NSW GOVERNMENT

T21/73504

SESLHD Safety and Quality Account

2021-22

SOUTH EASTERN SYDNEY LOCAL HEALTH DISTRICT
District Executive Unit
Locked Mail Bag 21
TAREN POINT NSW 2229

T +61 2 9540 7756 F +61 2 9540 8757
E SESLHDMail@health.nsw.gov.au www.seslhd.health.nsw.gov.au

Produced by:
SESLHD Clinical Governance Unit

South Eastern Sydney Local Health District

Contents

Foreword

I am pleased to present the South Eastern Sydney Local Health District Safety and Quality Account for 2021/22, as endorsed by the Local Health District Board.

Over the past 12 months, COVID-19 has placed a significant demand on resources in SESLHD and staff should be commended for their courage, resilience, dedication and commitment to patient safety and provision of high quality services.

Despite the ongoing challenges associated with the COVID-19 pandemic, staff across SESLHD have continued to progress a number of important safety and quality initiatives, as well as commence a range of new activities and programs. This year's Safety and Quality Account provides updates on how we have continued existing programs, showcases a number of new initiatives, and identifies our safety and quality areas of focus for the next 12 months. The Account also highlights the many achievements of our COVID-19 response, including the establishment of the St George Hospital vaccination hub, airport screening support and COVID-19 testing clinics.

With the SESLHD Journey to Excellence strategy concluding this year, work is underway to develop the District's new strategic plan, which is expected to be published in December 2021. It has been great to see the level of enthusiasm and collaboration displayed by staff, consumers and partners as they participated in planning forums and consultations. The 2022-2025 strategy will build on the many achievements made during the Journey to Excellence, and will continue to place patient safety and quality at the heart of our work.

Consistent with our commitment to continuous improvement, the SESLHD 2021/22 Safety and Quality Account identifies three priority areas for quality and safety over the coming 12 months. These are:

- Aboriginal and Torres Strait Islander Health;
- Quality Improvement; and
- Towards Zero Suicides.

These goals reflect SESLHD's commitment to providing the best possible compassionate care when people need it. Through our clinical services and programs of work we will continue to progress as a learning organisation by developing the capability of our staff to ensure improvement and innovation in partnership with patients and our community.

Tobi Wilson
Chief Executive

Introduction to SESLHD

South Eastern Sydney Local Health District (SESLHD) provides healthcare services across approximately 468 square kilometres, spanning from the Sydney Central Business District down to the Royal National Park. In addition, SESLHD assists with the provision of hospital and health services to residents of Lord Howe Island and Norfolk Island.

The SESLHD Geographic area lies within both the Eora and Dharawal Nations. The area encompasses the traditional lands of five Aboriginal language groups including the Dharawal, Gadigal, Wangai, Gweagal and Bidjigal peoples. Of the estimated 979,370 residents living in the District in 2021, people of Aboriginal and Torres Strait Islander heritage make up approximately 1% of the population, compared with 3% of the NSW population. The overall population of SESLHD is expected to grow 10% to 1,080,291 by 2031.

Whilst the SEIFA Index for Disadvantage for SESLHD is relatively high, indicating that the population is not experiencing high levels of disadvantage, there is a marked discrepancy between various sub-groups of the population in this regard.

The population within SESLHD is markedly culturally and linguistically diverse, particularly in certain areas. Overall, 40% of residents in the District were born overseas, which is higher than the 34 .5% recorded for NSW residents overall.

However, the distribution of residents born overseas is not consistent across the District with over 50% of residents in the Bayside and Georges River Local Government Areas born overseas compared with 18% of Sutherland Shire residents.

Alongside this, 36% of the residents in SESLHD speak a language other than English at home, with the most common languages being Mandarin, Cantonese and Greek. The linguistic diversity of the population is also not spread evenly across the District, with around 86% of residents in the Sutherland Shire speaking English at home, compared to around 44% in Georges River Local Government Area.

The ageing population within SESLHD is growing. It is projected that the population of residents over 70 years of age will grow from 10.9% to 12.9% of the population by 2031. An increasingly ageing population is predicted to increase demand for health services, as older people proportionally utilise health services more than younger people.

Key health issues for the District, other than an ageing population, include diabetes, hypertension, cancer and mental health. With an increasing number of residents being of older age and experiencing long-term health conditions as well as increasing complexity of conditions, demand for health services is anticipated to continue to increase.

Health
South Eastern Sydney
Local Health District

A Day in the Life of SESLHD in 2020-21

625
PEOPLE PRESENT TO OUR EMERGENCY DEPARTMENTS

21
BABIES ARE BORN

21
PEOPLE ARE HOSPITALISED DUE TO FALLS

5,850
NON-ADMITTED OCCASIONS OF SERVICE ARE PROVIDED

363
ADULTS ARE HOSPITALISED FOR ACUTE CARE

Medical
229

Surgical
133

9

PEOPLE ARE HOSPITALISED FOR MENTAL HEALTH CARE

41

PEOPLE ARE HOSPITALISED FOR SUBACUTE AND NON-ACUTE CARE

2 PEOPLE ARE HOSPITALISED DUE TO CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

105
ADMISSIONS COME FROM OTHER LHDs

National Standards and Accreditation

Having been delayed due to COVID-19, SESLHD facilities and services are due to commence accreditation surveys in 2022. Facilities and services will be surveyed by the Australian Council on Healthcare Standards (ACHS) against the eight National Safety and Quality in Health Service (NSQHS) Standards (2nd edition).

Standard One: Clinical Governance

Governance, Leadership and Culture (1.1 – 1.6)

The peak SESLHD governing bodies are the SESLHD Board, Quality and Safety Board Sub-Committee, District Clinical and Quality Council, District Executive Council and District Corporate Executive Council. The District is governed by the SESLHD By-Laws. The Governing Body Attestation Statement, which is required annually for accreditation, was endorsed by the SESLHD Board for 2021 - see Appendix 1 (page 70).

The District Executive Team are responsible for ensuring sound corporate and clinical governance assurance and performance, progress towards delivering the SESLHD key strategies and responding to external demands. The strategic directions of SESLHD are outlined in the Journey to Excellence Phase 2 (2018-21), SESLHD Quality Plan 2021-22 (recently revised), Clinical Governance Framework and the SESLHD Aboriginal Health Implementation Plan. District and facility Business Plans are developed annually in order to operationalise the Journey to Excellence and outline key priority initiatives for the upcoming financial year. The SESLHD Burudi Muru Yagu Committee monitors all local actions to inform safety and quality priorities to address the specific health needs of Aboriginal and Torres Strait Islander people and the Burudi Muru Yagu Aboriginal Health Plan is expected to finalised by August 2021.

The District Clinical Governance Unit (CGU) provides a link between site and service Clinical Practice Improvement Units (CPIUs) and the District Executive Team. CGU provides regular reports to the SESLHD Clinical and Quality Council and Quality and Safety Board Sub-Committee.

Patient Safety and Quality Systems (1.7 – 1.18)

SESLHDHB/19 SESLHD Framework for Policies, Procedures Guidelines and Business Rules guides the development, review, implementation, monitoring and documentation of policies, procedures and business rules. The newly established SESLHD Policy Team monitors these processes through the District Policy Governance Committee. SESLHD has developed a legislative compliance register to ensure that all legislative obligations are managed and reported on. Risks are reported and monitored using the Enterprise Risk Management System (ERMS) with the top clinical risks monitored and reported.

SESLHD Audit and Risk Management Committee provide oversight and monitoring of SESLHD's risk governance and control framework and its' external accountability requirements, while the Quality and Safety Board Committee provides the governing platform for Clinical Risks in line with SESLHD's Clinical Governance Framework. Incident notification, management and investigation occurs in line the NSW Health PD2020_047 Incident Management Policy and Open Disclosure is conducted according to NSW Health Open Disclosure Policy (PD2014_028) and SESLHDGL/058 Open Disclosure. Regular reports inform the governing bodies of data submitted to the Ministry of Health, including Hospital Acquired Complications (HACs), complaints and incident rates and outcomes of investigations.

SESLHD are currently working to implement the Clinical Excellence Commission's Quality Improvement Academy Curriculum. SESLHD uses a range of sources to monitor and act upon patient complaints and feedback (e.g. Care Opinion, Feedback Assist, Health Care Complaints Commission). The District Health Records Committee, Clinical Informatics Committee and Electronic Patient Record Committee oversee health care record management in SESLHD.

Clinical Performance and Effectiveness (1.19 - 1.28)

Formal orientation and ongoing education is provided to all staff through the Health Education and Training Instwitute (HETI) and the SESLHD Organisational Development and Learning team. Staff mandatory training is monitored and reported to the Quality and Safety Board Sub-Committee. People and Culture provide support for staff performance reviews and management, with professional divisions overseeing clinical scope of practice and credentialing. District and facility procedures/protocols/ guidelines/business rules and clinical pathways guide clinical practice, ensuring evidence based best practice care is provided to all patients. The SESLHD Clinical Streams work with clinical specialities within the District to develop best practice guidelines and clinical pathways to reduce variations in practice. Furthermore, Health Roundtable (HRT) and Quality Improvement Data System (QIDS) data enables the monitoring and benchmarking of clinical performance.

Safe Environment for the Delivery of Care: (1.29 – 1.33)

The Work Health and Safety teams provide oversight of the workplace and ensure staff safety. The SESLHD Security, Risk and Governance Committee provides governance, oversight and advice on the implementation of security risk management systems and processes. Maintenance services maintain buildings and respond to staff requests. Health Infrastructure supports redesign and re-development projects which comply with building requirements and include input from staff and consumers. Consumers provide advice for access and wayfinding in facilities. Person centred care principles guide all patient services including visitors' access. Care is provided to people with special needs in purpose built units, for example dementia units are incorporated into aged care departments. COVID restrictions have been put in place to protect patients and staff. A "Guide to Communicating with Aboriginal Communities" has been developed to assist facilities and services to empower local Aboriginal voices to inform policy and programs intended to address local Aboriginal community needs. The Aboriginal Health Unit and Aboriginal staff from local communities provide advice on Aboriginal artwork to be used in all district facilities. Acknowledgement to Country wall plaques have been developed following advice from the two Local Aboriginal Land Councils to appropriately acknowledge traditional custodians.

Standard Two: Partnering with Consumers

Our organisation met all of the requirements for Standard 2 in the previous organisational wide survey conducted in 2018, however the updated standards acknowledge that there are different types of partnership that occur across our complex health system. Consumer partnerships at all levels are necessary to ensure that our health service remains responsive to consumer input and needs.

SESLHD has a broad range of consumer engagement activities occurring from the individual to the system level. At the individual level, partnerships occur between individual patients, their families and carers, and our clinicians in the provision of person-centred clinical care. This enables the involvement of patients, carers and families to achieve the best possible health outcomes. Programs that support our staff in the provision of person-centred care such as the Teach-back Tool, Health Coaching, Advanced Care Planning, and Patient Reported Measures demonstrate our commitment to sharing information appropriately with patients, supporting their own self-care and management. The district also has access to Care Opinion, an online, independent digital platform where anyone can share their stories about their experience of care in a safe and confidential way. Care Opinion provides an opportunity to capture stories from our patients that can support staff to improve services, acknowledge when care provided is of high standard, and provide a rich source of information that will support quality improvement.

At a service level our partnerships draw on the experience of those who have used a service, are currently using a service, or may use it in the future, to improve the service, experience and outcomes for patients, families, carers and staff. Patient Reported Measures (PRMs) including Patient Reported Outcome Measures (PROMS), Patient Reported Experience Measures (PREMS), and Patient satisfaction surveys, support incorporation of the consumer voice in quality improvement and redesign programs and allow opportunities for consumers to participate in or provide feedback in how a service operates, as well as implementing and evaluating changes.

Our major facilities have Consumer Advisory Committees (CACs) chaired by consumers that provide an opportunity to shape the strategic direction of our services. The committees 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. Governance for consumer participation is well supported with two sub committees and a high level working group established at Board level. The SESLHD Quality and Safety Board Committee provides assurance on matters relating to patient safety and clinical quality including patient experience. There are two consumer representatives on this committee, drawn from the facility-based Consumer Advisory Committees. The related Strategic Community Partnerships Alliance engages with community members and agencies to deliver a coordinated and integrated strategic and community partnership approach. The goal is to improve outcomes related to better physical health, and emotional and social well-being outcomes for the community. Standing membership is drawn from local community members, the Department of Communities and Justice, Central and Eastern Sydney Primary Health Network (CESPHN), other external agencies and selected Non-Government Organisations (NGOs).

The chairs of the site and service based consumer advisory committees are also standing members.

SESLHD's model for consumer partnership is outlined in the Consumer Engagement Framework, which is currently in draft and undergoing formal approvals. Sites have also developed local consumer frameworks/strategies.

Patient stories are shared through various avenues, including the SESLHD Quality and Safety Board Committee. It is routine practice for clinicians to work collaboratively with patients and family as care is planned and delivered, consent standards are adhered to and patient feedback is sought and acted upon. The development of written patient information is guided to ensure consumer input and health literacy is addressed. The use of teach-back techniques by trained staff enhances communication with patients and carers.

The Planning and Partnerships team in the Strategy, Improvement and Innovation (SII) directorate include resources to support the maintenance of external partnerships and implementation of the consumer and community engagement framework.

SESLHD sites and services have local initiatives for partnering with consumers. For example, across all Population and Community Health (PaCH) services there is a comprehensive range of consumer and community engagement taking place, as well as a wealth of staff knowledge, expertise and commitment to the consumers and communities within the Local Health District. For example the Oral Health Service (OHS) provides services and promotes dental health to underserved populations across the District. Engagement examples include the provision of a dental mobile van designed primarily to service Aged Care clients in RACFs, an on-site dental clinic located within a Mission Australia residential facility to service people who are homeless (in partnership with the Priority Populations Homelessness Health Program), and the establishment of an Oral Health Service Consumer Consultative Committee to facilitate consumer and community consultation, involvement, collaboration and co-design. Consumers and community members experiencing homelessness are engaged in a meaningful and deliberate manner, including active feedback mechanisms and support to share their personal journey at staff meetings and forums.

Snapshot of achievements over the last 12 months

(July 2020 to June 2021)

SESLHD COVID-19 Pandemic Response

Staff across SESLHD have worked tirelessly over the past 12 months to ensure an effective health system response to the pandemic. Some highlights include:

- **COVID-19 Testing Clinics:** A number of facility and community testing clinics have been established across the district, offering 7 day access to testing. Testing clinics have continued to show adaptability and preparedness, demonstrated through the rapid establishment of pop-up clinics. Since the beginning of the pandemic, the highest testing date on record for SESLHD occurred during the Bondi outbreak in June, where the district processed 1,953 tests in one day.
- **Respiratory Protection Program (RRP)** – Fit Testing: SESLHD introduced Fit Testing as part of the state-wide Respiratory Protection Program (RPP) led by the Clinical Excellence Commission (CEC) to ensure health care workers are able to work safely and be protected against the exposure to respiratory pathogens. As at 30 June 2021, over 4,000 staff were fit tested, of which 96% successfully achieved a fit test pass.
- **St George Vaccination Hub:** Established in March 2021, the vaccination hub administered over 30,000 vaccinations by the end of June 2021.

Wellness Checks at War Memorial Hospital

This was an initiative to connect with clients to prevent avoidable hospital admission and deterioration during the COVID-19 pandemic. The project aimed to reduce the chances of clients deteriorating in the community due to social isolation, reduced formal and informal supports, and reduced uptake of regular health services including GP and specialist visits. The project involved developing processes for wellness checks (letters, phone calls), providing tools for clients, a questionnaire for clinicians to utilise, and a qualitative project evaluation. More than 1,023 calls were made to 474 patients between March and May 2020, including clients deemed at-risk on wait lists, current clients, and those discharged within the last six months from both the inpatient, outpatient, and community settings. The program received 'highly commended' recognition through the ACHS Quality and Safety Awards.

Roll out of new NSW Health Incident Management Policy and ims+

In 2020, a new incident management system (ims+) was rolled out across NSW Health. The system had a successful launch in SESLHD on 17 August 2020. Over 8,500 SESLHD staff have completed the notifier training and over 600 staff have completed the manager training. As at 16 June 2021 there have been 18,968 incidents reported in ims+.

In December 2020, the new NSW Health Incident Management Policy (PD2020_047) was released across the state. The revised policy introduced a number of mandatory process changes. The SESLHD Incident Investigation Improvement Working Party successfully implemented the policy in the District and continues to explore options for improving incident management

Patient Experience

A number of initiatives have commenced or continued in 2020/21 to capture, monitor and act on consumer feedback to improve the patient experience. Examples outlined in this year's Safety and Quality Account include the Patient Reported Measures (PRM) Program, the Real Time Patient Experience Surveys (RTPES) at Prince of Wales Hospital, Care Opinion, and Emergency Department Patient Experience Officers.

Wound Warrior Program – The Sutherland Hospital

Aiming to upskill nursing staff across the organisation in basic wound care knowledge, the program provides mentorship and leadership to enhance nursing workforce capability. The program aimed to reduce harm and promote best practice in wound care, skin integrity and pressure injury prevention and management, as well as promote wound healing and prevent chronicity of wounds to reduce hospital stay and prevent re-admission due to poor management. As a result of the program, The Sutherland Hospital had zero Pressure Injury Hospital Acquired Complications from December 2019 to November 2020. There has also been an improvement in Wound Care documentation and management.

NSW GOVERNMENT | Health
South Eastern Sydney
Local Health District

Journey to Excellence 2018 – 2021

The **Journey to Excellence 2018-2021** is the District's strategic plan. This document outlines our key strategic priorities for achieving SESLHD's fundamental purpose and vision.

Our Purpose: To enable our community to be healthy and well; and to provide the best possible compassionate care when people need it.

Our vision: Exceptional care, healthier lives.

Journey to Excellence achievements

During the life of this strategy, amazing progress has been made towards the goals and targets set out in the five strategic priorities. At the Consumers and Partners Forum held in April 2021, SESLHD Chief Executive, Tobi Wilson, delivered a presentation outlining key Journey to Excellence achievements. Some these included: Take Home Naloxone Programme (Drug & Alcohol Service), Racism Harms: Act On It, Telehealth, Prince of Wales (POW) Hospital Integrated Acute Services Building, The Sutherland Hospital Redevelopment, St George Hospital Stage 3, COVID-19 response, Royal Hospital for Women fertility service, Shisha No Thanks, Microbiome Research Centre, NSW Telestroke Service, Advanced Recovery Orthopaedic Program (AROP) at Prince of Wales Hospital and Diabetes Dashboard.

During this journey of transformation, SESLHD has strived to build local capacity and capability with a vision of improving systems and support for value-based change and improvement. Our ambition is to continue to strengthen and build SESLHD as a learning organisation in order to deliver safe, quality and compassionate patient care.

A time of transition

With the Journey to Excellence Strategy 2018-2021 coming to an end, preparations for the development of the next Strategic Plan are now underway. The new strategy will aim to build on the achievements from the Journey to Excellence and respond to the challenges facing today's clinicians, patients and leaders.

Following initial sessions with SESLHD Executives and Board members, in April 2021 a consumer and partners forum was held, bringing together a diverse and representative group of consumers and partners to help understand community experiences and expectations to inform the District's next strategy. Representatives from consumer advisory groups attended, along with partners including Central and Eastern Sydney Primary Health Network, local councils, NSW Police, La Perouse Local Aboriginal Land Council and UNSW Sydney. Delegates were supported by leaders from our sites and services to share their experiences and thoughts on the future priorities for SESLHD.

A number of forums are scheduled for the rest of 2021 in order to ensure everyone has a say in shaping the 2022-2025 strategy and future directions of SESLHD. The Strategic Plan is due to be published in December 2021.

Quality Planning

South Eastern Sydney Local Health District (SESLHD) Quality Plan

The SESLHD Quality Plan is aligned to the SESLHD Strategic Plan – the Journey to Excellence and is underpinned by the CORE values of NSW Health.

With the SESLHD Quality Plan 2017-2020 coming to an end in December 2020, teams have been hard at work to develop a refreshed Plan. In order to ensure strategic alignment, a shorter term Quality Plan was drafted until the new District strategic plan is completed (expected to be published in December 2021). Accordingly, the SESLHD Quality Plan 2021-April 2022 was published in early 2021. The Plan outlines SESLHD's commitment to providing safe, quality, compassionate care through:

Quality Assurance:

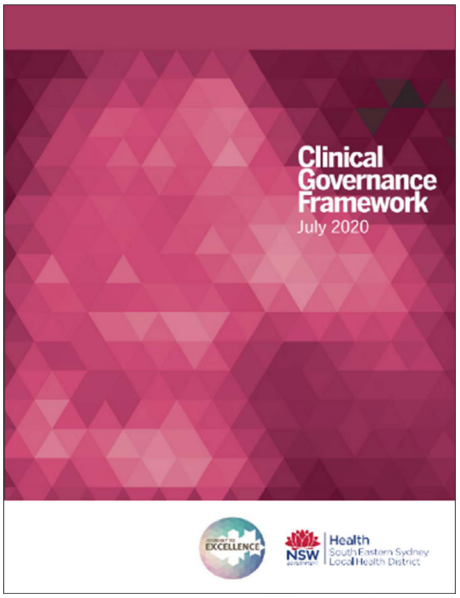
- Incidents and Complaints Management & Monitoring
- National Standards and Accreditation
- Audits of Clinical Practice
- Safety and Quality Key Performance Indicators
- Death Screening and M&M

Quality Improvement:

- Patient Safety
- Quality Improvement
- Person-Centred Care

The plan also outlines the systems in place for quality assurance, use of data and information for improvement, safety/ quality activities underway, priority areas, patient centre-care, and outlines a range of measures to which performance will be monitored.

Sites have also developed local quality plans to outline and plan local objectives, initiatives, and areas of focus.



South Eastern Sydney Local Health District (SESLHD) Clinical Governance Framework

Underpinning the Quality Plan, the SESLHD Clinical Governance Framework is the primary overarching clinical governance document. It describes the organisational systems and structures in place that ensure all staff are responsible for the safety and quality of patient care through effective risk management and continuous improvement.

The framework describes the levels of clinical governance accountability from frontline staff to the Board and is underpinned by the principles of the NSW Health Patient Safety and Clinical Quality Program including openness about failure; emphasis on learning; obligation to act; accountability; just culture; appropriate prioritisation of action and team work.

The key components of the Clinical Governance Framework include:

- Education: Incident management training, risk management training, and improvement science education.
- Quality Improvement Systems: Incident Management, Consumer Feedback, Death Review, Leadership walk-arounds, Policy Management, Consumer engagement, Indicator reviews, Risk Management and Safety Alerts.
- Internal Governance: Committee structure and organisational structures.
- External verification: Accreditation and Ministry of Health Key Performance Indicators.

An identified key priority of the 2021-22 SESLHD Business Plan is the development of a District Clinical Services Plan. The SESLHD Clinical Services Plan will be developed in broad consultation, complementing existing plans and reflecting a District wide approach to service delivery. Development of the plan sits within the Strategy, Innovation and Improvement directorate.

