South Eastern Sydney Local Health District

Safety & Quality Account

2022-23 Report
2023-24 Future Priorities

NSW GOVERNMENT

Acknowledgement of Country

South Eastern Sydney Local Health District would like to acknowledge the Traditional Custodians on whose land, and the lands our facilities are located on: the lands of the Dharawal, Gadigal, Wangal, Gweagal and Bidjigal peoples.

We would like to pay our respects to the Elders past, present and those of the future. We also acknowledge Aboriginal peoples' connection to country, culture and heritage.

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Introduction

Statement on Safety and Quality

The South Eastern Sydney Local Health District (SESLHD) is committed to providing high quality care that is safe and underpinned by its Strategic Plan, *Exceptional Care, Healthier Lives 2022-2025.*

Our strategic plan details how the District will meet its vision and strategic aims and considers the future healthcare and how to best meet the current and emerging needs of the local community.

The purpose of this *SESLHD Safety and Quality Account 2023* is to highlight the District's achievements relating to improvements in patient safety and quality over the past year, and to detail priority areas for our continuing improvement over the year ahead.

Over the past year, as the District entered a phase of recovery following the COVID-19 pandemic, it has continued to experience and meet challenges associated with workforce shortages and increasing demand across most services.

Staff have demonstrated skill, resilience, and flexibility in their ability to work through these challenges, and I acknowledge the compassion and commitment shown by staff as they serve our patients and community with such dedication.

We recognise the opportunities for the District to improve during the year ahead, based on past performance information, which is detailed in this report. We will continue to do this by defining and communicating clear safety and quality expectations across all levels of the organisation, monitoring performance of our services, and working closely with our clinical teams to deliver identified outcomes that are underpinned by person-centred care.

The SESLHD Safety and Quality Account 2023-24 outlines three priority areas for safety and quality:

1. Aboriginal and Torres Strait Islander health
2. Patient experience and access to care
3. Implementation of a revised SESLHD Clinical Governance Framework.

The SESLHD Board and Executive team are committed to these priorities and will work closely with our staff, consumers, and community to deliver on our objectives.

Tobi Wilson

Chief Executive

About SESLHD

South Eastern Sydney Local Health District (SESLHD) is one of the largest local health districts in New South Wales.

Covering a geographical area of 468 square kilometres, encompassing Sydney's Central Business District, the coastline from Bondi to Cronulla, and extending to the Royal National Park, we provide health services to almost one million residents.

Aboriginal and Torres Strait Islander people make up 1.1% of the total SESLHD population. Our facilities are located on lands of the Dharawal, Gadigal, Wangal, Gweagal and Bidjigal peoples, of both the Eora and Dharawal Nations

SESLHD encompasses a complex mix of highly urbanised, industrialised, and low-density suburban areas, across the Woollahra, Waverley, Randwick, Bayside, Georges River, the Sutherland Shire local government areas (LGAs), and parts of the City of Sydney. Several significant infrastructure hubs exist within our boundaries such as Sydney Kingsford Smith Airport and Port Botany

SESLHD offers a wide range of healthcare services including complex tertiary and quaternary services, community and inpatient mental health, and community-based services ranging from pre-birth, child youth and family, drug and alcohol, HIV and sexual health, and palliative care referral services for the District and beyond

SESLHD also provides a key role in assisting residents and visitors of Lord Howe Island with the provision of hospital and health services

Snapshot of achievements over the previous 12 months

Improvements in hospital acquired complications performance

A safety and quality priority for SESLHD during 2022/23, several local and district-wide projects were implemented, including:

- Establishment of an **organisation-wide Hospital Acquired Complications (HAC) Improvement Project**, with key activities including the development of a uniform reporting template for wards and facilities, comprehensive data analyses including "deep dives" of four complex HACs and commencement of a district-wide project to reduce hospital acquired infections, starting with a focus on urinary tract infections (UTIs).
- Reducing Harm from **Falls** project at The Sutherland Hospital (TSH): Four wards across TSH applied the Model for Improvement (MFI) methodology and implemented a range of strategies to reduce hard from falls. In the 10 months from project commencement, there was a 64% reduction in harm from falls across TSH. No deaths from falls were reported in a nine-month period.
- Multiple initiatives were implemented to address **delirium** across SESLHD, including the roll-out of a post-operative delirium project in collaboration with the University of Wollongong and Prince of Wales, St George and The Sutherland Hospitals, implementation of a new education program for hotel services staff and wardspersons at Garrawarra Centre and at Prince of Wales and War Memorial Hospitals, and implementation of the 4AT delirium screening project in the Emergency Department at St George Hospital.

Improvements in key performance indicators were observed over the course of 2022/23, with SESLHD reporting a 15% reduction in the number of patients discharged from its facilities who had experienced one of more HACs during their admission in April 2023, compared with the same period in 2022.

Aboriginal and Torres Strait Islander Health

As a priority area for SESLHD in 2022/23, work continued towards Closing the Gap and improving the health outcomes and experience of our Aboriginal and Torres Strait Islander consumers. This included the ongoing implementation of the Burudi Muru Yagu Aboriginal Health Plan 2022-2023, and several local initiatives aimed at improving healthcare delivery for Aboriginal and Torres Strait Islander consumers across SESLHD, including:

- Narrangy-Booris Aboriginal Child and Family Health Service: a multidisciplinary, multiagency hub model of care. The Narrangy-Booris Building Strong Foundation (BSF) program is a culturally sensitive and appropriate early childhood health service located in Menai for Aboriginal children, families, and their community.
- SESLHD Women's Health Program: a priority for the service is engaging Aboriginal women. As a result of initiatives implemented by this service, Aboriginal women attending women's health clinics increased from 8% of clients in 2018 to 12% of clients in 2022 supporting appropriate health care in the community.
- Development of a patient "Welcome Pack" at Prince of Wales Hospital (POWH): after receiving feedback from Aboriginal patients that they did not understand parts of their hospital journey, POWH worked with the local Aboriginal community to co-produce the hard copy and online 'Hospital to Home Journey' booklet to help Aboriginal patients navigate when they are admitted to our hospital.
- Implementation of targeted strategies to increase the Aboriginal workforce in allied health and oral health.

SESLHD's response to the global mpox outbreak

In May 2022, mpox (formerly monkeypox) cases began to be reported from Europe, predominantly among gay, bisexual, and other men who have sex with men (GBMSM). Cases were soon arising around the world, including in Australia.

SESLHD rapidly initiated a multi-component response to this outbreak, to detect and prevent cases, and limit local transmission. The Public Health Unit (PHU) and Sexual Health services worked together to respond to this emerging health issue. When the vaccine became available, SESLHD led much of the statewide work to develop booking and triage systems, resources, staff training, and engagement with priority populations. In contrast to other countries, Australia has recorded relatively few cases of mpox, and there has been no evidence of sustained local transmission in NSW.

Dementia and delirium training for non-clinical staff

A gap was identified in the educational offerings for hotel services staff and wardsperson staff in the specialised needs of older, confused patients in acute, subacute and residential care settings. Having frequent and consistent contact with patients, hotel services staff and wardsperson play a vital role in the patient experience.

To address this gap, an aged-care education package was created specifically for this group at War Memorial Hospital, Prince of Wales Hospital and Garrawarra Centre, and was implemented through face-to-face education sessions and a resource workbook. Pre- and post-education questionnaires were conducted: results of the post-education questionnaire indicated an improved level of confidence of staff when communicating with the older confused patients.

Continence Advisory Service (CAS): a collaboration between War Memorial Hospital and the Royal Hospital for Women

The Continence Advisory Service (CAS) is a recently established multidisciplinary assessment and treatment service for older people with incontinence. It is based at War Memorial Hospital (WMH) and represents a collaboration between WMH and the Royal Hospital for Women. From its inception in January 2022 to May 2023, the CAS Physiotherapists and Clinical Nurse Consultants have assisted over 200 patients to achieve their continence goals, and within Northern SESLHD, the CAS has significantly reduced the waiting list for access to Geriatric Continence services from six months to an average of 4-6 weeks.

Achievements in Safety and Quality 2022/23

Safety and quality planning processes and governance structure

The *South Eastern Sydney Local Health District (SESLHD) Exceptional Care, Healthier Lives Strategic Plan 2022-2025* looks towards the future of healthcare and how we can best meet the local community's current and emerging needs. The complexity of recent times has reinforced what is important – promoting healthy communities, delivering evidence-based, person centred care, and supporting and valuing our dedicated teams.

The *SESLHD Clinical Governance Framework: Transforming for the future* (the Framework) builds on the strategic plan and offers a solution to address the challenges and opportunities we continue to face including COVID-19 recovery, increasing demand and complexity of patients, ageing population and increasing chronic disease, disadvantaged groups, patient voice, workforce pressures, financial constraints, and short notice accreditation.

The Framework defines a **common purpose** around clinical excellence, sustainability, and patient centred care. There are four transforming principles that drive the Framework and establish the environment and pre-conditions which will allow SESLHD to transform its approach to clinical quality and safety into the future:

1. **Consumer Partnerships**: Partnering with patients, carers, families, and consumers is a cornerstone of healthcare delivery and a key contributor to achieving our strategic priority of providing person-centred care.

2. **Empowered Clinical Teams**: Highly skilled clinicians take ownership for safety and quality. Their expertise, ingenuity and dedication will drive improvements. Managers are responsible for providing support and guardrails.

3. **World Class Safety Systems**: A dynamic clinical governance system which prioritises new methods in patient safety science. Moves the focus from ensuring "*as few things as possible go wrong*" to ensuring "*as many things as possible go right".*

4. **Performance Focus**: Individuals and teams are responsible for their behaviours, decisions and outcomes in safety and quality. Not only does accountability improve results, but it also builds trust and team morale.

A fundamental component of the SESLHD Clinical Governance Framework is the **Framework for Performance**. The Framework for Performance outlines SESLHD's process for establishing safety and quality expectations and for monitoring the performance of each clinical unit within the organisation. It drives the continuous quality improvement cycle and sustains high performance with the capacity to capture lessons learnt, knowledge, and best practices which can be shared across the organisation.

Where gaps in performances are identified, the Framework for Performance sets out the process to escalate concerns and ensure support is available to remediate performance. It connects the Ward to the Board and supports our common purpose, uniting clinicians and administrators in joint responsibility and decision making for the quality of clinical care delivered by SESLHD. It also improves staff culture and wellbeing across SESLHD by supporting autonomy of clinicians, balanced with accountability.

