Background Information

South Western Sydney Local Health District is developing a ten year Strategic Healthcare Service Delivery framework. The framework will outline the development directions for Clinical Streams, clinical networks and facilities in South Western Sydney required to meet projected demand.

As part of the planning process for the SWSLHD strategic plan, Government agencies and non-government organisations that partner with SWSLHD in health related activities were invited to complete an on-line survey. The survey sought feedback on the experience of agencies and their clients with local health services in South Western Sydney and the issues that SWSLHD needs to address in its strategic planning. A broad remit of health was adopted, including health care and education provided in the community (by community health services, general practitioners and private specialists) and in local hospitals (in emergency departments, inpatient wards and outpatient departments). It also sought feedback on the activities of services such as the Health Promotion Unit which work systemically.

Written and email invitation to over 250 individual agencies and organisations with an interest in healthcare provision ensured broad coverage. Sixty two responses were made to the on-line survey, with other agencies choosing to make written submissions. A listing of agencies and organisations that provided identifying information in response is at Attachment A.

Questions

Feedback was sought against the following questions:

1. Please describe services, programs or initiatives between South Western Sydney Local Health District services and your agency which have worked well.
2. Please describe services, programs or initiatives between local general practitioners, other private health providers or local divisions of general practice and your agency which have worked well.
3. What are the major concerns that your agency has with health services provided by South Western Sydney Local Health District?
4. What are the main concerns that your agency has with other local health services such as general practitioners and medical, dental and allied health specialists?
5. What action should South Western Sydney Local Health District take to improve health service for your clients?
6. What action should South Western Sydney Local Health District take to improve its relationship with your agency?
7. What action could primary health care providers (such as local general practitioners) and health specialists take to improve health services for your clients?
8. From 1 July 2012 there will be a new Medicare Local in South Western Sydney to support general practitioners and other private health services, run health programs and improve coordination and care. What actions could be taken with the South Western Sydney Medicare Local to improve coordination and integration of care?
9. What are the three priorities your agency would like to see addressed in a local health strategic plan?
10. Any other comments?
Breadth of Coverage

Participants were asked to identify the geographic coverage and population grouping area of interest for their service.

Around 30% of respondents indicated that their service covered all of the LGAs of SWSLHD. Given the opportunity to specify a particular LGA of coverage, the highest frequency of response was for Bankstown and Campbelltown LGAs, with Liverpool LGA a little below that and the least frequent responses being for Wingecarribee, Camden, Wollondilly and Fairfield, all at much the same level. Overall, the frequency of responses suggests reasonable representation of coverage across the LGAs of SWSLHD.

When asked to characterise the demographics of their client group, the highest frequency reported was for covering all residents, although women, older people and carers were highly represented in response. Men, then babies and children, were least likely to be cited as characteristic of an agency client group.

A further question sought information on what health services in the community the agency mainly worked with. In frequency order, the services most often worked with were community health, mental health, general practitioners, aged care, drug and alcohol, private health providers (specialists, dental, allied health, private hospital), population health, specialist hospital services, maternity, emergency departments and oral health.

These areas of focus for agencies responding to the on-line survey should be kept in mind in assessing the qualitative information provided in response to the various questions.

1. SWSLHD Services, Initiatives or Programs that Work Well

Respondents were able to select up to five programs that worked well. Programs accorded high satisfaction included:

- **Interagency and intersectoral programs** - Aboriginal Maternal & Infant Health Strategy (AMIHS); Aboriginal Child, Youth and Family Strategy; Families NSW; Supporting Families Early Working Group; Joint Guarantee of Service (JGOS) between Health and Housing; Health-Housing partnerships across estates in Campbelltown; Health and Housing Ageing project; Brighter Futures; Justice and Human Services Regional Managers Group; Community 2168 Project between SWSLHD, Liverpool Council and Housing NSW; Skin penetration practices working party; joint community education programs e.g. early literacy project, well women’s clinics, CALD senior groups

- **Shared referral networks** - occupational therapy; psychosocial assessment and counselling; child and family community health with women’s health centres; TCAP brokering of Community Support Workers; Aged Care Assessment Team (ACAT), Referral & Information Centre (RIC), Dementia Advisory Service (DAS);

- **Liaison and information exchange** – regular meetings between Council Environmental Health Officers and the Public Health Unit
Other programs valued included:

