# It's your **health** that **matters**

**Health Care Services Plan 2020-2030**

NSW GOVERNMENT | Health
Illawarra Shoalhaven Local Health District

# Contents

*Artist: Aunty Cecily Wellington-Carpenter*

# Acknowledgement of Country

The District operates on the lands of the Dharawal and Yuin nations, which encompass five language groups: Wadi Wadi, Dharawal, Wandandian, Walbanga and Yuin. These groups have lived in the Illawarra and Shoalhaven region for millennia, and their cultures, laws, ceremonies and connection to the land and waterways are strong and enduring.

The District also acknowledges, regrets and is sorry for the pain and loss placed on the lives of Aboriginal people who have been dislocated from their culture, displaced from their homelands and watched their children being taken away.

# Our vision

The Health Care Services Plan describes a vision for an integrated health system in the Illawarra Shoalhaven region which supports people to stay healthy in their homes and communities.

A health system that supports people to stay well in the community needs to be organised differently. It must strengthen services which support health close to people's homes and focus less on hospital care to achieve value for investment of scarce resources. It must have a greater focus on prevention of illness and it must capitalise on the combined efforts of the many partners who contribute to the community's wellbeing.

International evidence shows that supporting people to stay well in their own communities will result in less need for hospital admissions. Less high-cost hospital demand will result in a more efficient health system and better health outcomes and experiences for the community.

We will use a population-based approach in our service planning – addressing the causes of ill-health and the disease burden areas with the biggest impact on our communities – so that we can deliver services with the greatest potential to improve their health.

To achieve this we need to work with others in the Illawarra and Shoalhaven regions to develop a shared, coordinated approach to improving the social determinants of health and to deliver health services that respond to the needs of our local communities.

The Health Care Services Plan is a 10-year roadmap for the delivery of the District's vision: Excellent Services, quality partnerships, healthy communities. Its areas of focus are:

## Focus Area A: Promote, protect and maintain the health of the community

Our efforts will focus on achieving these outcomes:
- Reduced rates of developmental vulnerability in children
- Reduced unhealthy and risky lifestyle behaviours
- Reduced overall burden of disease, independent of socio-economic status

## Focus Area B: Strengthen care in the community

Our efforts will focus on achieving these outcomes:
- Increased proportion of activity occurring in ambulatory care and community settings
- Reduced unplanned hospital readmissions and ED representations

## Focus Area C: Address the cultural and health needs of Aboriginal people

Our efforts will focus on achieving these outcomes:
- Improved health outcomes for Aboriginal people living in the Illawarra Shoalhaven
- Increased proportion of Aboriginal people working within the health sector

## Focus Area D: Commit to high value care

Our efforts will focus on achieving these outcomes:
- Reduced unwarranted clinical variation
- Increased measurement of patient reported and clinical outcomes
- Improved patient reported and clinical outcomes

## Focus Area E: Strengthen partnerships and engagement

Our efforts will focus on achieving these outcomes:
- Increased formal partnerships across the region
- Increased number of consumers involved in the planning and design of services

# Our Strategic Directions

**Vision**

Excellent services, quality partnerships, healthy communities

**Purpose**

To provide best practice health care and programs that promote the health and wellbeing of people in the Illawarra Shoalhaven

**Strategic priorities**

**1. Excellence in models of care, health programs and health services**

**2. An engaged and high performing workforce for the future**

**3. Innovation, agility and learning for continuous improvement**

**4. Efficient, effective, sustainable financial operations**

**What does success look like?**

ISLHD has a reputation for delivery of high quality health care and appropriate services

ISLHD is considered an employer of choice within the region

ISLHD is respected and recognised for research and innovation to improve health care

ISLHD is a financially sustainable and fiscally responsible organisation

**Critical enablers**

**1. Partnerships and engagement**
Build and maintain strong partnerships and relationships with our stakeholders, both health and more broadly

**2. Governance**
Strengthen governance and accountability at all levels of the LHD

**3. Information Technology and eHealth**
Expand the use of eHealth and information technologies to deliver health services more effectively and more efficiently

**CORE Values**

COLLABORATION     OPENNESS     RESPECT     EMPOWERMENT

# Why do we need change?

In Australia and internationally, health systems are under pressure. In the Illawarra Shoalhaven, we are faced with increasing numbers of people who will experience poor health, growing emergency department presentations and hospital admissions, longer waiting times for services and a growing and ageing population.

**If we keep doing things in the same way, by 2031 the District will have:**

**120**
more emergency presentations **a day**

**30,000**
more hospital admissions each year - requiring **290 more beds**

**65,000**
more **obese adults**

**27,000**
more adults living with **diabetes or high blood sugar**

Currently, we operate within the boundaries of the Illawarra Shoalhaven Local Health District (our District) with hospitals at the centre of what we do. General practice and the aged care sector are structurally separate, with minimal integration between organisations who all serve the same communities. Patients find the system difficult to navigate and services are fragmented, which often results in poorer outcomes and experiences of care.

We know that we need large scale transformation - one that sees a shift in public perception about how health care should be accessed and delivered.

Internationally, health systems are making big shifts in service delivery to address structural challenges and provide more patient-centred care. Priorities are shifting towards high value care and increased care in community settings.