Update on 2020/21 Priorities

Priority 1: Priority populations (including Aboriginal and Torres Strait Islander people and people who speak a language other than English)

Aboriginal Health

A key identified priority from the 2020-21 SESLHD Safety and Quality Account was the quality and safety of care delivered to Aboriginal and Torres Strait Islander people. Over the past 12 months SESLHD has worked hard to increase attention and accountability through a strategic revision of Aboriginal Health Governance. This has included:

- Highlighting sites within facilities and services where outcomes by Aboriginality are reviewed
- Four performance indicators to be addressed at facilities (especially Emergency Departments) and services are:
    - Increase reporting of Aboriginality
    - Discharge or Leave against medical advice
    - Unplanned readmission within 28 days
    - Respecting the Difference compliance in Face to Face training

Pleasingly, the District has either made progress or performed well in these areas:

- Mental Health follow up within 7 days
- Fully immunised at 5 years of age
- First ante-natal care before 14 weeks

Addressing Racism

Priority Populations and The Aboriginal Health Unit have collaborated to develop an 'Addressing Racism' strategy and implemented this training. This training commenced in 2020 and will continue to be provided. A 'train the trainer' educational package and suite of resources have been developed, as supported by the District Executive in District Leadership forums, livestreams by the Chief Executive and ongoing training opportunities. The video and education package has reached 635 staff over 47 sessions delivered up until 28th June 2021.

Aboriginal Cultural Engagement Audit

In 2020, all facilities and services undertook an Aboriginal cultural engagement self-assessment audit, which will now be conducted on an annual basis. This project was supported by the District Clinical Governance Unit and all facility Safety and Quality Managers. The results inform a strategic assessment of the Districts approach to Close the Gap in Aboriginal Health outcomes that are now observed in an Annual Aboriginal Health report card with a focus on accountability at multiple levels.

Two further foundational initiatives to inform cultural responsiveness of services include:

- Cultural Awareness Training: A review of the training package and development of a role to provide Respecting the Difference training has been undertaken. Recently this training was provided by an external consultant.
- Aboriginal Workforce Review: A review of Aboriginal workforce has provided the District Leadership Team and Managers insight into retaining, supporting, recruiting and developing Aboriginal staff. Consideration of approaches to increase Aboriginal workforce across all services and facilities has been led by the District Executive, the Directorate of People and Culture, and supported by the Aboriginal Health Unit. A focus on this has been discussed at all senior leadership committees and an analysis of selected government organisations has been undertaken, including other LHDs that have performed well in respect to Aboriginal workforce.

SESLHD Burudi Muru Yagu Aboriginal Health Plan and Aboriginal Health Governance

The South Eastern Sydney (SESLHD) Aboriginal Health Plan Implementation Committee was formed to lead and monitor the implementation of the plan across the District in 2013. In 2020 a revision of this was undertaken and a culturally appropriate name was selected by the Aboriginal Health worker staff; Burudi Muru Yagu means Better Path Today in the Sydney (Dharug) language. This was accompanied by a review of the Governance of Aboriginal Health in SESLHD during 2020. Aboriginal Health has been identified as 1 of 4 key principles to underpin initiatives following the District Leadership Forum in August 2020. The Aboriginal Health Unit has been invited to present and discuss approaches to more effectively Close the Gap in Aboriginal Health outcomes with a focus on specific Key Performance Indicators that consider outcomes by Aboriginality at committees including District Executive, Clinical Streams and Clinical and Quality Council, Emergency Department streams, and has been embedded across SESLHD Business Planning and Priority Community Collaborative initiatives (First 2000 days, Violence, Abuse & Neglect, Towards Zero Suicides, and on a Continuum of Care).

Cross Cultural Workers (CCWs) Service in Maternity and Child & Family Health Services

In 2018, there were 10,140 births in SESLHD, 38% of women were born overseas, of which 33% were from a non-English speaking country (n=3327). Women from migrant and refugee backgrounds are at increased risk of suboptimal perinatal outcomes and experience inequities in access. The importance of services meeting their needs is recognised internationally as a public health priority. The CCW Service has provided a unique response to this need since 2017 following community consultations and data review.

The Cross Cultural Worker Service is an initiative unique to SESLHD. The CCW Service supports women and families from migrant and refugee backgrounds to navigate maternity, child and family health (CAFH), and community-based services, enabling early and ongoing engagement across the continuum of pregnancy to a child reaching 5 years of age. The CCWs work collaboratively with health services, Non-Government Organisations, local communities, and agencies to provide culturally responsive, person-centred, integrated care across the continuum of pregnancy to parenting.

The CCWs have achieved a high level of engagement across a range of SESLHD services and external agencies, working collaboratively to develop alternative ways of responding to current and predicted needs of women and families from migrant and refugee backgrounds. This includes activities focused on enhancing health literacy, early access, psychosocial screening, interpreter use, cultural parenting practices, and sexual and reproductive health. The CCW Service directly aligns with the NSW Health First 2000 Days Framework, Henry Review, NSW Health priority of Leading Better Value Care, SESLHD Journey to Excellence, SESLHD Priority Communities Collaborative Work Plan, State and National policies and International literature.

During the 15-month period, 1 February 2020 to 30 April 2021, 1622 clients have been supported. The effectiveness and acceptability of the model is evaluated from the perspective of women, their partner, service providers, and impact on maternal and infant health outcomes. Surveys and interviews with women are conducted in pregnancy, 6 and 12 months postpartum, and surveys of partners when their baby is 6 months old. Surveys and interviews occur with service providers at 18 months post implementation. Preliminary findings (n=103) highlight a high degree of satisfaction. Women reported a positive impact on their maternity experience (95%), increased understanding of pregnancy, birth and parenting (100%), and would recommend the Service to friends/family (99%). Service providers perceived the Service to be critical to improving women's experience and satisfaction with care, reducing barriers to access, with the potential to improve perinatal outcomes. These results align to the Integrated Value Based Care Award.

Priority 2: Safety Culture

Over the past 12 months, a number of initiatives have continued or commenced to ensure a culture of safety exists in the organisation.

Incident Investigation Improvement Project

In late 2020, the implementation of ims+ and the new NSW Health Incident Management Policy presented the opportunity for SESLHD to re-think, strengthen and improve existing incident management processes and practices. Further, it was identified that the changes presented a broader opportunity to review incident investigation training, culture, accountability and staff capacity. In December 2020, SESLHD launched the Incident Investigation Improvement Project to work toward these goals. A working party was convened, with members representing their respective facilities and services to provide advice and contribute to the overarching goal of enhancing incident investigations in SESLHD by ensuring processes:

- are compatible with the ims+ system
- are compliant with the new NSW Health Incident Management Policy
- embed a closed loop incident investigation process with strong recommendations
- foster a culture and system of continuous safety and quality improvement.

The Incident Investigation Improvement Working Party is tasked with the following objectives:

- Embed the required changes under the new NSW Health Incident Management Policy into SESLHD practices
- Ensure that robust recommendations are formulated out of incident investigations
- Ensure incident investigations are completed within mandated timeframes
- Ensure staff capability across the District to conduct investigations and ensure novice investigation team leaders are supported
- Identify barriers to conducting effective serious incident investigations
- Ensure investigation recommendations are implemented in a timely and sustainable manner
- Provide support for monitoring and reporting of serious incident types

Key achievements so far include completing an analysis of SESLHD clinical incident themes and recommendation strengths, conducting surveys of past investigation team members to identify challenges and ideas for improvement, and implementing process changes required under the new policy. The project and working party continue to work towards its objectives and ultimately keep our patients safe.

Root Cause Analysis (RCA) Team Leader Training

In September 2020 the Clinical Governance Unit, along with a number of experienced Patient Safety Managers from across the District, ran a two-day RCA Team Leader course. The training was targeted at SESLHD staff with an interest in improving patient safety. The training aimed to increase clinical incident investigation capacity in SESLHD and ultimately ensure serious incidents are thoroughly investigated, with strong recommendations and in accordance with incident management policy. The training also introduced changes to the NSW Health Incident Management policy. The training consisted of both theory and practical group exercises, with the agenda focusing on:

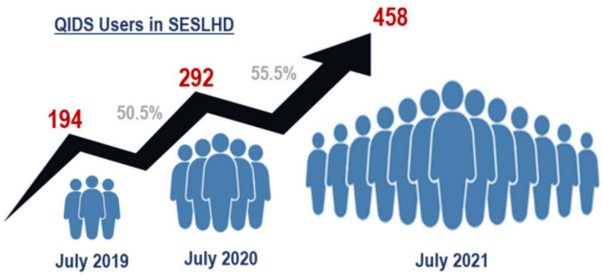
- An overview of incidents in healthcare
- Human factors
- Preliminary Risk Assessments and Open Disclosure
- Reportable Incident Briefs (RIBs) and timelines
- Team meetings
- Identifying primary causes and causation statements
- Recommendations
- Professional conduct issues

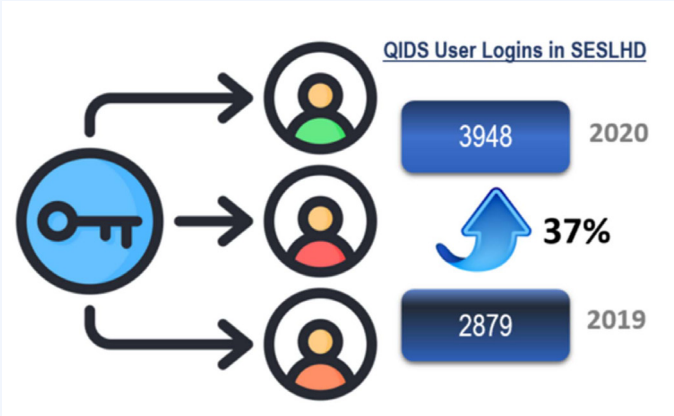
The training was a big success, with 20 participants from across SESLHD successfully completing the course. A course evaluation indicated that 82% of participants agreed (or strongly agreed) that after completing the training, they had the skills to lead an RCA investigation.

Safety and Quality Performance Dashboards

QIDS
Quality Improvement Data System

Improving SESLHD's safety performance is a team effort that starts with a number of metrics that can be monitored and measured to understand where the initiatives will have most impact. QIDS (Quality Improvement Data System) provides SESLHD staff with a single point of access to information and tools for the purpose of improving the quality and safety of health service delivery.





SESLHD facilities use this analytics platform to translate raw data into insights as trends over time, unwanted clinical variations and outcome measures of improvement innovations. There is continuous interest from staff to get access, learn this system and generate reports that will assist in improving safety and quality performance.

SESLHD had a 55.5% increase in the number of QIDS users in 2021 when compared to the previous year. Staff logins went up by 37% showing that the system was used more frequently than before across the District. More than 20,500 reports were generated within SESLHD and used for monitoring safety and quality performance in the last calendar year 2020.

Monthly Statistics Dashboard – Royal Hospital for Women (RHW)

eMaternity is the electronic medical record (EMR) for all maternity patient encounters. All antenatal and postnatal admissions will have a summary of each episode in eMaternity.

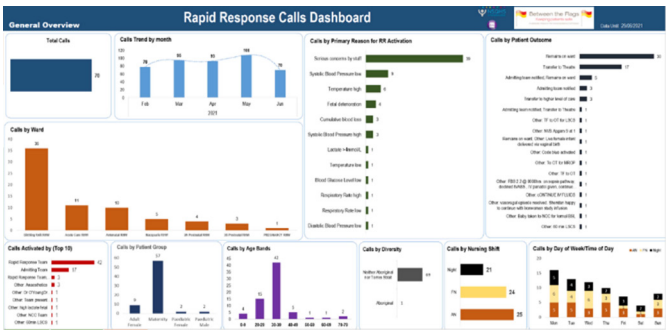
In November 2020, as part of RHW Maternity Service Resilience Improvement Project, the SESLHD Clinical Governance team and the key stakeholders at RHW developed a dashboard to enhance data and analytic capability that influences safety culture and resilience of maternity services and staff. The data source for the dashboard is from eMaternity, specifically designed to extract close to real time RHW birth outcome statistics.

The dashboard will assist clinicians with systematic review of clinical data including rates trended with the use of Statistical Process Control Charts. Also, it provides staff with more insights and narratives for easy identification of normal versus special cause variations.

Staff at RHW expressed that the dashboard enabled them to understand how well they are performing clinically, and provided further support in redirecting their focus and energy for routinely studying areas requiring improvement and innovation.

BTF - Rapid Response Calls Dashboard

The Between the Flags (BTF) system is a 'safety net' for patients who are cared for in SESLHD facilities. This protects patients from unnoticed deterioration and ensures appropriate care is provided if they do. SESLHD facilities moved from the PACE system to BTF in late 2019. The BTF system is designed for early intervention in the process of patient deterioration with two key actions, namely Clinical Review and Rapid Response. In February 2021, SESLHD Clinical Governance along with the Clinical Emergency Response CNCs developed a dashboard that provides an analytics platform for data deep dive in to Rapid Response Calls across SESLHD facilities.



The data for the dashboard is sourced from the rapid response form completed in eMR. The dashboard provides staff with trended data to identify the variations in the number of calls by month by facility, ward, time, week day along with more information on primary reasons, age band, patient outcome and recurrent calls. CERS staff across SESLHD facility expressed this dashboard is a great advantage in assisting them with the further analysis that they had wanted for many years.

NSQHS STANDARDS

Measuring and improving safety culture in a major teaching hospital using the Safety Attitudes Questionnaire

The Safety Attitudes Questionnaire (SAQ) is a validated tool from the University of Texas and is recommended by the Clinical Excellence Commission (CEC) as a useful tool for benchmarking and measuring safety climate within healthcare.

The aim of the questionnaire was to identify a baseline measurement of Prince of Wales Hospital (POWH) staff's safety attitudes at an individual ward/unit/department and organisational level in order to identify a safety culture. The first objective was to establish this baseline safety attitudes score through the six components of the questionnaire that influence clinical practice including: safety climate, work conditions, team work, perceptions of management, job satisfaction and stress recognition. The second objective was to use the safety measurements to monitor current quality and safety initiatives and guide future practice.

The first objective was measured by a 30% response rate for the organisation, clinical service and each individual participating ward/unit/department. The second objective was measured through the development of reports and facilitated feedback sessions which are focused on action planning. POWH will complete this process by June 2021 with a repeat of the cycle again commencing in October 2021.

Planned Future Safety Culture Initiatives

Work for these initiatives is planned to continue into 2021-22. Furthermore, District-wide implementation of a Safety Attitudes Questionnaire is planned in order to complete a baseline measure of SESLHD patient safety culture and identify appropriate actions using a validated tool - the Safety Attitudes Questionnaire (SAQ). The SAQ measures the components that influence clinical practice including organisational factors such as safety climate, work environment aspects such as staffing, management, teamwork and supervision and individual staff influences such as risk perception, job satisfaction and stress recognition. This piece of work is currently in the engagement and preparation phase, with the establishment of SESLHD Governance Multi-Disciplinary Team group. Next steps include survey distribution, establishing baseline measures of patient safety (captured at unit, facility and LHD level), distribution of result workbooks to all units with agreed response rate, and then local development of action plans.

Priority 3: Comprehensive Care

Comprehensive care is defined by the Australian Commission of Safety and Quality in Health Care as the delivery of coordinated care that is required or requested by a patient to meet their individual healthcare needs. Comprehensive care aims to ensure that patients are assessed for risk of harm and that these risks are managed through targeted strategies. The rollout of the Continuum of Care Framework described in the 2020-21 SESLHD Safety and Quality Account commenced and a number of the proposed initiatives have made great progress over the past 12 months.

Continuum of Care

The SESLHD Continuum of Care framework underpins our approach to comprehensive care for patients with chronic conditions and aims to help patients achieve healthier lives through greater flexibility, choice and access to healthcare. The Continuum of Care framework links virtual care and integrated care, two of the key systems required for coordinated care across primary, community, ambulatory, short stay and specialist inpatient settings.

Reporting to the Clinical and Quality Council, the Continuum of Care Steering Committee has been formed to progress a range of District initiatives relating to Continuum of Care. Reporting to this Committee, sub-committees and working parties are being convened to support these objectives: Diabetes Management Committee, Heart Failure Management Committee, Virtual Care Working group and Integrated Care Working Group.

Diabetes and Cardiac Models of Care

Diabetes pilot model of care:

The Medicine Clinical Stream has mapped the optimal diabetes patient journey and identified future areas of focus for diabetes care. The Diabetes Dashboard has been successfully piloted at POWH with plans to roll out to other SESLHD facilities to begin. A Diabetes Governance Committee has been convened and will oversight the priorities. The work around the diabetes model of care has been carried forward on the 2021-22 Business Plan to continue momentum.

Cardiac pilot model of care:

The Cardiac and Respiratory Clinical Stream have undertaken a desktop review and stakeholder mapping exercise across Cardiac Services in SESLHD and determined the key district wide focus will consistency of care for patients with Heart Failure living in the community. In partnership with the University of NSW, POWH is testing the use of a mobile phone app for patients who are living in the community with Heart Failure. The aim of the Remote Monitoring Service is to identify when patients with heart failure are starting to become unwell so that the treatment can be adjusted with the goal of preventing further deterioration and admission to hospital. The cardiac pilot model of care will continue as part of the 2021/2022 Business Plan with a focus on broadening the use of the application and remote monitoring service for patients with heart failure to other cardiac services across the district.

Virtual Health

The SESLHD Virtual Health Strategy 2022-2024 has been developed using a consultation and co-design approach. Over 270 stakeholders were engaged from our consumers and partner organisations to a range of SESLHD staff including staff working in five priority cohorts, Cardiac, Diabetes, Mental Health, Respiratory and Aged Care. The Virtual Health Strategy is one of the key SESLHD priorities and incorporates a three-year implementation road map to guide our work.

The SESLHD Virtual Care Centre (VCC) that will incorporate district wide functions for central access, referral management and remote monitoring is a key component of the Virtual Health Strategy. We have started the process of establishing an innovation partnership for the VCC and planning is underway for the infrastructure and technology needed.

Virtual health in the Pandemic

With the surge in COVID-19 cases in NSW, SESLHD responded to ensure patients who tested positive for COVID-19 care could be safely cared for in the community. Planning for the rapid implementation of a COVID-CMC (Community Management Centre) was prioritised. The structure of the COVID-CMC is aligned to the proposed structure of the VCC described in the Virtual Health Strategy with a central intake and triage service and a remote monitoring service (RMS).

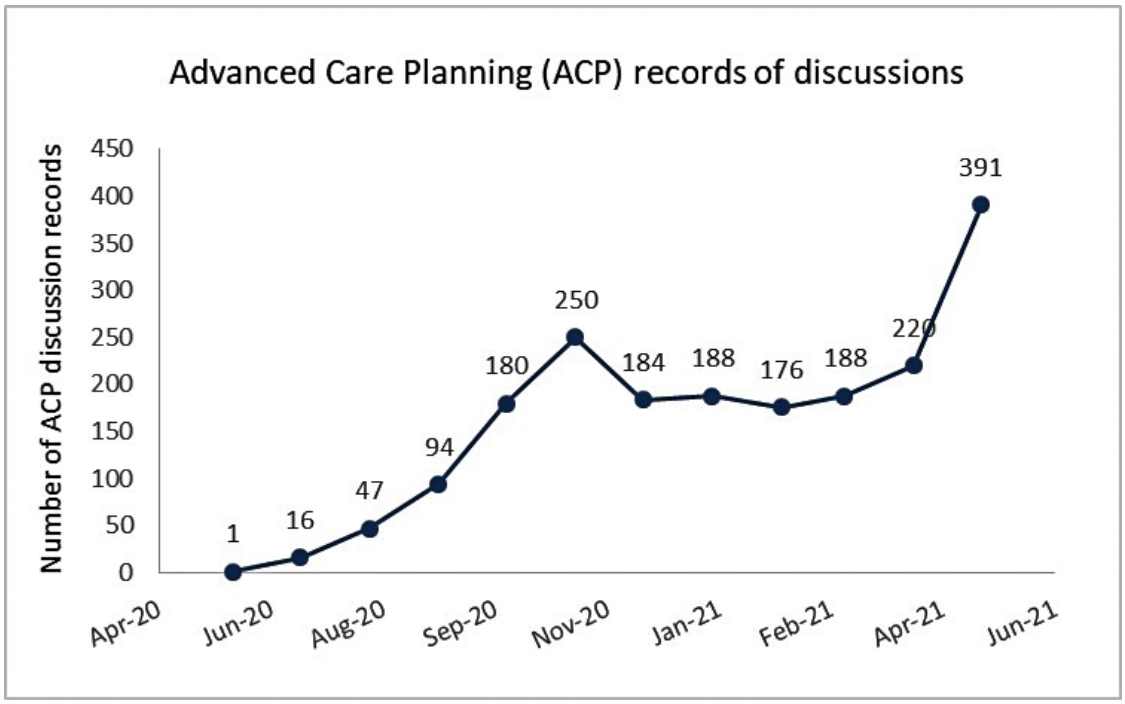
Virtual care models already in use across SESLHD including telehealth platforms and remote monitoring concept were instrumental in allowing safe COVID Community care. Utilising the same technology as the cardiac app, a COVID app was designed and activated to allow patients with COVID-19 in the community using a remote monitoring service. Telehealth platforms become a core part of care delivery for both COVID care and for routine clinical care for suitable patient groups. Telehealth communications aimed to enhance awareness of the available telehealth platforms, provide training for administration teams and clinicians and improve the public facing information for patients about how to access telehealth. Telehealth platforms have also been utilised to connect admitted patients with their family members at home. Evaluation of experience through the introduction of a patient reported measures survey will help refine and improve our use of telehealth in the coming 12 months. Models for ‘e-Consultation’ have commenced in clinical settings across the District including intensive care and neonatal units, emergency departments and COVID-19 inpatient wards.

The response to COVID-19 case surge has resulted in some of the initiatives highlighted in 2020-2021 quality account, including Integrated view of the community services, electronic discharge services and secure messaging, being postponed. The postponed initiatives will be revised and considered in conjunction with our learnings from standing up the COVID CMC as we transition from providing acute COVID care at scale, to continuing the implementation of our Virtual Health Strategy and the SESLHD Continuum of Care Framework.

