South West Sydney Diabetes Regional Service Statement – Scoping Paper

Background

Diabetes Mellitus (DM) or diabetes is a group of chronic medical conditions which include type 1 diabetes; type 2 diabetes; gestational diabetes (GDM) that develops or is recognised for the first time during pregnancy and usually disappears following the birth of the baby, although women who have had GDM are at the significant risk of subsequently developing diabetes; and a variety of rarer forms of diabetes. The impact of diabetes and its complications has far-reaching implications not only for people at risk, or with diabetes, and their significant others, but also for all providers of health care services. The complexities of these conditions result in people with diabetes requiring on-going specialised multidisciplinary health care.

The South West Sydney Region includes seven Local Government Areas (LGAs): parts of the Canterbury-Bankstown, Fairfield, Liverpool, Campbelltown, Camden, Wollondilly and Wingecarribee, with an estimated resident population of 966,450 people, comprising (12.5%) of the total NSW population.

The percentage of people in South West Sydney (SWS) with DM who are registered with National Diabetes Services Scheme (NDSS) was 6.3% in 2011. Based on this data there will be an estimated population of people with diabetes of 67,030 within the SWS by 2021. The SWSLHD average hospital length of stay (LOS) for all separations [aged 16 years and greater] in 2014 was 3.95 days; however this average was 5.55 days for patients with a primary diabetes care and 6.25 days for patients with diabetes as a secondary issue. The increased LOS is estimated at 2.3 days [for 24,987 separations], or 57,470 bed days in 2014 across the LHD. Gestational diabetes which affects both mothers and their unborn children requires monitoring and screening which represents a major challenge for SWS with its incidence of 21.2% in 2014 of women giving birth.

The SWS is expected to experience rapid population growth of (33%) over the next fifteen years (2016-31). Large population growth is also expected in the older population - the number of residents over 65 years of age will reach up to 212,650 by 2031, an increase of (73.5%). The growth will be particularly strong amongst those over 85 years of age, with an increase of (90.3%).

The SWS is socioeconomically and culturally diverse with a large proportion of people born overseas 404,000 or (43.3%) compared with (34.5%) for NSW; a large proportion of the population identifying as Aboriginal 16,540 or (1.8%) compared with (2.9%) for NSW, with a

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1 Local government amalgamations have resulted in the creation of Canterbury-Bankstown LGA (formerly Bankstown and Canterbury LGAs)
2 Australian Bureau of Statistics 2016, Census of Population and Housing
3 SWSLHD Diabetes Review 2015/16
majority of the population residing in the Macarthur Region (Campbelltown, Camden and Wollondilly) and Liverpool LGA;

In addition, SWS has some of the most disadvantaged communities in NSW according to the Index of Relative Socioeconomic Disadvantage (IRSD), which ranks geographic areas across Australia according to their socio-economic characteristics, such as income, unemployment and low levels of education. Fairfield, Campbelltown and Liverpool LGAs are among the ten most disadvantaged LGAs in metropolitan Sydney, with disadvantage often concentrated in specific suburbs.\(^4\) The increasing population, it’s demographic and population profile, and incidence and prevalence of diabetes in SWS, will have significant implications on diabetes care in the future.

Best practice, high quality diabetes care is best achieved when health care professionals work seamlessly and in partnership across primary health, community and specialist care services with direct consumer, carer and family involvement. The focus is on consumer engagement, awareness and diabetes self-management.\(^5\)

The focus of specialist diabetes services in South Western Sydney Local Health District (SWSLHD) has been primarily on hospital avoidance and maintaining health in people with diabetes referred for specialist care.

South Western Sydney Primary Health Network (SWS PHN) has been working directly with general practitioners (GPs), other primary care providers, secondary care providers and hospitals to better coordinate care across the local health system so that consumers with diabetes who require help from multiple health care providers, receive the right care in the right place at the right time.

SWSLHD will need to develop highly specialised health care services supported by enhanced technology to meet growing demands. There is a need for coordination and integration of diabetes care across services, settings, technology and sectors including SWSLHD, private providers and non-government and Aboriginal health sectors. This can be achieved through the regional service statement in partnership with the SWSPHN.

**Strategic and Organisational Context**

A range of policies, key reforms and reviews have informed diabetes services planning at a national, state and regional level.

- **Australian National Diabetes Strategy 2016-2020** outlines Australia’s national response to diabetes and informs how existing limited health care resources can be better coordinated and targeted across all levels of government.