The Clinical Governance Framework, inclusive of the Framework for Performance, provides the foundation for clinical units and sites to develop an annual Quality Plan. The Quality Plan identifies priorities based on past performance and outlines the strategies to be put in place to address, including evaluation measures.

The SESLHD Clinical Governance Framework is in the final stages of the endorsement process and will be accompanied by a detailed implementation plan, including dedicated resourcing, to ensure a successful transition and rollout into 2024.

Accreditation

All SESLHD sites were assessed to the National Safety and Quality Health Service (NSQHS) Standards in 2022 and were awarded ongoing accreditation status until 2025. From July 2023, accreditation assessments will occur via short notice. Surveys will also include assessment to the National Clinical Trials Governance Framework against a maturity scale. Population and Community Health have been approved to transition to assessment to the National Safety and Quality Primary and Community Healthcare Standards. To support these changes, SESLHD have commenced an Accreditation Preparation Working Party with the following aims:

- Identify current accreditation risks, determine priorities, and implement coordinated strategies to address identified risks and priorities
- Develop and implement an ongoing assurance system that informs the organisation of compliance with the NSQHS Standards, proactively identifying areas of risk to be addressed
- Build capacity in clinical governance to support accreditation preparation and participation through district-wide collaboration
- Streamline resources for consistency and efficiency and develop a standardised communication strategy.

With the introduction of short notice assessment, SESLHD has undertaken a due diligence process to determine the most appropriate independent provider of accreditation services to engage moving forward. An analysis of suitable providers and subsequent recommendation is progressing through the final stages of approval.

Clinical Governance

Governance, leadership, and culture (Actions 1.01-1.06)

The governing body of South Eastern Sydney Local Health District (SESLHD) is the SESLHD Board. The SESLHD Quality and Safety Board Committee (QSBC) is a mechanism for the SESLHD Board to refer quality and safety matters for more detailed oversight. At management level, SESLHD has three peak Committees:

1. SESLHD Executive Council
2. SESLHD Corporate Executive Council, and
3. SESLHD Clinical and Quality Council.

As part of the implementation of the revised SESLHD Clinical Governance Framework, a SESLHD Patient Safety and Quality Committee will be established as the peak safety and quality governance committee to align with the existing committee structure at site level, whereby the SESLHD Clinical and Quality Council will act as an advisory committee.

The *SESLHD Exceptional Care, Healthier Lives Strategic Plan 2022-2025* outlines the priorities and strategic directions for the district:

- Partnering for healthier communities
- Providing person-centred care
- Supporting teams to thrive
- Shaping the future

The *SESLHD Clinical Governance Framework 2024-29: Transforming for the future* builds on the strategic plan, providing a framework for operationalising activities to support continuous improvement in quality and safety.

In 2022, SESLHD began undertaking an annual district-wide survey (Safety Attitudes Questionnaire) of staff to better understand the safety culture within the organisation. This informs the development of action plans to address identified priorities.

The SESLHD Aboriginal Health Unit now reports directly to the Chief Executive (previously within the Population and Community Health Directorate) and is responsible for the strategic management and coordination of Aboriginal health initiatives across the district. The Burudi Muru Yagu (Better Path Today) Aboriginal Health Plan 2022-2023 outlines SESLHD's implementation plan for the NSW Aboriginal Health Plan 2013-2023 six strategic directions.

Patient safety and quality systems (Actions 1.07-1.18)

The SESLHD Clinical Governance Unit oversees the management of serious incidents and corresponding investigations, including open disclosure processes, in accordance with the NSW Health Incident Management Policy (PD2020_047) and the NSW Health Open Disclosure Policy (PD2014_028). A monthly report is compiled which provides incident details, recommendations, themes, and trends. Reports are shared to inform improvement at site and unit level.

Clinical and corporate risks are managed in accordance with the NSW Health Enterprise-wide Risk Management Policy Directive (PD2022_023) with documentation in the Enterprise Risk Management System (ERMS). Policies and procedures are reviewed through a risk management lens. To further improve identification and management of clinical risks, as well as integration with policy, enterprise risk management and policy units transitioned to the clinical governance portfolio (previously within the Corporate and Legal Services Directorate) in July 2023.

Performance is monitored through mandated and agreed key performance indicators (KPI's), with reporting at regular performance meetings. A Framework for Performance was integrated into the revised SESLHD Clinical Governance Framework 2024-29 to strengthen performance monitoring, including identification of emerging risks for a more proactive approach to patient safety.

There are mechanisms in place for patient feedback and complaints that ensure timely response and resolution of concerns raised, as well as recognition of staff where positive feedback is received. Complaint data is compiled monthly to identify themes and trends that can inform improvement priorities.

The SESLHD Multicultural Health Service works towards equitable health outcomes and ensures services are appropriate for people from culturally and linguistically diverse backgrounds across the district, through community engagement, support for health professionals, projects, and research. The work of the Multicultural Health Service is guided by the SESLHD Implementation Plan for Health and Culturally Diverse Communities and Refugee Health Plan 2021-2023.

In SESLHD, the Electronic Medical Record (eMR) is the system used to collect, store, and utilise this patient related information. eMR currently utilises the Cerner suite of applications, which are integrated with the Patient Administration System, laboratory, medical imaging, and other clinical information systems used in patient care. Additionally, systems have been implemented to allow access to the My Health Record system via eMR (HealtheNet tab) so that clinical information can be viewed and entered into the My Health Record System. Healthcare Record governance is provided by the Digital Health Steering Committee.

Clinical performance and effectiveness (Actions 1.19-1.28)

Staff position descriptions outline the quality and safety responsibilities and expectations implicit in each role for each professional group. Annual performance and development plans include a review of the position description and reinforcement of the quality and safety responsibilities of the role, as well as alignment with scope of practice.

All staff undertake mandatory training relevant to their role. This includes an introduction to quality and safety for all staff as part of their corporate orientation program. Additional programs such as the Safety and Quality Essentials Pathway (Foundational, Intermediate, Adept) are also offered to staff to enhance capacity in this area.

Safe environment for the delivery of care (Actions 1.29-1.33)

Physical spaces throughout SESLHD are designed with the needs of all consumers and the community in mind, also guided by the SESLHD Disability Inclusion Action Plan 2020 – 2023. Patients and consumers with a greater risk of unpredictable behaviour receive care in service areas sympathetic and considerate to their condition. In conjunction with staff highly trained in the de-escalation and management of aggressive incidents, SESLHD provides access to calm and quiet environments when clinically required, whereby protecting patients and staff.

Carefully considered signage is in place to support wayfinding for our consumers, with flexible visiting offered to accommodate diverse needs.

SESLHD seeks to create a welcoming environment for all people, including those from culturally diverse backgrounds and for Aboriginal and Torres Strait Islander people. As such, Acknowledgement of Country plaques and Aboriginal artwork is displayed at sites, and Aboriginal Health Liaison Officers are available to meet with identifying patients, ensuring an inclusive and supportive environment.

Improvements achieved in Safety and Quality

Aboriginal and Torres Strait Island Health

As a priority area for SESLHD in 2022/23, SESLHD continued to work towards Closing the Gap and improving the health outcomes and experience of our Aboriginal and Torres Strait Islander consumers. This included the ongoing implementation of the Burudi Muru Yagu Aboriginal Health Plan 2022-2023, and several local initiatives aimed at improving healthcare delivery for Aboriginal and Torres Strait Islander consumers across SESLHD, including:

Narrangy-Booris Aboriginal Child & Family Health Service - a multidisciplinary, multiagency hub model of care

The Narrangy-Booris Building Strong Foundations (BSF) program is a culturally sensitive and appropriate early childhood health service aimed at Aboriginal children, families and their community.

The program's success lies in the collaboration between Aboriginal Health Workers and various professionals including Child & Family Health nurses, speech pathologists, occupational therapists, and social workers. This multidisciplinary team works together to establish culturally safe spaces, fostering trust and ensuring families feel comfortable accessing health services. BSF seamlessly integrates with the maternity-based New Directions program, delivering comprehensive support to Aboriginal families during both the antenatal and early childhood stages.

By facilitating smooth transitions between maternity and child and family health services, the program engages families with Aboriginal Health Worker support, enabling early intervention pathways and promoting school readiness. Based on a partnership model, BSF places families at the centre, supported by clinicians and external service providers. The program embraces a strengths-based approach, aiming to create optimal environments where Aboriginal children can thrive within strong family units responsive to their needs. Collaboration with the community helps identify support strategies beyond health-focused interventions, such as walking or art groups and swimming lessons that enhance overall wellbeing. Over its 12 years of operation, the Narrangy-Booris BSF program has consistently delivered exceptional care to the Aboriginal community.

A successful hub-based model, BSF demonstrates scalability by reaching more families and expanding its impact each year. The program's innovative communication methods, such as the use of an annual calendar, magnets, and an active online presence, facilitate sustainability and scalability by effectively connecting with a wider audience.

SESLHD's Women's Health Program

SESLHD's Women's Health Program has identified a key priority of engaging Aboriginal women. The Aboriginal Women's Health Coordinator is an integral team member, providing cultural leadership and guidance, facilitating engagement with community, and cultural safety.

Consistent with the strategic directions of the Burudi Muru Yagu Aboriginal Health Plan, the principles of collaboration, co-design, cultural safety and community capacity building are fundamental to the success of the program in engaging with Aboriginal women and communities. The program provides nurse-led clinical services and develops initiatives for women who face barriers to accessing health care with a focus on screening, prevention and linking women to appropriate health and social services. The Women's Health Program works in partnership with the Aboriginal Health Unit, other SESLHD services and Aboriginal community organisations to address health disparities experienced by Aboriginal women. Collaborations include the establishment of two outreach clinics in trusted locations at La Perouse Aboriginal Community Health Centre (CHC) and Menai CHC and a project aimed at increasing cervical screening in Aboriginal communities with a high level of community support. Culturally responsive approaches and partnerships have enabled capacity building and an improved response for Aboriginal women.

As a result of the initiatives implemented by this service, Aboriginal women attending women's health clinics has increased, from 8% of clients in 2018 to 12% of clients in 2022. Approximately 70% of Aboriginal women attending the clinics have been linked with GPs and other health services for further care. Feedback from participants who have attended Aboriginal Women's wellbeing workshops has been very positive: women reported they increased knowledge about their bodies, health, and wellbeing, and reported that they felt comfortable and safe being able to ask about sensitive women's health issues. Aboriginal health and community workers who attended health education sessions reported increased knowledge and confidence to promote women's health screening with clients.