Advance Care Planning

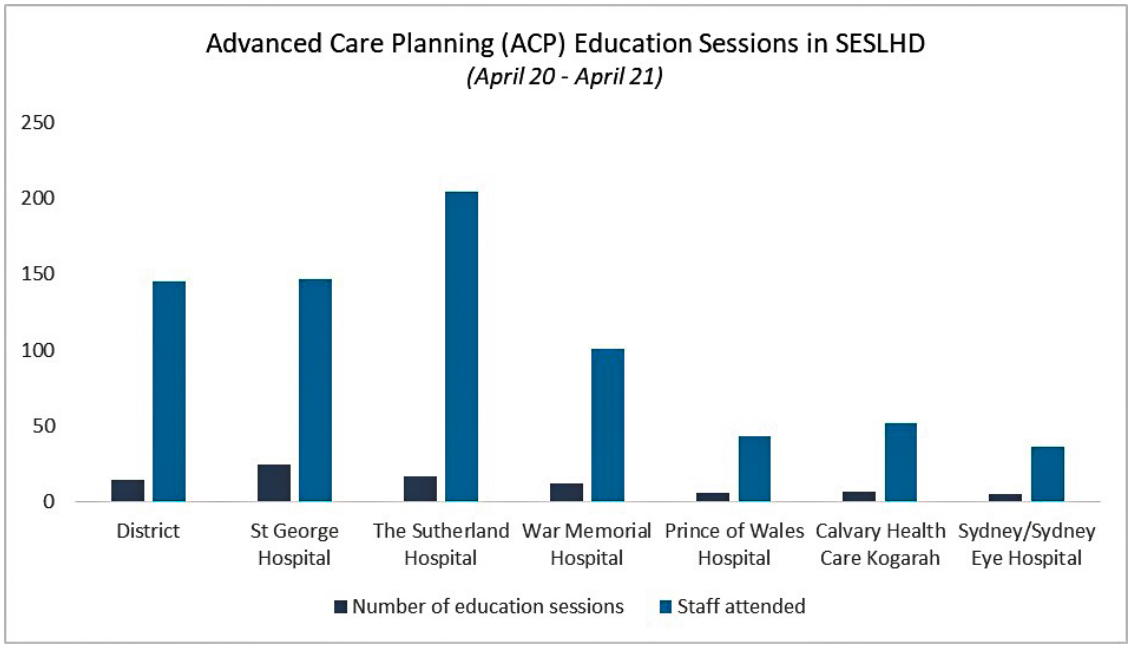
From April 2020 to June 2021, the SESLHD Cancer and Palliative Care Stream funded a nursing position to improve the governance and education of staff in Advance Care Planning. As part of the initiative, a SESLHD Procedure was developed to upload Advance Care Planning (ACP) documents into patients' Electronic Medical Record (eMR). As part of this, a flowchart was developed on the Upload Procedure for staff to have an 'on hand' resource. In order to facilitate monitoring of documents for compliance prior to upload, a QIDS (Quality Improvement Data System) database was developed. The SESLHD Upload Committee was established and meets bimonthly to review and monitor compliance of documents submitted for upload according to the 'Upload Procedure'.

A 'Record of Advance Care Planning' free text field was also developed in eMR for staff to document an ACP discussion. The information saves in four documentation areas to ensure this important information is not missed. A QARS (Quality Audit Reporting System) database was also developed to monitor data related to upload, education and use of the Record of Advance Care Planning Discussion free text field. The data has shown good usage in busy acute clinical areas, such as Aged Care and Palliative Care. Between 1 July 2020 and May 2021, over 1,900 Advanced Care Planning (ACP) records of discussions have been entered in eMR. Rates of recorded ACP discussions per month are increasing, as shown below:



The QIDS (Quality Improvement Data System) and QARS data is provided to the SESLHD End of Life (EoL) and Palliative Care Governance Committee. Prince of Wales, St George and The Sutherland Hospitals have established EoL Committees where the Advance Care Planning data, improvements and issues are tabled.

An ACP Guideline was developed for staff to understand key definitions, roles and responsibilities of staff, having ACP discussions, and resource order details. Furthermore, ACP resources have been added to the Stream solutions order catalogue. SESLHD staff have been educated on Advance Care Planning, Advance Care Planning discussions and the new Record of Discussion field. Between April 2020 and April 2021, 89 education session sessions were delivered in SESLHD to over 700 staff.



The next steps for this initiative include:

- Implementing the 'Amber Care Bundle' and develop a QARs table to monitor use
- Implement the use of Recognition of End of Life Trigger tool and monitor use
- Continue to educate to embed Advance Care Planning into normal care.

Achievements in Safety and Quality

SESLHD COVID-19 Pandemic Response

SESLHD St George Vaccination Hub

In March 2021, SESLHD established a COVID-19 Vaccination Hub at St George Hospital (SGH COVAX Hub), with an initial focus on priority populations as part of the national rollout strategy. Included in this cohort were quarantine and border force, high risk healthcare workers, aged care and disability care. The hub initially operated 5 days a week during regular business hours administering the AstraZeneca vaccine.

By June 2021, the SGH COVAX Hub had evolved significantly, introducing the Pfizer vaccine to become a dual vaccination hub, and extending operating hours to 7 days a week. The vaccination team at the SGH COVAX Hub continue to play an integral part of the COVID-19 response, expanding their service to support a number of priority populations, including: Georges River Council, Garrawarra Centre, local Aboriginal Communities, Disability, Homelessness, Lord Howe Island and vulnerable high risk inpatient groups. The SGH COVAX hub has administered over 30,000 COVID-19 vaccinations to the end of June 2021, with a record high of 1,060 doses administered in a single day.

Respiratory Protection Program (RRP) – Fit Testing

The COVID-19 pandemic has highlighted the need to ensure health care workers are able to work safely and be protected against exposure to respiratory pathogens. In response, SESLHD introduced Fit Testing as part of the state-wide Respiratory Protection Program (RPP) led by the Clinical Excellence Commission (CEC). Fit Testing is a validated method that can reduce the risk of infection in healthcare workers by determining the brand and size of respirator that provides an adequate seal on an individual's face. Commencing in October 2020, SESLHD saw 21 staff successfully complete the Fit Test Assessor Training. These staff have dedicated their time to the program, offering fit testing to priority health workers, and by 30 June 2021, over 4,000 staff were fit tested of which 96% successfully achieved a fit test pass. The next phase of the RPP program will focus on building fit test assessor capacity and capability across the district through the introduction of a Train the Trainer model, of which will support program sustainability.

COVID-19 Testing Clinics

An essential component of the COVID-19 response is high testing rates, particularly at times where there is community transmission. A number of facility and community testing clinics have been established across the district, offering 7 day access to testing for the community. Throughout the duration of the pandemic, the clinics have implemented a number of changes to improve the experience for the community, including the introduction of a QR code system to support the delivery of quick results. In addition to this, the testing clinics have continued to show adaptability and preparedness demonstrated through the rapid establishment of pop-up clinics in circumstances where there is high population testing demand due to community transmission. To the end of June 2021, the highest testing date on record for SESLHD occurred during the Bondi outbreak in June 2021, where the district processed 1,953 tests in one day.

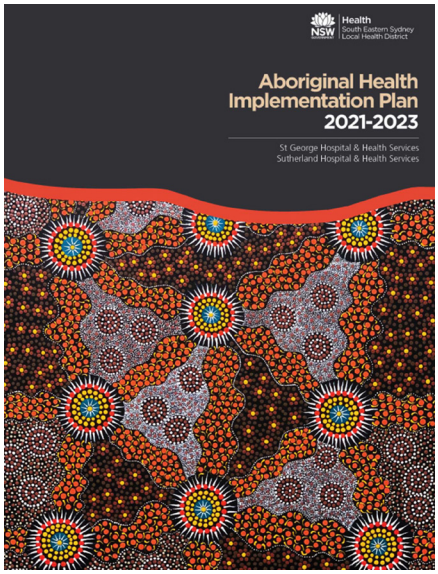
The district has also established a number of partnerships with the private pathology providers that has resulted in additional community testing clinics opening up in temporary arrangements for higher risk communities. Outside of the testing clinics, SESLHD has also developed a COVID-19 on-call swabbing roster that supports access to testing for high risk groups in scenarios outside business hours. It is this quick action and responsiveness that has been pivotal in minimising the spread of COVID-19, made possible through strong leadership and coordination, and a willingness and commitment from our staff to keep our community safe.

Door Screening

The COVID-19 Door Screeners have provided vital support to the health system to bolster SESLHD's response to COVID-19 as part of the commitment to achieving optimal patient outcomes and the best possible healthcare experience. The Door Screening Officers are located across the hospital campuses and have the important task of screening every patient, visitor and staff upon entry, checking for any COVID-19 symptoms and recent travel to exposure sites. Being faced with continuous changes to health screening advice and visitor restrictions, as well as operational changes, for example the implementation of QR code for screening, these staff have shown a tremendous level of flexibility and resilience throughout the pandemic. Our Door Screeners have been key in helping to limit the spread of COVID-19 and minimise infection risk to the wider community, but above this, it is their consistent warm, friendly and helpful presence that has truly stood out in these challenging times.

Aboriginal Health Implementation Plan 2021-2023 for St George Hospital and The Sutherland Hospital

The Aboriginal Health Implementation Plan (AHIP) 2021-2023 for St George Hospital (SGH) and the Sutherland Hospital (TSH) identifies a range of strategies and actions aimed at developing and enhancing a culture of sustainable, culturally informed practice. This plan focuses on improving health and wellbeing outcomes for Aboriginal people attending our health services. It builds upon the previous Aboriginal Health Action and Implementation Plans, and is consistent with NSW Health and South Eastern Sydney Local Health District's (SESLHD) strategic direction for Aboriginal Health.



The plan outlines six strategic directions to drive the changes needed within the health system that will lead to improvement in Aboriginal health outcomes:

- Building trust through partnerships
- Implementing what works and building the evidence
- Ensuring integrated planning and service delivery
- Strengthening the Aboriginal workforce
- Providing culturally safe work environments and health services
- Strengthening performance monitoring, management and accountability

The AHIP has been implemented to address gaps and help improve health and wellbeing outcomes of Aboriginal People within St George and Sutherland Hospitals. Some of the improvements and achievements include the following:

- A newly established SGH/TSH Aboriginal Health Implementation Committee with multidisciplinary staff and chaired by the General Managers to oversee the implementation and monitoring of the Plan. Deliverables and outcomes are then reported through the appropriate governance channels and committee structures.
- Recruitment of an additional Aboriginal Health Liaison Officer (AHLO) position/ resources to support the position at SGH and TSH is underway.
- Aboriginal cares rooms have been established at SGH and TSH that can be used for Aboriginal specific purposes, such as case conferences and meetings for our Aboriginal patients, carers and their families.
- Aboriginal artwork and posters and Acknowledgment to Country plaques are displayed at both hospitals.
- Aboriginal flags and flags poles at both hospitals.
- A range of training opportunities to improve staff knowledge and awareness of Aboriginal culture, history and healthcare are offered to staff.
- Project is currently underway to raise staff awareness of the importance of 'asking the question about identification'
- Celebrations of key events including NAIDOC week and Close the Gap are held annually.
- Aboriginal patient surveys are handed out to all patients by the Aboriginal Hospital Liaison Officer.
- In 2018/19, 376 hospital separations at TSH and 372 hospital separations at SGH were recorded for people who were identified as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander. Bed days recorded were 1,713 at TSH and 2,459 at SGH.

Emergency Department key findings for patients identifying as Aboriginal in 2019 are:

- Demographic profile is significantly younger than those who have no identified Aboriginal status
- 2% of ED patients at TSH identified as Aboriginal and 1% at SGH
- At TSH, Aboriginal patients had higher rate of 'Departed – Left at own risk' compared to the Non-Aboriginal population (5.5% compared to 3.9%). At SGH this was almost double (8.4% compared to 4.6%)

Inpatient key findings for patients identifying as Aboriginal in 2019 are:

- At TSH, the Average Length of Stay (ALOS) was 0.2 days shorter than for non-Aboriginal patients. This is two consecutive years of ALOS increase since 2017.
- At SGH, the ALOS was 1.5 days longer than for non-Aboriginal patients and represents three consecutive years of ALOS increase since 2016
- Patients were discharged at own risk at almost three times the rate compared with the non-Aboriginal hospital population

Wellness Checks at War Memorial Hospital (WMH)

This was an initiative to connect with our clients to prevent avoidable hospital admission and deterioration during the COVID-19 pandemic. Since March 2020, COVID-19 has posed unprecedented changes in our way of life. For our clients, isolation measures meant the ability to access formal and informal support and health services was reduced. Despite services remaining open for at-risk clients, anecdotally clinicians were aware of clients deteriorating in the community due to social isolation, reduced formal and informal supports, and reduced uptake of regular health services including GP and specialist visits. Initiating a more formal structure to ensure the wellbeing of our clients during the COVID-19 pandemic was considered a priority for clinicians and managers. A proactive and targeted approach to contacting clients where face to face consultations were not possible or declined by clients, was considered an urgent need.

As such, a process was developed to provide wellness checks to clients to understand their current or emerging social support and health needs. It provides tools to educate clients, a questionnaire for clinicians to apply consistency to wellness checks, and pathways for follow up as required. This initiative include a number of aspects:

- A letter was developed (including input from consumers around its content) and sent to clients to pre-empt a phone call from our clinicians and to encourage clients to seek help for urgent needs from their GP, specialist or WMH as required.
- A Wellness Check questionnaire was developed to guide consistency and efficiency with the clinicians' phone calls to clients. The questionnaire was designed to prompt clinicians to ask about 12 specific areas of change in wellbeing that have been shown to predict heightened risk of health deterioration and hospital admission. It also included a decision making component to enable onward referral or follow up as required.
- The phone call wellness follow-ups were conducted in August, after the initial wellness check calls had been conducted, and captured qualitative information from clients around the benefits of the calls.

The program received 'highly commended' recognition through the Australian Council on Healthcare Standards Quality and Safety Awards. The outcomes described arise from a qualitative review of the wellness check outcomes by the Wellness Check Team, with a client-experience focus (National Safety and Quality Health Service Standards 1.08 & 1.09). More than 1023 calls were made to 474 patients in the months from March until May 2020, including clients deemed at-risk on our wait lists, current clients, and those discharged within the last six months from both the inpatient, outpatient, and community settings. We work with the 'older old'; our clients are ten years older than their Australian rehabilitation peers, and have an average age of 84.2 years compared to 74.2 years old for patients cared for at other aged rehabilitation settings. According to the Australasian Rehabilitation Outcomes Centre (AROC), 88% of WMH inpatients have at least one comorbidity compared to rehabilitation patients across the rest of Australia at 51%.

By completing these Wellness Checks, including the provision of education on the importance of maintaining regular health and social supports, there was earlier identification by the team of clients at risk of deterioration during the period of COVID-19, enabling onward referral and follow up to reduce the risk of crisis. This meant reducing avoidable emergency or hospital admission into the acute facilities, and most importantly, a better outcome for clients through this proactive approach. There are many examples of positive outcomes for clients related to the wellness checks. A number of clients have been referred back through direct community admission to War Memorial Hospital inpatients to address significant functional issues and health deterioration. For example, a client was identified as having a significant cardiac issue which has been subsequently addressed, preventing an acute hospitalisation and a potentially fatal outcome.

Roll out of new NSW Health Incident Management Policy and ims+

NSW Health Incident Management Policy roll out

Incident investigations are an essential part of the NSW public hospital system to ensure incidents are comprehensively and effectively examined, and that learnings from investigations inform continuous quality and safety improvements. In December 2020, the updated NSW Health Incident Management Policy (PD2020_047) was released across the state. Enacting changes to NSW legislation, the revised policy introduced a number of mandatory process, timeframe and terminology changes to incident management and investigations including:

- The requirement to undertake a Preliminary Risk Assessment (PRA) within 72 hours of an incident occurring
- Separating Reportable Incident Briefs in to Part A and Part B
- The requirement to submit Serious Adverse Event Reviews (SAER) and recommendations to the Ministry of Health within 60 days
- A SAER is not restricted to the Root Cause Analysis (RCAs) methodology; rather a number of other investigation methodologies are permitted
- Splitting SAERs into two distinct stages; findings and recommendations.

In order to implement the changes in SESLHD, the Incident Investigation Improvement Project and working party were established. The working party and clinical governance units across the district have now successfully embedded all required changes to help ensure all obligations are met. Ultimately the work helps ensure all incidents are thoroughly investigated to identify root causes and systems issues, and embed a closed loop process for implementing investigation recommendations to keep patients safe.

ims+

In 2020, a new incident management system, known as ims+, was rolled out across NSW Health. The SESLHD Clinical Governance Unit was tasked with implementing the system in SESLHD. After much anticipation, the new system successfully went live in SESLHD on 17 August 2020. ims+ provides an improved system for reporting patient/work health and safety, corporate incidents, hazards and near-misses and consumer feedback. This system makes reporting easier by automatically generating the harm score rating and advanced reporting capabilities to inform and support continuous improvement across the Local Health District.

Over 8,500 SESLHD staff have completed the notifier training and over 600 staff have completed the manager training. As at 16 June 2021 there have been 18,968 incidents reported in ims+.

Introduction of Discharge Lounge – Sydney/Sydney Eye Hospital (SSEH)

Utilising evidence based practice, the NSW Health Perioperative Toolkit and the Agency for Clinical Innovation/Clinical Excellence Commission Perioperative Service Guidelines, the Discharge Lounge was initiated to improve patient access to timely cataract procedures without requiring an overnight stay. Introducing the Discharge Lounge would mean a more efficient patient journey from the Day Procedure Unit (DPU), to theatre and then to discharge without the patient being moved unnecessarily around the hospital. This would improve flow and waiting times for the patient and their family/carers on the day of the procedure. The aim was also to introduce post-surgery follow up phone calls rather than the patient having to travel back into the hospital the following day. This process alleviated patients having to travel again into the hospital setting and reduced the burden on family and carers.

The initiative was implemented alongside the restructure of the wards at SSEH in 2020. It also complemented the model of care change around cataract patients as a day only procedure and a necessary workflow for the introduction of a High Volume Short Stay (HVSS) ward located in the DPU. The introduction of the HVSS ward would halve the space in the DPU, and make it purely the place where patients were clerked in for their procedures, admitted by nursing and medical staff and post-op care for patients not suitable for discharge from the Discharge Lounge (against criteria list in Business Rule). The initiative will achieve a smoother, timelier process for the patient and their relatives/carers. It promotes engagement at every step of the journey of the patient and provides opportunity for the patient to engage in their own care. The initiative utilises a safer space to discharge post procedure by locating the discharge lounge adjacent to recovery with access to medical staff post procedure if any further care/ review is necessary.

What have been the outcomes?

- Patients are discharged quicker and the flow of patients through the service is seamless.
- Less movement of patients between floors.
- Improved patient satisfaction measured via localised patient survey, post implementation (how they found the day of their procedure and any suggestions they could make) and identified further opportunity to improve the discharge process with themed feedback.
- Patient centred with greater medical support at hand post procedure.
- Length of stay of cataract patients has reduced from 9.5 hours to 7.2 hours for a cataract procedure.
- Cataract procedures requiring overnight admission have shown an 8 % increase for patients being discharged same day (83% to 91%)

Reducing Psychotropic Use and Harm

The Sutherland Hospital

A program of regular Clinical Nurse Consultant (CNC) and geriatrician review was developed with proactive de-prescribing of antipsychotics and benzodiazepines in appropriate residents. This project has been supported by well-resourced and trained clinical staff, a comprehensive diversional therapy program and an open environment with easy access to outdoor spaces, allowing good behaviourally interventions into behaviours of concern.

Since May 2020 this project has reduced prescription of regular psychotropics from 69% of residents to 42% of residents, and has reduced regular benzodiazepine prescription from 28% of residents to 13%. There has been a similar reduction in PRN antipsychotic use from 52% of residents to 32%. Concurrently fewer residents have died; in 2019 40 residents died, at a rate of 1 every 9.1 days. In 2021 this currently sits at 1 every 12.3 days.

Wound Care Warrior Program – The Sutherland Hospital

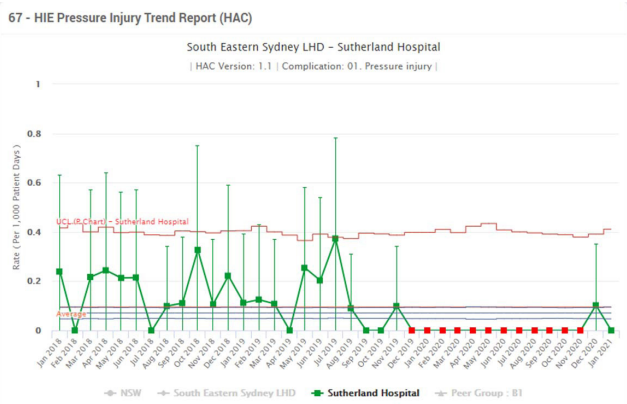
The aim of the Wound Care Warrior Program is to upskill nursing staff across the organisation in basic Wound Care knowledge over a 12 month period. The program provides mentorship and leadership to enhance nursing workforce and capability.

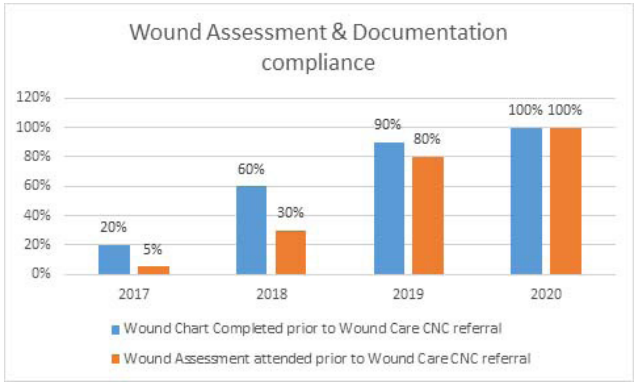
The program objectives include:

- To reduce harm and promote best practice in wound care, skin integrity and pressure injury prevention and management.
- Promote wound healing and prevent chronicity of wounds to reduce hospital stay and prevent re-admission due to poor management.
- The program empowers nursing staff, using knowledge and leadership provided by the Wound Care Clinical Nurse Consultant (CNC) to drive change and promote best practice in their departments/wards. The program benefits patient care, as it increases wound care and pressure injury prevention and management knowledge to ensure patients are assessed and treated in line with the current best practice guidelines, policies and procedures. The program assists the health care system by teaching nursing staff how to conduct effective and measureable quality improvement projects using the PDSA (Plan, Do, Study, Act) cycle methodology. These skills empower nursing staff to create change and innovation and provide sustainable and achievable goals in wound care to help benefit the patients and reduce unnecessary harm and improve patient outcomes.

The program influences both the patient and community outcomes by the following;

- Evidence is shown by a decrease number of inappropriate Wound Care CNC referrals across the organisation
- 12 months of ZERO Hospital Acquired Complications (HACs) pressure injuries since the program commenced
- Improvement in Wound Care documentation and management across the organisation
- An increase in patient involvement of care lead by holistic approach in wound care management.
- Wounds and Pressure Injuries are assessed and managed earlier due to the increase in knowledge and representation across all the wards in the organisation.
- Increase in reporting and early identification of pressure injuries.
- Appropriate referrals and escalation is made to the Wound Care CNC.
- Wound Care assessments are being completed using best practice guidelines and treatment is implemented early and efficiently from the time of assessment to minimise harm to the patient.
- Increased representation and support by the Wound Care Warriors across the organisation after hours and over the weekend to support staff and patients outside the Wound Care CNC's working hours.





Hospital Acquired Complications (HACs) are based on severity of the pressure injury, pressure injuries from Stage 3 and above are considered a HAC due to the level of damage and risk of permanent injury to the patient. This has significantly improved as shown in this graph TSH had ZERO Hospital Acquired Complications from December 2019 to November 2020.