- **Programs outreaching into the community for agency clients** - Specialist Mental Health Services for Older People (SMHSOP) community teams; occupational therapists doing home assessments; psychiatric consultations and clinical assessments for disability services; participation in Community Drug Action Teams; Macarthur outpatient transport service; Aboriginal Women’s Support groups

- **Participation in community health needs assessment** - Seniors Living Health Impact Assessment in Campbelltown; chronic and complex care meetings; focus groups and needs analysis on older refugees such as in Assyrian and Khmer communities; Assyrian Cancer Support Group

- **Community capacity development** - Hart Park Warwick Farm and other community gardens; Food 4 Life Market Warwick Farm; 2168 Training and Research Centre; mentoring programs; various projects between Council Community Development Teams on Healthy Lifestyles and the Health Promotion Unit

- **Community education** - World AIDS Day; Hepatitis Awareness Week; Drug and Alcohol programs; “It’s Time to Talk” joint partnership project with Bankstown City Council on domestic violence; mental health promotion; suicide prevention; anxiety reduction; information distributed at expos and forums; programs with Bankstown City Council – Dementia Picnic Day, Bankstown Seniors Network, Mental Health Week events, Bike around Bankstown, Community Access Worker, Cycle Skills workshops, Being Active Staying Safe Falls Prevention Project; professional education of nurses, doctors, community workers in reproductive and sexual health

- **Youth health** - Adolescent Mental Health; Fairfield-Liverpool Youth Health Team; Corner Youth Health Service

- **Other well regarded SWSLHD services** - Campbelltown ED; Waratah Mental Health Unit; Karitane; Karitane at Camden; day care services; physiotherapy; Anxiety Clinic Banks House; Wingecarribee ACAT; Antenatal Care; Aboriginal early childhood teams; Dementia Advisory Service

2. **General Practice and Other Private Health Provider Programs that Work Well**

Generally, respondents identified a smaller range of programs with general practitioners and private healthcare providers that were considered to work well. Almost all responses referred to programs with Divisions of General Practice. Programs in the following areas were well regarded:

- **General Practice participation at community events and on agency committees** - local interagency committees; local Vietnamese GP participating in cultural stories workshop with HACC funded providers; 2168 Health and Fun day; Mental Health Recovery and Support (RAS) network meetings; Mental Health Coordinating Council (MHCC) Meet Your Neighbour program; GP Division support of the Ageing and Disability Forum and Dementia Network; Focus on New Families program; Bankstown City Council Disability advisory Committee;

- **Information Exchange and Training** - Families NSW Service Directory in GP surgeries; promotion and training of women’s health services; GP Division liaison on domestic and family violence; professional education of nurses and doctors in reproductive and sexual health; accredited ALM with Bankstown GP Division on Family Health and Safety involving participation of Bankstown Women’s Health Centre; involvement of bereavement care in education
sessions for medical students organised by GP Division; mapping of local aged care and disability care services in Bankstown; promotion of agency services to GPs by Divisions; involvement with agency Dementia Grant application; shared information and resources e.g. Senior’s Social Isolation, Older Women and Abuse Forum; South West Sydney ageing and Disability Forum

- **Case management and referrals for clients** - reciprocal referrals with paediatricians; psychological assessment; further help for disability clients in addition to counselling; mental health friendly GPs

- **GP Program activity** - antenatal shared care; proposal to involve Medicare Locals in a wellbeing program for carers; home detox program; visiting GP to detention centre; Assyrian GP active in dementia awareness project; “wellness for Women” program for Arabic speaking women and girls in the Bankstown LGA

- **Programs with other private health providers** - chemists; psychologists under Medicare; Council physical activity and healthy eating programs with Tharawal Aboriginal Corporation

### 3. Major concerns of agencies about SWSLHD health services

A range of concerns were expressed. The highest frequency of responses expressed concern with access to responsive and comprehensive care for mental health clients in the community. The issues identified included:

- Insufficient resources available in community mental health including lack of case managers for those not on a Community Treatment Order; difficulties in obtaining assessments from Community Mental Health Emergency Teams unless client is threatening self harm; lack of comprehensive Independent Living Skills assessments backed by service packages to support sustainable tenancies; lack of reach into locationally disadvantaged areas