Welcome Packs at Prince of Wales Hospital (POWH)

After receiving feedback from Aboriginal patients that they did not understand parts of their hospital journey, POWH worked with the local Aboriginal community to co-produce the hardcopy and online Hospital to Home Journey booklet to help Aboriginal patients navigate when they are admitted to our hospital.

Input was sought from Aboriginal consumers to guide the content in the booklet, through yarning circles, a survey, and meetings with the Aboriginal community. The booklet includes a welcome in the Dharawal language, provided by the local Aboriginal Land Council, the journey in the hospital and different staff they will meet, why we ask about Aboriginal origins, our Aboriginal Hospital Liaison service, staying in hospital to complete treatment, keeping safe in hospital, discharge and follow up, local Aboriginal health service contact details, and how to provide feedback to the hospital. Community felt this was the information they needed to feel comfortable in the hospital system and ensure a welcoming environment for Aboriginal people.

The booklet is offered in Admissions, by Social Work and in the Emergency Department. Further evaluation of the content of the book is planned.

The Aboriginal Allied Health Cadet Program

The NSW Aboriginal Allied Health Cadetship program involves Aboriginal students undertaking full time study in an undergraduate allied health course while being employed in a NSW Health facility. The cadetship is funded by the Ministry of Health Workforce Planning and Talent Development and Centre of Aboriginal Health. The Health Education & Training Institute approached SESLHD to accept the transfer of two cadets to commence in January 2023. A Cadet Coordinator, Aboriginal Mentor and Clinical Educators were identified to support the cadets.

The Sutherland Hospital was established as the lead facility, partnering with St George Hospital, and involving the Speech Pathology Department and Population and Community Health (Child, Youth and Family Services) for the program. A fourth-year speech pathology student and a third-year occupational therapy student commenced in February 2023. A psychology student cadet is expected to start with SESLHD later in 2023.

The cadetship program is one strategy to increase the number of Aboriginal Allied Health professionals working in NSW Health. This presents an opportunity for SESLHD Allied Health to become more culturally competent when working with Aboriginal and Torres Strait Islander peoples.

Aboriginal Oral Health Recruitment Strategy

During planning and building of the La Perouse Aboriginal Dental Clinic, the oral health service implemented an Aboriginal access program to foster cultural safety and community collaboration, with employment of an Aboriginal Health Education Officer to liaise with the Aboriginal community and to facilitate access to dental care at a mainstream dental clinic. When La Perouse Dental Clinic opened, the service created and recruited to an identified senior dental assistant position to manage the clinic and for ongoing community liaison.

The service also established an Aboriginal Traineeship program. Trainees are employed for a period of twelve months, during which time they are supported to complete formal qualifications in either dental assisting or administration. The service has employed eleven Aboriginal trainees in the past eight years.

On completion of their traineeship year, five trainees to date have gained permanent employment with the oral health service. Of those, one has since enrolled at university, one has been employed elsewhere in the organisation as a project coordinator, and two have received promotional positions within the oral health service. Trainees who left the service have secured other positions in health or have enrolled in further courses. Entry level traineeships are an effective way of growing the Aboriginal workforce and bridging the gap in cultural competence of health employees.

Improving cultural safety for Aboriginal and Torres Strait Islander health care users can improve access to, and the quality of health care. When the health system is a safe environment and cultural differences are respected, Aboriginal people will be more likely to access care and to seek employment within the system. The La Perouse Dental Clinic forms an important part of an integrated Community Health Service and is providing oral health services to Aboriginal people across the continuum of care. It provides a strategically placed geographic base for outreach health promotion with Aboriginal community groups and facilitates linkages with services offered by health providers.

One employee recalled that when she applied for the traineeship, she had low confidence in ever gaining employment having been unsuccessful in many job applications. The trainee is one of those who gained a permanent position with oral health, and subsequently a promotional position. She is a valued team member with seven years of service.

Improving Hospital Acquired Complications Performance

As a safety and quality priority for SESLHD in 2022/23, a number of local and district-wide projects were implemented:

- **Establishment of an organisation-wide Hospital Acquired Complications (HAC) Improvement Project, with key activities including:**
  - Development of a uniform reporting template for wards/facilities.
  - Comprehensive data analyses including “deep dives” of four complex HACs.
  - Temporal trend analysis of total and individual HACs through COVID-19.
  - Commencement of a district project to reduce hospital acquired infections, starting with urinary tract infections (UTIs).
  - Trial of HAC performance reporting at departmental level at St George Hospital.

- **Reducing Harm from Falls at The Sutherland Hospital (TSH)**
  - The fall harm rate at TSH was increasing with three deaths from falls reported and 13 patients sustaining major harm from falls over a 12-month period between May 2021 to April 2022. Four wards across TSH applied the Model for Improvement (MFI) methodology and implemented a range of strategies as detailed below.
  - In the ten months from project commencement, there was a 64% reduction in harm from falls across TSH.

- **Multiple initiatives were implemented to address delirium across SESLHD, including:**
  - Roll out of a post-operative delirium project in collaboration with the University of Wollongong and Prince of Wales, St George and The Sutherland Hospitals.
  - Implementation of a new dementia and delirium education program for hotel services staff and wardspersons at Garrawarra Centre and at Prince of Wales and War Memorial Hospitals.
  - Implementation of the 4AT project and education in the Emergency Departments at St George and Prince of Wales Hospitals to better screen for and identify delirium.

Improvements in key performance indicators were observed over the course of 2022/23, with SESLHD reporting a 15% reduction in the number of patients discharged from SESLHD facilities who had experienced one of more HACs during their admission in April 2023, compared with the same period in 2022. In the financial year to April 2023, SESLHD achieved targets in nine out of 14 HACs, an improvement from achieving target in only six of these HACs in the same period the previous year.

Ongoing monitoring and improvement of HAC performance is now embedded in usual business for SESLHD, with performance monitored at all levels of the organisation, from department level up to and including the SESLHD Board. This approach will be supported by the roll out of the Framework for Performance as outlined in the updated SESLHD Clinical Governance Framework.

Reducing Harm from Falls at The Sutherland Hospital

Following identification of an increasing rate of harm from falls, with three deaths and 13 patients sustaining major harm from falls over a 12-month period to April 2022, staff at The Sutherland Hospital (TSH) commenced a project with the aim of achieving a 50% reduction in harm from falls by 30 April 2023.

Four wards were identified as in scope, and each applied the Model for Improvement (MFI) methodology. Each ward collected baseline data through analysis of fall incidents, held focus groups with staff to identify issues and engaged with patients and families. Issues were themed and prioritised, and proposed solutions were tested. Interventions implemented included:

- increasing supervision of patients at the bedside and in the high falls risk room
- re-stocking medication trolleys in patient rooms
- safe toileting strategies for confused patients
- increasing signage for patients at risk of falls
- early mobilisation of patients
- communicating patients at high risk of falls at daily huddles

A **64% reduction in harm from falls** across TSH was achieved in the ten months after project commencement. There were no deaths from falls reported in a nine-month period, to 26 June 2023.

The project philosophy was that the approach be data driven, person centred, and clinician led. The investment of executive sponsors and key stakeholders contributed to improved hospital wide communication that supports sustainability. This has enabled scalability by implementation of the interventions designed by the areas in scope to be diffused throughout the organisation as positive outcomes achieved encouraged other clinical areas to act. Other patient safety risks are now being managed using this improvement science model.

Person Centred Care: Enablement and Empowerment in Aged Care

A gap was identified in the educational offerings for hotel services staff and wardspersons in the specialised needs of older, confused patients in acute, subacute and residential care settings. Having frequent and consistent contact with patients, hotel services staff and wardspersons play a vital role in patient experience.

To address this gap, an aged-care education package was created specifically for this group of staff and implemented through face-to-face education sessions and provision of a resource workbook. Education sessions focused on dementia, possible reasons for challenging behaviours, delirium, communication strategies, and how to approach and respond to a person at risk.

Participants included wardspersons at Prince of Wales Hospital and hotel services staff at War Memorial Hospital and Garrawarra Centre.

Pre- and post-education questionnaires were conducted. Results of the post education questionnaire indicated an improved level of confidence of staff when communicating with the older confused patients, including at War Memorial Hospital where results improved from 47% pre-education to 75 % post-education. The questionnaires also revealed an opportunity to improve the communication between nurses and wardspersons and consider them a resource to evaluate patient behaviour.

Regular education sessions have been requested by staff across all sites.

Improving the quality of clozapine monitoring in The Sutherland Hospital Community Mental Health Service

Clozapine, an atypical antipsychotic medication, is widely used in the treatment of schizophrenia and other severe psychiatric disorders. Extensive research and clinical evidence supports the superior effectiveness of clozapine compared to other antipsychotics in the treatment of schizophrenia and treatment-resistant forms of the disorder. While effective, clozapine requires close monitoring due to its potential for life-threatening side effects. Thus, it is essential to monitor healthcare provider preferences, practices and adherence to the clinical guidelines and patient's compliance or adherence to the medication.

An initial audit was undertaken in October 2021 by clinicians within The Sutherland Hospital's Clozapine Clinic. Results confirmed discrepancies between policy recommendations and practice within the clinic. Many patients were not undergoing pathology tests, and side effect monitoring and psychiatry reviews were not being undertaken at the intervals outlined in local policy. A project was commenced to address these gaps.

The **aims** of the project included:

- Assess concordance of practice in the clinic with SESLHD's clozapine monitoring policies.
- Design and implement change ideas to improve these concordance rates to a minimum of 80%, over a 12-week testing period.
- Design and implement a tool to assess concordance with local clozapine policy, which is easy to use and can be adopted by a range of clinicians to re-audit all SESLHD clozapine clinics in the future.