Development of Pharmacy Workforce Capacity and Escalation Strategy

A significant safety and quality achievement has been the pharmacy service capacity plan & escalation strategy, developed at the Randwick campus to optimise patient care and safety and to better support the workforce. The primary objective was to develop a tool to assess staffing resources and workload demand on a daily basis and then to prioritise resource allocation according to service demand, staff availability, skills and experience. The pharmacy department services are campus wide inclusive of Prince of Wales Hospital, Sydney Childrens Hospital and the Royal Hospital for Women. This required collaboration of all service units across the campus.

A list of duties to be performed according to staff level and skill mix was developed. This incorporated a traffic light rating assessment matrix:

- Red – prioritisation of activities which have an immediate impact on patient care and safety.
- Amber – including all tasks in red plus activities which have less immediate impact on patient care.
- Green – includes all tasks in amber plus value adding activities e.g. Quality Assurance projects which have ongoing impact.

TThis tool facilitates discussion at daily huddles within each service unit to determine an initial colour rating assessment for the day. Service gaps identified are then discussed across the department to facilitate re-allocation of resources to prioritise essential work demands and better support workplace safety. Utilisation of this management framework facilitates improved capacity planning, communication, collaboration, and rapid realignment of resources to better meet service deliverables. Appropriately addressing pharmacy workforce resources on a daily basis ensures optimisation of staffing capability to ensure quality and safety of patient care. The prioritisation of the pharmacy workload utilising the matrix ensures continuous delivery of high quality core business and patient care. The management framework significantly improved productivity and efficiency within the workforce. The framework supports rapid realignment of the workforce targeting capability and capacity ensuring optimal positioning to deliver care.

Improving pain management in Advanced Dementia with BPSD (Behavioural and Psychological Symptoms of Dementia) using Artificial Intelligence (AI): PainChek®

The Garrawarra Centre cares for people at end stage dementia who exhibit high risk behaviours. On presentation, 94% of residents have prescribed antipsychotic medications, with less than 30% on regular pain relief. Over 80% of Garrawarra residents have known trauma histories. Contemporary research continues to identify the pain profile of Post-Traumatic Stress Disorder, anxiety, depression, comorbidities, and advancing dementia illness. People living with advanced dementia have difficulty in articulating their pain, which may result in BPSD.

Garrawarra Centre trialled PainChek® in 2020, which uses Artificial Intelligence driven technology to identify facial muscle micro-movements indicative of pain. The facial recognition software is supported by a framework that incorporates the resident's pain history and guides staff to observe and record pain related behaviours.

An average of 680 pain assessments are completed each month, 33% recording mild to severe pain. Non-pharmacological strategies are first line in the management of pain. Pain relief is used as required to monitor pain patterns, which may indicate the need for regular pain management. In 10 months, psychotropic use at Garrawarra Centre has shown a reduction in prescriptions by:

- 20% in antipsychotics

- 15% in benzodiazepine

There has been a 10% improvement in pain relief, with a reduction in high-risk behaviours. PainChek® has provided us with a reliable and validated tool that not only consistently identifies pain but also the severity of pain. There has been a notable reduction in high risk behaviours of residents living at Garrawarra Centre, despite the reduction in the use of antipsychotics and benzodiazepines commonly and at times inappropriately used to manage BPSD. The PainChek® program is easy to use, and produces a validated, robust, and reliable result. Pain assessments are recognised as being fundamental to understanding changes to a resident's function and baseline behaviours. There has been an increase in pain assessments being undertaken, and where indicated a rapid response to managing pain. Medical teams involved in resident care, are happy with how robust this technology is, how it is being applied, and the outcomes from these assessments. There has been a decrease in the use of antipsychotics and benzodiazepines, having both a physical and financial benefit to residents.

Vulnerable Patients Project

The goal of this project is to improve the experience of care for vulnerable patients during their hospitalisation to provide a safe and responsive stay.

Case for change

Between 2018 and 2020 there were three serious adverse events (Harm Score 1) resulting in patient deaths that involved vulnerable patients (VP) admitted to The Sutherland Hospital (TSH). Consistent themes from the three incident reviews identified the following areas for improvement;

- compliance with the Ministry of Health policy (PD2017_01), Responding to the Needs of People With Disability during Hospitalisation, which involves:
    - » Governance processes and risk management strategies during pre-planning, admission and transfer of care out of hospital
    - » Educational strategies and resources for better management of the vulnerable patients
- Communication, documentation and information sharing processes that support and maintain the safe care of the vulnerable patient.

Over the past 18 months zero patient deaths or serious injury (Harm Score 1 or 2 incidents) have been reported involving patients who have an intellectual disability, reside in a group home or have a legal guardian. This can be attributed to implementation of the below strategies that have resulted in streamlined processes supporting effective communication with the patient and their carer, family, guardian and support staff, to ensure reasonable adjustments are made for equitable access, appropriate and safe health care;

1. a multidisciplinary pre planning meeting occurs prior to the patients preadmission clinic visit to discuss the plan of care covering the physical, psychological, emotional and social requirements
2. a Multi-Disciplinary Team meeting occurs within 24 hours of the patient's admission to the ward
3. the weekly huddle occurs to discuss the plan of care for all vulnerable patients
4. the afterhours report contains any new vulnerable patients that have been admitted
5. vulnerable patients are included in the handover document circulated each Friday

Process measures currently being collected that include:

- % known highly vulnerable patients are discussed at the weekly hospital vulnerable patient meeting
- % highly vulnerable patients who have had their planning for admission Multi-Disciplinary Team meeting prior to the surgery date allocated
- % highly vulnerable patients who have had an Multi-Disciplinary Team meeting within 24 hours of admission

Next steps include:

- Capturing the patient and carer experience as part of evaluation and ongoing improvement
- The recommendation for admission form is amended to include vulnerable patients
- A flag is added to the electronic medical record for early identification of vulnerable patients.

SESLHD Disability Inclusion Action Plan 2020-2023

People with disability make up around 10% of the population of our district, and are at heightened risk of both poor health outcomes and poorer access to health care. Health services play a critical role in improving the health and quality of life of people with disability. People with disability – as with all members of the community, require access to both preventive education and care, and more specialised care when they are unwell or injured.

For many people with disability, the system can be difficult to access and navigate, resulting in poorer outcomes and poorer experiences of care. The South Eastern Sydney Local Health District Disability Inclusion Action Plan 2020-2023 ('SESLHD DIAP') identifies the strategic priorities and key actions for making our services more inclusive of people with disability in the coming years.

There have been a number of achievements around implementation of the Disability Inclusion Action Plan (DIAP) 2020-2023, including:

- **The SESLHD Disability Inclusion Action Plan (DIAP) 2020-2023** reflects the district's focus on a joint capacity building plan between the Disability Strategy Unit, the Specialist Intellectual Disability Health Team and the Intellectual Disability Mental Health Team with the aim of a streamlined and person centred approach to improving how we respond to the needs of people with a disability (PWD) when accessing our health services.
- The DIAP has been co-created with consumers and carers with a lived experience of disability.
- The DIAP has supported the implementation of the NSW Health Policy Directive – Responding to Needs of People with Disability during Hospitalisation (PD2017_001) at SESLHD.
- **Establishment of a Disability Admissions Pathway** which enables direct admission of people with intellectual disability (PWID) during an emergency to the General Medicine ward. This avoids the potentially distressing experience of being in an Emergency Department (ED), or having an extended stay in ED, and facilitates medical assessment in an environment that is more conducive to supporting people with intellectual dissability. This model is a key patient safety mechanism and is currently being trialled at The Sutherland Hospital with a view to rolling it out across the district.
- The district is undertaking a review of the Admission to Discharge (A2D) Tool and Website (developed in SESLHD) to bring it up to date and broaden its reach to people with Cognitive Disability (not just Intellectual disability). Once updated, education sessions will be rolled out across the district.
- **COVID-19 Disability Response Team (DRT)** established by the Disability Strategy Unit in partnership with the PHU and the Specialist Intellectual Disability Health Team. The aim is to minimise the spread of COVID-19 in the disability community by offering a rapid response to outbreaks in disability group homes, and to people who live in private dwellings with significant disability support needs.

In addition, SESLHD has many outstanding services that are recognised as leaders in disability inclusion such as:

- State-wide Clinical Speciality Referral Networks - One of the two Adult State Spinal Cord Injury Services is located at Prince of Wales Hospital. St George Hospital is a part of the NSW Major Trauma Referral Network (Adult).
- Disability Developmental Assessment Service - Provides a comprehensive range of multidisciplinary and inter-agency clinic services for people with developmental disability or intellectual disability.
- Specialist Intellectual Disability Health Team - Provides advice and information on management of care for patients with Intellectual Disability, such as information on reasonable adjustments on the ward or in a service, and staff training on the use of communication tools.
- The Intellectual Disability and Mental Health (IDMH) Team - Provides advice and information on management of care for people with Intellectual Disability who present with mental disorders.
- The Mental Health Intensive Care Unit (MHICU) - located at Prince Of Wales Hospital (POWH) campus, offers a therapeutic approach for people with very complex needs. The MHICU team provides specialist, intensive multidisciplinary care to people with high levels of clinical complexity and risk that cannot be safely and effectively cared for in a standard acute mental health inpatient unit.
- Inpatient rehabilitation units - These are located across SESLHD, in Prince of Wales Hospital, St George Hospital and The Sutherland Hospital, as well as Calvary Health Care Kogarah and War Memorial Hospital.
- The Disability Strategy Unit - Provides governance and stewardship for the local implementation of the NSW Health DIAP and National Disability Insurance Scheme (NDIS). Supporting the district by establishing access and discharge pathways, building the capacity of staff to operate effectively under the NDIS, engaging consumers, carers, external agencies and staff in local planning for the provision of inclusive health care services for people with a disability.

New Directions: Woman Centred Care for Indigenous Families – Yarning Circle

The New Directions Service at The Sutherland Hospital offers culturally appropriate antenatal and early postnatal care to Indigenous families. The team comprises two registered midwives and an Aboriginal Health Education Officer. The Service provides continuity of care for women and their families from the antenatal period through to early childhood as they transfer to the child and family health service post-birth, supporting the First 2000 Days Framework. The team has had significant success in being able to achieve positive outcomes for the women and families they care for. Over the last 12 months there were 684 occasions of service, with 86 women receiving antenatal care and 54 women receiving antenatal and postnatal care within a culturally appropriate model. The New Directions Service is highly regarded by the local community and the number of women accessing the model is growing. In 2019 the team introduced the Yarning Circle to facilitate antenatal and postnatal education, and encourage the establishment of networks with other Indigenous families to decrease isolation. The education is timed with an antenatal visit. In 2020 the Yarning Circle was evaluated and updated to ensure the women received continued support through the COVID pandemic utilising the introduction of telehealth and teleconferencing.

In 2020 due to the COVID-19 Pandemic, Yarning Circle was re-evaluated to identify strategies to ensure the sustainability of the program while maintaining physical distancing. The New Directions Team created a Telehealth Yarning Circle, enabling the women and their families to participate in the education and social interaction without increasing risk to themselves or their families. This model can be reintroduced at any time if needed. The introduction of Student Midwives to the New Direction Team is creating a workforce that acknowledges the vulnerabilities of these mothers and babies - working towards improving their outcomes for families.

The aims of the Yarning Circle were to provide Indigenous families antenatal and early postnatal education, antenatal care and decrease isolation by encouraging social interaction. The Yarning Circle is also a means to increase engagement between families and the health system. The Yarning Circle was created within the resources available to the New Directions Team under the guidance of the Aboriginal Heath Education Officer to ensure it was culturally appropriate. It is reviewed every 12 months to ensure it continues to meet the needs of the women receiving care from the New Directions Team.

This program has seen a number of positive results:

- Engagement with antenatal care at <13 weeks was has changed from 72% to 81%. Most importantly there was a significant decline in the number of late bookings within the service from 28% to 19%, with only 1% of all women seen at 20 weeks gestation
- Smoking reduction/cessation at time of birth was slightly improved from 64% to 70% and 100% of women were offered the Quit for New Life package. This remains one of our most challenging KPIs
- Get Healthy in pregnancy accepted referrals increased from 20% to 70%
- Infants born with a normal birthweight increased from 89% to 96%
- Breast feeding rates increased from 73% to 82%

Improving the Patient Experience

SESLHD is committed to improving the patient experience. The District has a number of ways of capturing consumer feedback including Care Opinion, Patient Reported Measures, the Health Care Complaints Commission, Real Time Patient Surveys, Emergency Department Patient Experience Officers, and direct complaints and compliments to facilities and services. The major sites have consumer feedback managers to manage complaints and compliments and ensure this information is fed up to management to facilitate continuous quality improvement. Consumer feedback managers across the District meet monthly to share lessons and learnings across facilities. As outlined in 'Standard Two', SESLHD partners with consumers to ensure feedback is used to inform quality improvement and co-design of services and initiatives.

Patient Reported Measures (PRMs): Using patient feedback to improve care

Patient Reported Measures is a program that enables patients to give feedback to their care team on the outcomes and experiences of their healthcare that matter most to them. Patient Reported Measures are captured in surveys to give the patient's healthcare team an insight into the needs and expectations of patients at the point of care.

Patient Reported Measures can be grouped into two categories – Outcome measures and Experience measures.

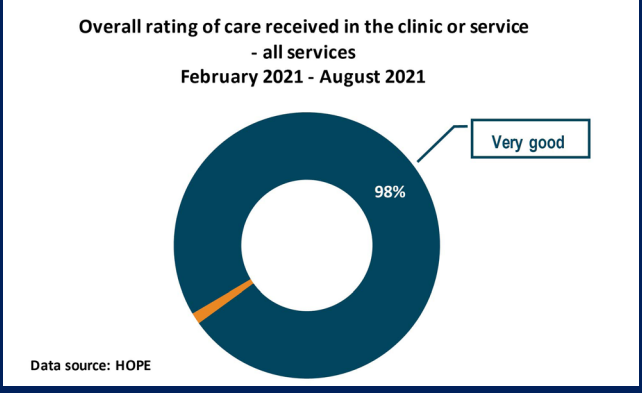
Outcome measures capture the patient's perspective about how their illness and care impacts on their physical, mental and emotional health and wellbeing. Experience measures gauge the patient's experience and satisfaction with their healthcare. Experience measure surveys are completed anonymously.

Feedback from patients received through the Patient Reported Measures Program shows where we are performing well and where there are opportunities for improvement. This information helps to inform clinical care delivery so patients can have the best possible experiences and outcomes from their healthcare.

A purpose built electronic platform called HOPE - Health Outcomes and Patient Experience - is being rolled out across SESLHD to support the Patient Reported Measures Program. HOPE captures the survey responses from patients, manages the online surveys and provides database functions.

In 2021, five services across SESLHD have successfully implemented HOPE for Patient Reported Measures, and another seven services are scheduled to go-live with the system before the end of the year.

The HOPE system brings a number of benefits to the clinicians and patients. Patients can provide their responses at the point of care which can be accessed by their healthcare providers in real time which supports healthcare providers to make informed decisions about care and treatment. Patients have access to their own Patient Reported Measures information in HOPE – this enables patients to monitor their own healthcare and supports patient knowledge, engagement, confidence and self-efficacy.



For clinicians, Patient Reported Measures improves patient care:

"it helps to identify other issues that may be impacting on a patient and therefore affecting their overall health outcomes"

"to improve quality of service and close the gaps between the patient and clinician"

"improved overall care for patient - data to assist with referring to other health professionals - holistic care"

The chart below shows patient experience responses for overall rating of care of the services currently using the HOPE platform:

Patient Reported Measures in action:

A patient being treated by the podiatry team was finding it difficult and stressful to manage their foot condition. When the healthcare team asked the patient to complete a quality of life patient reported measure, the patient reported that they were having trouble sleeping, exercising or even socialising, all because of the adjustments they had to make in their life as a result of their diagnosis.

Using the information reported by the patient, the team were able to make early recommendations that were relevant and important to the patient such as encouraging the patient to walk around with their cast to exercise and socialise, as well as making referrals to an Exercise Physiologist to support appropriate and safe exercises to help the patient keep fit and prioritise their mental health and wellbeing.

This example highlights how Patient Reported Measures were used to support communication between the patient and clinicians about other factors that were impacting their life, focusing the conversation on what matters most to the patient to encourage a holistic and person-centred approach.

Care Opinion

SESLHD has continued its partnership with Care Opinion (previously Patient Opinion) across all SESLHD facilities to improve the care we give our patients, improve response rates to patients concerns and decrease complaints.

Staff and executive have been actively promoting the use of Care Opinion which has led to nearly 400 stories submitted over the past financial year across all sites within SESLHD. Stories submitted through the Care Opinion website provide valuable information about patient experiences within our services and have led to a number of improvements in response to the feedback.

There have been more than 10 responses to stories where changes have been made:

The COVID-19 testing clinic at Prince of Wales and the Vaccination HUB at St George Hospital have planned changes to signage and wayfinding to assist those requiring these new and essential services. The Sydney Eye Hospital have made changes to their discharge planning process to better ensure patients are well prepared for discharge and have made physical changes to their ward environment to enhance it aesthetically.

Each patient story contains themes and words which are “tagged”. The most common positive tags added to stories highlight quality of care professionalism, friendly staff and thanks.

Mental Health Service Consumer Engagement

SESLHD Mental Health Services engage broadly in consultations and focus groups with consumers. For example, a co-design workshop was held for two new Towards Zero Suicide initiatives, the Safe Haven and the Suicide Prevention Outreach team. Mental health services operate a peer worker model which employs peer support workers to support consumers through their mental health service journey. Peer support workers have personal experience as consumers of mental health services and are employees of SESLHD. The Mental Health Service has also undertaken work to partner with consumers to enhance the Serious Adverse Event Review (SAER) process. In undertaking work to align with best practice guidelines for SAERs, the MHS has incorporated co-design into the process by including lived experience representation in the core SAER team. Co-design goes beyond traditional methods of consultation by forming authentic partnerships with consumers, carers and key stakeholders. It utilises their knowledge and experience in the design, delivery, review and evaluation of mental health services and is underpinned by the principles of early engagement, inclusivity, transparency and equity of knowledge.

Real Time Patient Experience Surveys (RTPES) at Prince of Wales Hospital

Prince of Wales Hospital introduced the Real Time Patient Experience Survey (RTPES) in August 2020 to gain real-time feedback about what was good in the individual patients experience and where the hospital could make improvements. The survey is based on the Australian Commission Australian Hospital Patient Experience Question Set (AHPEQS). The survey asks patients about their experiences of care, the consistency of care and treatment in a healthcare setting.

Surveys are conducted by the Clinical Practice Improvement Unit (CPIU) Team, Nursing Education, Workforce and Research (NEWR), and Allied Health representatives, and results are tabled at ward meetings, peak committees and also displayed on ward based quality and safety boards. Any issues related to patient harm or issues of concern identified during the survey, and with the patients' permission, are escalated to the Nurse Unit Manager (NUM) and/or Executive if required. To date since August 2020, 498 patients have actively participated in the RTPES.

The RTPES program is evolving with the development of part two to capture patient experience and understanding of risks of harm (e.g. falls, pressure injury) and other key areas that impact on a patient stay (e.g. visiting hours, wayfinding). Another aspect is the Aboriginal Real Time Patient Experience, which has involved working with the Aboriginal Liaison Officer and Aboriginal Education Officers to undertake culturally sensitive real time patient experience.

The results of the RTPES are being use to inform day to day clinical practice at the ward level. Improvements in patient care can be made at the point of care to reduce the incidence of patient harm and/or distress. In the long term, the results will be used in service planning and delivery and to compliment other forms of data in the provision of safe and quality healthcare. The survey findings from all responses since August 2020-May 2021 demonstrate 8/10 patients report that clinicians Always listened to their views and concerns, 87% say they Always feel cared for, 89% feel safe and confident while receiving treatment, 71% report they are Always involved as much as they want to be when making decisions about care and treatment and 92% report that the overall quality of care and treatment is very good.

A dashboard in QIDS (Quality Improvement Data System) has been developed to monitor results over time, which can be displayed at ward level as an indicator of quality and safety. Through this survey initiative, a number of specific patient incidents and complaints were identified and escalated to the appropriate handling by the Nurse Unit Manager. Survey data is displayed on Unit and Executive Quality and Safety boards and the comments can be used to drive the 'you said…we did' section of the Quality and Safety Board. Reports are also tabled at the Prince of Wales & Sydney/Sydney Eye Hospitals Consumer Advisory Committee (CAC) for monitoring and identification of future improvement initiatives. For example, falls feedback has been used by falls working party to drive fall prevention and management strategies.

Emergency Department Patient Experience Officers (PEOs)

Patients and their carers who visit an emergency department across SESLHD are being met by the friendly faces of those dedicated to making them feel welcomed, safe, looked after and empowered.

Since July 2020, Patient experience officers have been posted to Sydney/Sydney Eye Hospital, St George Hospital, Prince of Wales Hospital and the Sutherland Hospital as part of the NSW Health Emergency Department Patient Experience initiative and continue to do great work around our district.

Kim Olesen, Acting Executive Director of Operations, SESLHD, said the roles act as a concierge service for visitors to SESLHD emergency departments and COVID-19 assessment clinics. “The patient experience officer role is a non-clinical position that enhances communication between our clinicians, clerical staff, patients, families and carers, while also supporting our mission to provide safe, person-centred and compassionate care.”

After a successful Ministry of Health review in May 2021, the project received confirmed funding until 30 June 2024. The review showcased the overwhelming positive feedback received by Emergency Department staff and patients responding to surveys that were sent. These surveys highlighted the importance of patient experience through feedback, complaints, compliments, patient/consumer survey results comments and testimonials.

During 2020/21 our SESLHD Patient experience officers were involved in many initiatives including the “#kindness works here” campaign and coordinated Patient Experience Week activities such as a morning tea with patients and their carers to celebrate partnering with patients, consumers and carers in healthcare decision making and the co-design of services. There was also an interview on National Radio with one of our PEO’s highlighting the skills/experience needed to fill the role, the service provided and how participation in this safety and quality improvement has led to an improved service for patients, carers and staff since they were introduced to NSW hospitals.

Health Care Complaints Commission (HCCC) Project

Complaints in SESLHD arise through numerous channels, including via the Health Care Complaints Commission (HCCC). The HCCC is an independent body set up under the Health Care Complaints Act 1993, which acts to protect public health and safety by resolving, investigating and prosecuting complaints about healthcare. SESLHD works closely with HCCC Assessment Officers to respond to HCCC complaints in a timely manner. In 2020 a review was conducted to improve district HCCC complaint management processes. The review comprised data analysis, work flow mapping and interviews of various stakeholders involved in complaints management. The review made a number of recommendations primarily aimed to refining administrative processes and improving timeliness of SESLHD responses to the HCCC. Some of the changes implemented include:

- Adjusting District-level approval to speed up approvals
- Developing customised HCCC brief and letter templates to assist with drafting
- Eliminating duplication of documentation requirements
- Increasing support for consumer feedback/complaints managers through revamping monthly meetings to facilitate lesson sharing and education sessions
- Documenting District-level administrative processes
- Embedding processes to ensure identification of complaints requiring escalation

Although the changes are recent, there has been an improvement in the proportion of HCCC responses submitted on time. Changes have been well received and there has been a lot of positive feedback about the monthly complaints managers meetings.