- **NSW Diabetes Prevention Framework** focuses on population health drivers for prevention of the onset or delay of diabetes in high risk populations (primary prevention) and the prevention of the immediate and longer-term consequences for individuals with diabetes (secondary prevention).

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\(^4\) Australian Bureau of Statistics, Socioeconomic Indexes for Areas (SEIFA), 2016  
• **NSW State Plan 2021: A Plan to make NSW Number One** is the NSW Government 10-year plan to guide policy and budget decision making and to deliver on community priorities including goals to “Keeping people healthy and out of hospital and to Provide world class clinical services with timely access and effective infrastructure”. Specific targets have been set to support achievement of these goals.

• **The NSW State Health Plan: Towards 2021** provides a framework which brings together NSW Health’s existing plans, programs and policies and sets priorities across the system for the delivery of ‘the right care, in the right place, at the right time’. The Plan’s directions focus on keeping people healthy, providing world class clinical care and delivering truly integrated care. These directions will be achieved via supporting and developing the workforce, supporting and harnessing research and innovation, enabling access to eHealth, and designing and building future-focused infrastructure.

• **Agency for Clinical Innovation: Inpatient Management of Diabetes Mellitus - Quality Improvement Priority Brief** for addressing and improving hyperglycaemia in an acute hospital setting through identification and screening, insulin management, access to specialist care and optimising health through ongoing care in order to support the transfer of patient care to the community for ongoing management. Adoption of the initiative in SWSLHD is underway.

• **SWSLHD Strategic Plan 2018-2021** sets out the direction for the District over the next four years, consistent with our vision of ‘Leading care, healthier communities’.

• **The SWSLHD Diabetes Review 2015/16** was completed to examine the impact of DM on the SWS population. It developed recommendations to address gaps in the service model and included the significant development of services over a four year enhancement period. The Review focussed on the uplift of Diabetes specialist services in SWSLHD, primarily located within hospital facilities.

• **The Draft SWSLHD Care in the Community Clinical Service Plan** is an overarching Local Health District strategy based on Integrated Health Care Neighbourhood model of care. It outlines the services required to meet the needs of the SWS population for primary care, ambulatory care, and other community based services into the future.

• **The Wollondilly Health Alliance (WHA)** is a partnership established in 2014 to develop new and innovative ways to connect health services and improve health care in the region. Wollondilly Shire Council, South Western Sydney Primary Health Network and South Western Sydney Local Health District are the key members of the Alliance, with other health service providers, consumers and carers also playing an important role. One of the priorities for WHA is to prevent the ‘at risk’ population from developing diabetes, and people with diabetes type 2 from developing complications by establishing multidisciplinary teams in community health centres (Endocrinologist, Podiatrist, Dietitian, Diabetes Educator), to provide advice to GPs, raising community awareness of the program and training and education of community members who are able to support others.
The South Western Sydney HealthPathways program has been developed collaboratively between SWSLHD, the South Western Sydney PHN and HealthPathways Australasia to provide GPs with detailed clinical information, red flags which highlight the need for active monitoring and/or referral, assessment tools, management tools and referral and support information. A number of HealthPathways pertaining to diabetes care has been developed.

Other initiatives outside of SWS

The Western Sydney Diabetes (WSD) initiative has been established in response to the growing threat diabetes poses to our community's health and wellbeing. It calls for all levels of government, the private sector and non-government partners to work together. The WSD initiative recognises that diabetes is everybody’s business and that partnerships between community health services, general practice, hospitals, specialist practices and allied health need to be improved so that people with diabetes or at risk of diabetes have access to more integrated and comprehensive diabetes services.

Scope

The South West Sydney Diabetes Regional Service Statement aims to develop an integrated Diabetes Model of Care comprising of primary, secondary and tertiary care intersections, using a service statement approach. This Model of Care will focus on how the SWS regional health services currently manage diabetes, and the needs for the future (including development of new opportunities and approaches). It will have a primary, secondary and tertiary focus. This Model would be developed by the Planning Unit in conjunction with key stakeholders including clinicians, PHN, LHD and other key stakeholders.

The integrated Diabetes Model of Care would incorporate significant changes and the developing primary health care reform, including the Quality Improvement (QI) Practice Incentive Program, the move towards medical neighbourhoods and risk stratification.