Change ideas implemented as part of the project included:

- A medical review template for Psychiatrists and Psychiatry registrars, covering all aspects of recommended monitoring as per the two relevant policies, available in multiple formats.
- An orientation document for incoming staff outlining the roles and responsibilities of all team members.
- A reminder system for the clozapine coordinator for patients due or overdue for psychiatry review.
- The Clozapine Clinic Audit Tools (CCAT) was designed based on two key local policies. The CCAT measures four key parameters based on electronic medical records and pathology results:
  - Blood tests and cardiology
  - Physical measurements
  - Frequency of psychiatry review
  - Quality of psychiatric review documentation

Results

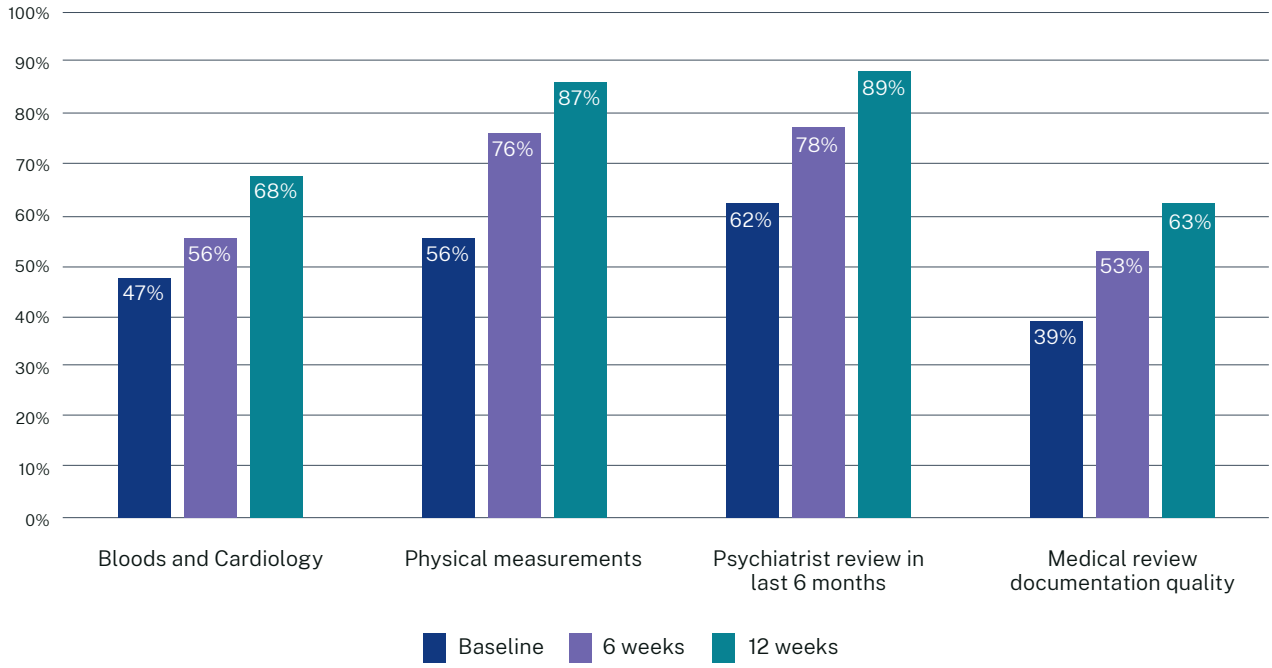
The CCAT measures were repeated twice following the introduction of change ideas, at six and 12 weeks. Performance on all CCATs improved at six and 12 weeks. Blood tests and cardiology monitoring improved from 47% at baseline to 56% at six weeks, and finally 68% at 12 weeks. While adherence with all blood tests improved, at 12 weeks there were still some tests being omitted more frequently than others, showing more room for improvement.

Adherence with physical measurements improved from 56% at baseline, to 76% at six weeks and 87% at 12 weeks, meeting the goal of 80% adherence.

The percentage of patients who had undergone psychiatrist review in the preceding six months improved from 62% at baseline, to 78% at six weeks, and 89% at 12 weeks, also surpassing the goal of 80%.

Medical documentation quality improved from 39% at baseline, to 53% at six weeks and 63% at 12 weeks.

Clozapine Clinic Audit Tool Performance



To ensure sustainability of this project, the CCAT was developed for the clinic staff to re-audit over time, and tools were developed for ongoing use in clinic. The tools which have been developed can be shared with other clinics within SESLHD to monitor compliance with local policies.

Physiotherapy-led Shoulder and Elbow Orthopaedic Clinic

The number of patients being referred to the Prince of Wales Orthopaedic Outpatient Service for elbows and shoulder is above current capacity. In September 2022, there was a 513 day wait for category three patients to be seen for their initial assessment.

Many patients referred into this clinic do not require surgical intervention, but rather can be effectively managed conservatively.

A six-month pilot of a new model of care was implemented: a Physiotherapy-led Shoulder/elbow Orthopaedic Clinic. The Physiotherapy-led Shoulder/orthopaedic Clinic, involves a Senior Physiotherapist assessing, diagnosing, and managing selected patients triaged to the non-urgent '365 day' waiting list. The clinic has resulted in a significant decrease in wait times for new assessments as well as the number of patients breaching the 365-day waitlist.

Patients have seen an average reduction of 3.64 in worst perceived pain score rating in the previous 24 hours rating out of 10. The QuickDASH, measuring pain and disability, has reduced on average per individual by 17 points, demonstrating a significant improvement in patient outcomes.

Following the success of the pilot program, opportunities to implement the clinic in a permanent capacity are being identified.

Continence Advisory Service (CAS): a collaboration between War Memorial Hospital and the Royal Hospital for Women

Incontinence disproportionately affects older Australians and is associated with significant morbidity, mortality, long hospital stays and poor quality of life. The Continence Advisory Service (CAS) is a recently established multidisciplinary assessment and treatment service for older people with incontinence. It is based at War Memorial Hospital (WMH) and represents a collaboration between WMH and the Royal Hospital for Women (RHW), who provide staffing for the continence physiotherapist working with the service. The service has successfully reduced SESLHD wait times for older adults presenting with incontinence and has recently integrated with an established WMH program, iREAP, which provides multidisciplinary rehabilitation to frail community dwelling adults and those with neurodegenerative disease.

The service includes education around common bladder and bowel conditions and exercise classes facilitated by both the CAS and WMH physiotherapists. The service has integrated a specific pelvic floor muscle training program to address incontinence into established classes targeting balance, strength and frailty. This approach addresses incontinence through functional group-based exercise, reducing the need for one-on-one management.

From its inception in January 2022, to May 2023, the CAS Physiotherapists and Clinical Nurse Consultants have assisted over 200 patients to achieve their continence goals. Within northern SESLHD, CAS has significantly reduced the waiting list for access to Geriatric Continence services from six months to an average of four to six weeks.

Through integrating care, RHW and WMH bring together specialist continence services to older people in the community to improve their quality of life. Early participant feedback shows CAS is a roaring success: of those who presented with bladder and bowel concerns at the start of the iREAP pilot, 100% found the pelvic floor training helpful, enjoyable and translational into day-to-day life. Group sessions have seen full resolution of symptoms for some patients with stress incontinence without the need for an individual session.

“The service has completely changed how I’m living my life – I'm 100% better, it’s like magic.”

CAS is the only integrated service dedicated to geriatric continence outcomes in NSW. Through collaboration between multiple SESLHD sites and disciplines, it strives for best-value care in an often-overlooked population.

A recent patient story was shared by our CAS Physiotherapist:

"I just wanted to share that I just had the most lovely feedback from a patient. She initially presented with significant urge urinary incontinence that started after a stroke in 2018 and on initial appointment told me "after the stroke, I've never had a normal wee." Today she was discharged 100% better (her words) and is jetting off overseas next week without taking any pads. She told me the service completely changed how she's living her life and it was too nice to keep to myself."

Community Management Centre

In October 2021, the Community Management Centre (CMC) opened with the aim of providing telehealth services to patients within SESLHD who tested positive to COVID-19. This is a multidisciplinary team consisting of nursing, medical, physiotherapy, occupational therapy, exercise physiology and psychology.

This model of care is unique, with the provision of care virtually to patients in their home. This is achieved by utilising technology solutions to interact and assess patients without the need for them to enter the hospital environment. During the pandemic, this helped to minimise the risk to patients and staff of contracting COVID-19. Patients are assessed by telephone and offered either a daily telephone call or an app-based Remote Monitoring Service. Pulse oximeters are couriered to patients' homes and follow up support is provided by the clinical team.

This model of care has now been extended to the management of chronic heart failure patients in the community. The chronic heart failure service has recruited 25 patients to-date.

This model allows patients and their families to be partners in their care. The remote monitoring service allows for multiple patients living in different suburbs to be monitored in real time, meaning that appropriate clinical care can be assessed and delivered in a timely fashion.

The CMC model is sustainable as it does not require any dedicated clinical space to operate and by monitoring patients at home, we are able to reduce healthcare cost without compromising care delivery. The CMC has demonstrated scalability by implementing a model to manage chronic heart failure patients in the community. This trial is planned to expand to service a larger catchment area.

Since its inception, the CMC has triaged and coordinated care for over 12,000 patients. The CMC utilises an escalation pathway in line with the between the flags model of vital sign monitoring which is time measured to ensure patients are navigated towards the right care, at the right time. The emergency department presentation rate for the service is less than 3%.

To date, the CMC has received 55 positive stories on Care Opinion from patients reporting positive experiences and outcomes with the service.

Implementation of a Clinical Emergency Response System for admitted patients in the Emergency Department at St George Hospital

Increasing patient presentations and increased length of stay for admitted patients has contributed to overcrowding in the St George Hospital Emergency Department (ED). Overcrowding is directly associated with failure to recognise and respond to signs of clinical deterioration and results in poorer patient outcomes. St George Hospital ED, like many other ED's, had no formal system in place to ensure a consistent response to deterioration for admitted patients.

In November 2022 a formal structured Clinical Emergency Response System (CERS) was implemented in the ED. This concentrated on early detection of and response to admitted patient deterioration in the ED, providing a hybrid of internal specialty expertise and external support to escalate care in a timely manner. The overall objective of this initiative was to improve patient safety in the ED.

The six-month (November 2022 – May 2023) experience to date has demonstrated that the St George Hospital ED has been able to safely introduce and sustain a CERS for admitted patients within the ED, that is consistent with the recommended response to deterioration for admitted patients. Following implementation of the model, the median time to review for both Clinical Review and Rapid Response calls are well within Ministry of Health benchmark timeframes for inpatients. There has also been an improvement in the number of patients who have had a Rapid Response activated within four hours of transfer from ED, with a 53% reduction, as a percentage of total admissions from ED. Staff have reported that implementation of CERS in the ED has strengthened teamwork, partnership and collaboration within the ED multidisciplinary team and also with the inpatient speciality teams.