A workplace culture that drives safe and quality care

A workplace culture that drives safe and quality care

Royal Hospital for Women Zoom Lectures: Educating the World in COVID-19

COVID-19 stopped face-to-face meetings, the cornerstone of collaboration, networking and knowledge by clinicians. Rather than be isolated and stagnated, the Royal Hospital for Women, with the University of NSW, launched the first global series of free zoom lectures in neonatal medicine on 11 June 2020. The aim was to enable online state of the art education, networking and collaborative opportunities for neonatal clinicians during COVID-19.

Zoom was used as the meeting platform. We ensured lectures:

1. Were by peak experts
2. Addressed critical knowledge gaps
3. Were free and accessible (e.g. translated into Mandarin)

Speakers were engaged through our connections, advertised through social networks.

We were the first in the world to use an existing and free communication platform, Zoom, to organise state of the art, free and equitable lectures for neonatal clinicians. The lectures were aimed to acquire knowledge from the most eminent experts in the world and to be accessible to all clinicians, regardless of their location. Our program has ensured clinician access to state of the art knowledge for improving care for all mothers and infants. One of the most important knowledge gains is access to the experience of Japanese clinicians, who have the best outcomes for “micropreemies”, babies <500g birthweight. We have also engaged non-clinical experts including parents, community groups and foster carers to provide lectures for clinicians in substance use, one of the most pressing areas of need in vulnerable populations, leading to invitations for SESLHD clinicians to head the 2021 NSW guidelines for substance use in pregnancy from the Ministry of Health.

The intensive teamwork required to successfully deliver the lectures has generated enormous esteem and respect amongst our staff that we were the first and continue to be the only Australian and probably global institution to deliver the longest running and most accessible cutting-edge platform for sharing neonatal knowledge in the pandemic world.

To date, there are 40 lectures, from over 60 presenters from more than 10 countries, and some 4,000 attendees from over 20 countries. Some talks were viewed by more than 15,000 Facebook members. The topics have contributed to:

1. Two state of the art plenaries at the largest paediatric meeting (Paediatric Academic Societies Meeting, May 3, 2021, Virtual)
2. 2021 Substance Use in Pregnancy and Parenting Guidelines, NSW Ministry of Health
3. Multiple research collaborations and speaking engagements for our clinicians

Digital Portfolio

The aim of this project was to co-design, develop and implement a post graduate education model supported by digital technology to remove paper, enhance Nursing and Midwifery skills development and increase the effectiveness and reach of Nurse Educators. It is expected this platform will enable pathways for transitioning nurses into specialty areas including, critical care areas, operating theatres, and acute medical and surgical specialities.

Given the current pandemic response environment there is a critical need to develop an industry-leading Nursing and Midwifery skills development approach enabled by emerging technology that addresses:

- Growing healthcare system pressures requiring remote and innovative ways of delivering education and information to clinicians
- Evidence suggests that the addition of the app will enhance the access to information and education and provide an alternative medium to interact with educators
- New generation of clinicians that require on-demand access and learning
- Program and content analysis identified significant disparity between the quality of information and education delivered across the specialties, it is expected this variance exists across facilities
- The platform will enhance other initiatives including recruitment and retention of the nursing workforce including work rotations, nursing student support programs, local workforce cultural programs (supervision, mentoring, mindfulness)

Feedback to date has demonstrated significant improvements in engagement of new graduates including increased attendance at education sessions and a greater feeling of connection between grads and the site coordinators. The rollout of the solution has provided grads with a tool to support their development and connect them with the right information at the right time for their needs. There are 315 active users across SESLHD who have used 4,520 sessions and on average spend 3m and 15s per session. The vast majority of the most viewed content is related to Orientation Graduate Guides, information on Graduate Program Requirements and information on in-services and education sessions.

An ethics application is currently in development that will support the evaluation of the pilot. Surveys, one to one, and focus group interviews will be held with grads and site coordinators to understand benefits and a time in motion study will demonstrate benefits in relation to access of information and return of clinical time through reduction in administrative tasks.

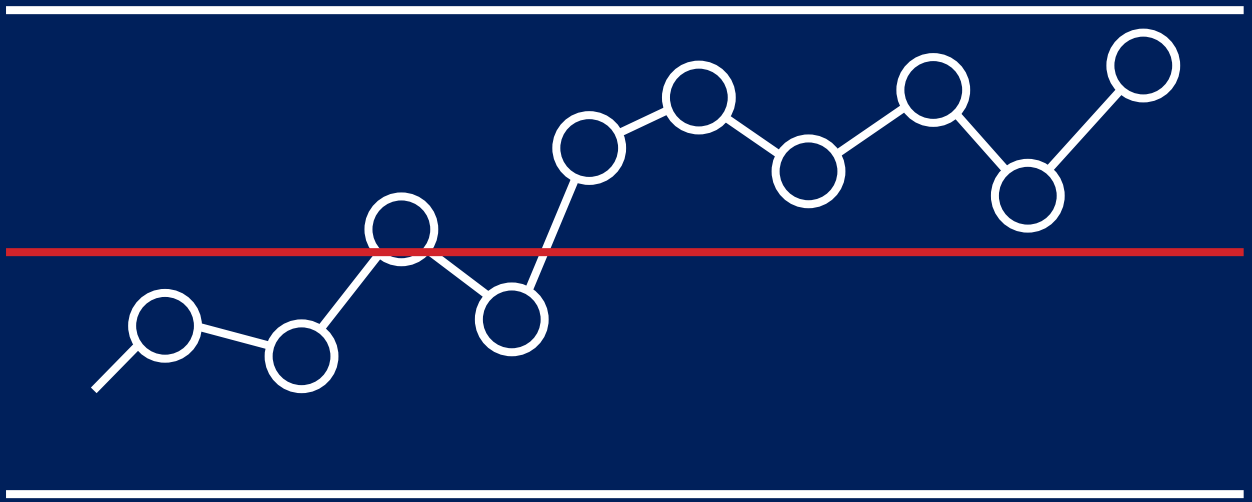
Foundational Clinical Leadership Program (FCLP)

The Foundational Clinical Leadership Program (FCLP) continued in 2021 after a brief pause as a result of restrictions related to the COVID-19 pandemic. Utilising virtual mechanisms where possible to support the delivery of the program, 18 participants successfully completed the program across 2020-2021. FCLP builds on the learning outcomes achieved in Module 1, Effective Leadership in Health. The program aims to improve patients' experience of care by developing clinicians' leadership capacity and ability. FCLP provides participants with the opportunity to influence change in their local health care context through the application of exemplary leadership practices. The acquired skills and knowledge enable participants to work with teams to identify and explore opportunities to improve clinical care and safety, with the intention of creating meaningful and sustainable practice change. To enable participants to lead practice improvement in their workplace, participants will be exposed to a range of approaches and tools designed to build their competence and confidence in scoping, designing, implementing, evaluating, disseminating and sustaining such improvements, namely through the Model for Improvement methodology and supported through continued leadership development.

Participating in active learning groups, learning partnerships and workplace coaching will offer opportunities to deconstruct and clarify workplace issues, and includes learning from others, engaging in critical discussions and looking both inward and outward for innovative solutions to clinical and professional issues.

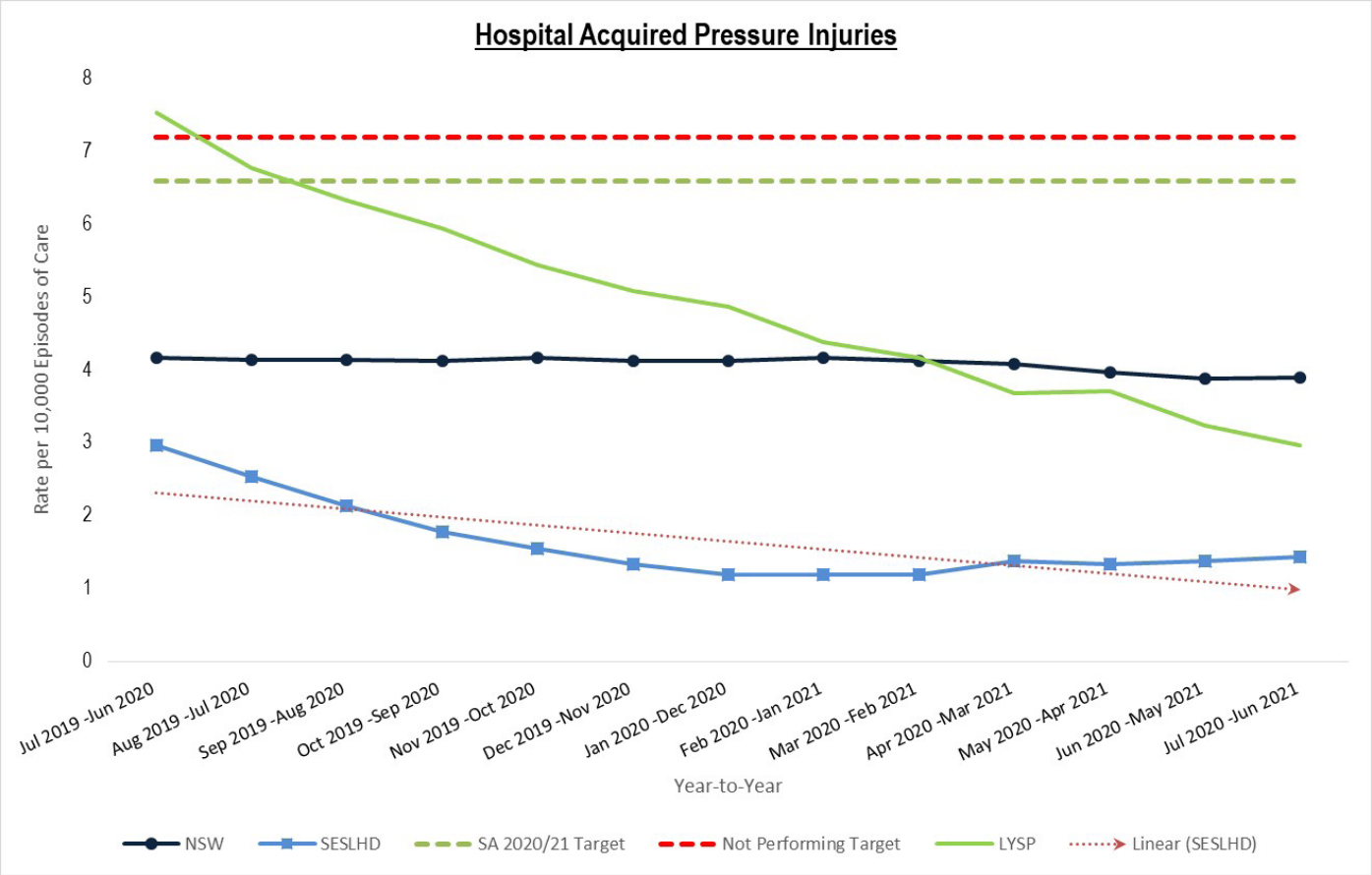
18 participants completed Quality Improvement projects over the course of the program. The key themes that emerged were a strong focus on patient safety, improving the patient experience, improving access to care, improving patient outcomes and supporting staff and patient well-being. All projects align with the National Standards and SESLHD's Strategic Priorities. Through completion of the program, participants have built their capability in undertaking Quality Improvement Projects and have developed their leadership to support and lead cultures of quality and safety.

Formal Results



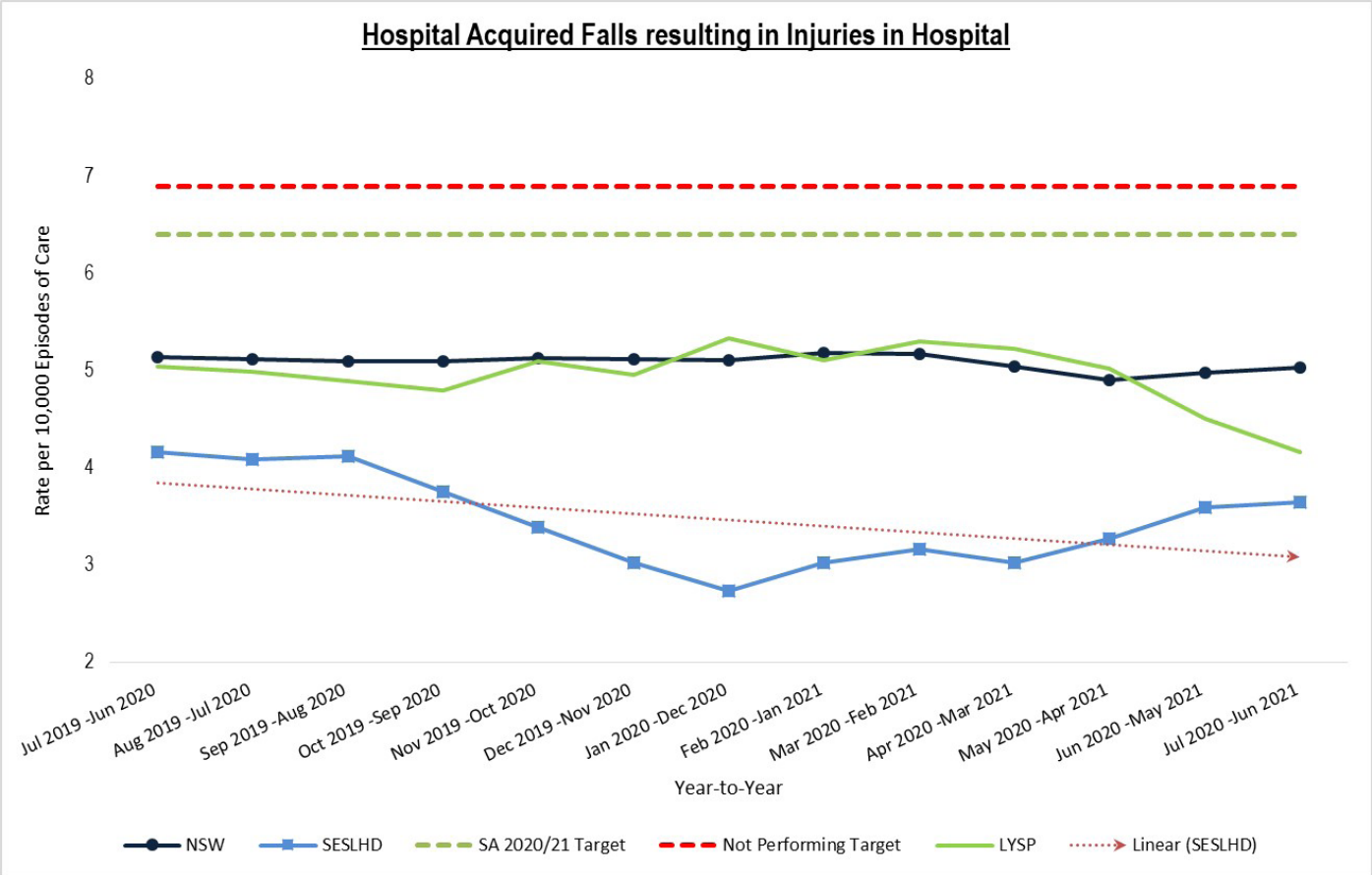
Hospital Acquired Complications (HACs)

Hospital Acquired Pressure Injury



Average rates of hospital-acquired pressure injuries (HAPIs) has been maintained well below target and NSW state average. This pleasing result is due to the ongoing commitment from SESLHD sites to reduce HAPIs. The Sutherland Hospital Skin Integrity Prevention and the Nursing Practice Committees are working to increase nursing staff knowledge and skill through completion of the staging quiz, continuation of the wound care warrior program (providing staff with targeted education on pressure injury risk assessment and management), and providing education to staff on the correct use of pressure mattresses and cushions. Sydney/Sydney Eye Hospital HAPI prevention initiatives include monitoring of Waterlow risk assessments and skin assessment, and participation in the state wide HAPI collaboration. Pressure injury HACs are monitored at St George Hospital though the Peak Pressure Injury Committee, Divisional Performance meeting and Peak Patient Safety meeting. At Prince of Wales Hospital, the Pressure Injury Prevention and Practice Improvement in Nursing (PIPPIN) study with University of Wollongong commenced in December 2020 with 11 clinical units participating. This aimed to reduce the numbers of HAPIs through development and co-creation of a comprehensive pressure injury prevention program. War Memorial Hospital also participates in the NSW Health 'HAPI Project', with a local project underway in context of broader HAPI Project with educational toolkit.

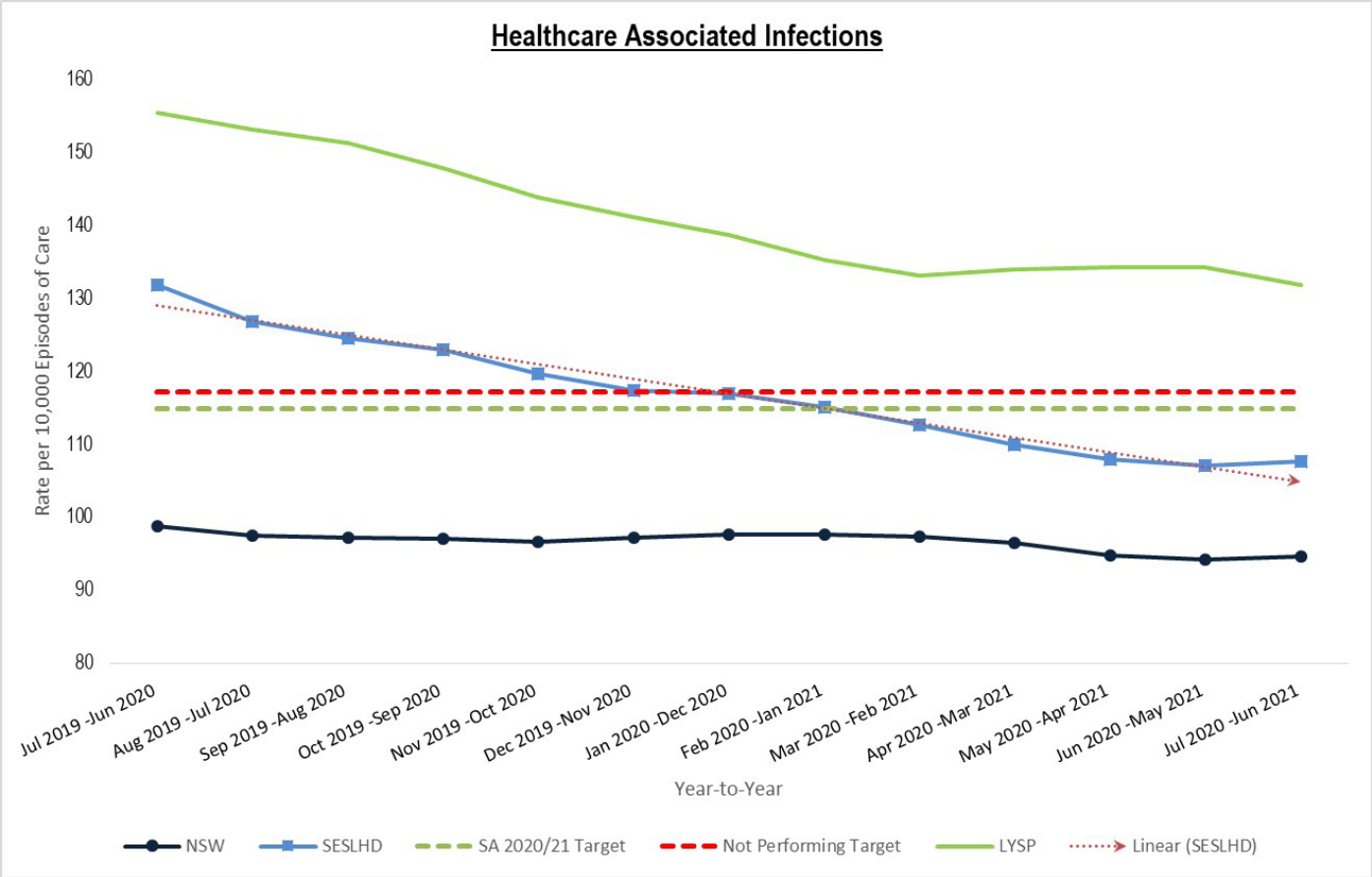
Falls resulting in fracture or other intracranial injury



SESLHD rates of hospital-acquired falls resulting in injury have maintained positive results, with the trend line remaining below target and NSW state average. Work continues at sites to prevent falls.

At St George Hospital, falls HACs are reviewed regularly at the falls committee, divisional performance meeting and peak patient safety meeting. A data dive has been conducted by the patient safety manager, confirming the accuracy of the rates. At Sydney/Sydney Eye Hospital (SSEH), a communication board in medical ward with high patient falls risk and fall prevention strategies have been introduced. SSEH has also seen the introduction of a lifting round in medical ward (modified version of IR) and targeted education in post fall management in the outpatients and emergency departments. QARS (Quality Audit Reporting System) is used for auditing post fall management and falls screening in both inpatient wards at SSEH, and a hospital inpatient observational audit of all patients who were deemed high risk use a modified Falls Observation audit. Furthermore, the Director, Nursing has also set up a Falls Focus Meeting to identify issues and mitigate risks. At War Memorial Hospital, the SESLHD Patient Reported Measures (PRMs) falls project planning is underway with a view to commence by 2022. The hospital is also implementing recommendations from two Harm Score 2 investigations for previous falls. Prince of Wales Hospital has a number of initiatives underway, including a review of medication use across the facilities that are linked with falls, Real Time Patient Experience Survey on falls, implementation of nurse clinical leads for falls prevention, dissemination of referral service information, and the development of a log to register equipment and devices used in falls prevention and management. The Sutherland Hospital (TSH) Falls Prevention Management Committee continues to focus on ensuring staff have the knowledge and skills to risk assess patients for falls and to implement falls minimisation strategies. Risk assessment audits continue monthly, falls prevention awareness activities take place such as the annual April Falls Day event. At TSH there is also a falls project underway in the Emergency Department Short Stay Unit: ‘Call before the fall’.