- Dual diagnosis clients falling in the cracks between mental health and disability services, not receiving assistance until crisis situations in tenancy, homelessness, hoarding and squalor

- Lack of preventative care utilising physical exercise, diet, counselling and social supports to prevent escalation of illness; patients falling into the gap between acute mental health and preventative mental health

- Access to bulk billing psychiatrists and services that go beyond medication to provide post discharge care and support to avoid re-presentation to hospital, including long term therapies such as dialectical behaviour therapy

- Access to psychology services for clients with PTSD, anxiety, depression, grief and loss

- Lack of coordinated response to “at risk” clients including reluctance to apply to the Guardianship Tribunal placing clients at risk

- Lack of residential/overnight respite for mental health clients so the carer can take a break

Long waiting times for access to SWSLHD services was also well represented in responses including for:

- Geriatric referral and assessments and ACAT
- Community services such as psychology, psychiatry and child health
- Lengthy waiting times for allied health services in the community such as occupational therapy and speech therapy compared to LGAs closer to the city
Lack of communication, information sharing with agencies and integrated processes linking services across sectors was mentioned often including:

- Service mapping information not available; little communication about what services are out there and how they can help; little information about which health services can be accessed at little or no cost; poor knowledge from acute areas on community services available and required with amorphous and ill defined links between health services and community care; little information about new services and initiatives
- Disappointing communication and slow turnaround times in project collaborations
- Poor communication and lack of awareness, motivation, commitment and resources
- Lack of representation at HACC Forums and strategic planning sessions
- Lack of understanding of ADACH & disability clients and CALD backgrounds
- Lack of sharing data on unmet needs or local health issue concerns
- Little promotion from health services to community organisations to increase access to their services
- Failure of information transfer whilst in hospital and on discharge including no checking on support services in place at home; lack of notice for discharges; unreasonable expectations of timeframes to commence programs post discharge; information reliability for clients presenting at hospital with multiple errors occurring; discharging of patients with nowhere to live; lack of knowledge in ED and ICU of home ventilation programs
- Difficult referral processes
- Lack of collaboration and MOUs
- Few partnerships with NGOs that provide support to people with a mental illness outside Health funded ones

Lack of service availability in local areas or for high need population groupings was also frequently cited including for:

- No Hepatitis C clinic or bulk billing ENT in Wingecarribee
- Dementia support services including a service for medication administration for people with dementia or who are otherwise unable to self administer
- PTSD and Trauma services specifically related to domestic violence
- Sexual assault in intimate relationship training in community languages
- Specialised services for Aboriginal people in Liverpool e.g. free public dental care
- Accessible youth health services – only four youth specific health services, none easily accessible from Liverpool
- CALD communities – lack of appropriate female interpreters; inaccessible education programs if not translated into at least top five languages; doctors priority line to Telephone Interpreting Service not used frequently enough
- Limited education on early intervention and prevention with teenage pregnancies
- Service gaps for clients with acquired brain injury and once housed services generally stop
- Difficulties in finding suitably qualified nurses for immunisation clinics
- Focus on acute and chronic disease means health services fail to recognise the role they could play in prevention of domestic and family violence
- Accessibility of health services e.g. disadvantaged clients who have limited transport options i.e. Claymore

Finally transport to health facilities was specifically identified by some agencies as a continuing major concern. Transport was seen as the key to access for the transport disadvantaged. It was considered that although there was long standing recognition
as an issue, little action had been taken in response to concerns. Some agencies did not consider that there was good understanding of the resources, costs and efficiency of transport fleet services. Specific issues were raised such as no parking for Community Transport vehicles that transport clients with mobility restrictions e.g. frail aged and disabled. The growth of Campbelltown hospital was also raised as contributing to parking and traffic problems in Park Central. Lack of accessible and affordable parking at Bankstown Hospital for carers and infrequent public transport was emphasised as a significant barrier. The lack of health-related transport was a particular difficulty for cancer patients as they don’t qualify for community transport.