The CERS in ED model has been embedded as business as usual in terms of the ED response to deterioration. The project has received significant interest from other ED's within the Emergency Care Institute Community of Practice, with many sites looking to implement a similar pathway following the success of the project at St George Hospital.

'Sip til Send' at Sydney-Sydney Eye and Prince of Wales Hospitals

Sip til Send is a change to the traditional fasting regime that requires patients to fast for six hours prior to surgery. 'Sip Til Send' allows patients to sip small volumes of clear fluids up until the time the patient is transferred to the operating theatre. Similarly, 'Sip Til Send for paediatrics' allows children to sip small volumes of clear fluids up until the time the child is transferred to the operating theatre.

The project intends to reduce harm to patients from over fasting. International evidence suggests that by reducing fasting times, patient outcomes improve, including improved post-operative wellbeing and reduced headaches, nausea and anxiety for patients. Reductions in haemodynamic instability and post-operative delirium in older patients are expected, as are reductions in risks associated with theatre cancellation and delay. Additionally, prolonged oral fluid deprivation is unpleasant for patients and associated with dehydration, nausea and vomiting, headache, and possibly post-operative delirium.

'Sip til Send' is now the default for all patients, supported by a formal Business Rule at both Sydney and Sydney Eye Hospital and Prince of Wales Hospital. Formal evaluation is planned with auditing of patients' preoperative fluid intake and staff surveys to be completed to ensure the fasting regime is maintained and that the expected improvements in patient outcomes are realised.

SESLHD's Response to Mpox

In May 2022, mpox (formerly monkeypox) cases began to be reported from Europe, predominantly among gay, bisexual, and other men who have sex with men (GBMSM). Cases were soon arising around the world, including in Australia.

SESLHD rapidly initiated a multi-component response to this outbreak, to detect and prevent cases, and limit local transmission. The Public Health Unit (PHU) and Sexual Health services worked together to respond to this emerging health issue. As many of the first cases in Australia occurred in SESLHD, the teams developed response procedures which were later adopted statewide. The PHU developed case notification tools, referral pathways, and ran webinars for clinicians to ensure prompt case detection. SESLHD also supported community organisations with education sessions for at-risk populations.

When vaccines became available, SESLHD led much of the statewide work to develop booking and triage systems, resources, staff training, and engagement with priority populations. In contrast to other countries, Australia has recorded relatively few cases of mpox, and there has been no evidence of sustained local transmission in NSW. Throughout the response, PaCH worked closely with partners from the Ministry of Health, laboratories, clinicians, GPs and the Primary Health Network, and ACON (a LGBTQI+ health NGO).

Falls Working Party at Garrawarra Centre

Falls are a significant cause of potentially avoidable harm to older people living in Residential Aged Care Facilities (RACF) and there is strong evidence that falls can be prevented.

Garrawarra Centre is home to 104 residents living with complex and advanced dementia. One of the highest risks to residents is falls, due to the nature of the disease and associated effects. Garrawarra Centre has reported an average of 500 falls per year over the last three years. The Falls Working Party is a collaborative group of clinicians who provide direct care, including Assistants in Nursing, Enrolled Nurses, Registered Nurses, Allied Health and Medical staff.

In addition to reducing the rate and harm from falls, the goals of the Garrawarra Falls Working Party include:

- improving resident's experience
- increasing the reliability of falls prevention strategies
- improving falls risk assessment processes
- improving resident, carer and staff engagement

Strategies implemented by the Falls Working Party have led to increased awareness of falls across all teams, improved compliance with falls management procedures and a more effective clinical handover across all shifts for falls risks and planning. This has collectively resulted in a reduction in falls rate of approximately 30% over a six-month period.

Garrawarra Centre plans to maintain these improvements through the establishment of Falls Champions across the facility, who will lead and advocate for falls awareness. Additionally, falls data and trends are tracked weekly during leadership huddles, and the Falls Working Party continue to meet monthly.

Improving the patient experience

Partnering with Consumers

Partnering with patients, carers, families, and consumers is a cornerstone of healthcare delivery and a key contributor to achieving SESLHD's strategic priority of providing person-centred care. The SESLHD Consumer Partnership Framework 2021-2024 articulates the commitment of SESLHD to engage with consumers at all levels of the organisation and to work in partnership.

Governance for consumer participation is well supported in SESLHD with consumer representation through membership at the Quality and Safety Board committee (QSBC), Board Strategy and Community Partnerships Committee (BSCPC), and SESLHD Clinical Quality Council (CQC). Additionally, each SESLHD site has a Consumer Advisory Committee, chaired by consumer members, providing an opportunity to shape the strategic direction of health care services and be involved in projects and initiatives. These committees also play a role in reviewing and developing patient information resources that reflect consumer involvement in health literacy. Consumers are recruited and participate in Health Consumers NSW training to support their roles. Consumer representatives are also members of other committees across SESLHD where the consumer voice is pivotal to that committees' objectives.

Partnering with consumers in their care, to the extent that they choose, is also supported across SESLHD through person-centred models of care. This includes multiple mechanisms for consumer feedback that are actively encouraged, recognising that positive and negative consumer feedback is an invaluable resource for improving the quality of care provided at SESLHD. Compliments and complaints provide unsolicited feedback which is useful for identifying incidents, risks and performance issues, monitoring standards of care, and patient experiences, as well as areas of excellence, and is vital for improving care outcomes. Mechanisms currently in place include, but are not limited to, Patient Reported Experience Measures (PREMs), Patient Reported Outcome Measures (PROMs), Care Opinion, Bureau of Health Information surveys, and real time patient experience surveys.

Patient experience information in action

The integrated Rehabilitation and Enablement program (iREAP) at Uniting **War Memorial Hospita**l, has been collecting Patient Reported Experience Measures (PREMs) alongside Patient Reported Outcome Measures (PROMs) as part of the electronic collection of measures on the HOPE (Health outcome and Patient experience) platform. Patients independently, or with assistance, complete an electronic survey on an iPad at the beginning and end of their program. Areas for improvement have been identified from this information, including provision of information for clients to independently manage care and provision of a treatment plan for their condition that can be carried out in daily life, as well as offering appointment times that better suit patient needs.

In the **Emergency Departments** (EDs) across SESLHD, Patient Experience Officers share the GoShare survey with patients discharged from the ED. Data from the GoShare survey platform is collected monthly by all four sites with an ED and is submitted to the Ministry of Health monthly. Feedback obtained through the surveys is used locally within EDs to celebrate staff who are commended for their efforts, to drive local improvement activities and create changes in response to the feedback.

At **Sydney-Sydney Eye Hospital,** consumer feedback gathered through Care Opinion, complaint submissions and ED patient survey comments, was themed and used to direct priorities in the first phase of the FRED (Future Ready Emergency Department) project. The initial phase of the project aimed to improve key performance indicators and patient experience measures related to process of patient flow, communication and waiting times. This information continues to be used to evaluate the changes made as part of the project.

The **Allied Health teams at Prince of Wales Hospital** collaborated to implement routine collection of feedback from consumers of allied health outpatient services to optimise patient experiences and inform service development. The project was initiated following an identified gap in the measurement of patient experience in outpatient settings for allied health, a performance indicator in the NSW Ministry of Health Outpatient Framework. A review of the data collected across all five allied health disciplines showed that 98% of Allied Health appointments were carried out at a time that suited the consumer. Feedback received was overwhelmingly positive regarding the outpatient services they provide, results showing that the allied health clinicians partnered with patients in care planning and decision making, and were able to explain treatment in a way that patients were able to understand.

This project has resulted in improved collaboration across allied health disciplines as well as with consumers by providing an open forum for feedback, which in turn leads to consumers feeling respected and empowered to use their voice to drive change in the services they access.

"Staff listen to me and are informative about options. Honest and thoughtful."

"Always treated very well and respectfully. Questions always answered no matter what they were. Really appreciated their assistance in getting moving again. A big thank you"

Patient feedback was sought following the commencement of the Birthing Service triage: a two bed and two chair triage service with a dedicated midwife built in 2021 at the **Royal Hospital for Women.** 58 families responded to a survey seeking women's feedback of their experience and care. As a result of the feedback, the following improvements have been made:

- Dim lighting, aromatherapy and music to create a calming environment
- Artwork installed
- Installing a dedicated triage service phone (landline and mobile) to improve efficiency in communication.

SESLHD Patient Experience Working Group

The Patient Experience Working Group was established to provide a strategic approach to patient experience measurement, reporting, analysis and improvement. The working group was established after an environmental scan of patient feedback collection systems was requested by the Clinical Excellence Commission in early 2022. The scan identified over 25 systems for collecting patient experience data, with no universal measure and no means of aggregating information from the multiple sources.

The Patient Experience Working Group is committed to developing and implementing an effective Patient Experience information collection system, with the initial goals of:

- developing a consistent measure of patient experience at SESLHD;
- streamlining the number of measures collected;
- identifying collection methods/systems that provide real time, actionable data, visible to all and enables aggregation with other data sources; and
- allowing all patients, consumers, carers, family and friends to provide feedback in a way that is accessible to all and considers individual language needs and preferences, digital/technological accessibility and disabilities.

The Working Group includes four consumer representatives who have participated as key members from the initial meeting. More than 25 additional consumers have been consulted with for their feedback, which has been incorporated into the ongoing development of a universal patient experience measure for SESLHD.

To support the work going forward, the broader Patient Experience Group has been placed on hold and a smaller Proof of Concept Working group is being convened to further develop and test the Patient Experience information collection solution. The group intends to continue to collaborate with consumers to ensure the solution is culturally appropriate and accessible, throughout the next phase of the project.

Patient experience and the design and implementation of a solution to capture, share and respond to real-time patient experience measures is a priority for SESLHD in 2023/24.

Partnering with consumers and the community in safety and quality

Royal Hospital for Women Clinical Redesign Project

A two-year Clinical Redesign Project has recently commenced to achieve the Royal Hospital for Women's (RHW) maternity vision:

> ***Pregnancy and birth are a unique, intense and transformative psychological experience that can generate a sense of empowerment, esteem, confidence and accomplishment that remain with a woman throughout her life. This is the vision for all women choosing to birth at the Royal Hospital for Women.***

Multiple working parties have been established to address priority areas identified by the hospital team. Consumers are members of all individual working parties. They contribute to the service review, solution design and resource development.