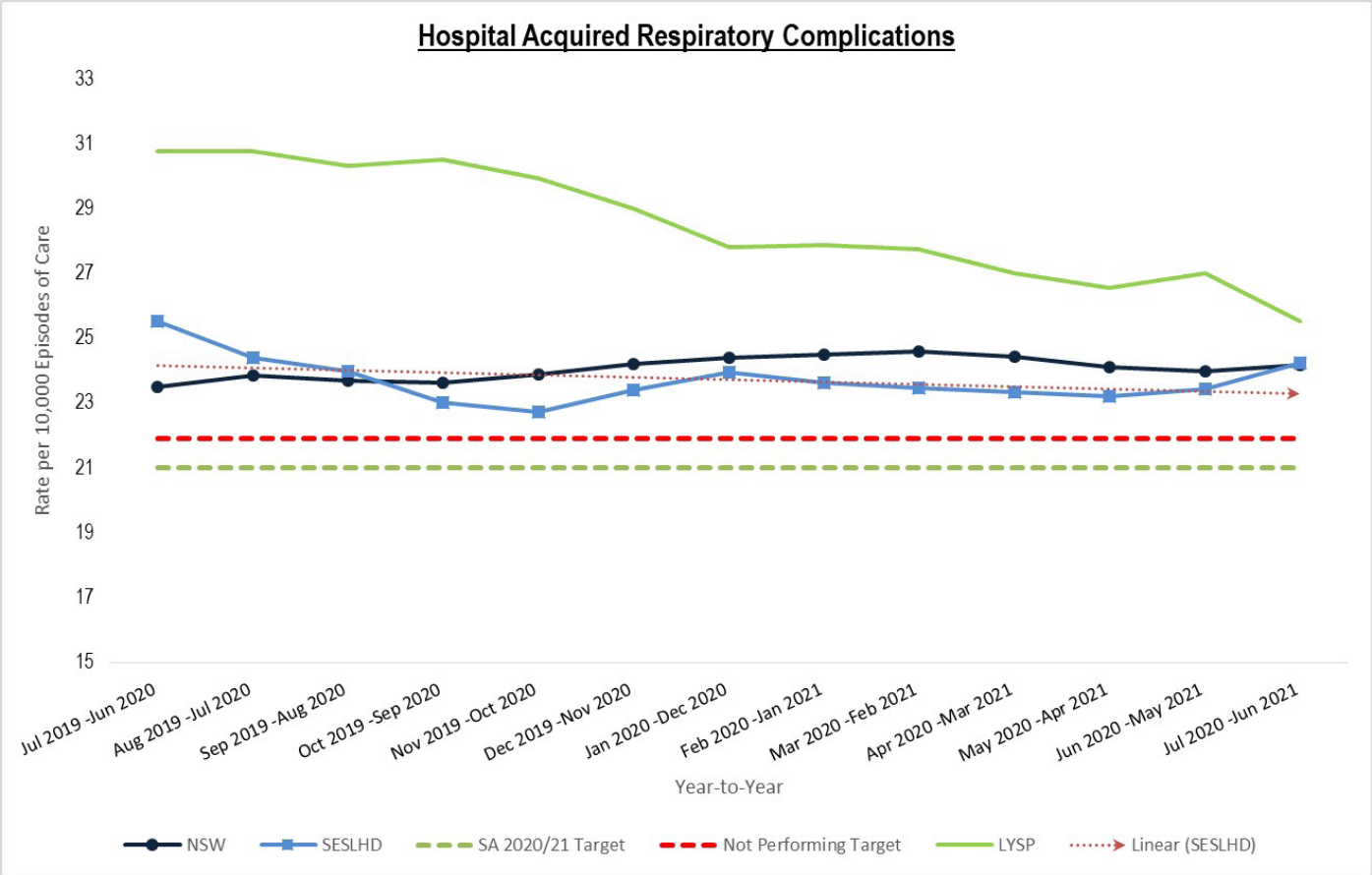
Healthcare associated infection (HAI)



SESLHD Healthcare Associated Infections (HAIs) continue on an overall downward trend, although currently tracking above state average. District HAI data is monitored through the monthly SESLHD Infection Prevention Control Committee. Sites continue work through a range of initiatives.

The Prince of Wales Hospital (POW) HAI Strategy is almost at the end of its second year. Six executive-led working groups have implemented multiple strategies addressing hand hygiene and aseptic technique, environmental cleaning and clutter, sepsis detection and management, infection control precautions, invasive device management and surgical site infection prevention in cardiothoracic surgical patients. A new research project will be focused on the implementation of care bundles for urinary catheters, PIVC (peripheral intravenous cannulas) and CVAD's (central venous access device) and will start in August 2021. POW hand hygiene has improved to overall 86.6% June 2021 with all five moments over 80% for the first time. Microfibre has now implemented in most extreme high risk areas. At St George Hospital (SGH), HAI rates have increased and are being reviewed at the Infection Control Committee. The SGH clinical governance team is currently seeking a resource outside of the Infection Control team to undertake a data dive. At Sydney/Sydney Eye Hospital, there are minimal HAI events and continued surveillance is reported. The new Clinical Excellence Commission Infection Control Manual will be used for implementation and training. At The Sutherland Hospital, HAIs are tabled at Infection Prevention and Control meetings. There will be bedspace mapping of Vancomycin Resistant Enterococci (VRE) acquisitions in comparison to Deprox cleansing and an aim for Deprox cleaning on a monthly basis in all possible bed areas. At War Memorial Hospital previous consultation between Infection Control Clinical Nurse Specialist (IC CNS) and Medical Records has occurred to improve documentation and correct coding of HAI's, with ongoing regular screening of patient records by IC CNS to ensure HAI data recorded and captured correctly.

Hospital acquired respiratory complications



Hospital acquired respiratory complications in SESLHD have generally tracked below state average, but are above the target rate.

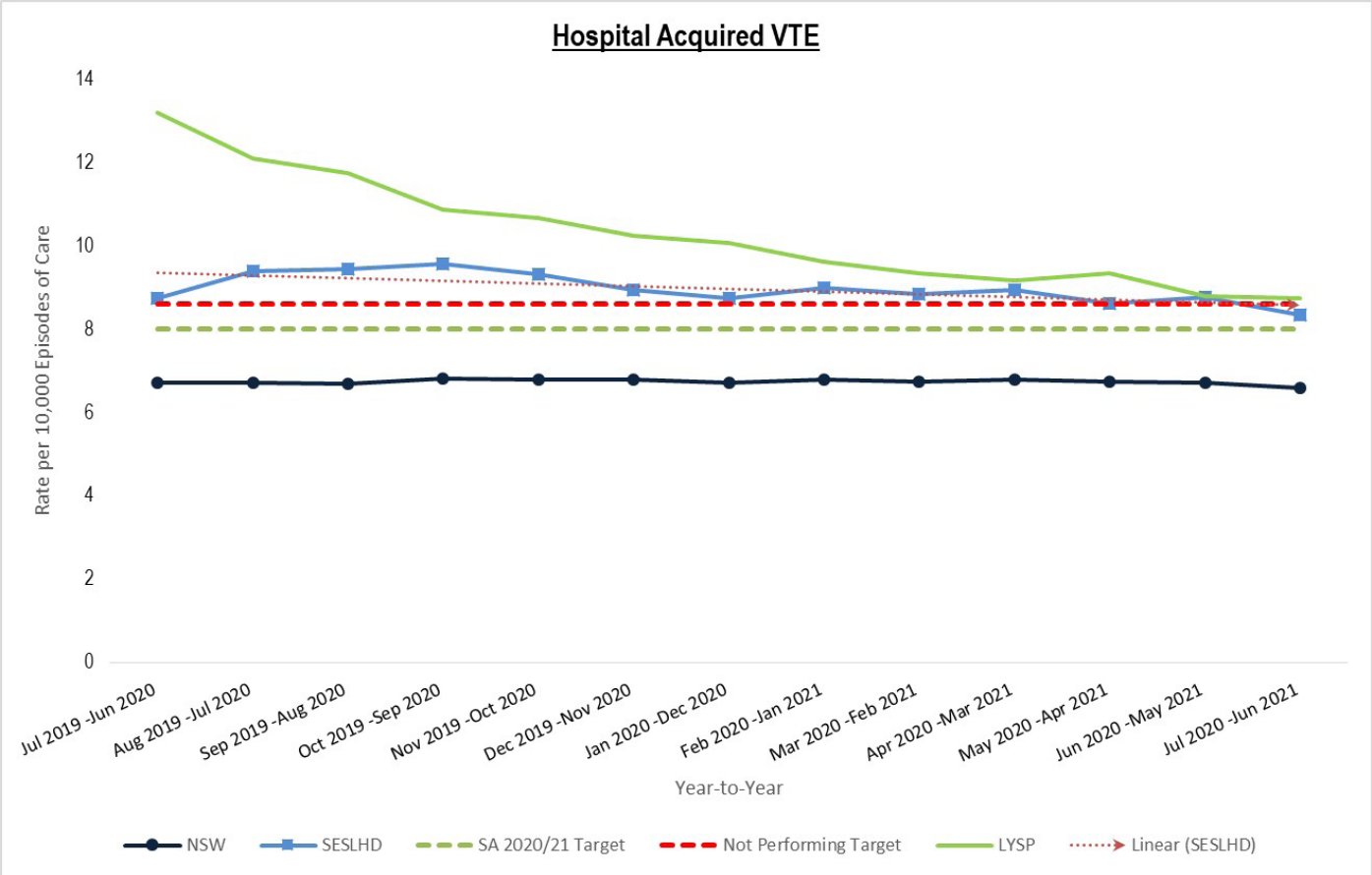
At the Prince of Wales Hospital (POWH), the focus has been on aspiration pneumonia cases within this HAC category. A multidisciplinary project team was formed in 2019, consisting of doctors, nurses, medical records and speech pathologists and led by the Head of Department, Speech Pathology. They have been reviewing identified cases of Hospital Acquired Aspiration Pneumonia (HAAP). Actions to date have included:

- Reviewed the literature to determine the evidence based risks of developing aspiration pneumonia
- Formulated an evidence based definition of aspiration pneumonia
- Conduct a medical record audit of patients diagnosed with HAAP using the evidence based definition
- Revise education packages for nursing staff incorporating risks and prevention strategies
- Continue to work with Health Information Unit (HIU) regarding coding
- Develop a dysphagia education handout, including definition, to give to medical staff rotating to a new ward

POWH has also formulated an evidence based definition of aspiration pneumonia, education sessions have been given to medical staff about correct diagnosis of aspiration pneumonia and the nursing staff education packaged has been revised.

St George Hospital respiratory complication HAC rates have been stable and are reviewed at Divisional Performance meetings. The Sutherland Hospital continues to review these HACs each month, with Allied Health Lead/ Head of Department, Speech Pathology following up cases. Of all cases reviewed, there were no gaps in management identified (all unavoidable).

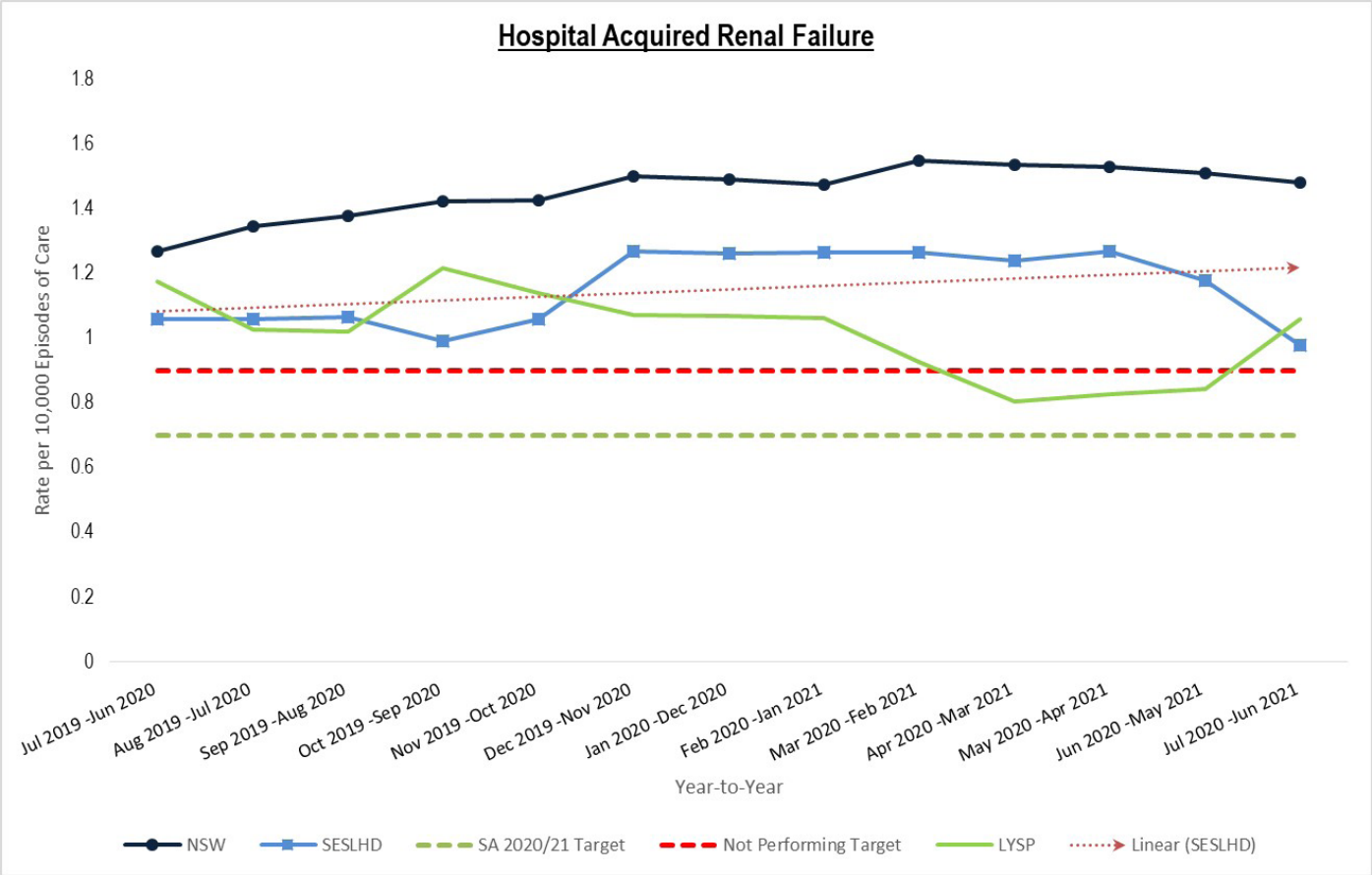
Venous thromboembolism (VTE)



SESLHD Venous Thromboembolism (VTE) rates have an overall downward trend but remain above target and state average. Reporting to the SESLHD Clinical and Quality Council (CQC), a District VTE Working Party meets bi-monthly to provide governance of VTE risk assessment processes and VTE prevention and management strategies.

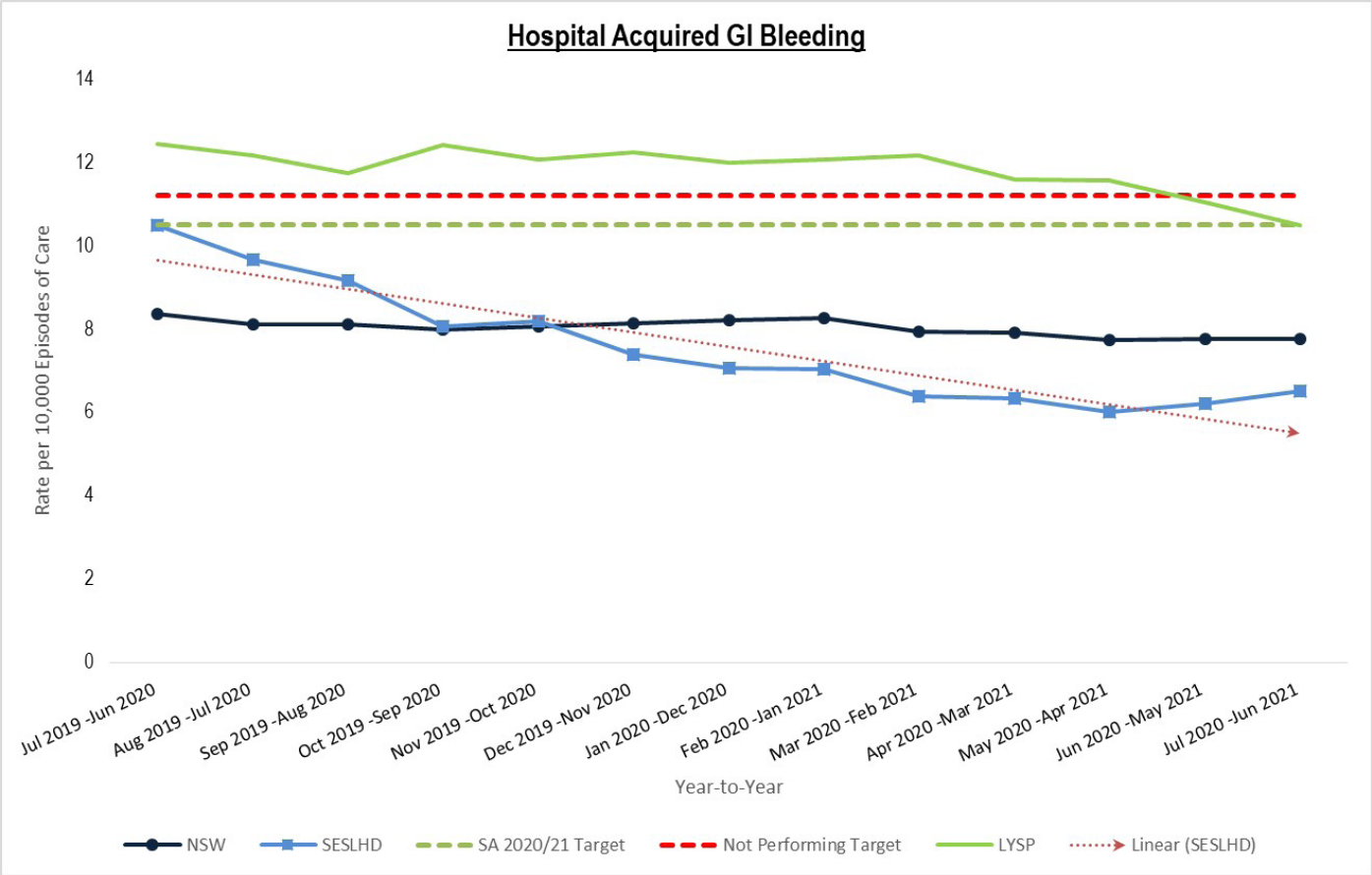
At the Prince of Wales Hospital (POWH), the Junior Medical Officer induction VTE learning package has been reinstated in 2021. Each incidence of VTE identified at POWH in the incident management system (ims+) is assigned a Harm Score 2 rating and a detailed review is conducted using the Clinical Excellence Commission's VTE incident review tool. A POWH VTE working party is also in place. St George Hospital reviews VTE HACs at Service Line Performance meetings. VTE HACs have been increasing at St George Hospital and a data dive has been planned by the Safety Manager. The Sutherland Hospital continues to review HACs each month and HACs are sent to the relevant clinician and/or department head for review.

Hospital acquired renal failure



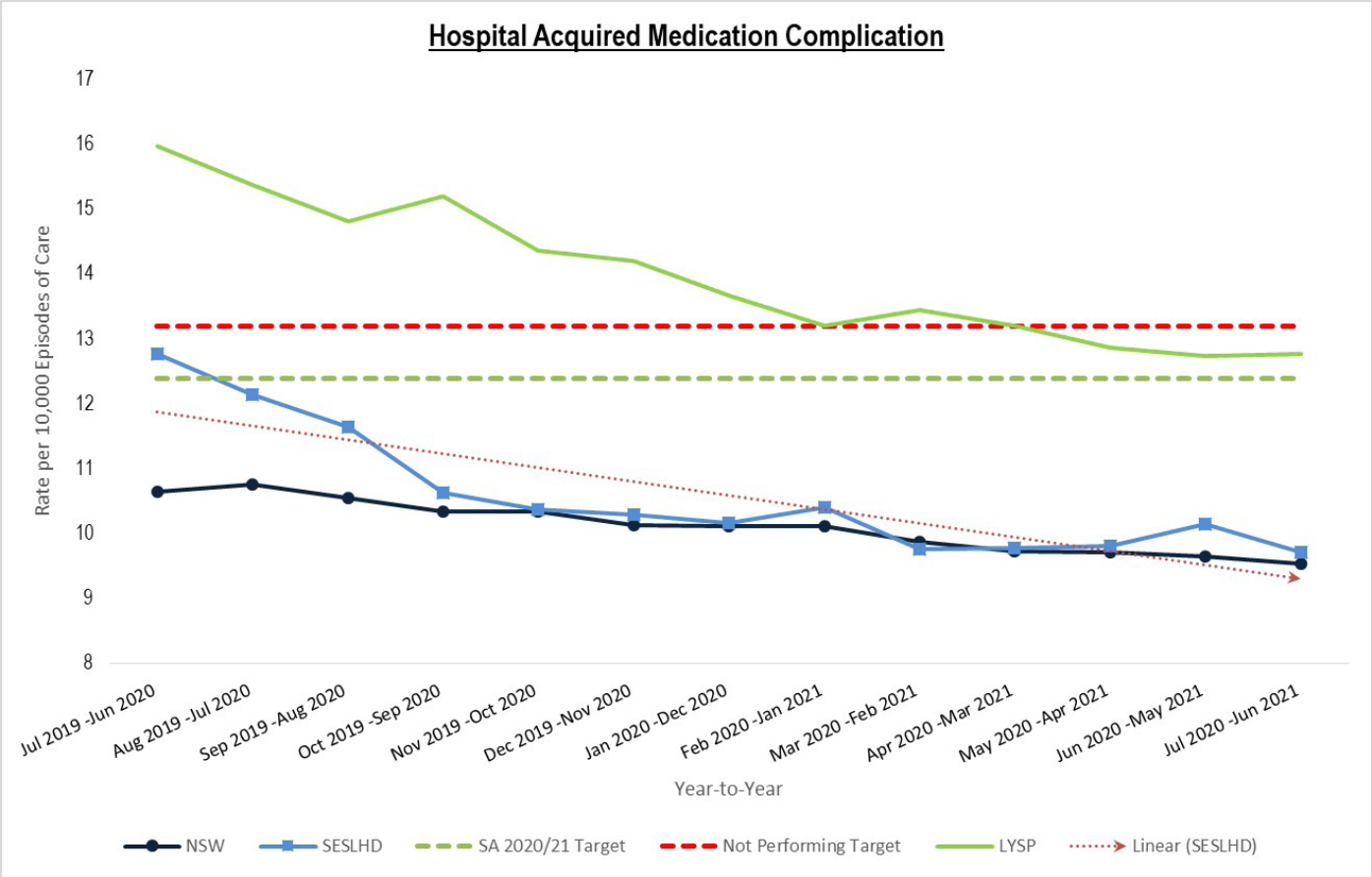
SESLHD renal failure HACs are currently tracking below state average, but outside the target range. Prince of Wales Hospital Renal Services implemented an Acute Kidney Injury (AKI) alert in the electronic medical record (eMR) in 2019 and has improved the alert in the last 12 months. Each case of AKI that requires haemodialysis or continuous veno-venous haemodialysis is reviewed for preventability. A key patient population are patients with cardiac disease or post-operative surgical patients. An event where a code blue was called for a patient led to a project in 2020 to examine preoperative and intraoperative hydration in the orthogeriatric population in order to prevent AKI. Uptake of management plan for AKI has been promising. At St George Hospital renal failure HACs are reviewed at Divisional performance meetings, where HAC rates have been stable. The Sutherland Hospital continues to review each month and HACs are sent to the relevant clinician and/or department head for review.

