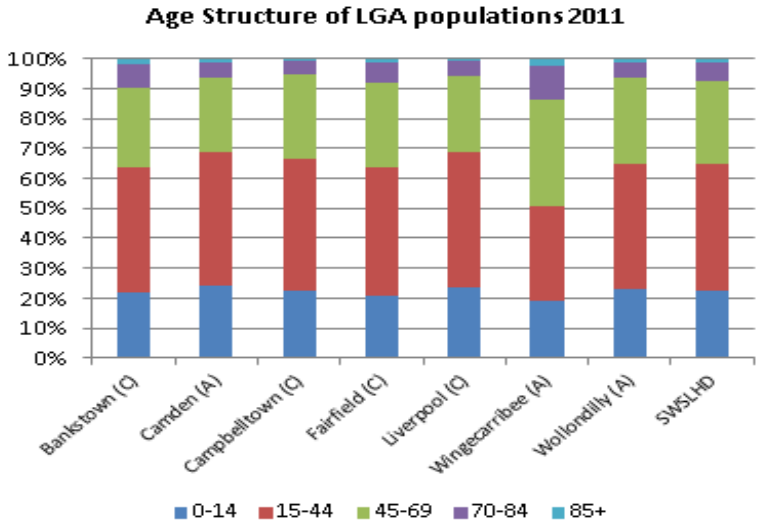
Age groups

- Infants and children aged 0 – 14 years represent 22.2% of the population and will increase from 195,727 to 236,048 children by 2021. Although the largest change will occur in the Camden LGA

where the number of children will grow by 82%, the largest number of children will continue to reside in Liverpool (55,071) and Bankstown (45,203)

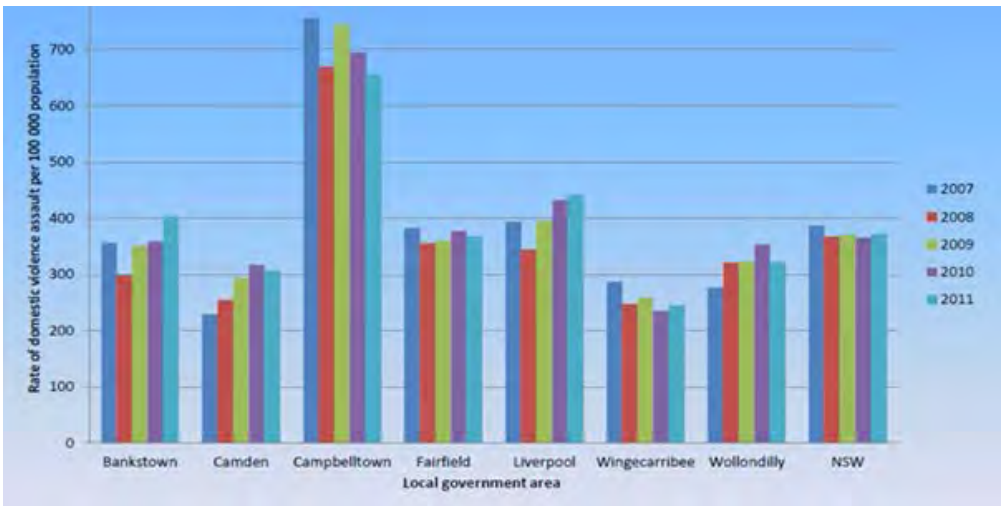
- In 2011 there were 171,834 young people aged 12-14 years in the District, growing by 13.5% to 195,101 young people by 2021. Greater growth is projected for adults aged 25 – 64 years, increasing by 16.6%
- The number of people aged 65 years and over is projected to grow by 48% from 98,089 (2011) to 145,538 people (2021) and compared to 2011 will grow by 80% by 2026
- Highest projected growth for people aged 65 years and over will be in Camden and Campbelltown LGAs, 153% and 77% respectively in the next decade
- The number of people aged 85 years and over will increase from 11,998 (2011) to 17,709 people (2021) i.e. 47.6%





Other:

Rates of Domestic Violence (SWS)



Appendix 4: Role Delineation Level of Community Health Services

Service[1]	Bankstown	Fairfield	Liverpool	Campbell-town	Camden	Wollondilly	Winge carribee
Family and Child Health[2]	4	4	4	4	3	3	3
Adolescent Health[3]	3	3	3	4	0	1	3
Child Protection (CPCS)	3	3	4	3[4]	3	3	1
Palliative Care	3	2	6 [5]	3	5 [6]	2	3
Sexual Assault	3	1	4	3	1	3	3
Aboriginal Health[4]	5	5	5	5	5	5	5
Community Health – General[5]	5	5	5	5	5	3	5
Community Nursing[6]	5	5	5	5	5	5	5
Multicultural Health[7]	4	4	4	3	3	3	3
Sexual Health[8]	1	1	4	3	1	1	1
Women's Health[9]	4	4	4	4	4	4	4

[1] Role delineation identifies integrated community and hospital services e.g. Palliative Care, Family and Child Health. Integrated services have been included in the table

[2] Family and Child Health. The service is provided at a role level 4 where paediatric inpatient services are available. At other sites a level 3 service is provided

[3] Adolescent Health. A level 3 service is provided across most of SWSLHD. Level 4 services are available at Campbelltown.