The Canterbury Health System in New Zealand is an example of a recent transformation in the way a health system operates, resulting in improved patient outcomes. For example, a range of conditions that were once treated predominantly in hospital are now provided in general practice. Outcomes in the Canterbury region include:

- In one year, almost 30,000 people who would previously have been admitted to hospital received treatment in their own homes

- Patient waiting times for care have shortened

- Older people stay at home longer and need less residential aged care

- The Maori people on average live longer than in other parts of New Zealand

# Why do we need change?

We know that there are many factors outside the health care system that influence an individual's health and well-being, including:

**There is an unacceptable difference in health between population groups, particularly Aboriginal and non-Aboriginal people**

Some population groups experience worse health and well-being. Although the health and welfare of Aboriginal people is improving, they continue to experience disadvantage and health inequity.

Exposure to particular stressors before birth and to adverse experiences in early childhood increases the probability that an individual will have poor health and wellbeing later in life.

**Evidence points to the first 2000 days of a child's life as critical to their health in the future**

**Exposures to modifiable risk factors are unevenly spread across the population**

Risk factors such as tobacco use, risky alcohol consumption, illicit drug use, poor diet and lack of physical activity are known to have a detrimental effect on health.

Half of the population have at least one of the 8 common chronic conditions. These conditions often occur together. Collectively they contribute to more than 60% of the disease burden.

**Increasing numbers of people are experiencing chronic diseases, such as diabetes and mental illness.**

**The population is growing and ageing**

Many residents will require more health care and support as they age.

People are becoming increasingly informed as consumers. They are seeking greater empowerment and engagement in decision making and service planning.

**Consumers' expectations are changing**

**There is unsustainable growth in demand for and cost of health services**

The growth in demand for and cost of providing acute care services and hospital beds means that overall health expenditure is growing at double the rate of GDP in Australia. This is unsustainable.

# Health of the community

# Our community profile

## Our geographic region

The Illawarra Shoalhaven extends from Helensburgh in the northern Illawarra to North Durras in the southern Shoalhaven and covers the Local Government Areas of Wollongong, Shellharbour, Kiama and Shoalhaven. The region's landscape concentrates residential areas into a narrow strip of suburban communities and coastal towns.

The population is growing and this growth will continue due to natural increases as well as the sustained migration of young families and retirees. The make-up of the population will change over the next 20 years, with the majority of growth occurring in the older age groups.

**Figure 1: Illawarra Shoalhaven population growth by age group**

In **2015** the population was **400,000**
In **2031** the estimated population will be **455,000**
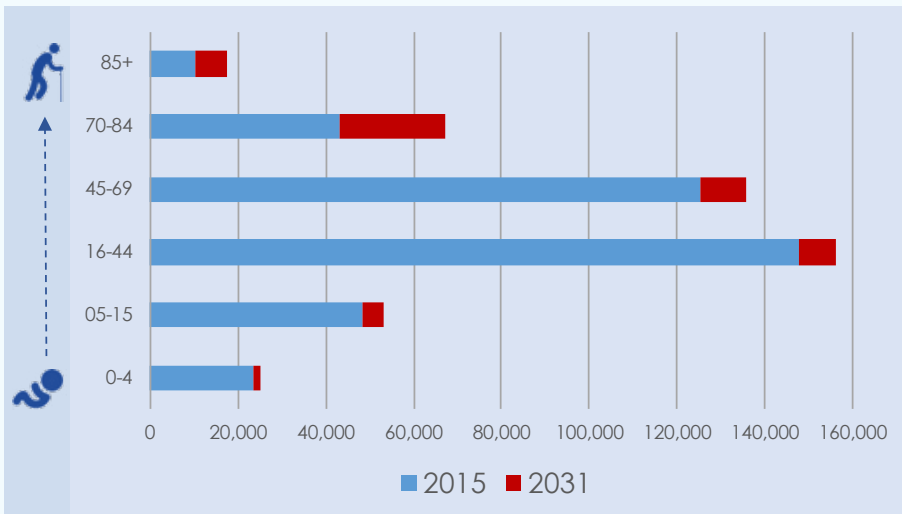


Source: NSW Health HealthAPP

## The people who live here

The Illawarra Shoalhaven region is the traditional home of the Dharawal and Yuin nations. The Aboriginal communities retain strong cultural connections to the region's coastline, hinterland and escarpment.

People who were born overseas are well represented in the Illawarra Shoalhaven, many of whom report low English proficiency. There is also a growing number of refugees in the region.

Some of the smaller communities along the southern coastline are quite isolated with limited public transport. Many of the people who live there are ageing.

Certain communities in the Illawarra and Shoalhaven are some of the most disadvantaged in the State, with a number of factors contributing to their disadvantage.

# The health of our communities

## Factors that affect health and well-being

Many factors combine together to affect the health of individuals and communities. A healthy lifestyle helps to protect us from the onset of disease and improves our quality of life, but a person's health is also determined by their circumstances and environment. In addition to genetics, factors including where people live, their physical and social environments, employment, income and education level, and interpersonal relationships all have considerable impacts on a person's health. These are known as 'determinants of health'.

In addition, we now know exposure to particular stressors before birth, and exposure to adverse experiences in early childhood, increase the probability that an individual will have poor health and well-being later in life.

The higher the number and significance of stressors and adverse experiences in the earlier years, the greater the likelihood of unhealthy behaviours and poor health as an adult.

Marginalised people and communities experience discrimination and exclusion (social, political, economic) and are at a higher risk of poor health.

Adverse experiences, trauma, domestic and family violence, neglect and abuse are not common discussions during adult health consultations. There is clear evidence, however, that these issues are often the causes of significant disease and ill health later in life, and in many cases are hidden by social convention and taboo.