4. Major concerns of agencies about other local health services such as general practitioners and medical, dental and allied health specialists

As per previous questions, again respondents identified a smaller range of concerns with general practice and other private healthcare providers in the community. One of the predominant concerns expressed was in access to services. This concern was expressed across a number of dimensions:

- **Geographic isolation** – in outlying areas such as Wingecarribee access to specialists was considered poor with patients generally having to go to Campbelltown or Liverpool; some areas reported poor access to GPs; transport impediments to accessing services in the community

- **Financial impediments** – Limited Medicare funded services for low income earners; lack of and very difficult to access bulk-billing clinical services; clients on Disability Support or Newstart unable to afford private clinical services; poor access to free dental, allied and psychiatric care; costs for disadvantaged groups particularly Aboriginal people, migrants and refugees; upfront costs for specialist appointments; dental services too expensive and public dental care underfunded; no option for free alternative and complementary therapies; cost of filling out forms an additional expense and barrier for clients; cost and transport as barriers for low-moderate income earners

- **Structural impediments** - limitations on allied health visits under Medicare; waiting times to access dental services; lack of allied health professionals such as Speech Therapists for young children with disabilities and Occupational Therapists for rehabilitation and home modification assessment; children being placed at bottom of 5 year waiting list for dental services after not meeting an appointment time; waiting times to see GPs where no appointments taken and can wait >3 hours; poor access to mental health services, particularly in the Villawood area; GPs are overworked, skill set is such that can’t be expected to do more in mental health as small part of their responsibility; parking at GP surgeries and medical centres; aging practitioners; not following through with referrals; not providing a holistic service; lack of an up to date database of specialists, the types of services available and whether they bulk bill

There were a range of concerns expressed about the outcomes of patient contacts with health providers in the community, including:

- GPs sometimes make premature diagnosis and prescribe medication rather than exploring hospital based mental health services, particularly for women in the perinatal period, on the other hand GPs are sometimes not confident in prescribing medication to perinatal women

- Needs to be greater liaison by GPs with non-health services for patients with mental health issues
- Allied health providers duplicating services and not working in effective partnerships;
- GPs unwilling or unable to be flexible with their usual practice routines e.g. appointment times
- Low level of cervical screening available from trained GPs, particularly female GPs
- Providers not knowing where to refer victims of domestic and family violence
- Lack of incentives for GPs to spend more time with those with chronic disease or to thoroughly assess and refer on patients experiencing social isolation and domestic violence or abuse
- GPs not referring patients to the range of health information that may be available
- Providers not going the further step to ensure that the patient is assisted to action a referral
- GPs and community health not referring on to NGO services and overall lack of knowledge of these services except for Homecare
- Lack of continuity of general practitioner
- Difficulties in getting reports from specialists on clients with intellectual disability to support applications to ADHC
- Lack of awareness of the ageing population’s ever increasing complex needs, including the prevalence of mental illnesses, dementia, domestic violence, abuse, social isolation, poverty and the needs of the carer and CALD sub-populations

5. Actions SWSLHD providers could take to improve services to agency clients

There were wide ranging suggestions as to how SWSLHD providers could improve services provided to agency clients, including:

- **Expanding preventative health activity** – early intervention initiatives; improved education packages on prevention of teenage pregnancies; more community awareness campaigns; information sessions on health topics targeted at particular groups; use schools and TAFE colleges to reach community members; fund health promotion and preventative health projects e.g. food security; overweight/obesity, exercise, smoking; “one stop shops” with early intervention and prevention strategies to have a long term impact on demand and prevent crisis presentations; take a holistic view on health promotion and recognise domestic and family violence as a significant concern for women in South West Sydney and social isolation, domestic violence and abuse as significant concerns for older people, people with disabilities and carers

- **Communication, liaison and integrated responses with agencies and the community** – think more in terms of community wellbeing and not a narrow hospital focus; consult with the community about what services they would like to see available to make a difference to wellbeing; supply services that take into account the user’s perspective; have a joint MOU amongst Housing, Health & Police; revive the JGOS and follow up clients after being housed; regular inter-agency meetings; community Open Days; quarterly newsletter in local papers updating residents on services and capital works; integrated case management across agencies; emphasise client ownership of support services; support family services which can improve continuity between services and identify gaps; more communication with agencies about new SWSLHD services and initiatives including information sessions for Community workers on service availability; more information on and simpler mechanisms for referral and access to services; focus on working better with NGOs; attend Ageing Disability Forums and participate in local community strategic
planning days; establish good working protocols between health services and community care e.g. mental health protocol being developed by Bankstown Area Multicultural Network; ensure HACC services have a say in planning processes and health promotion programs and work collaboratively with HACC services on community projects e.g. Dementia Network and its workgroups; ensure gender parity of provider/client in service provision to Aboriginal clients and gender separation in hospital care; GP and Allied Health attendance at forums to understand the needs of people with needs in disability and mental health; address social stigma in all initiatives e.g. no needle drop-offs in places that enhance shame and hinder people accessing bins; work with Community Transport services to ensure efficiencies across both fleets, to improve not duplicate service provision