Hospital acquired gastrointestinal (GI) bleeding



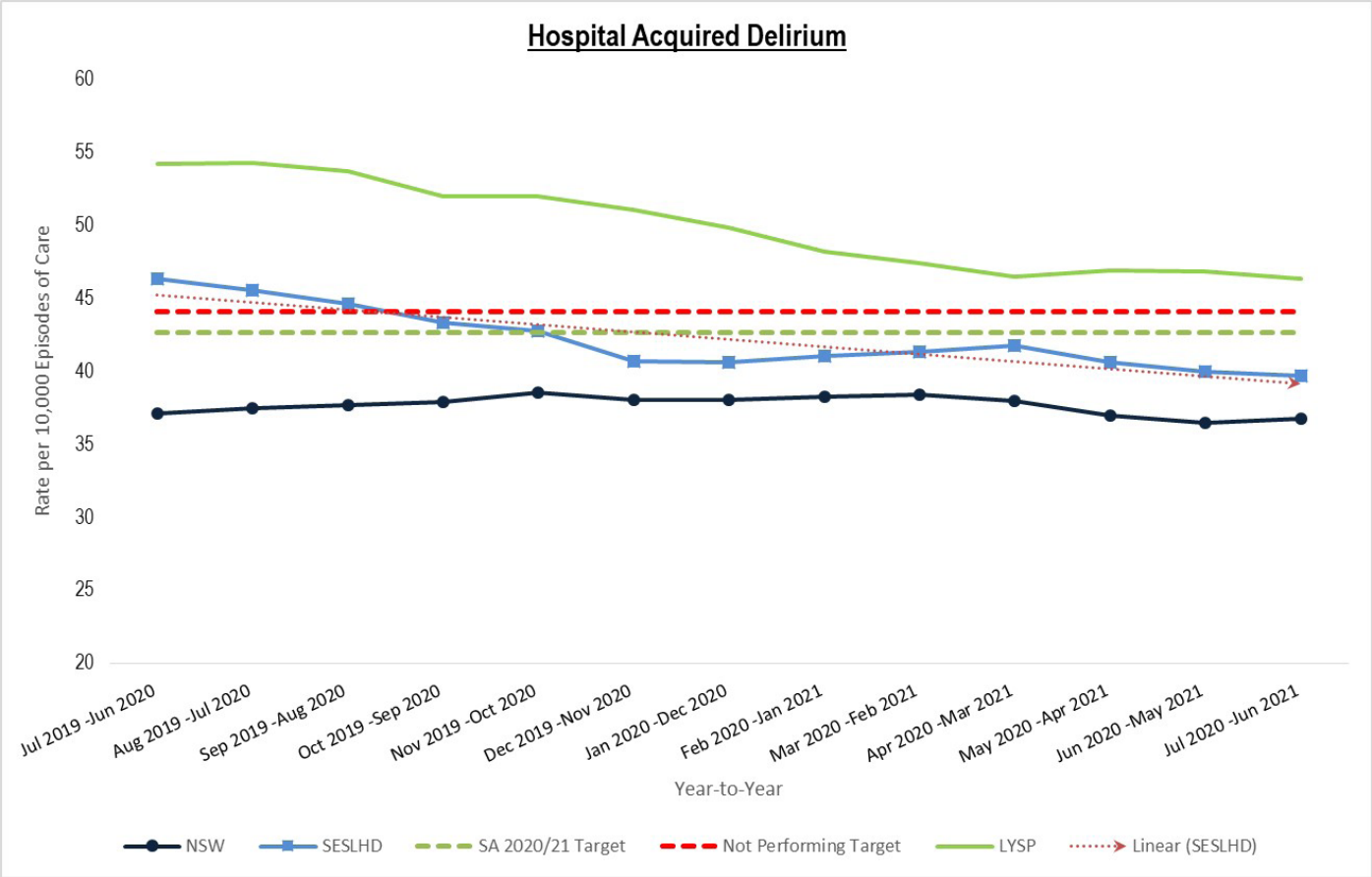
SESLHD gastrointestinal (GI) bleeding HAC rates are performing below target and state average. At St George Hospital, GI bleeding HACs are reviewed at Divisional Performance Meetings and HAC rates have been stable. The Sutherland Hospital continues to review each month and HACs are sent to the relevant clinician and/or department head for review. Prince of Wales Hospital formed a working group in mid-2020 to review 12 months of cases of GI bleeding. This group will complete a review of the last 12 months of cases by the end of September 2021. 30 cases were reviewed and analysed in mid-2020.

Hospital acquired medication complications



SESLHD medication complications have performed below the target rate in 2020-21. At Prince of Wales Hospital (POWH), an anticoagulants working party has been established. The pharmacy intranet page information has recently been updated, and patient information leaflets are now easier to find. Furthermore, action is in progress to reduce the use of Hydromorphone use at POWH. At St George Hospital, medication complication HAC rates have increased and a data review was completed in May 2021. Action plans were initiated for identified risks and discussed and reviewed at Safe Use of Medicines Committee. The Sutherland Hospital tables and discusses medication complication HACs at Safe Use Medicines Committee and continues to review each month.

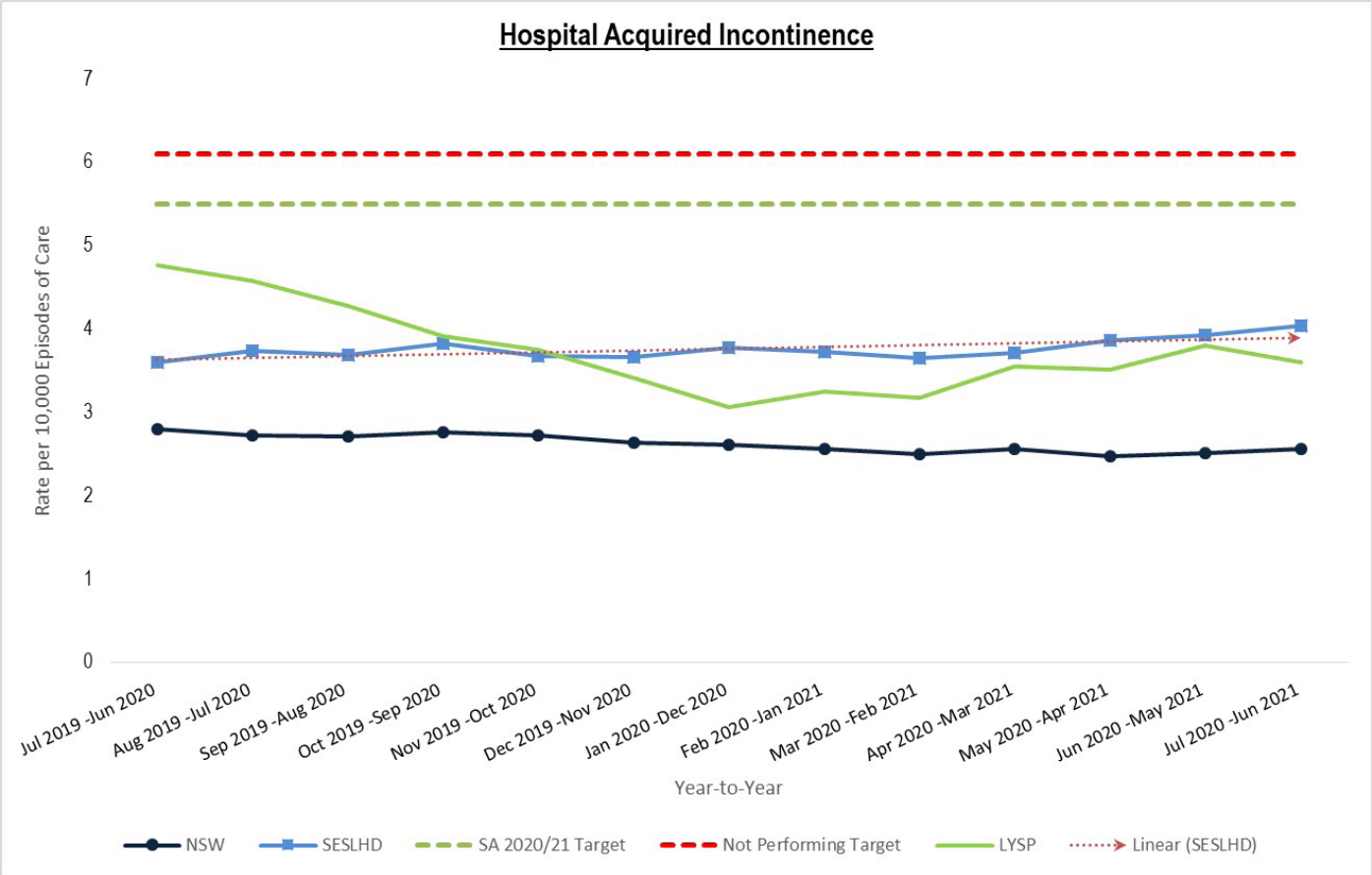
Hospital acquired delirium



SESLHD hospital acquired delirium rates have continued on a downward trend and are currently below target. As part of preparedness for accreditation, a gap analysis for Comprehensive Care (National Standard 5) was conducted at all SESLHD sites. Resulting from this, a number of initiatives have been undertaken to improve the prevention, screening, diagnosis and management of delirium. One example is 'Detecting Delirium'; a 45-60 minute interactive face-to-face session that was rolled out to assist staff in preventing, screening, diagnosis, and managing delirium. The session enhances capacity and capability of staff to promote person-centred care and the use of non-pharmacological strategies. Some of the benefits of this consistent approach include improved quality and safety for the people with delirium, enhanced person-centred care, reduction of hospitalisation related costs, reduction in admissions to RACFs, strengthened knowledge and practice of person-centred care principles. There is interdisciplinary role play/collaboration between medical, nursing and allied health.

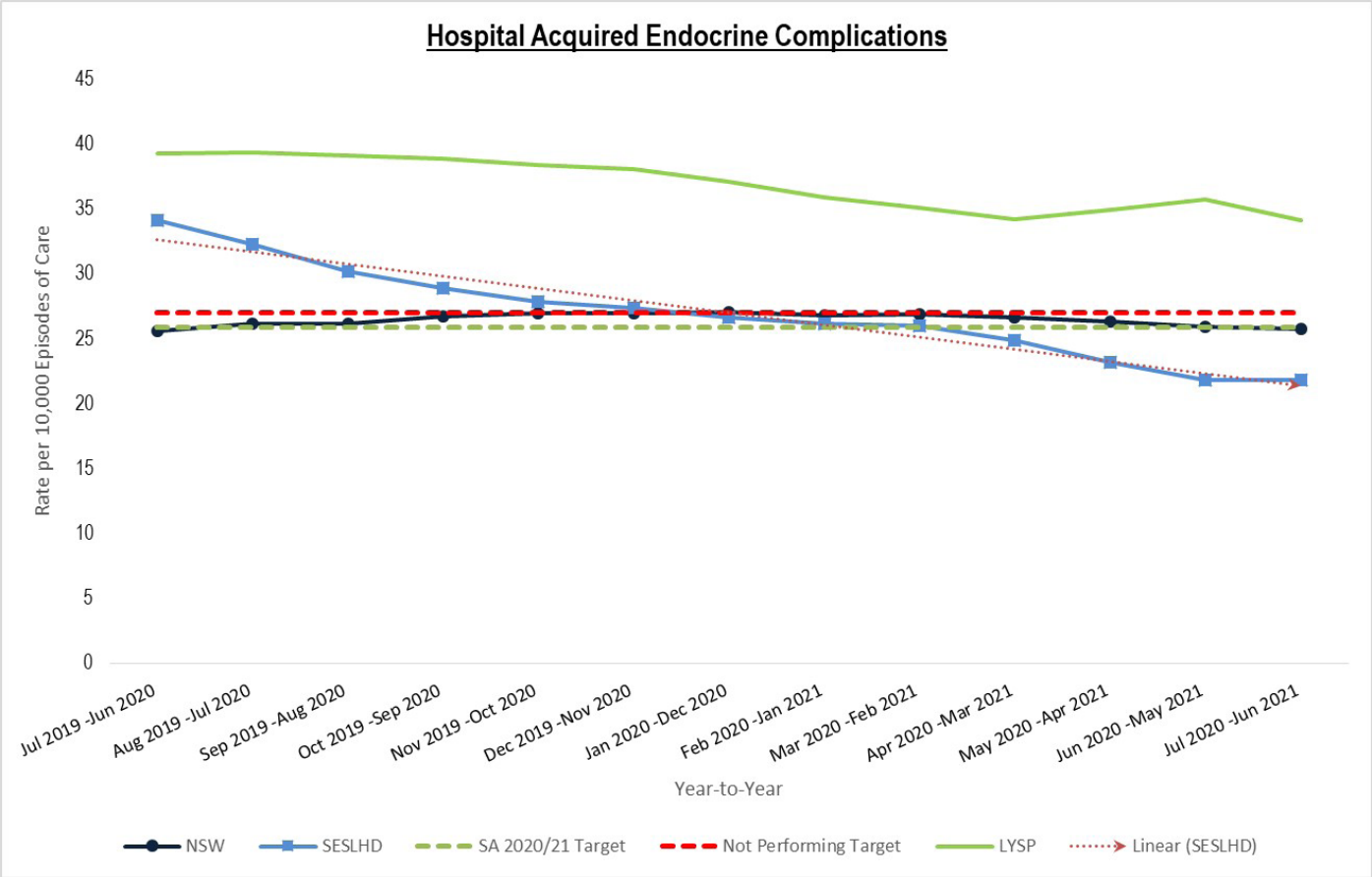
A number of other activities are occurring at SESLHD sites. At The Sutherland Hospital (TSH), education regarding pre and post operation delirium occurs, as well as ensuring laxatives and pain relief are charted adequately on admission. A quality improvement project is to be commenced on laxatives charted pre and post operation. A TSH Delirium Clinical Business Rule has been created, monitoring implementation and education roll out. A Critical Care Medicine (CCM) delirium project is being undertaken, which is now looking at minimising and preventing delirium through non-pharmacological interventions. At War Memorial Hospital, implementation of Person Centred Profile/Top 5 with multi-disciplinary team education is provided by SESLHD Dementia/ Delirium CNC, with ongoing auditing of completion to increase compliance. At the Prince of Wales Hospital, a delirium working group has been in place for almost 2 years, including development of an annual project plan. Education about the new electronic medical record (eMR) screening tool has commenced.

Hospital acquired incontinence



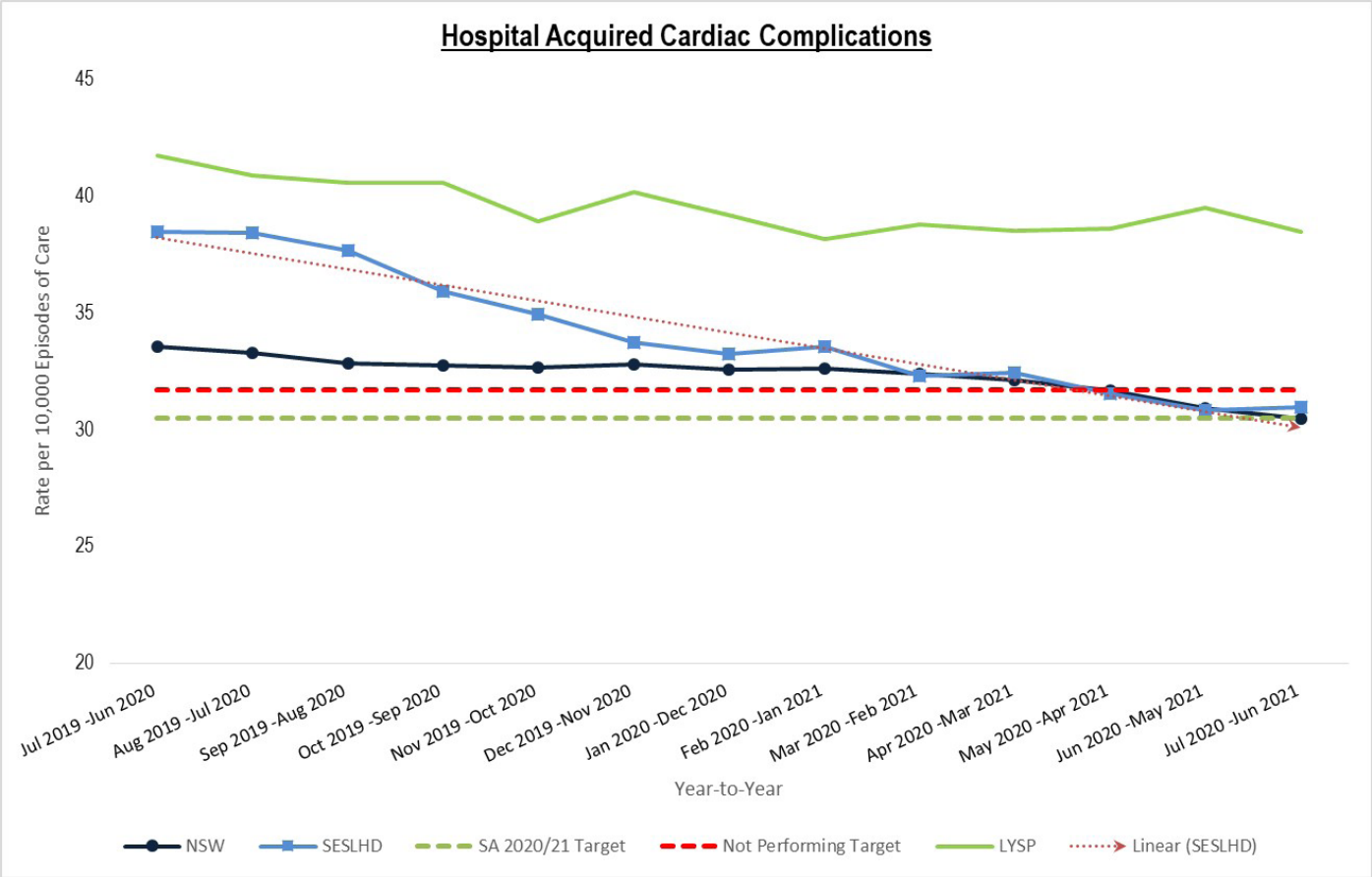
SESLHD rates of hospital acquired incontinence have remained below target for the 2020-21 financial year. Sites continue to engage in a range of initiatives to maintain these positive results. At Prince of Wales Hospital, this HAC has been included in the Comprehensive Care Committee work, as it has a strong relationship with falls and pressure injury HACs. There is a Continence Clinical Nurse Consultant in the Community Service and an Aged Care Clinical Nurse Educator with an interest in continence. Much of the work in the last 12 months has been focused on improving continence in the community, however many of these activities are relevant to the inpatient setting. The two staff will form a new improvement team shortly. At the Royal Hospital for Women(RHW), episodes of persistent incontinence has been identified as an area of focus, with the RHW Clinical Governance Unit engaging with the multidisciplinary team to understand the issue more and identify opportunities for improvement. At St George Hospital, HAC rates are stable and a data dive has been completed in June 2021. At War Memorial Hospital, there has been an expansion of staffing for out-patient continence advisory service through CHSP funding to cover holistic assessment, care plans, and preventative exercise components.

Hospital acquired endocrine complications



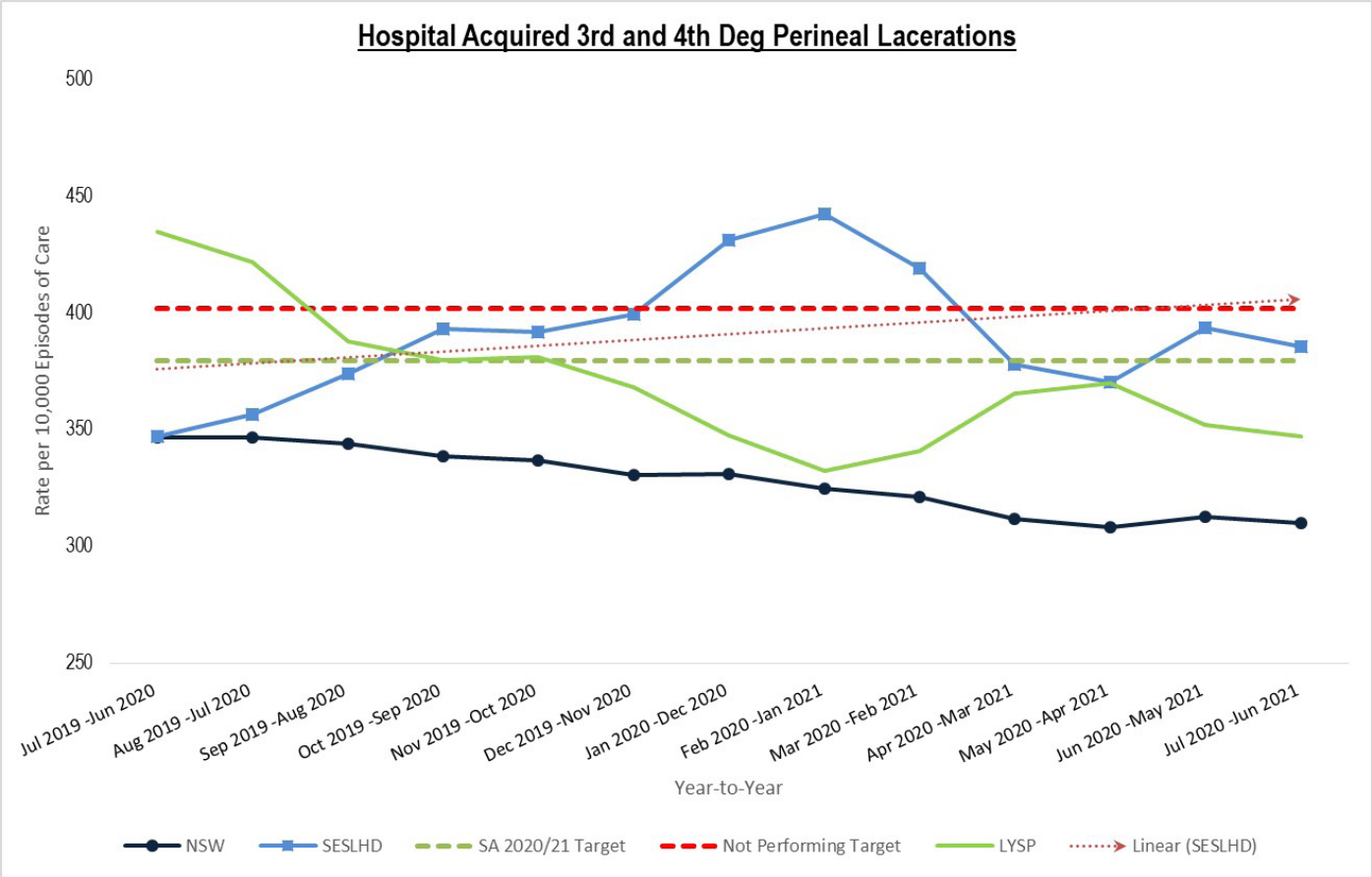
SESLHD rates of hospital acquired endocrine complications have improved from last year and are currently performing below target level. At St George Hospital, endocrine complication HACs have been stable and are reviewed at Divisional Performance Meetings. At Prince of Wales Hospital (POWH), a new Diabetes Educator has been appointed in May 2021 and a hospital-wide education plan regarding hypoglycaemia, steroids & insulin infusions is being developed. A project about insulin pen pilot will be commencing shortly. A hypoglycaemic dashboard has been developed and is now live at POWH. This tool supports a new proactive approach to the management of in-patients with diabetes. At The Sutherland Hospital (TSH), the HAC continues to be reviewed each month and endocrine complication HACs sent to the relevant clinician and/or Dietetics Head of Department for review. A TSH Malnutrition Working Party is in progress and there have been significant improvements in malnutrition HACs (nil severe malnutrition reported in last 7 months). Monitoring for the use of sodium–glucose co-transporter-2 (SGLT2) inhibitor medicines on wards during deteriorating patient reviews, and monitoring for the development of euglyceamic diabetic ketoacidosis occurs.