Individuals are unable to directly control many of these determinants of health and commonly experience a combination of these factors. Often these circumstances and their effects occur across generations.

Vulnerable people and communities are at higher risk of poor health as a result of barriers they experience to social economic and environmental resources.

Adverse experiences in childhood can include: physical, sexual or emotional abuse; physical or emotional neglect; exposure to domestic violence; household substance abuse; household mental illness; parental separation or divorce; a household member who is in jail.

**Figure 2: Factors that affect health**
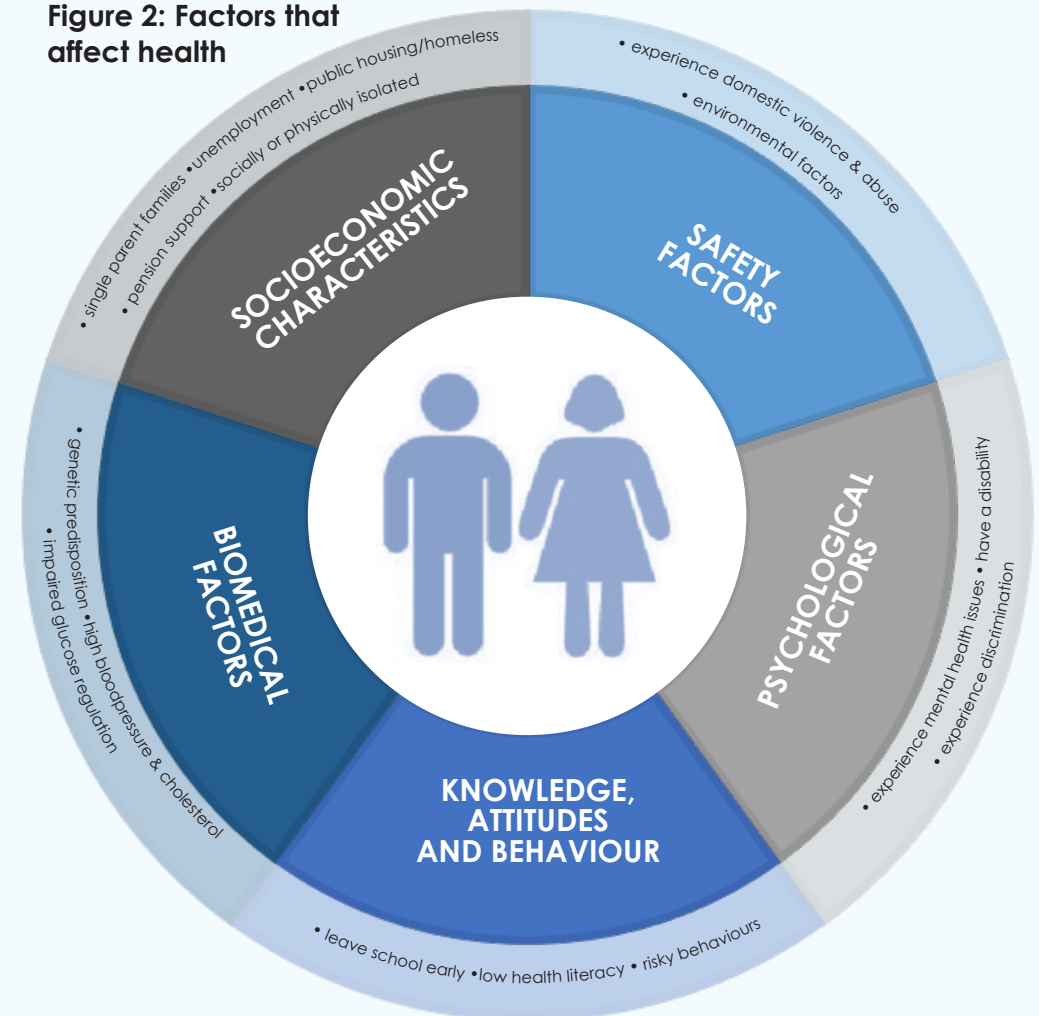
# Population groups in the Illawarra Shoalhaven at higher risk of poor health

**3.4%**
13,600 people
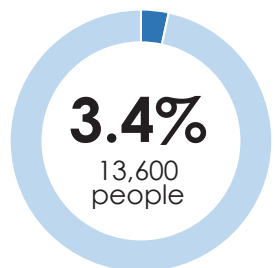
Identify as **Aboriginal or Torres Strait Islander**
(compared to 2.9% in NSW)

**19%**
75,000 people
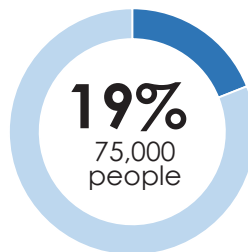
Are aged **65 years or older**
(compared to 16% in NSW)

**14%**
53,000 people
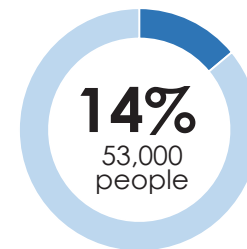
Have **mental health or behavioural conditions**

**9%**
37,000 people
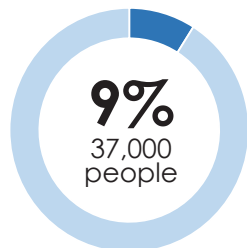
Were **born** in a **predominantly non-English speaking country**
(compared to 21% in NSW)