- Improvements achieved to date include:
- Increased continuity of care within our models of care
- Refurbishment of birthing rooms in the birth unit
- Provision of a postnatal kitchenette for use by families
- Improvements to the RHW website
- Improved communication resources for women and families

The RHW looks forward to continuing to work with their consumers in 2023/24 as the project continues.

GPCanShare: a collaborative program with the Primary Health Network

GPCanShare is a collaborative program between the Central and Eastern Sydney Primary Health Network (CESPHN) and SESLHD, established with the goal of implementing an integrated model of care for SESLHD cancer patients.

The primary objective of the program is to enhance patient experience within the cancer system by fostering a cooperative approach between cancer service specialists and general practitioners (GPs). Secondary objectives include facilitating the transition of care from acute (hospital) care to primary care settings when appropriate.

The small team of three GPCanShare Clinical Nurse Consultants (CNCs) established the service in southern SESLHD. Patients receive comprehensive support from the hospital-based CNCs, who act as intermediaries between the patient, their specialists and the patient's GP, ensuring effective communication and collaboration. GPs receive regular updates on the patient's care plan, covering all aspects of their treatment and care. The care coordinators facilitate alternating appointments between the acute hospital cancer clinic and the patient's GP for patients whose ongoing cancer care follow up can be managed in the primary care setting. They provide ongoing support to GPs to assist them in managing their patient's cancer care follow up in the community. GPs and patients are comfortable knowing that the CNCs are available to act as an escalation point back to the cancer specialists if needed. Patients prefer to be able to see their GP for some of their follow up appointments and reduce the need to navigate the complex healthcare system which is stressful, time-consuming and can be costly with travel and car-parking. Furthermore, relatives and carers do not have to sacrifice their own schedule to help their loved ones attend the hospital.

Consumers, including GPs and patients, along with Cancer Specialists, actively participated in shaping the program to ensure successful outcomes. This included implementation of co-designed comprehensive care plans and establishment of preferred communication channels, catering to the requirements of both the GPs and the patients.

450 patients are enrolled in the well-established project within St George Hospital and The Sutherland Hospital, providing support to 165 GP practices and 250 GPs. The team have been working with Prince of Wales Hospital to commence enrolments in the Northern Sector. The care plan has now been built into the oncology information system with patient enrolments commencing in August 2023.

This program aligns with the SESLHD Exceptional Care, Healthier Lives Strategic Plan 2022-2025 to work in partnership to improve health and wellbeing outcomes and transform experiences by providing integrated, easy-to-navigate services across the continuum of the patient's cancer journey. Shifting patient care from acute to primary settings enhances health system efficiency amidst the ever-increasing demands being made on our health systems. The adaptability and scalability of this project is important in ensuring we can continue to meet the future healthcare needs of our communities.

The program saved approximately 90 clinic hours for the oncologists between January 2021 and June 2023. Formal external evaluation of the program is underway.

A workplace culture that drives safe, high-quality care

Staff culture and leadership

Racism Harms: Act On It

"Racism Harms: Act On it" is an innovative, evidence-based strategy to address racism in health care. Sponsored by the Chief Executive, the strategy is led by the Multicultural Health Team, in collaboration with Aboriginal Health, People and Culture, and Media and Communications. The strategy, the first of its kind across NSW Health, aims to reduce the experience and impact of racism on staff and consumers.

Objectives include increasing staff awareness of racism and its negative impact on physical and mental health; and increasing staff knowledge and confidence to appropriately respond to and report racism. The strategy comprises an integrated set of activities including: leadership forums for staff and managers; staff training focused on the impact of racism and bystander intervention to appropriately address racist incidents; screensavers; an intranet site with information for staff and managers on reporting racist incidents and supporting people who have experienced racism; and patient/visitor facing posters. Evaluation of staff training demonstrates a workforce that is more able to identify and respond to racism. The People Matter Employment Survey (PMES) results indicate there is a small but promising decrease in the experience of racism and an increase in satisfaction with how the organisation handles racist complaints.

The strategy delivers systemic change by empowering staff to recognise and appropriately respond to and report racism. Reports of racism are now being tracked by People and Culture. The bystander intervention training has been delivered to over 1,500 staff across SESLHD. Evaluation, conducted in partnership with Western Sydney University, demonstrates that participants increased their confidence to respond to racism (up 49%), and 84.2% have a better understanding of how to respond if they experienced or witnessed a racist incident. To enhance reach and sustainability, the training is included in staff orientation programs, and a train-the-trainer module is in development.

Experiencing racism can impact on workplace productivity due to absenteeism, turnover and job dissatisfaction. The sustained effectiveness of anti-racism training is enhanced when supported by broader organisational responses. One minute bystander intervention videos are an evidence-based, efficient, and cost-effective method to influence change. These videos are embedded in training and sit alongside a set of broader organisational initiatives to reduce the experience and impact of racism within healthcare settings. By providing education, resources and executive level support for responding to racism, the strategy represents an efficient and effective way of supporting staff productivity and wellbeing by reducing the harms of racism to their physical and mental health.

The PMES results demonstrated a decrease in the experience of racism (9% in 2019; 6.4% in 2022) and an increase in satisfaction with how the organisation handles racist complaints (22% in 2021; 39.5% in 2022). Evaluation of staff training demonstrates a workforce that is more able to identify and respond to racism. Experiences of racism within healthcare settings have more negative impacts than in other settings, contributing to poorer access to care, poorer experiences of care and poorer health outcomes. Reducing the incidence and impact of racism is essential for better staff and patient outcomes.

Safety Attitudes Questionnaire

The Safety Attitudes Questionnaire (SAQ) was implemented in 2022 to help understand the safety culture of each facility, ward, unit or department in SESLHD. Safety culture measurement explores six components that influence clinical practice:

- safety climate
- work conditions
- teamwork
- perceptions of management
- job satisfaction and
- stress recognition.

The measurement of safety climate and culture is utilised internationally and is recognised as a valuable tool in assessing attitudes towards safety and quality, which are directly linked to patient outcomes. Supportive growth of positive safety culture and attitudes correlate to a reduction in all hospital harm, serious safety events and severity of mortality.

The SAQ was repeated in 2023, with the aim of continuing with improvement initiatives within current areas of strength and the development of action plans for identified areas of priority. 2023 and 2022 data can be analysed comparatively at each facility, service and team level.

A total of 4,299 staff from across SESLHD responded to the 2023 questionnaire. This was a 12% increase in SESLHD staff engagement from 2022.

2023 SAQ results will be provided by a group of facilitators to all levels of the organisation: district level, facility/service level and to individual teams. Feedback from 2022 SAQ site co-ordinators identified the need for increased support in the provision of feedback. In response, the project team developed the SAQ Facilitation Development Program for a group of 35 self-nominated facilitators from all participating SESLHD sites. The two-week program provided training, support and connection for our SAQ feedback facilitators with the aim of providing timely and meaningful results and feedback across the organisation.

This additional focus on the provision of timely and meaningful SAQ results aims to assist the transition of survey feedback into structured, prioritised action plans for sustainable projects that affect quality and safety improvement. Prioritised action planning will align with the Management and Planning System (MAPS) and be available across sites and services as evidence towards quality improvement initiatives. All feedback sessions are projected to be completed by September 2023.

The SAQ 2023 outcome data is in the latter phase of analysis. Preparation of customised data sets and facilitated feedback sessions to all facilities/services and teams that achieved a validated data set (with greater than 30% participation rate) are in progress. The project team will support over 200 teams and services in the receipt of this data set. The initial feedback sessions will be prioritised by Executive teams across SESLHD from July 2023.

NSW Health key performance indicators

Measures	Target	SESLHD Result	Reporting Period	Commentary
Patients and carers have positive experiences and outcomes that matter				
Overall Patient Experience Index (Number)				
Adult admitted patients	8.7	8.8	Oct - Dec 2022	SESLHD is meeting and exceeding target.
Emergency department (ED)	8.6	8.73	Oct - Dec 2022	SESLHD is meeting and exceeding target.
Patient Engagement Index (Number)				
Adult admitted patients	8.5	8.68	Oct - Dec 2022	SESLHD is meeting and exceeding target.
Emergency department	8.5	8.1	Oct - Dec 2022	SESLHD did not meet target for this key performance indicator (KPI), however performance has improved on previous year. For continued monitoring.
Mental Health Consumer Experience: Mental Health consumers with a score of Very Good or Excellent (%)	80	78	Apr - Jun 2023	SESLHD did not meet target for this KPI, however performance has improved on previous year and is above state average. For continued monitoring and review.
Safe care is delivered across all settings				
Harm-free admitted care: (Rate per 10,000 episodes of care)				
Hospital acquired pressure injuries	≤6.6	5.6	FYTD Apr 2023	SESLHD is meeting and exceeding target.
Fall-Related Injuries in Hospital	≤6.4	6.1	FYTD Apr 2023	SESLHD is meeting and exceeding target.
Healthcare associated infections	≤114.9	128.1	FYTD Apr 2023	SESLHD did not meet target for this KPI, however performance has improved on previous year. This KPI is monitored closely by the SESLHD Infection Prevention and Control Committee, and a district-wide project has commenced aiming to reduce urinary tract infections.
Hospital acquired respiratory complications	≤21	26.6	FYTD Apr 2023	SESLHD did not meet target for this KPI, however performance has improved on previous year. There has been ongoing focus on aspiration pneumonia and accurate diagnosis at POWH, and a “data deep dive” of aspiration pneumonia and ventilator associated pneumonia is planned at TSH.
Hospital acquired venous thromboembolism	≤8	9.1	FYTD Apr 2023	SESLHD did not meet target for this KPI, however performance has improved on the previous year. The SESLHD venous thromboembolism (VTE) working party is implementing changes to risk assessment alerts in eMR with the aim of increasing accuracy and quality of the assessments.