- **Outreaching services to the community** – outreach and alternative service models to local villages and towns; Drug Health to have joint visits with Housing at clients’ homes; improve outreach services for mental health and drug health particularly in disadvantaged communities such as the 2168 area; a single facility in the Campbelltown CBD for Mental Health, Community Health and Youth Health services which could be co-located with related government and NGO services e.g. HACC

- **Improve access to services** – more resources for mental health teams in recruitment and training, to meet increased demands; more resources for geriatric mental health assessment; more resources for ACAT teams for mobility assessment and property modification; close the gap in lengthy timeframes for clients waiting to see specialists; shorter waiting lists for community health services; improved referral to clinical support in psychiatry and psychology; more transport for the elderly in Villawood and surrounding areas; improve and increase parking near facilities including for Community Transport services; make more free services available

- **Expand range and quality of services available** – further training in maternity services for psychosocial screening; midwives to be a source of support for perinatal women where additional support is required during pregnancy but the need does not require mental health referral; increase case management places in mental health; actively promote use of TIS line and HCIS use in all communication with CALD clients; have a better understanding of client confusion and cognitive difficulties; increase number of female interpreters available; ensure Domestic Violence policies are embedded in workplaces and contact list for referral is available at health agencies; have current information available to carers on services available; involve local community organisations in care plans; employ more social work, nursing and occupational therapy staff to fill gaps and improve waiting times; provide information, counselling and support services to parents and children from separated families, across different cultural groups; improve access to dental care through hospitals; provide a space at Campbelltown Hospital for NGO support services to assist with discharge planning and referral, accessed by hospital staff, patients and family members to reduce readmission rates for vulnerable patients
6. Actions SWSLHD can take to improve its relationship with agencies

For this question there was some overlap with responses to the previous question. Nevertheless, a number of practical suggestions for improvement were made, broadly categorised under the following themes:

- **Structures to facilitate interagency collaboration** – MOUs between agencies around provision of services to mutual clients; clearer understandings of each agencies requirements; protocols across agencies to address complex client needs e.g. integrating the response from Police and Social Housing to clients requiring scheduling for mental health CTO orders; work in partnership with agencies to identify targeted initiatives to increase access to health, employment and welfare services; continue work on joint initiatives such as Community 2168 project; participate in local interagencies such as Migrant and Refugee Interagency, Youth workers Network, SWS Disability Forum, SWS Homelessness Interagency, to remain up to date on support services in the community and referral pathways; consultation and project development with local Councils and services to identify emerging health issues for communities; develop partnerships, more networking and sharing of resources; regular briefing and communication with Local Councils including participation on Council committees and involving Councils in decision making processes where appropriate; increasing the range of mental health services provided through community organisations that are supported by Health providers; funding Domestic Violence training for non-DV workers e.g. doctors, nurses

- **Improving information sharing and shared learning** – Drug Health professionals addressing community organisation staff about their programs, resuming local meetings between Housing and health staff; different Health services coming to community organisation staff meetings to introduce themselves; improved information sharing between the client’s health providers and case managers; better communication with contact details; increased frequency and range of interactions with agencies; better understanding of service availability and correct referral processes; Health providers understanding that there are support services out there that can work with clients if Clinical Supports are available; better communication with agencies about interpreter service availability; be open to constructive criticism and not defensive; participation at community events such as Family Health and Fun day to distribute information

- **Joint action to improve client outcomes** – streamlining of effective referral pathways; focus on case management approaches with shared outcome targets to avoid agencies working independently and unconnected; improving the process for obtaining Clinical Assessments from Health providers, some clients may only require an Assessment that the GP can follow up on; making sure all clients who approach Community Health for services that cannot be provided are given information and support to call NGO services; work more often in partnerships with Local Councils on health promotion and education in local communities
7. **Actions primary health providers and specialists can take to improve services to an agency’s clients**