**10%**
of young children
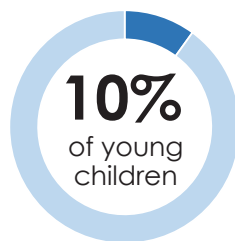
Are **developmentally vulnerable** in two or more domains

**7%**
26,000 people
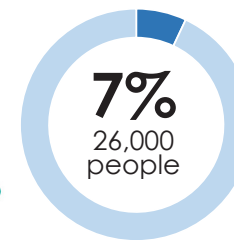
Have a **profound or severe disability**

**18.4%** were **born overseas**

**11%** (44,000 people) identify as **LGBTQI+**

**2,400** people are **homeless**

**9%**
36,000 people
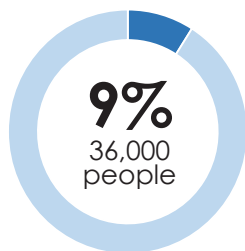
Live **alone** and are susceptible to **social isolation**

**1 in 6 women** aged 15+ have experienced physical or sexual violence by a current or former partner

**26%** (103,000 people) are living in the **most disadvantaged communities** in the Illawarra Shoalhaven region (compared to 20% in NSW)

**Figure 3: Illawarra Shoalhaven Areas of Disadvantage**

Least disadvantaged in NSW

NSW Average

Most disadvantaged in NSW

**CORRIMAL – TARRAWANNA – BELAMBI**
- Aboriginal: 3.7%
- 65+: 17.7%
- **CALD: 11.2%**

**DAPTO – AVONDALE**
- Aboriginal: 3.7%
- 65+: 19.7%
- CALD: 7.4%

**BERKELEY – WARRAWONG – WINDANG**
- Aboriginal: 4.2%
- 65+: 20.8%
- CALD: 7.4%

**ALBION PARK RAIL, SHELLHARBOUR – OAK FLATS**
- Aboriginal: 3.5%
- 65+: 15.7%
- **CALD: 9.9%**

**WARILLA**
- **Aboriginal: 5.0%**
- 65+: 20.5%
- **CALD: 11.5%**

**NORTH NOWRA – BOMADERRY**
- **Aboriginal: 6.5%**
- 65+: 19.5%
- CALD: 4.0%

**NOWRA**
- **Aboriginal: 10.8%**
- 65+: 16.6%
- CALD: 4.7%

**CALLALA BAY – CURRARONG – CULBURRA**
- Aboriginal: 5.9%
- **65+: 27.7%**
- CALD: 5.7%

**ST GEORGES BASIN – EROWAL**
- Aboriginal: 5.9%
- **65+: 28.6%**
- CALD: 4.8%

**JERVIS BAY**
- **Aboriginal: 52.9%**
- 65+: 14.8%
- CALD: N/A

**ULLADULLA**
- Aboriginal: 2.8%
- **65+: 29.2%**
- CALD: 4.5%

## Modifiable risk factors

**One third** of the burden of disease in our communities is due to modifiable risk factors.

**Tobacco** contributes almost **10%** of the total disease burden

**12%** of ISLHD adults are current smokers

**High body mass** contributes over **5%** of the total disease burden

Over **60%** of ISLHD adults are overweight or obese

**Alcohol use** contributes **5%** of the total disease burden

**Physical inactivity** contributes **5%** of the total disease burden. For ISLHD residents, **30%** are not doing enough physical activity

**High blood pressure** contributes **5%** of the total disease burden

**30%** of ISLHD residents have high blood pressure

**10%** have diabetes or high blood glucose levels

## Burden of disease

About **50%** of Australians have at least one of 8 selected common chronic conditions: arthritis, asthma, back pain and problems, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, and mental health conditions. Collectively, these conditions contributed to:

**61%**
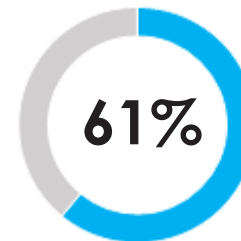
Disease Burden
2011

**37%**
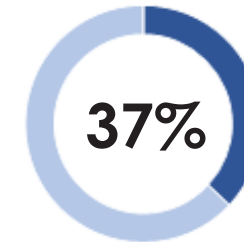
Hospitalisations
2015/16

**87%**

Deaths 2016

The distribution of the burden of disease across age groups of the population

Age group
(x-axis labels: 0, 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85-89, 90-94, 95-99, 100+)
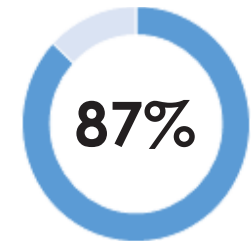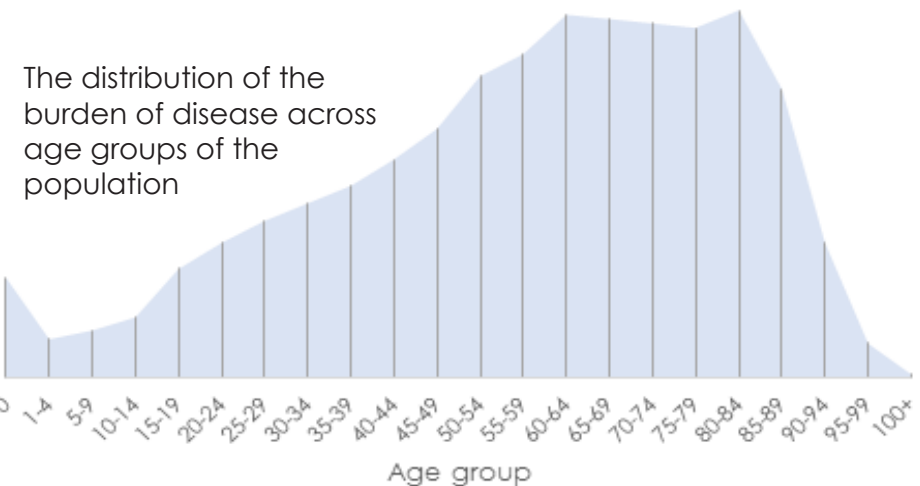
If each person of average height lost **3 kilograms**, this could reduce disease burden in the population due to overweight and obesity by **14%.**