Measures	Target	SESLHD Result	Reporting Period	Commentary
Hospital acquired renal failure	≤0.7	1.1	FYTD Apr 2023	SESLHD did not meet target for this KPI, however performance has improved on previous year. An eMR alert is in place to encourage referral to renal services.
Hospital acquired gastrointestinal bleeding	≤10.5	7.9	FYTD Apr 2023	SESLHD is meeting and exceeding target.
Hospital acquired medication complications	≤12.4	8	FYTD Apr 2023	SESLHD is meeting and exceeding target.
Hospital acquired delirium	≤42.7	40	FYTD Apr 2023	SESLHD is meeting and exceeding target.
Hospital acquired incontinence	≤5.5	4.2	FYTD Apr 2023	SESLHD is meeting and exceeding target.
Hospital acquired endocrine complications	≤25.9	27	FYTD Apr 2023	SESLHD did not meet target for this KPI, however performance has improved on previous year. A "data deep dive" will be undertaken at TSH to better understand episodes of hypoglycaemia in non-diabetics and T1 and T2 Diabetes Mellitus during hospital admissions, and the hypoglycameia dashboard continues to be used at POWH.
Hospital acquired cardiac complications	≤30.5	29.8	FYTD Apr 2023	SESLHD is meeting and exceeding target.
3rd or 4th degree perineal lacerations during delivery	≤379.6	329.5	FYTD Apr 2023	SESLHD is meeting and exceeding target.
Hospital acquired neonatal birth trauma	≤98.1	64.4	FYTD Apr 2023	SESLHD is meeting and exceeding target.
Emergency Treatment Performance (ETP) – Admitted (% of patients treated in ≤ 4 hours)	50	24.80	FY2022/23	Continued high demand and length of time to access inpatient and isolation beds continues to impact patient flow out of the emergency department (ED) in a timely manner, decreasing Admitted ETP performance (and overall ETP performance). Increased isolation needs are not only related to COVID-19 patients, increases in presentations with venous thromboembolism (VTE), influenza and other infectious diseases are impacting isolation and single room bed capacity. Workforce shortages (due to both leave and recruitment shortages) have limited the district's ability to open additional surge beds or staff preventative initiatives within the primary and community health settings and outpatient setting, increasing patients presenting to ED.
Emergency department extended stays: Mental Health presentations staying in ED > 24 hours (Number)	0	15	FY2022/23	SESLHD has not met target for this KPI. Processes are in place to notify and review all extended stay Mental Health records. There is ongoing integrated care planning for complex ED presentations.

Measures	Target	SESLHD Result	Reporting Period	Commentary
Emergency Department Presentations Treated within Benchmark Times (%)				
Triage 1: seen within 2 minutes	100	100	FY2022/23	SESLHD is meeting target.
Triage 2: seen within 10 minutes	95	72.70	FY2022/23	Several strategies have been implemented across SESLHD to improve this KPI, including: • Clinical Initiatives Nurse role implemented at POWH for early initiation of care including symptom relief, diagnostic test ordering, escalation of care, patient communication • Development of specific "triage escalation" process at SGH. TSH implemented new Technical Assistant role in ED to help with prompt treatments, starting in January 2023 • At SSEH, the FRED Project has commenced, reviewing ED Pathways and practices for at risk and homeless ED presentations
Triage 3: seen within 30 minutes	85	63.80	FY2022/23	
Inpatient Discharges from ED Accessible and Rehabilitation Beds by Midday (%)	≥35	26.10	FY2022/23	SESLHD is not meeting target for patient discharges from ED Accessible and Rehabilitation beds by midday. SESLHD has implemented several strategies to try and improve the performance, including (but not limited to), daily meetings at sites; increased use of Patient Discharge Lounges; working with families and carers about time and day of discharge of patient; improving collaborative approaches to ensure all paperwork and medications are ready for patients who are being discharged.
Transfer of care – Patients transferred from ambulance to ED ≤ 30 minutes (%)	90	73.70	FY2022/23	Sites continue to monitor offload timeliness and ED capacity with open dialogue between sites, NSW Ambulance and the LHD to discuss plans for delays and escalations. In line with the 2023 Winter plan all SESLHD facilities with an ED have engaged in local improvement strategies to improve Transfer of Care Performance.
Elective Surgery Overdue - Patients (Number)				
Category 1	0	0	As at 30 June 2023	SESLHD is meeting target.
Category 2	0	373	As at 30 June 2023	Backlog of surgery caused by the cancellation of non-urgent surgery during the COVID-19 pandemic. COVID-19 hospitalisations, emergency activity and demand on inpatient beds remained high across the LHD and this has impacted on overall inpatient bed capacity -including surgical capacity - at all facilities and has limited the ability to perform additional non-urgent elective surgery activity requiring an overnight stay. Increases in leave, particularly unscheduled leave such as Sick and Carers leave has had significant impacts on planned surgery
Category 3	0	507	As at 30 June 2023	

Measures	Target	SESLHD Result	Reporting Period	Commentary
Elective Surgery Access Performance - Patients treated on time (%)				
Category 1	100	100	As at 30 June 2023	SESLHD is meeting target.
Category 2	97	56.12	As at 30 June 2023	Backlog of surgery caused by the cancellation of non-urgent surgery during the COVID-19 pandemic. COVID-19 hospitalisations, emergency activity and demand on inpatient beds remained high across the LHD and this has impacted on overall inpatient bed capacity -including surgical capacity - at all facilities and has limited the ability to perform additional non-urgent elective surgery activity requiring an overnight stay. Increases in leave, particularly unscheduled leave such as Sick and Carers leave has had significant impacts on planned surgery
Category 3	97	52.14	As at 30 June 2023	
Mental Health: Acute Seclusion				
Occurrence - (Episodes per 1,000 bed days)	<5.1	2.28	FY2022/23	SESLHD is meeting and exceeding target.
Duration – (Average Hours)	<4.0	3.59	FY2022/23	SESLHD is meeting and exceeding target.
Frequency (%)	<4.1	1.75	FY2022/23	SESLHD is meeting and exceeding target.
Mental health: Involuntary patients absconded from an inpatient mental health unit – Incident Types 1 and 2 (rate per 1,000 bed days)	<0.8	1.29	FY2022/23	SESLHD has not met target but performed within tolerance range for this KPI. Processes are in place to notify and review all involuntary abscond incidents, to determine risk and mitigation strategies. Anti-climb has been installed at two sites.
Electronic discharge summaries sent electronically and accepted by General Practitioners (%)	≥51	67.60	FY2022/23	SESLHD is meeting and exceeding target.
Virtual Care: Non-admitted services provided through virtual care (%)	30	15.58	FY2022/23	30% is a three-year target, SESLHD calculated target for 2022-23 is 20.8%. Virtual care activity delivered as audio/video (as per KPI definition) has remained stable. The investment in the SESLHD Virtual Health Hub & Remote Patient Monitoring models, is likely to increase the proportion of virtual health activity within the next 12-24 months. Achievement against the three-year target is expected to continue to improve with an increased focus on accurate capture of the virtual care activity that is already happening across SESLHD.
Mental Health Acute Post-Discharge Community Care - Follow up within seven days (%)	75	83.52	FY2022/23	SESLHD is meeting and exceeding target.

Measures	Target	SESLHD Result	Reporting Period	Commentary
Unplanned Hospital Readmissions: all unplanned admissions within 28 days of separation (%)				
All persons	Reduction on previous year	5.80	FYTD May 2023	SESLHD is not meeting target. Improvement actions in progress include: • Virtual care services to proactively connect at risk discharged patients with primary care; • Continued engagement with Primary Health Network; • Review and Triage Service for the Geriatric Flying Squad; • Ongoing Integrated Care services; and • Increasing rollout of hospital in the home (HITH) model of care.
Aboriginal persons	Reduction on previous year	9.20	FYTD May 2023	SESLHD is not meeting target. Improving Aboriginal and Torres Strait Islander health remains a priority for SESLHD in 2023/24. SESLHD recently recruited to the new Director of Aboriginal Health position, a positive step towards Closing the Gap and continuing work to improve this KPI.
Mental Health: Acute readmission - Within 28 days (%)	≤13	15.04	FY2022/23	SESLHD has not met target but performed within tolerance range for this KPI. Returned to within target for all monthly results from February 2023.
Discharge against medical advice for Aboriginal in-patients (%)	≥1% decrease on previous year	2.4	April -June 2023	SESLHD is not meeting target. Improving Aboriginal and Torres Strait Islander health remains a priority for SESLHD in 2023/24. SESLHD recently recruited to the new Director of Aboriginal Health position, a positive step towards Closing the Gap and continuing work to improve this KPI.
Potentially preventable hospital services (%)	≥2% lower than benchmark	17.80	FYTD Mar 2023	SESLHD has not met target but performed within tolerance range for this KPI.
Hospital in the Home (HITH) Admitted Activity (%)	5	1.86	FY2022/23	SESLHD is not meeting target for HITH patients. HITH activity declined during COVID-19, due to priorities in other staffing areas. This has been identified and SESLHD is working to reinvigorate the use of the HITH model of care throughout the district and is on opening new HITH beds to increase HITH utilisation across the district. HITH is also being integrated into new virtual models of care (via Virtual Clinical Care Centre), all of which should increase activity in 2023/24 period.
Renal Supportive Care Enrolment: End-Stage Kidney Disease Patient (% variation to target)	242- 290 (20% increase)	312	FY2022/23	SESLHD is meeting and exceeding target.

Measures	Target	SESLHD Result	Reporting Period	Commentary
People are healthy and well				
Childhood Obesity – Children with height/length and weight recorded (%)	70	72.00	Apr-June 2023	SESLHD is meeting and exceeding target.
Smoking During Pregnancy - At any time (%):				
Aboriginal women	28.2	30.6	2022	SESLHD is not meeting target. Improving Aboriginal and Torres Strait Islander health remains a priority for SESLHD in 2023/24. SESLHD recently recruited to the new Director of Aboriginal Health position, a positive step towards Closing the Gap and continuing work to improve this KPI.
Non-Aboriginal women	2.2	1.9	2022	SESLHD is meeting and exceeding target.
Pregnant Women Quitting Smoking - by second half of pregnancy (%)	37.3	40.3	Oct 2021 – Sept 2022	SESLHD is meeting and exceeding target.
Get Healthy Information and Coaching Service - Get Healthy in Pregnancy Referrals (% variance)	1,328	1,113 (-16.2%)	FTYD Apr-Jun 2023	SESLHD is not meeting this KPI target. Performance impacted by staffing shortages, casual and new staff, competing priorities in maternity units and different levels of engagement across TSH, SGH, RHW. Facility level monitoring and reporting by Health Equity Promotion and Prevention Service to be reviewed in collaboration with clinical leads.
Children fully immunised at one year of age (%)	95	94.20	Apr 2022-Mar 2023	All childhood vaccination in SESLHD is provided by general practitioners. The Public Health Unit supports general practitioners directly and via working with the Central and Eastern Sydney Primary Health Network to optimise uptake of childhood vaccines and accurate reporting to the Australian Immunisation Register. Data errors in the Register mean that reported coverage is consistently 1-2% lower than actual coverage.
Hospital Drug and Alcohol Consultation Liaison -number of consultations (% increase)	10,215	15,349	FY2022/23	SESLHD is exceeding this target. This increase reflects that Hospital Drug & Alcohol Consultation Liaison has been fully staffed across all sites during 2022-2023. The data source is not an eMR extracted data collection: the current system relies on individual staff recording occasions of service, resulting in variable data quality. NSW Health has designed a new statewide data collection form for deployment in the eMR in 2023-2024 FY.