The planning process will include:

- Review of current evidence-based and comprehensive needs assessments
- Service mapping and model of care development
- Primary care services and their interface with diabetes services provided by SWSLHD, private providers and non-government and Aboriginal health sectors
- Principles of Stepped Care, which includes interventions and approaches for the well population and groups at high risk of diabetes, as well as people requiring a complex mix of services
- Development of targeted, responsive interventions to meet the needs of high risk and vulnerable populations: Aboriginal people and people from culturally and linguistically diverse (CALD) communities who are at greater risk of chronic conditions such as DM; as well as older people, people living in regional/remote areas and people who are socio-economically disadvantaged
- Screening and diabetes treatment services and identifies ways to further reduce the incidence of DM through preventive and other measures.
The scoping of the SWS Diabetes Regional Service Statement will explore potential collaboration with the Western Sydney Diabetes initiative as diabetes was considered in the Strategic Partnership Agreement signed between SWSLHD and WSLHD.

The Service Statement will be complemented by the second document with a population approach to preventing and reducing obesity in the adult population of SWS, to complement the existing SWSLHD Childhood Obesity Plan. Taking into account that obesity is broader than diabetes, and addressing it at a systems level will address a number of risk factors for the SWS population.

**Opportunities**

- Formalise existing working relationships between SWSPHN and SWSLHD Diabetes Services
- Further establish joint planning approaches across primary and secondary care settings
- Establish an integrated vision for service and system improvement to improve diabetes health outcomes for priority groups
- Identify and address duplication, inefficiencies and gaps in service provision and provide solutions to address them
- Provide a platform for regional service integration through the development of new service pathways
- Embed a stepped care approach to diabetes care to ensure that a broad range of service types are available
- Identify opportunities to improve transitions of care from primary to secondary to tertiary care
- Identify opportunities that leverage current PHN & LHD collaborations, partnerships and initiatives across the region.

**Conduct of Planning**

A Steering Committee which will include members of the Diabetes Planning Executive Steering Committee is proposed to provide oversight and direct the planning process.

The Committee will meet to discuss key deliverables of the project. A small working group consisting of SWSPHN and SWSLHD Diabetes clinicians and Planning Managers and senior staff will be established to support the planning process.

The major elements of the planning process are as follows:

- Agreement on scope, timeframe, focus of the Plan and vision for the SWS
- Establish clear governance and consultation arrangements including carers and consumers
- Undertake initial interviews with significant stakeholders
- Service mapping of SWS Diabetes services across settings and sectors
- Identify population needs/service targets and gaps in current service provision
- Development of a Discussion Paper compiling background data and service information and current and projected activity for primary, secondary and tertiary service providers
- A Plan development workshop facilitated by a consultant
• Development of the draft *SWS Diabetes Regional Service Statement*.

The development of the regional Service Statement will be supported by the SWSLHD Planning Unit. It is proposed to engage a consultant to facilitate the Plan consultation workshops and consultation with broader stakeholders and support development of the document.

**Preliminary List of Stakeholders**

Consumers and Carers of people living with diabetes
Aboriginal Community Controlled Health Services
SWSLHD Multicultural Health Services
NGOs and CMOs representing CALD and other vulnerable populations
SWSLHD Diabetes Services Executive
SWSLHD diabetes specialist and clinical staff
SWSLHD Women’s Health
SWSLHD Paediatric and Neonatology
SWSLHD Oral Health
SWSLHD Mental Health
General Practitioners
SWSPHN representatives in Chronic Care/Diabetes
Health Promotion Services within SWSLHD/SWSPHN and NGOs sector
NSW Health specialist networks and pillars e.g. Agency for Clinical Innovation
Diabetes NSW
Educational institutions e.g. Western Sydney University, University of NSW, University of Sydney, University of Wollongong
NSW Ministry of Health
Service Provision Partners (NGOs, other government departments and private sector).