# Burden of disease

The leading diseases that contribute the most to the population's total burden of disease and the District's hospital admissions are shown below.

| Table 1: The top 8 diseases causing the most burden for our population and health system | % of burden that is modifiable |
|---|---|
| 1 Cancer | 44% |
| 2 Heart and vascular diseases | 69% |
| 3 Mental health conditions & substance abuse | 21% |
| 4 Muscle & bone conditions | 6% |
| 5 Injuries | 30% |
| 6 Respiratory diseases | 40% |
| 7 Digestive diseases | 23% |
| 8 Neurological conditions | 6% |

**Cancer** is the leading cause of disease burden in the community, with almost 44% of cancer burden attributed to modifiable factors. **Heart and vascular** diseases make up 15% of the total burden with almost 70% attributed to modifiable risk factors.

Diabetes, chronic kidney disease and dementia are also key health problems and growing burdens for the Illawarra and Shoalhaven communities. Between 2009 and 2014, there was a 10% increase in the number of deaths related to **type 2 diabetes**. Rates of diabetes are 3 - 6 times higher among Aboriginal people compared to non-Aboriginal Australians.

> **Over 95% of the diabetes burden could potentially be prevented if the risk factors were better managed.**

1 in 5 Illawarra Shoalhaven residents have signs of **chronic kidney disease**, which is one of the highest rates in the country. The number of cases of end stage-kidney disease are also continuing to grow.

**Dementia** is a growing challenge as the population ages and life expectancy increases. In 2018 it was estimated that 8.7% of the population aged 85 and over had dementia with 61% of sufferers being female. Dementia prevalence is estimated to be 2–5 times higher among Aboriginal people than non-Aboriginal people.

# Our future health system

# Our future health system

We know we need a shift in perspective. We need an increased focus on keeping people well in the community. We need better integration and coordination across primary, secondary and tertiary health services. We need to better respond to the circumstances that shape the health of our consumers – things like their social and physical environment, experienced discrimination, vulnerability, risks and behaviours – as well as skills and strengths.

Figure 4 below represents our vision for the future health system, with healthy communities at the centre.

## People will be supported to stay well in their own homes and communities

The District will engage with people to help them live safely within their own communities. This will be achieved by building on existing services within the community and primary health setting, developing new models of health care delivery, strengthening partnerships with other organisations and improving our community health infrastructure.

## Timely and appropriate hospital care will be provided when people need it

Inpatient hospital care is usually a small component of care over a person's lifetime. In the health system of the future, hospitals will play a role in caring for patients requiring a high level of clinical care, but some services will be re-oriented to outpatient, home and community based settings. This will be supported by better use of technology.

The hospitals within the Illawarra and Shoalhaven will work in a networked model, with Wollongong Hospital serving as the tertiary referral hospital for the District, providing the most specialised care.

**Figure 4: ISLHD's Future Health System** (adapted from Canterbury District Health Board)



People only go to hospital when they need treatment or care that can't be provided in their community

Mental Health · Primary & Ambulatory · Planning & Environment · Justice · Child & Family · Oral Health · Local Councils · NGOs

**Healthy Communities**

Community Groups & Activities · Family Support · Education · Health Promotion · FACs · Volunteers · Primary Health Network · Specialist Medical & Diagnostic

Drug & Alcohol · GPs · Aged care

Navigation & Referral Point

People are supported to take responsibility for their own health

People are supported to stay well in their own homes and communities

Acute · Sub-Acute

Appropriate hospital care is provided when people need it

*Excellent Services  |  Quality Partnerships*

Care is centred around communities and people, and is focussed on wellbeing, self-care and prevention

# Our focus areas

# What our community and stakeholders told us

In developing this Health Care Services Plan, the Illawarra Shoalhaven Local Health District led the "Your Health Future" consultation process to ensure that the Plan was informed by our community, our partner organisations and other key health stakeholders. A number of themes emerged, which underpin the focus areas identified in the following section:

| What you told us | Our response |
| --- | --- |
| **The District needs to change what and how it communicates**<br>*"Communication is the key to everything"* | Information about how to make healthier choices and what health services are available and how to access them needs to be made available |
| **Accessing and navigating health care is difficult**<br>*"Lack of access to services makes people more vulnerable"* | People need help to navigate the health system and be able to access services they need when they need them |
| **Investment is needed in prevention and early intervention**<br>*"If we support families to access good food and improve cooking skills, increase physical activity levels and be exposed to a healthy environment – their health burden will reduce"* | An investment in prevention and early intervention will support the community to be healthy and reduce the onset of illness |
| **Organisations must partner together**<br>*"Utilise each other's strengths"* | Service providers will partner and work together to support the health and wellbeing of the community. Our partners are looking to ISLHD to take more of a leading role in facilitating collaboration |
| **A population-based approach is needed**<br>*"It makes sense – taking a population approach"* | The model will have the community in the centre, wrapped around by close support networks and primary care |

# Where our efforts will be focussed

The District's vision is for a healthy community that is supported by a well-connected and well-designed system which maintains health and wellbeing. This will require a shift in perspective – from a focus on treating the sick to a system designed to keep people well.