Hospital acquired cardiac complications



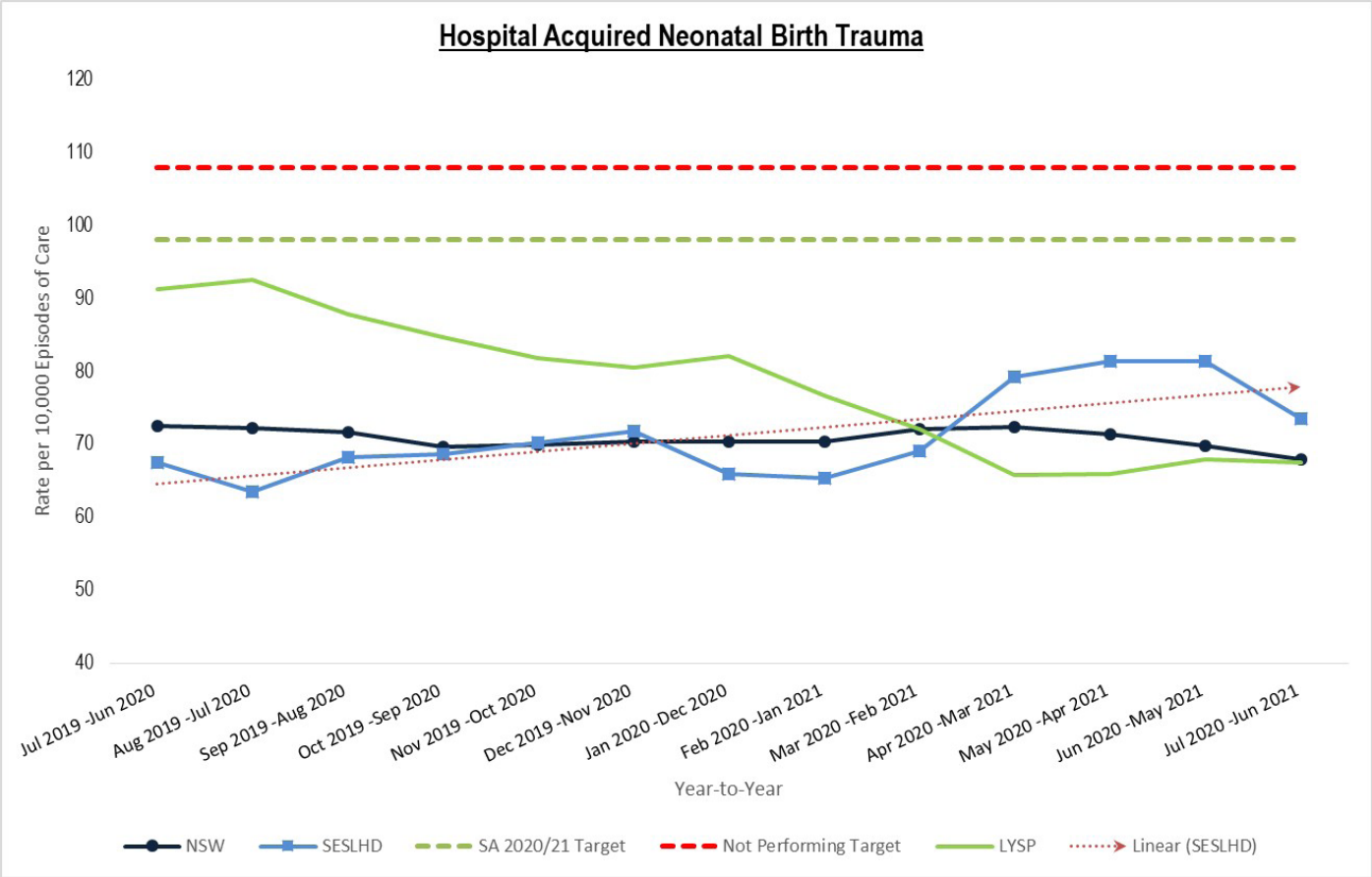
SESLHD hospital acquired cardiac complication rates have seen a reduction over the past 12 months and trends are monitored across the District. At The Sutherland Hospital, cardiac complication HACs are reviewed each month and HACs sent to the relevant clinician/department head for review. At Prince of Wales Hospital (POWH), the cardiology department reviews HAC data periodically. All cardiopulmonary arrest events are reviewed by the Clinical Emergency Response System Clinical Nurse Consultant. Performance has improved at POWH in the last 12 months with decline in cases for 2019/2020 from 297 to 187 in 2020/2021 (or about 30%).

Hospital acquired 3rd & 4th degree Lacerations



SESLHD rates of hospital acquired 3rd and 4th degree perineal lacerations saw a spike in between November 2020 and February 2021. At TSH, 3rd and 4th degree perineal lacerations continue to be reviewed at Women's & Children's Health weekly clinical review meetings. The Sutherland Hospital is also undertaking the Protecting Our Perineum (POP) project, which has contributed to an increased use of warm compress during perineal stretching. Further, there has been increased education provided to women antentally about perineal massage and perineal trauma. Birth position and mobilising throughout labour has also assisted to reduce this HAC. At St George Hospital, HAC rates are stable and a data dive has been completed in June 2021. The Royal Hospital for Women continues to have a downward trend in 3rd and 4th degree tears.

Hospital acquired neonatal birth trauma



For hospital acquired neonatal birth trauma, SESLHD continues to perform below the target rate, although there has been an upward trend. At the Royal Hospital for Women there has been a maintenance of Fetal Safety Training and ongoing audits measuring compliance with the 'Fetal monitoring and record keeping in labour" Guideline. At The Sutherland Hospital, this HAC continues to be reviewed at Women's and Children's Health weekly clinical review meeting. At St George Hospital, HAC rates are stable and a data dive has been completed in June 2021.

General KPIs Report

Safety and Quality Domain	Measures	SESLHD Result	Target	Current Period
Strategy 1: Keep people healthy				
Effectiveness	Childhood Obesity – Children with height and weight recorded (%)	75.3% (5.3 better than target)	70%	Jan-Mar 2021
Equity	Smoking During Pregnancy – At any time (%): • Aboriginal Women • Non-Aboriginal Women	Aboriginal: 34.8% (1.9 worse than target)	32.9%	2019
		Non-Aboriginal: 3% (0.1 better than target)	3.1%	2019
Efficiency	Hospital Drug and Alcohol Consultation Liaison - Number of consultations	14,221 (1,281 better than target)	12,940	FYTD Mar-21
Effectiveness	Hepatitis C Antiviral Treatment Initiation – Direct acting - by LHD residents	91 (12 worse than target)	103	FYTD Dec-20
Outcome 1: Keeping people healthy through prevention and health promotion				
Effectiveness	Children fully immunised at one year of age (%)	94.4% (0.6 worse than target)	95%,	Jan-Dec 2020
	Pregnant Women Quitting Smoking - By second half of pregnancy (%)	38.4% (0.5 better than target)	37.8%	Jul 19-Jun 20
	Get Healthy Information and Coaching Service – Get Healthy in Pregnancy Referrals	1,194 (584 better than target) We only have the absolute number	611,584	FYTD Mar-21
	BreastScreen participation rates (%) • Women aged 50-69 years • Women aged 70-74 years	Women aged 50-69 years: 46.5% (8.5 worse than target)	55%,	Jul 19-Jun 21
		Women aged 70-74 years: 49.4% (5.6 worse than target)	55%	Jul 19-Jun 21
Strategy 2: Provide world class clinical care where patient safety is first				
Equity	Discharge against medical advice for Aboriginal inpatients (%)	94.4% (0.6 worse than target)	1.6%	Jan-Mar 2021
Efficiency	Elective Surgery Overdue – Patients (Number): • Category 1 • Category 2 • Category 3	Cat 1: 2 (target: 0, 2 worse than target) Cat 2: 51 (target: 0, 51 worse than target) Cat 3: 56 (target: 0, 56 worse than target)	0	Jun 2021
Timeliness and Accessibility	Paediatric Admissions from Elective Surgery Waiting List - % variance from target (Number)	48 (20 worse than target)	68	Jun 2021
Timeliness and Accessibility	Emergency Treatment Performance – Admitted (% of patients treated in <= 4 hrs)	28.5% (21.5 worse than target)	50%	Jun 2021
Outcome 4: People receive high quality, safe care in our hospitals				
Effectiveness	Unplanned Hospital Readmissions – All admissions within 28 days of separation (%): • All persons • Aboriginal persons	All persons: 5.8% (0.2 worse than target) Aboriginal persons: 9.7% (3.5 worse than target)	5.6% 6.1%	May 2021 May 2021
Efficiency	Elective Surgery Access Performance – Patients treated on time (%): • Category 1 • Category 2	Cat 1: 100% (target 100%) Cat 2: 89.6% (7.4 worse than target) Cat 3: 91.7% (5.3 worse than target)	Cat 1: 100% Cat 2: 97%	Jun 2021
Outcome 2: People can access care in and out of hospital settings to manage their health and wellbeing				
Patient-Centred Culture	Electronic Discharge Summaries – Sent electronically and accepted by General Practitioners (%)	80.6% (29.6 better than target)	51%,	Jun 2021

Mental Health Service Performance Indicators

Mental Health Service Agreement indicator	Performance
Acute Post-Discharge Community Care - Follow up within seven days (%)	Currently SESLHD is performing better than target on the Acute Post-Discharge Community Care. Follow up within seven days (%) reporting 77.4% (May 21). Target is 70%. **Initiatives:** Zero Suicide in Care - aiming to standardise and develop a universal Suicide Prevention Pathway with follow up (face to face) from presentations to the Emergency Department within 48 hours.
Acute readmission - Within 28 days (%)	Readmissions increased in 2019/20, however have declined in 2021/22 so far. There are significant fluctuations against target due to complex consumers. 2020/21 YTD (year to date) - LHD Result - 11.84% Target is ≤13%. **Initiatives:** Partnerships Team - complex care reviews and management. Prevention and Recovery Centre (PARC) - supporting step up transitions from community to avoid inpatient stays and step down transitions from inpatient settings to reduce length of stay in acute care facilities. Pathways to Community Living Initiative - supporting complex clients transition into the community. Tertiary Referral Service for Psychosis Pilot. SESLHD Mental Health Service Housing, Homelessness, and Mental Health Pathways Project in partnership with Department of Community Justice. Towards Zero Suicide Aftercare expansion with community support following suicidal crisis.
Acute Seclusion Occurrence - Episodes (per 1,000 bed days)	SESLHD has significantly improved its seclusion rate over the past 4 years moving from 11.0 Acute Seclusions per 1000 bed days in 2015/16 to 2.39 YTD (Mar) 2020/21. This is better than the Target 5.1 and the state average of 5.7. MHS aims to continue to reduce the use of restrictive practices within its services. **Initiatives:** Diversional Therapy Initiative.
Acute Seclusion Duration – Average (Hours)	SESLHD 2020/21 YTD (March) average seclusion time was 4.7 hours, which was above the target - this was significantly impacted by high complex consumers that are housed within our tertiary Mental Health Intensive Care Unit. This time still remains better than the Target 5.1 and the state average of 5.7. The Mental Health Service aims to continue to reduce the use of restrictive practices within its services. **Initiatives:** Diversional Therapy Initiative.
Involuntary patients absconded from an inpatient mental health unit – Incident Types 1 and 2 (Number)	Involuntary Patients Absconded Results 2019/20 = 47 - 2020/21 = 38 Reduction from previous year, work to reduce number of absconding patients continues. **Initiatives:** Diversional Therapy Initiative.
Mental Health Consumer Experience: Mental Health consumers with a score of Very Good or Excellent (%)	Mental Health Consumer Experience reported - 74% (last available quarter). Mental Health is working with consumers to involve them in service development and ensuring lived experience is represented in the development of models of care developing care programs and enhancing the consumer workforce. **Initiatives:** Enhancement and professionalism of consumer/peer workforce. Peer Co-Delivered Services. SafeHaven - Peer delivered service. Suicide Prevention Outreach Team. DBT & BLIP Teams. Youth Brief Intervention Service.
Emergency Department Extended Stays: Mental Health Presentations staying in ED > 24 hours (Number)	2020/21 - consumers admitted to Mental Health ward: 10. Difficulties in determining accurate numbers as based on diagnosis not on patients who were seen by the Mental Health Service. For those patients who were admitted under Mental Health, the majority of delays were due to ongoing medical treatment or monitoring due to sedation given to the patient. **Initiative:** Improved partnerships with Emergency Departments.

Patient Experience Performance

Overall Patient Experience Index – Adult admitted patients

8.75 (0.25 above target)

(June 2021)

Patient Engagement Index – Emergency Department patients not admitted to hospital

8.15 (0.35 below target)

(June 2021)

Patient Engagement Index – Adult admitted patients

8.47 (0.03 below target)

(June 2021)

Overall Patient Experience Index – Emergency Department

8.90 (0.40 above target)

(June 2021)

2021 - 22 Future Priorities

2021-22 Future Priorities

Aboriginal and Torres Strait Islander Health

The SESLHD Geographic area lies within both the Eora and Dharawal Nations. The area encompasses the traditional lands of five Aboriginal language groups including the Dharawal, Gadigal, Wangai, Gweagal and Bidjigal peoples. Of the estimated 979,370 residents living in the District in 2021, people of Aboriginal and Torres Strait Islander heritage make up approximately 1% of the population.

Aboriginal people face a number of disadvantages. With respect to healthcare, the rates of hospitalisation for all causes is increasing at a higher rate in Aboriginal people than in non-Aboriginal. Aboriginal people are over-represented for potentially preventable hospitalisations; up to 50% higher for chronic conditions compared to the non-Aboriginal population. The rate of hospitalisations for all causes in 2015-16 among Aboriginal people in SESLHD was 29% higher than in non-Aboriginal people.

In 2020, as part of the 'Closing the Gap' initiative, the Commonwealth Government has emphasised a greater focus on partnership between governments and Aboriginal and Torres Strait Islander people and heralds a new way forward, where Aboriginal and Torres Strait Islander people share ownership, responsibility and accountability to drive progress for current and future generations. In order to address this priority, SESLHD has included a number of Aboriginal Health priorities on the 2021-22 District Business Plan.

Improve Aboriginal Health outcomes and contribute to Closing the Gap.

Outcome:

- Finalise and implement Burudi Muru Yagu SESLHD Aboriginal Health Plan.
- Review of Aboriginal Health Governance that improves reporting mechanisms, addressing performance indicators in Aboriginal health
- This includes regular meetings and opportunities to improve health outcomes by Aboriginality at these forums; District Executive, Clinical and Quality Council and ED and clinical streams.
- Address falling rates of Reporting of Aboriginality which will then influence the following performance indicators; Decrease did not wait and re-presentation rates for Aboriginal and Torres Strait Islander patients
- Increasing the cultural responsiveness of services through the following actions:
    - » The Ministry of Health mandate attendance at Respecting the Difference face to face cultural awareness sessions. This education is essential to improving identification of Aboriginal people and referral to appropriate services.
    - » Increasing Aboriginal workforce.
    - » Developing culturally welcoming spaces, through the use of artwork and the Aboriginal and Torres Strait Islander flags and
    - » Acknowledging significant days for Aboriginal and Torres Strait Islander staff and community members such as Sorry Day, Reconciliation week and NAIDOC week by holding events. This also further informs all staff on the strengths of Aboriginal culture and supports an understanding of the physical, emotional, social and spiritual dimensions of wellbeing for Aboriginal and Torres Strait Islander individuals and communities and what assists Aboriginal people to trust and access services.
- All facilities have established Aboriginal and Torres Strait Islander health working parties. These will continue steps in 2021-2022 to improve health outcomes for Aboriginal and Torres Strait Islander patients. All facilities addressed needs in an Aboriginal cultural engagement self- assessment tool in 2020 and have plans to address gaps in service delivery. This assessment will be undertaken annually.

Strategic alignment:
Safe, person-centred and integrated care
Workforce wellbeing
Community wellbeing and health equity

Build the capacity of Aboriginal and Torres Strait Islander health workforce

Attract more Aboriginal and Torres Strait Islander applicants, then support and retain these staff employed in the SESLHD workforce.

Discussion to support these outcomes have focussed on workforce initiatives. This includes advice given to assist Managers of Aboriginal and Torres Strait Islander staff to enable roles and services that are culturally welcoming and support both the staff and the Aboriginal community who access the service. Examples of effective programs and the steps to develop trusted services for Aboriginal people have been highlighted.

Strategic alignment:
Safe, person-centred and integrated care
Better value
Workforce wellbeing

Exec Sponsor:
Director, People and Culture

Furthermore, the Population and Community Health (PACH) directorate, has also included the objective to increase the Aboriginal Health workforce in SESLHD. For this to occur, focus will be on supporting, retaining and increasing the Aboriginal workforce in PACH services, supporting Managers of Aboriginal staff, participation in traineeship programs, in alignment with SESLHD Aboriginal Workforce initiatives.

Quality Improvement

A key area of focus in SESLHD over the next 12 months is Quality Improvement. This will encompass a number of initiatives, ultimately striving to embed systems, processes and capability for improving service quality and patient care. Activities will include the implementation of the CEC's NSW Health Safety and Quality Curriculum, development of the SESLHD Improvement Framework, and a broader project to bring a number of workforce development and clinical improvement activities together to ensure a consistent approach to Quality Improvement in the District.

Implementation of the Safety and Quality Curriculum

With the launch of the Clinical Excellence Commission's NSW Health Safety & Quality Curriculum in 2021, SESLHD will be aiming to implement the program across the District, with a key goal of implementing the Foundational, Intermediate and Adept Pathway Levels by June 30th, 2023. Through committing to a 2.5-year partnership, the objective is to realise tangible outcomes for patients, staff and SESLHD by:

- Sustainable implementation of the safety and quality curriculum and capability building pathways into the capability development infrastructure of the District.
- Enhancing practical deployment of patient safety and quality improvement capabilities by individuals and teams at all organisational levels.

Stretch goals for the project include:

- By December 31st 2021, embed the Foundational & Intermediate pathway into SESLHD Orientation and on boarding processes with promotion to all staff.
- By March 31st 2022, commence applications for and recruitment to the first cohort of the Applied Safety and Quality Program.
- By June 30th 2022, commence the first cohort of the Applied Safety and Quality Program.

Strategic alignment:
Safe, person-centred and integrated care
Workforce Wellbeing

Improvement Framework

In order to establish clear processes and governance structures for quality improvement in SESLHD, the District Business Plan has identified the development and implementation of a SESLHD Improvement Framework as a key priority for the next 12 months. This initiative will occur collaboratively with the Strategy, Innovation and Improvement (SII) directorate, Clinical Governance Unit (CGU), People and Culture (P&C), and Nursing and Midwifery Services. The Improvement Framework will align with, and enhance, the Quality and Safety Curriculum.

Strategic alignment:
Foster research and innovation.

Towards Zero Suicides

A key area of focus for SESLHD in the next 12 months will be the Towards Zero Suicide project. The objective of this program, as outlined in the 2021-22 SESLHD Business Plan, is to reduce the rate of suicide deaths in NSW by 20 percent by 2023. NSW Health provided funding to SESLHD to implement three initiatives seeking to provide best practice crisis care and support, build local community resilience and improve systems and practices to reduce the suicide rate in NSW. These initiatives include establishing an alternative to the Emergency Department ("SafeHaven") for those experiencing suicidal crisis, stablishing Suicide Prevention Outreach Teams (SPOT) aimed at providing assertive care to people in the community and implementing the Zero Suicides in Care (ZSIC) strategy across SESLHD aimed at ensuring health services have incorporated suicide prevention as a core component

Over the next twelve months, SESLHD will be working to scale and spread the local SPOT to support both the St George Hospital and Sutherland Hospital areas, monitor the initial implementation of SPOT and conduct a preliminary evaluation of these services. In line with the ZSIC strategy, development and implementation of standardised universal screening, risk formulation and safety planning processes for will occur across SESLHD.

Strategic alignment:
Safe, person-centred and integrated care
Workforce wellbeing
Community wellbeing and health equity

Zero Suicide in Care (ZSiC)

Zero Suicides in Care is a part of the Towards Zero Suicides initiatives and supports the goals and priorities of the Strategic Framework for Suicide Prevention in NSW 2018 – 2023. ZSIC will support staff within SESLHD to redesign procedures, reduce risks and build skills to prevent suicide deaths and attempts in acute and community health settings. ZSIC will foster a just and restorative organisational culture with strong service leadership to promote safety for patients and staff. A blame-free working environment will be upheld where excellent health care ensures that people with mental health conditions and their family are active participants in their care and are supported to recover and be protected from self-harm.

Plan for next 12 months:

Implementing the essential elements of the Zero Suicide Framework (ZSF) including:

- Leadership – Creating a safety driver, and continuing to build a just and restorative culture informed by evidence and lived experience;
- Training – building teams who are confident to engage those who are suicidal, and reduce variation in clinical risk formulation and treatment approaches to suicidality;
- Suicide Prevention Pathway - Providing a consistent and collaborative approach to identification, assessment, safety planning, treatment and transition from the health service for those presenting to emergency departments in suicidal crises.
- Improve - Using data to drive continuous improvement through implementation science to contribute to sustainable systemic change.

Strategic alignment:

Safe, Person Centred and Integrated Care

Baseline data:

Baseline Data indicated that in the 2019 Calendar year there were 92 suicides of consumers residing in the 7 Local Government Areas that fall within the SESLHD catchment area. In 2020 that number increased to 105. NSW Health has established a Suicide Monitoring System as a part of the Towards Zero Suicides initiative to support LHD with data to help driver service development and response.

Appendix 1. SESLHD Governing Body Attestation Statement 2021

Health
South Eastern Sydney
Local Health District

This attestation statement is made by	**Michael Still** *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.

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	**29/07/2021**

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

Signed	
Position	**SESLHD Chief Executive**
Name	**Tobi Wilson**
Date	29.7.21

Schedule of health service organisations covered by this attestation statement

Name of health service organisation	Address
150025 SESLHD Mental Health Service	Level 2, 11 South St KOGARAH 2217
110748 The Sutherland Hospital	The Kingsway CARINGBAH 2229
110141 St George Hospital	Gray St KOGARAH 2217
110333 Royal Hospital for Women	Barker St RANDWICK 2031
116366 SESLHD Northern Sector	
Prince of Wales Hospital	Barker St RANDWICK 2031
Sydney/Sydney Eye Hospital	8 Macquarie Street, SYDNEY 2000
117366 Population and Community Health	8 Macquarie Street, SYDNEY 2000

(NB: Page 4 of the Attestation Statement is blank and therefore has not been included)