Measures	Target	SESLHD Result	Reporting Period	Commentary
Hepatitis C Antiviral Treatment Initiation – Direct acting by District residents: Variance (%)	308	84	FYTD Mar 2023	Impacts of COVID-19 on staffing levels and recruitment have contributed to low initiation numbers for hepatitis C treatment. Multiple projects have been implemented across SESLHD to increase treatment initiation, including: • Expansion of Point of Care Testing to all Community Corrections services in SESLHD • New funding for hepatitis Clinical Nurse Consultant (CNC) position at Alcohol and Other Drugs (AOD) services • Ongoing funding for hepatitis C CNC positions at POWH and Kirketon Road Centre (KRC) • Hepatitis C virus (HCV) point-of-care testing now occurring in community mental health services. • Partnerships with NSW Users and AIDS Association (NUAA) and Hepatitis NSW to include peer-led models of care. • SESLHD Blood Borne Virus (BBV) Testing Policy embedded in nursing and medical education sessions and in local departmental procedures. • Public Health Unit notification project • District-wide HCV testing scale-up group formed to coordinate priority settings within the district.
Aboriginal paediatric patients undergoing Otitis Media procedures (number)	5	1	FY2022/23	SESLHD is not meeting target. Improving Aboriginal and Torres Strait Islander health remains a priority for SESLHD in 2023/24 and work continues to improve this KPI.
Domestic Violence Routine Screening – Routine Screens conducted (%)	70	54.90	Oct-Dec 2022	Mental Health (69%) and Drug & Alcohol (79%) meet target, but Child & Family Health Nursing (49%) screening is lower due to presence of partner or other family members, or protocol exclusions, at consultation.
NSW Health First 2000 Days Implementation Strategy - Delivery of the 1-4 week health check (%)	85	65.32	Jan- Mar 2023	Current Child & Family Health Nursing vacancies, clinic closures and advice to mothers in the Maternity, Antenatal and Postnatal Service and Midwifery Support Program not to attend Child Youth & Family Service until 2 weeks after birth impacting upon performance. SESLHD performance of 86.47% for 1-4 week Blue Book check within 4 weeks of birth meets target.
Sustaining NSW Families Programs				
Families completing the program when child reached 2 years of age (%)	50	64.71	Jan-Mar 2023	SESLHD is meeting and exceeding target.
Families enrolled and continuing in the program (%)	65	75.00	Jan-Mar 2023	SESLHD is meeting and exceeding target.
Mental Health Peer Workforce Employment – Full time equivalents (FTEs) (number)	≥15	23.2	FY2022/23	SESLHD is meeting and exceeding target.

Measures	Target	SESLHD Result	Reporting Period	Commentary
BreastScreen participation rates (%)				
Women aged 50-69 years	55	41.80	Jul 21- Jun 23	SESLHD has not met target but performed within tolerance range for this KPI.
Women aged 70-74 years	55	40.90	Jul 21- Jun 23	SESLHD has not met target but performed within tolerance range for this KPI.
Our staff are engaged and well supported				
Workplace Culture – People Matter Survey Culture Index – Variation from previous year (%)	≥-1	-1.00	2020/21	SESLHD is meeting target.
Take Action - People Matter Survey – Take action as a result of the survey – Variation from previous year (%)	≥-1	-1.00	2020/21	SESLHD is meeting target.
Staff Engagement - People Matter Survey Engagement Index – Variation from the previous year (%)	≥-1	0.00	2020/21	SESLHD is meeting target.
Staff Engagement and Experience – People Matter Survey – Racism experienced by staff – Variation from previous survey (%)	≥5% decrease on previous survey	3.00	2020/21	There has been no change in the People Matter Employee Survey (PMES) results related to staff experience of racism. In response to this, a one-hour training session has been included in Corporate Orientation from August 2023, which is mandatory for all new staff to complete. P&C have also developed a Diversity and Inclusion Strategy and Action Plan, with strategies targeted at improving the employee experience for both CALD and Aboriginal populations. For example, training was provided through English language skills workshops as part of SESLHDs campaign to increase cultural sensitivity and inclusion.
Staff Performance Reviews – Within the last 12 months (%)	100	42.70	Apr 2022-Mar 2023	The performance review rate was 46.2% to close out FY22/23. SESLHD is continuing the transition over to the new Performance and Talent (PAT) system, which has required a significant investment in training, education and organisational change management. There is a focus on uploading paper-based forms into PAT and inputting goals into PAT, in preparation for Performance Development Reviews (PDRs) that will follow. People and Culture (P&C) have developed resources to support SESLHD staff, which have now been uploaded onto the P&C Intranet page. P&C also continue to deliver regular 'Lunch and Learn' sessions to increase PDR rates, providing information on navigating the PAT system and how to have effective performance conversations. However, P&C have not received additional resources to achieve this performance review target, which limits the scope of strategies that may be implemented to support the desired improvements.
Recruitment: Average time taken from request to recruit to decision to approve/decline/defer recruitment (business days)	≤10	8.72		SESLHD is meeting and exceeding target.

Measures	Target	SESLHD Result	Reporting Period	Commentary
Aboriginal Workforce Participation – Aboriginal Workforce as a proportion of total workforce at all salary levels (bands) and occupations (%)	3	1.12	FY2022/23	Aboriginal workforce participation has steadily increased in recent months, sitting at 1.19% in June and 1.23% in July. As at July 2023 the total number of staff who identify as Aboriginal is 189 full time equivalent (FTE) staff which is a record high for SESLHD. As total FTE staff has increased across SESLHD, the percentage is therefore not reflective of the progress that has been made. It has been difficult to fill positions in the higher salary brackets due to an undersupply of qualified applicants who identify as Aboriginal. However, SESLHD recently recruited to the new Director of Aboriginal Health position, a positive step towards Closing the Gap within SESLHD. P&C have developed a Diversity and Inclusion Strategy and Action Plan, with strategies targeted at improving the recruitment experience and opportunities for employment within SESLHD for Aboriginal populations. For example, partnering with schools to promote traineeships and cadetships, developing employee networks, and increasing our investment in targeted advertising campaigns.
Employment of Aboriginal Health Practitioners (Number)	3	0	Jan 2023-Jun 2023	There are currently no Aboriginal Health Practitioner positions within SESLHD.
Compensable Workplace Injury – Claims (% of change over rolling 12 month period))	0	-9.70	Jul 2022-Jun 2023	SESLHD is meeting and exceeding target
Research and innovation, and digital advances inform service delivery				
Research Governance Application Authorisations – Site specific within 60 calendar days - Involving greater than low risk to participants - (%)	75	76.90	Oct-Dec 2022	SESLHD is meeting and exceeding target.
Ethics Application Approvals - By the Human Research Ethics Committee within 90 calendar days - Involving greater than low risk to participants (%)	75	95.20%	Oct-Dec 2022	SESLHD is meeting and exceeding target.

Future Priorities

Safety and quality priorities for the next 12 months

SESLHD have identified the following safety and quality priorities for 2023/24:

Aboriginal and Torres Strait Islander Health

SESLHD remains committed to health equity and Closing the Gap, as identified in the SESLHD Exceptional Care, Healthier Lives Strategic Plan 2022-2025. Specifically, in 2023/24, SESLHD will focus on:

- Ongoing implementation and evaluation of Burudi Muru Yagu, the SESLHD Aboriginal Health Plan 2022-23, and supporting local site and service plans;
- A targeted approach to support Aboriginal Health Workers and communities with smoking and vaping cessation; and
- Improving access to expert eye care, utilising virtual telehealth for First Nations people, rural and regional consumers with eye disease.

Patient Experience and Access to Care

SESLHD is committed to continuing its work towards improving patient experience over the next 12 months.

This includes the:

- design and implementation of a solution to capture, share and respond to real time patient experience measures; and
- implementation of the SESLHD Virtual Health Strategy, to expand options for access to care.

Implementing the Clinical Governance Framework

Implementation of the revised *SESLHD Clinical Governance Framework: Transforming for the future*, is a key priority for SESLHD in 2023/24 and beyond.

The Clinical Governance Framework builds on SESLHD's strategic plan and is a key step in embedding world-class quality and safety systems within our organisation. Key to the success of the framework is the rollout of the **Framework for Performance**.

The Framework for Performance outlines SESLHD's process for establishing safety and quality expectations and for monitoring the performance of each clinical unit within the organisation. It drives the continuous quality improvement cycle and sustains high performance with the capacity to capture lessons learnt, knowledge, and best practices which can be shared across the organisation.

The Clinical Governance Framework, inclusive of the Framework for Performance, provides the foundation for clinical units and sites to develop an annual Quality Plan.

The implementation of the structures and processes outlined in the *SESLHD Clinical Governance Framework* and the Framework for Performance are a priority for SESLHD in 2023/24.

Appendix

Attestation Statement

Health
South Eastern
Sydney Local Health
District

T23/50579
Related: T23/50577
and: T23/50578

This attestation statement is made by **Dr Debra Graves**

Name of office holder/member of Governing Body

Holding the position/office on the Governing Body **Board Chair**

Title of officeholder/member of Governing Body

For and on behalf of the governing body titled **South Eastern Sydney Local Health District**

Board *Governing body's title (the Governing Body)*

South Eastern Sydney Local Health District

Health service organisation name (the Organisation)

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

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

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

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

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

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

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

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

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

T23/50579
Related: T23/50577
and: T23/50578

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

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

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

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

Signed 

Position **SESLHD Board Chair**

Date 19.08.2023

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

Signed 

Position **SESLHD Chief Executive**

Name **Tobi Wilson**

Date 19.8.23

T23/50579
Related: T23/50577
and: T23/50578

Schedule of health service organisations covered by this attestation statement

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

South Eastern Sydney Local Health District

NSW GOVERNMENT