As for other questions there were a range of comments about how primary care providers could work more effectively, communication mechanisms and partnership development. There were a number of suggestions for improvement made, broadly categorised under the following themes:

- **Focus of service provision** – more emphasis on prevention and early intervention programs including going out to schools to raise awareness on health impacts and talking to parents; involve the whole family in the solution for the care recipient; identify GPs who can work alongside family services such as Karitane to streamline referrals and ensure continuity of care; promote active ageing; don’t assume a week’s worth of medicines have solved a problem in its entirety, give the person more options; more case coordination; take time to discuss interventions for clients; invite the person to be involved in decision making about their own health irrespective of their level of wellness; non-judgemental, respectful and acknowledge validity of patient view; provide appropriate follow-up

- **Access** - make places available for low income families, block appointments for those patients requiring access via community transport; implement appointment system to minimise waiting times; access to free dental care in Liverpool area; more home visits

- **Structural issues** – monitors in waiting rooms promoting and educating about healthy lifestyles and well being; bilingual services promotion; integrate Bankstown Division of GPs into Medicare Local with no loss of local service provision; use TIS priority line and HCIS; increase bicultural & bilingual workforce to cater for language barriers and cultural differences; improve parking close to services for patients with mobility issues; provide more outreach health and alternative services to local villages and towns

- **Training and skills development** – better understanding of the ageing needs of people with disabilities, dementia and people from CALD backgrounds; training and information on the needs of people with disabilities and their families; knowledge and awareness about community organisations and clarity about referral pathways; improve knowledge of services available in the community; better understanding of the impact of and issues arising from separation and divorce for parents and children particularly from diverse backgrounds and in emerging communities; training, education and information on perinatal mental health; understand HACC services provided in the community and how to refer appropriately; increase skills in dealing with CALD women in areas of reproductive and sexual health; professional training in mental health; raise awareness on issues surrounding domestic violence including reporting requirements where children are involved

- **Communication and linking up services** - ask questions and listen rather than purely updating prescriptions; when seeing the care recipient ask carers how they are doing; be aware, promote and not ignore the existence of community services; liaise with Housing staff on mental health of clients; work more collaboratively with hospital mental health services; work with community organisations to support their patients; communication about the different specialists available in an area and the services they offer to disadvantaged clients e.g. bulk billing; more referrals to specialists/support services for mental health issues such as anxiety and depression; partnerships with Aboriginal controlled organisations such as AMS; work with local services on a streamlined approach to providing healthcare to seniors and homeless
people; appropriate referral for situations of grief and loss; improve links to community mental health services, increasing accessibility not only for individuals but also for organisations; quarterly newsletter in local papers, promoting health and health services; form regular committee/working group with Local Council and Medicare local to discuss ideas on improving the health of local communities

8. Actions that could be taken with SWS Medicare Local to improve coordination and integration of care

Agencies identified a range of approaches through which the SW Medicare Local could seek to enhance coordinated and integrated care provision, broadly categorised under the following themes:

- **Integrated planning and setting of service development directions** – develop partnerships with service providers in the community; work closely with community organisations; identify the high priorities in health need in LGA areas, improving services to address issues and producing targeted training material; identify service agencies that could inform the needs, gaps and possible solutions in an interagency framework; make sure to keep the Bankstown area on the agenda and participate actively in interagencies; investigate co-location with other health services and community services; hold joint planning meetings between the Medicare Local and NGOs to discuss priorities and opportunities; survey the community on needs; ensure the community is part of the decision making process within the Medicare Local; remain connected to local networks and seek regular feedback from services on the ground to understand the issues affecting local communities