There are 5 areas in which we will focus our efforts in order to achieve our vision for the future:

Focus Area A: **Promote, protect and maintain the health of the community**

Focus Area B: **Strengthen care in the community**

Focus Area C: **Address the cultural and health needs of Aboriginal people**

Focus Area D: **Commit to high value care**

Focus Area E: **Strengthen partnerships and engagement**

Each focus area has a number of strategies, actions and outcome measures which will form the basis for the implementation of the Plan. A separate Implementation Framework has been developed which describes the key delivery mechanisms for the Plan, including how the Plan's priorities and regional planning approach will be operationalised within existing District structures and processes.

# Focus Area A: **Promote, protect and maintain the health of the community**

The "NSW State Health Plan – Towards 2021" stipulates that "Preventive and population health programs are critical to keeping people healthier, fitter and out of hospital." NSW Health is currently responsible for "Developing and implementing health promotion and disease prevention strategies to help people stay healthy and better manage their health and well-being."

Health promotion and preventive medicine are a fundamental part of comprehensive health care. Health promotion and preventive medicine precede and complement disease management by supporting individuals to increase control over their health through self-management, while also forming collaborative partnerships across sectors to address the social, environmental and economic impacts that influence health outside of the individual's control.

Disease progression is a process which often starts with subtle changes in a person's health. Prevention and early intervention is key, with the aim to prevent disease or injury before it occurs, halt progression to early disease or reduce impact of disease that has already occurred. Appendix 1 aligns the health care system with the health-disease continuum and identifies the focus points for the District under the service delivery framework.

The evidence shows that effective prevention is capable of:

- reducing the personal, family and community burden of disease, injury and disability
- allowing better use of health system resources and generating substantial economic benefits
- producing a healthier workforce, in turn boosting economic performance and productivity.



> " *Creating a more connected health system across the primary and acute settings will not only improve patient outcomes but will help in reducing unnecessary hospitalisations and Emergency Department presentations, creating a more financially sustainable health system for the future.* "
>
> - NSW State Health Plan

# Focus Area A: Promote, protect and maintain the health of the community

The strategies in this focus area are built upon the following evidence-based concepts:

## Tailored approach to vulnerable populations

In order to adequately support vulnerable populations, it is critical to tailor any preventive approaches or clinical interventions to a person or population's specific circumstances. We need to ensure we:

1. Invest in supporting vulnerable families and young children, as evidence shows that the first 2000 days of life are the most critical in shaping future health and life success

2. Consider the whole person and respond to their unique personal experiences (including socioeconomic situation, social and physical environment, personal vulnerabilities and strengths, risks and behaviours) and recognise the complexity of need

3. Practise trauma-informed approaches to care when working with people who are survivors of trauma

4. Build stronger partnerships to create conditions that support good health

## Comprehensive primary health care

A comprehensive approach to primary health care delves into the "why" of a person's illness, as opposed to just identifying and managing "what" the illness is. An approach to healthcare that promotes health, prevents illness and raises awareness of diseases goes beyond the management of disease - it relieves illness by modifying factors contributing to the illness in the first place and improves people's lifestyles to protect and maintain their health into the future.

## Impact of climate change

Climate change is having negative impacts on human health. Temperatures are gradually increasing, rain patterns are changing, and adverse weather events are becoming more frequent. The impact on human health may be:

- Immediate or direct, such as a heatwave causing dehydration

- Indirect, or delayed, such as changes to ecological and biophysical systems which can limit food production, increased bacterial growth, increased insects that spread disease (eg. mosquitos) and reduced water flows and quality

Local Health Districts are faced with managing the increased risks from climate change, which include increased morbidities from diseases and health conditions, emergency incidents and extreme weather events, and increased stress on infrastructure, workforce and operational costs.

## Prevention of illness

Prevention is defined as "approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder or reducing disability." (WHO, 2009)

Primary prevention reduces the likelihood of the development of a disease or disorder (eg. support for families in the early years of children's lives, immunisation programs and anti-smoking campaigns). Secondary prevention interrupts, prevents or minimises the progress of a disease or disorder at an early stage (eg. cancer screening programs and regular hearing tests for people exposed to industrial noise). Tertiary prevention focuses on halting the progression of damage already done (eg. self-management programs for people with chronic illnesses and rehabilitation programs for people recovering from an accident or illness).

## Self-management of health

Self-management can provide benefits for services as well as improved health outcomes and quality of life for people living with chronic conditions. Evidence shows that supporting people to self-manage can result in significant gains in health status, improved symptom management and reduced health service utilisation.

Self-management requires fundamentally different conversations between individuals and health care professionals. The focus is on managing the illness experience, building individual strengths, promoting health and supporting the person to pursue pre-illness health and life-related goals.