**Appendix 1 –Steering Committee Membership**

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<thead>
<tr>
<th>Status</th>
<th>Position</th>
<th>Name</th>
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<tbody>
<tr>
<td>Chair</td>
<td>Complex Care and Internal Medicine Clinical Stream</td>
<td>Dr Alan McDougall</td>
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<tr>
<td>Executive Sponsor</td>
<td>SWSLHD Director Allied Health</td>
<td>Sue Colley</td>
</tr>
<tr>
<td>Member</td>
<td>Clinical Manager Complex Care and Internal Medicine</td>
<td>Bradley Warner</td>
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<tr>
<td>Secretariat</td>
<td>Executive Assistant Clinical Stream Office</td>
<td>Lisa Green</td>
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<tr>
<td>HOD</td>
<td>Clinical Director</td>
<td>Dr David Simmons</td>
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<td>HOD</td>
<td>Clinical Director</td>
<td>Dr Jeff Flack</td>
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<tr>
<td>HOD</td>
<td>Clinical Director</td>
<td>Dr Vincent Wong</td>
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<tr>
<td>Member</td>
<td>Associate Director, Strategic Projects</td>
<td>Josephine Chow</td>
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<tr>
<td>Member</td>
<td>General Manager-Liverpool</td>
<td>Karen McMenamin</td>
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<tr>
<td>Member</td>
<td>General Manager-Campbelltown/Camden</td>
<td>Alison Derrett</td>
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<tr>
<td>Member</td>
<td>General Manager-Bankstown</td>
<td>Peter Rophail</td>
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<tr>
<td>Member</td>
<td>General Manager-Fairfield</td>
<td>Ken Hampson (A)</td>
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<tr>
<td>Member</td>
<td>General Manager-Bowral</td>
<td>Joel Bardsley</td>
</tr>
<tr>
<td>Member</td>
<td>SWSLHD Clinical Information Department</td>
<td>Diana / Daniela Markovski</td>
</tr>
<tr>
<td>Member to support development of the plan</td>
<td>Director of Planning and Performance, SWSPHN</td>
<td>Amy Prince</td>
</tr>
<tr>
<td>Member to support development of the plan</td>
<td>GP with an interest in diabetes care</td>
<td>TBC</td>
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## Appendix 2 – Indicative Process and Timeframes for Consultation

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<tr>
<th>Objectives</th>
<th>Strategies</th>
<th>Indicative Timeframes</th>
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| 1. Scope project | • Scoping paper developed  
• Scoping Paper considered by SWSLHD and SWSPHN Executives | November 2018 |
| 2. Consolidate planning process strategy | • Establish and hold the first meeting of the SWS Regional Diabetes Service Statement Steering Committee.  
• Consult with the SWSLHD Manager Consumer and Community Participation and SWSPHN Community Manager and with consumers network members, and Director Aboriginal Health about preferred consultation processes  
• Consolidate and confirm detailed planning process and consultation approaches  
• Preliminary consultation with the CCC about potential community issues and concerns | December 2018 |
| 3. Identify and analyse current service provision | • Map existing services, networks and relationships  
• Identify and review current and projected activity  
• Identify local responses to NSW Ministry of Health plans and government policies  
• In consultation with the Steering Committee, determine/finalise consultation process i.e. in depth interviews, surveys, focus groups and consultation questions and key stakeholders  
• Undertake initial interviews with key stakeholders  
• Undertake data analysis and flow analysis  
• Review existing models of care and networking arrangements  
• Engage consultant to support stakeholder workshops and provide planning support | January 2018 |
| 4. Gain stakeholder views | • Undertake consultation process – gaps, needs, issues and strategies  
• Develop Discussion Paper with background information and data to inform Plan development workshop  
• Hold Service Statement development workshop and prepare independent report of outcomes and recommendations for further consultation  
• Progress further consultations with clinicians, facilities, establish working groups as required to define issues and describe models of care/approaches  
• Conduct facilitated forums and targeted meetings and discussions if required | February 2019 |
| 5. Draft strategic direction | • Steering Committee to review feedback and identify priority areas for action; process for consultation on strategies confirmed  
• Models further refined  
• Areas of strategic action drafted and consolidated | March 2019 |
| 6. Direction consolidated and Plan drafted | • Detailed draft Diabetes Regional Service Statement developed  
• Hold Service Statement confirmation workshop  
• Draft circulated for submit comments and meetings with targeted communities and groups to confirm direction | April 2019 |
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| 7. Finalisation of the Plan | • Discussion with CCC and via support and other groups with consumers
• Steering Committee considers feedback and confirms implications for draft strategies including governance arrangements
• Draft Service Statement finalised
• Strategies costed
• Aboriginal Health Impact Assessment completed | May/June 2019 |
| 8. Approval | • Endorsement by SWSLHD and SWSPHN Diabetes Executives
• Endorsement by SWSLHD Clinical and Quality Council
• Diabetes Regional Service Statement finalised, sent to printers for publication
• Formal launch and placed on SWSLHD/SWS PHN Webpage
• The Service Statement distributed to key partners, facilities and streams
• Implement governance arrangements for the Service Statement implementation. | July/August 2019 |