- **Improved communication and information exchange** – a coordinated approach from all levels of staff to ensure information exchange i.e. who is doing what in the service and ensuring regular updates are provided to all staff; decrease barriers in the sharing of information; meet with other government agencies and NGOs and listen to their issues; meet with client stakeholders e.g. carers; personal introduction to community organisation staff e.g. at staff meetings, with ongoing networking and communication; actively participate in Bankstown interagency committees e.g. Bankstown Domestic Violence Committee, Drug Action Team, Workers with Youth Network, Multicultural Committee; presence at Ageing Disability Forum, Dementia Network; workable dialogue with HACC organisations, Multicultural Access Project, Ageing and Disability Council workers; a website that provides information about the Medicare Local and acts as a portal to related health information and related health services; inform community of policy changes well before implementation; use local inter-agencies to update knowledge of referral agencies, utilise networks to promote services via government and community agencies; attend forums to explain role and explore ways of working together; share information to arrive at more uniform practices; promote services to the general community; seek regular feedback from services on the ground to promote referral to local support and counselling services; provide information about availability of local community support organisations e.g. Fairfield Family Relationship Centre; open, transparent communication and consultation with the community sector with feedback mechanisms; inform local services of changes, what to expect and how best to work together; shopping centre displays, pamphlets and web based information that helps consumers navigate the system
• Training of primary care providers and health education to the community – training for GPs in managing mental health for perinatal and postnatal women, including medications, support services, when to refer to specialised mental health services and on other issues that arise; develop comprehensive service directory i.e. referral, wait list times, community languages spoken; information on how to liaise with and improve coordination with Medicare; updated information sent to NGOs on new services

• Improving outcomes for those with mental illness – better access for clients with mental health issues; listen to services/NGOs that support people with a mental illness and work with ALL of the support services, not just a few

• Improving engagement with CALD communities – engage CALD services in planning and decision making processes; establish strategic bilingual & bicultural Linkage workers with the role of interfacing health with community care; employ more Medicare Liaison Officers to handle telephone, face to face liaison and training of health services to cater for language barriers and cultural differences; acknowledge the residents of Liverpool, Fairfield & Bankstown and their particular cultural and diverse needs, having staff with cultural competency skills to understand the issues of these clients

• Improving engagement with Aboriginal communities – engage with Aboriginal service providers to better understand the needs of Aboriginal people in the region; develop and implement strategies to assist Aboriginal people in navigating the health sector

9. Three priorities agencies would like to see in a local health strategic plan

Agencies focussed more on services to be provided, although issues around coordination and communication were mentioned. In order of frequency of response priorities tended to theme around addressing:

• Mental Health – increased mental health case management beyond Community Treatment Orders; continuity of care for clients with mental health issues, to support independent living; improved access through streamlining of referrals and coordination of services; more resources for mental health teams and geriatric mental health assessment; strategies to help clients with mental illness sustain tenancy including increase position of accommodation officer at Banks house from 3 days to 5 days per week; greater mental health awareness and improved treatment options; recovery oriented practice training for mental health services; better access to after care for mental health patients; increased availability of mental health and wellbeing services in areas such as child abuse and domestic violence; involve the family in decisions about care for those with mental illness; more youth mental health services

• Increased access to services for disadvantaged communities – increased services for the aged, people with disabilities and people with mental health issues; services for homeless people; health support services e.g. disability employment services etc to have a sound knowledge of the psycho social; improved services for CALD and newly arrived refugee populations; outreach services available to disadvantaged communities, minimising travel and costs to access services, particularly mental health and drug health; easier access to local specialist services; developing strategies identified in partnership with Aboriginal service providers in addressing Close the Gap indicators; equitable services to the most disadvantaged with increased availability of bulk billing and reduced waiting lists; multicultural health accessing different cultural
groups; targeted approaches in disadvantaged areas; recognising domestic and family violence and brokerage for women on visas attached to partners so they can access services; addressing the impact of domestic violence on children; ensure access and equity principles at the core of all planning; appropriate, accessible and affordable resourcing of services such as allied health professionals, transport and parking

**Better partnerships and working arrangements between agencies** –
incorporate Health working actively with other organisations and being actively represented on local committees; improved collaboration and coordination for joint/mutual clients across agencies for better outcomes; improved relationships with major health providers working together to obtain optimum outcomes for clients; engagement and understanding of the diverse needs of communities, leading to collaborative partnerships; work with local service providers to develop cooperative strategies for improved health strategies; coordinated planning with Councils around capital works and service development; improved coordination of care between health systems i.e. hospitals, community health, NGOs and GPs; inclusion focus by opening up lines of communication and collaborating with NGOs and community agencies outside of a health framework; well linked and well connected networks involving local community organisations e.g. South West Sydney Ageing and Disability Forum

**Population health focus** – creative health education and stress management programs; prevention and early intervention programs; preventative health systems and activities to promote physical, mental and social health; prevention focus incorporating issues such as family and domestic violence; health education/promotion through “active” programs and events to address high prevalence of overweight and obesity in South West Sydney