## Focus Area A: **Promote, protect and maintain the health of the community**

**Strategic Outcome Measures**
- *Reduced rates of developmental vulnerability in children*
- *Reduced unhealthy and risky lifestyle behaviours*
- *Reduced overall burden of disease, independent of socio-economic status*

| Strategies | | Actions |
|---|---|---|
| 1 | Implement the First 2000 Days Framework | • Ensure staff across all service streams access evidence-based information and education about the first 2000 days<br>• Develop clear pathways to deliver the right care for families who are vulnerable and at a higher risk of negative health outcomes, including individuals and families at risk of or already experiencing domestic and family violence<br>• Work with partners to ensure that families who need extra support get it when they need it<br>• Promote access to evidence-based parenting programs and interventions, from pregnancy onwards |
| 2 | Invest in primary, secondary and tertiary prevention across the continuum of care | Primary prevention:<br>• In partnership with others, co-commission primary prevention activities<br>• Continue to reduce tobacco use in our community<br>• Promote healthy eating, healthy weight and active living<br>• Promote the responsible consumption of alcohol<br>• Promote the responsible use of prescription drugs and harm minimisation of illicit drugs<br>• Promote uptake of immunisation across the lifespan<br>• Promote good oral health practices<br>• Work with local government and other partners to promote built environments that support good health<br>• Promote the use of the 'Blue Book' with parents of newborn babies<br><br>Secondary prevention:<br>• Invest in comprehensive universal care and screening for families through the stages of pregnancy, antenatal and early childhood<br>• Implement a systematic approach to early detection and intervention for the top avoidable hospitalisations, including domestic and family violence<br>• Continue to promote access to screening programs for the local community<br>• Health promotion activity focussed on supporting secondary prevention e.g. smoking reduction in mental health facilities<br><br>Tertiary prevention:<br>• Invest and partner in the proactive management of chronic conditions, including the promotion of self-management approaches<br>• Co-commissioning of care coordination and specialist community based in-reach services<br>• Invest in rehabilitation for people recovering from illness or accident<br>• Continue investment in Leading Better Value Care program<br>• Deliver services and programs using trauma-informed approaches to care that support the recovery of victims of domestic and family violence |

| Strategies | | Actions |
|---|---|---|
| 3 | Systematically target the major modifiable risk factors across the care continuum | • Educate clinical staff in brief intervention techniques and self-management strategies and tools<br>• Implement a systematic approach to health assessment and referral system to programs that support healthy living, incorporating existing programs and services (both internal and external)<br>• Implement a systematic approach to the recording, measurement and analysis of modifiable risk factors in our patients and clients, including risk factors and signs of domestic and family violence |
| 4 | Support people who are vulnerable or have complex needs | • Target investment in prevention strategies focusing on vulnerable and at risk groups e.g. targeted oral health services for children in sustained home visiting program, intensive antenatal programs for high risk women<br>• Educate clinical staff in trauma-informed approaches to care in order to work more effectively with people who are survivors of trauma or experiencing domestic and family violence, in recognition that a diverse range of emotional and physical problems, conditions and disorders are trauma-related<br>• Work with partners to support community activities in local communities that connect people to address social isolation<br>• Plan and deliver services in a targeted way, addressing the vulnerable communities and groups<br>• Advocate for improved access to transport options for patients and carers |
| 5 | Increase direct communication and engagement with the community to help people make better health choices | • Work in partnership to communicate health education messages and engage with the community to promote health and wellbeing<br>• Continue the investment in health literacy including the development of a framework that supports consumer enabling methodologies (eg. Teach-back) |
| 6 | Respond to the impacts and risks of climate change | • Continue to develop coordinated responses to extreme weather events, including direct communication strategies with the public<br>• Continue involvement in interagency planning around public health responses to climate change (eg. the Shoalhaven Illawarra Enabling Regional Adaption (SIERA) project)<br>• Continue to utilise the NSW State Climate Change Policy Framework to guide decisions about the District's procurement, energy use and travel<br>• Set ongoing targets and measures in line with NSW government policy and national standards |

# Focus Area B: **Strengthen care in the community**

By strengthening care in the community, people will be supported to stay well and manage any health conditions in their own homes or community. Care teams (clinicians and service providers) will work together to wrap services around the patient with the aim of reducing the need to visit the emergency department or hospital. If hospital care is required, the aim is to reduce the length of time people stay in hospital and support them to receive as much of their care as possible at home.
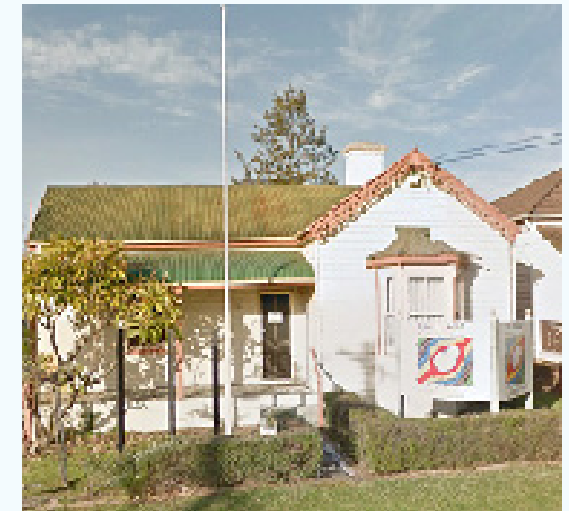
" *Local community centres are a good place to start when connecting with the community.* "
*- Consultation Workshop Participant*

" *If we support families to access good food and improve cooking skills, increase physical activity levels and be exposed to a healthy environment – their health burden will reduce.* "
*- Consultation Workshop Participant*

# Focus Area B: **Strengthen care in the community**

The strategies in this focus area are built upon the following evidence-based concepts:

## Providing purpose-built community health infrastructure

Purpose-built infrastructure is an essential building block for effectively supporting people to stay well in their own homes and communities. This includes facilities, equipment and co-location where possible, providing shared space. Community Health Centres need to be able to facilitate multidisciplinary teams to train and practice together, enabling models of care for specific population groups.