[4] Campbelltown PANOC does not have social work after hours coverage hence a Level 3 service

[5] Liverpool Palliative Care while it meets some aspects of a level 6 service there are no designated beds managed by the Palliative Care Specialist and no allied health within the Palliative Care Team.

[6] Camden Palliative care has support services which are provided through the group Campbelltown Hospital

[4] Aboriginal Health. A level 5 service is provided across SWSLHD

[5] Community Health – General. A level 5 service is provided across SWSLHD. Some services within community health such as palliative care provide level 6 services.

[6] Community Nursing. A level 5 service is provided across SWSLHD.

[7] Multicultural Health. A level 3 service is provided across SWSLHD.

[8] Sexual Health. A level 4 service is provided at Liverpool and a Level 3 service at Campbelltown. Other hospitals provide level 1 services.

[9] Women's Health. A level 4 service across SWSLHD

Appendix 5: Core Activity Indicators from the Performance Management Framework

SWSLHD Performance Management Framework				
Indicator	**2010/11**	**2011/12**	**2012/13**	**Target**
Non-admitted patient occasions of Service (NAPOOS)	303,471	387,078	409,023	
Community Health Nursing referrals received (total)	686	925	1003	1,000/mth
Palliative care home death rates (average across all teams)	N/A	N/A	22.5%	16%
Universal Health Home Visiting - families offered a visit	N/A	97%	98%	100%
Universal Health Home Visiting - visit attended within 2 weeks	N/A	58%	61%	65%
Universal Health Home Visit - visit attended within 4 weeks	N/A	79%	81%	85%
Children offered a Statewide Eyesight Preschool Screen (StEPS)	N/A	N/A	100%	90%
Children who receive a StEPS screen	N/A	N/A	73%	80%
Newborn hearing screening	N/A	N/A	99%	>95%

Financial Year Activity 2011 to 2014				
		2011 - 2012	**2012 - 2013**	**2013 - 2014**
Early Intervention Services				
Psychosocial Support (Counselling Services - all)	No. Reg. Clients (total)	1094	1445	2929
	No. Reg. Clients (CALD) COB	181	289	862
	No. Reg. Clients (ATSI)	33	66	192
Women's Health	No. Reg. Clients (total)	349	761	773
	No. Reg. Clients (CALD) COB	160	269	311
	No. Reg. Clients (ATSI)	7	16	16
Youth Health	No. Reg. Clients (total)	867	725	489
	No. Reg. Clients (CALD) COB	153	96	71
	No. Reg. Clients (ATSI)	65	64	46
Paediatric Developmental	No. Reg. Clients (total)^	64077	66550	66200
	No. Reg. Clients (CALD) COB	8551	9403	10370
	No. Reg. Clients (ATSI)	1589	1689	1773
Community & Post-Acute Services				
Community Nursing	No. Reg. Clients (total)	12693	12487	12065
	No. Reg. Clients (CALD) COB	5069	5256	5252
	No. Reg. Clients (ATSI)	134	164	219
Chronic Care	No. Reg. Clients (total)	60	56	113
	No. Reg. Clients (CALD) COB	2	2	5
	No. Reg. Clients (ATSI)	36	47	67

Connecting Care	No. Reg. Clients (total)	N/A	73	800
	No. Reg. Clients (CALD) COB	N/A	45	355
	No. Reg. Clients (ATSI)	N/A	4	115
^ Includes mothers and babies registered, plus multiple registrations for some follow-up checks				

Appendix 6: Community Health Workforce Profile: April 2013

Employment Category	Community Health	
	Headcount (Number) of Employees	% of Employees
Nursing	277	49%
Medical	24	4%
Allied Health and Complementary Therapy	110	20%
General Hospital Employees	86	15%
Other	63	11%
Total	560	100%

Source: SWSLHD Workforce Profile, April 2013

Appendix 7: Service Development Directions for SWSLHD Community Health

Extract from SWSLHD *Strategic & Healthcare Services Plan*

SWSLHD Community Health Services will enhance the linkage and interaction with general practice and the South Western Sydney Medicare Local across all models of care; and will explore an integrated primary and community care service model within existing CHC(s) to trial and embed innovative practice prior to the development of RIPCCCs in the SWGC. In addition, opportunities will be explored for providing services such as palliative care, women's health, immunisation clinics, chronic disease programs, primary and secondary prevention initiatives, rehabilitation, aged care, mental health, allied health, day procedures and infusion therapies in multiple settings (e.g. community health centres, GP clinics, community centres and patient's homes) through closer partnerships with GP's and other service providers. This will require a review of existing models of care to ensure that they meet the needs of modern health practice.