**Focus on families and young people** – families with children 0-8, with additional focus on young parents; Aboriginal families and young people, with additional focus on young parents, CALD families and young people, with additional focus on young parents;

**Improved processes for coordinating care** – more efficient streamlined processes across hospitals and GPs e.g. pre-prepared admission forms, template letters, social workers better informed of external support services and referral pathways, improved promotion of services and programs to ease accessibility, improved communication of system changes; education for discharge planners and social workers re services available; more consistency in processes across the district; open transparent communication; promote a better understanding for workers and clients on when to make a referral; use of language services by GPs and specialists improved; reduced ED waiting times; identifying the right specialist for the right issue, recognising the skills and knowledge of other sectors may be appropriate for providing a holistic response to health issues

**Increased availability of services** – increased service levels for community based allied health services; Drug Health particularly expanded availability of counselling services and more outreach services; more resources for ACAT teams to enable timely mobility assessment and recommendations on property modification; dental services; Clinical Assessments; expanded hospice care; improvements to services at Bowral Hospital; Pain Clinic for long term and chronic pain sufferers; accessible transport to health facilities; accessible parking for community transport vehicles at health facilities; GPs and youth health services for the western parts of Liverpool LGA with resources reserved for these growth areas; increased funding for community health
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services; resources required with doubling of aged population – dementia, mental illness, social isolation

- Providing more services locally – greater local access to services with more qualified outreach workers; more outreach health and alternative services to local villages and towns; decentralise services away from high density areas; provide simple easy-to-read and accessible information about local services, their location and the process for accessing services

10. Any other comments?

Most respondents left this question unanswered, with some being thankful for the opportunity to participate and others taking the opportunity to raise further issues. Supportive comments included:

- SWSLHD has an excellent relationship with this agency and commitment to supporting the agency’s strategic planning and implementation
- Glad to see other services invited to comment on planning for future services, shows a better understanding of how we can all work together to improve outcomes for patients and their families
- Interested in seeing what the outcome of the survey is
- Hope there is another follow-up survey shortly

Further issues raised included:

- Need for greater supported accommodation for mental health clients as too many are residing in public housing without living skills. Many do not cooperate with HASI and case management programs. Case management needs to take a broader perspective than solely dealing with clinical issues. There is a need for more respite provision locally
- Parking remains a huge issue at Liverpool Hospital and at local medical centres and GP surgeries. More free parking close to services is needed for those with mobility issues
- With the redevelopment of Liverpool Hospital people are finding it difficult to access hospital entrances and particular departments/units within the hospital.
- Liverpool Hospital is a confusing maze for many people to navigate, particularly for people who cannot read English and for the elderly. Provision of a shuttle service using golf buggy type vehicles is supported.
- Referral of patients to specialist services outside of Liverpool is intimidating for people not familiar with travelling around Sydney. Scheduling appointments and providing clear instructions and directions including duration of travel (either using public transport or for driving) to the patient would assist the patient to prepare for and get to the appointment on time.
- Need for centre based meals for elderly people in the community
- Health should consult with Local Councils in recognising the current and future demographic profiles of LGAs and ensuring that future demands can be met.
Attachment A

Identifying Agencies and Organisations to On-Line Survey

Aboriginal Affairs NSW (2)
Anglican Retirement Villages (ARV) Community Anglicare (2)
Bankstown Area Multicultural Network (BAMN)
Bankstown City Council – Community Planning and Development Team
Bankstown Community Resource Group (BCRG)
Bankstown Women's Health Centre
Cabramatta Community Centre
Campbelltown City Council
Campbelltown Family Relationship Centre
CatholicCare
Fairfield Family Relationship Centre, UnitingCare Unifam Counselling and Mediation
Family and Community Services, NSW Government Department
Family & Community Services - Community Services - Communities and Early Years Division
Family and Community Services - Housing NSW (2)
Family Planning NSW
The Haven Project
Housing NSW
Housing NSW- Parramatta Housing Operations
Immigrant Women's Health Service
Lifeline Macarthur
Liverpool City Council
Macarthur Disability Services Personal Helpers & Mentors Program
Mary’s Place
MTC Work Solutions
Planning & Infrastructure, NSW Government Department
Southern Cross Community Healthcare
Southern Highlands Bereavement Care Service
South West Community Transport
Villawood Senior Citizens Club
Wingecarribee Shire Council