Greater service flexibility will be pursued including extended hours into evenings and weekends, flexible models of delivery such as outreach, increased utilisation of community health centres for clinical activity, improved transition of care from post-acute to maintenance care with appropriate providers and new and innovative models of care, services and facilities in areas of housing development, significant population growth or emerging health risks.

To support these directions, a SWSLHD Community Health Services Infrastructure Renewal Strategy will be developed to match infrastructure requirements to: emerging models such as IPPCCs; potential outreach of ambulatory hospital services; fibre optic enabled practice and to changed and evolving population growth patterns. Specifically, there will be a focus on:

Post-acute and chronic care nursing - clarifying the role of community health in post-acute care service provision, particularly in relation to increasing rates of day surgery and the shared interface between Ambulatory Care Services; increasing demands for Primary Health Nursing services to meet the needs of ageing communities; determining the mix of services delivered directly by the District and those manageable by non-government providers; and enhancing capabilities to provide holistic community nursing support for cancer patients (eg. blood-taking, symptom control); and introduction of electronic point-of-care tools to more effectively manage demand and safe and timely transfer of care for patients in the community.

Early Years and School Aged Children - continued movement towards Targeted Sustained Home Visiting across SWSLHD; expanded use of trans-disciplinary practice to respond to families with high needs; increasing access to early intervention therapy services for children between the ages of 0-6 years, maximising learning and development opportunities; and consolidating models of care for young people living in south western Sydney.

Community Development and Partnerships - working with other agencies to deliver "whole of government" responses to community needs; and building partnerships in innovative multidisciplinary primary health care to improve health outcomes for marginalised and at risk populations (e.g. homeless young people).

Service Integration and Care Coordination – building on the role of the Triple I (Hub) to facilitate care coordination of community-based referrals.

In addition to existing services, the development of Integrated Primary and Community Care Centres (IPCCCs) has been proposed for new housing developments such as the South West Growth Centre (SWGC), supported by hospital based services at Campbelltown, Camden and Liverpool. There are currently no IPCCs in South Western Sydney, however extensive planning has been undertaken.

The proposed model to support delivery of appropriate health services to 2021 revolves around the development of three tiers of service, based on a SWGC catchment of 300,000 people. The tiers are:

Team General Practice (Tier 1) - servicing a catchment population of 4-5,000 people. Approximately 70 TGPs are required. The expected minimum services include various configurations of general practice supported by practice nursing.

Primary Care Clinics (Tier 2) - servicing a catchment population of 15 - 18,000 people. Approximately 18 PCCs are required. The expected minimum services include group general practice, practice nursing, additional on-site and visiting services. On-site options might include private dental, private diagnostic imaging and private pharmacy. Visiting service options might include early childhood health, medical specialist clinics and community nursing.

Regional Integrated Primary and Community Care Centres (RIPCC) (Tier 3) - servicing a catchment population of 75 - 100,000 people. Proposed RIPCCs include the major centre at Leppington, and other centres at Oran Park and eventually the western portion of SWGC as that develops (potentially at Bringelly). The expected minimum services might include group general practice, practice nursing, multidisciplinary specialist clinics, medical procedural care/day surgery, chronic care, aged care, child, youth and family services, mental health and drug health. Additional options might include diagnostic imaging, pharmacy, satellite dialysis, day therapy cannulation, satellite radiotherapy bunker(s), oral health, sexual health and training and education.

Services identified as being suitable for delivery in an RIPCC include: Infusion therapy, including chemotherapy; radiotherapy (contingent on state-wide planning); satellite dialysis; cancer survivorship centres; screening/diagnostic endoscopy; ambulatory care - minor procedures, intravenous infusion; specialist nursing support - cardiac, respiratory, diabetes; community health services - community nursing, women's health, child and family; oral Health; mental health; aged care; rehabilitation; drug health; research and education.

Appendix 8: Outpatient Activity (NAPOOS) Projections for 2016 / 2017

Clinical Services	2011/12 Equiv Non Admitted Patients Occasions of Service	2017 projections	2011/12 Privately Referred Non-Inpatients	2017 projections	2017 projections (NAPOOS & PRNIP)	% Growth
Community Health Total	370,093	419,799	0	0	419,799	13.4%

Data Sourced Dec 2012, and is consistent with that in the *SWSLHD Strategic & Healthcare Services Plan*. Variance between data in this table and the SWSLHD Performance Management Framework (data sourced Dec 2013) is due to exclusion of PRNIP data, ongoing auditing and service realignment)

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