## Post-discharge follow up

Systematic follow up after hospital discharge is a key tertiary prevention strategy that has been shown to reduce readmissions. The most prevalent health problems such as diabetes, asthma, heart disease and mental health conditions require extended and regular healthcare contact.

Follow ups can also ensure greater safety and recovery following discharge from admissions caused by assaults resulting from domestic and family violence.

Programs that target vulnerable and high risk populations and include multidisciplinary teams achieve the greatest reductions in potentially avoidable hospitalisation and ED presentation rates.

## Hospital avoidance

Hospital avoidance services are aimed at reducing unplanned presentations, admissions or readmissions to hospital - they are usually provided at home or in community health centres.

Hospital avoidance interventions are more effective if they are directed towards specific conditions. Ischemic heart disease (IHD), cardiac arrhythmias, heart failure, psychoactive substance use, mental health, asthma, chronic obstructive pulmonary disease (COPD) and oral health disease are identified in the literature as the most effective conditions to target.

The evidence shows that targeting people with the highest risk of unplanned presentations, admissions or readmissions is the best approach.

## Care at home supported by technology and information systems

Evidence shows that the use of digital health solutions which facilitate access to up to date clinical information when working in the community has resulted in: reduced length of stay; reduced demand on emergency services; improved access to health care; improved quality of services; improved clinical outcomes; decreased costs; reduced inconvenience and improved management of chronic and complex conditions.

## Hospital substitution

Hospital substitution strategies deliver care and services in the home that would otherwise be provided only in hospital and can include avoidance (ie, full substitution for hospitalisation) and early discharge followed by care at home (ie, shortened hospitalisation).

It has been shown that for clinically stable patients with chronic obstructive pulmonary disease, chronic heart failure, deep vein thrombosis, asthma, and community-acquired pneumonia, hospital alternative models are safe, feasible and effective and there is evidence that these programs achieve better outcomes and patient/carer experience than equivalent hospital services.

## "One stop shop" two-way referral and connection point

Guiding patients to actively process health information and navigate the health care system is essential in improving health care delivery, outcomes and eliminating disparities. Systems that support patients to navigate health services and utilise systematic protocols for contacting patients are critical for maximising care coordination and integration.

# Focus Area B: **Strengthen care in the community**

**Strategic Outcome Measures**
- *Increased proportion of activity occuring in ambulatory care and community settings*
- *Reduced unplanned hospital readmissions and ED representations*

| Strategies | | Actions |
|---|---|---|
| 1 | Improve community health infrastructure to support care being provided in the community | • Invest in new or redeveloped community based infrastructure – starting with investment in Dapto, Ulladulla, Northern Illawarra, Wollongong, Warrawong, Shellharbour/Warilla, Nowra community health centres<br>• Include ambulatory care infrastructure in new hospital developments<br>• Utilise existing community hubs (eg. schools, community centres, neighbourhood centres) to provide targeted services to at-risk and vulnerable communities |
| 2 | Prioritise and implement alternatives to hospital-based care through expansion of current models<br>   a. Hospital avoidance<br>   b. Hospital substitution<br>   c. Post admission patient follow-up | • Review and re-design current hospital avoidance programs, identifying high value care opportunities and expand same<br>• Expand hospital substitution programs (e.g. HITH) and align referral pathways with community based services<br>• Implement programs that support at-risk / high-needs groups that frequently attend Emergency Departments or are at risk of re-admission<br>• Expand allied health-led role and function in outpatient clinics to better manage and support specialist outpatients services and elective surgery waiting lists<br>• Co-commission services that support care coordination and hospital substitution in both physical and mental health care, including general practice (GP) based care<br>• Increase capacity of the community based acute care mental health teams<br>• Systematic implementation of predictive tools that identify consumers at risk of admission or re-presentation, including flags for people experiencing domestic and family violence |
| 3 | Promote the use of technology and information systems to support care being provided at home or in the community | • Develop a District-wide Digital Health Plan<br>• Invest in systems and IT processes which are compatible with general practice (eg. Argus, secure messaging, electronic discharges)<br>• Expand the use of telehealth and other technologies to increase access and facilitate the provision of hospital avoidance and substitution services<br>• Continue the development and roll-out of HealthPathways |
| 4 | Facilitate a "one stop shop" two-way referral and connection point across the Illawarra Shoalhaven | • Facilitate a "one stop shop" two-way referral and connection point which will:<br>   • Process two way (in and out) referrals<br>   • Provide information about other services that support people to stay healthy<br>   • Systematically identify at-risk patients for follow up / support services<br>   • Support access to services for vulnerable or at-risk communities<br>   • Coordinate access to acute, post-acute, care and other programs that support health and well being<br>• Systematically link people into existing programs provided by the District or other partner organisations |

# Focus Area C: Address the cultural and health needs of Aboriginal people

Aboriginal people have shown, and continue to show, extraordinary resilience and strength, drawing upon their own health and social systems to meet ongoing challenges. Aboriginal people in Australia have experienced trauma due to colonisation, which involved violence, loss of culture and land, and the forced removal of children. In many Aboriginal communities, this trauma has been passed through several generations, resulting in devastating effects.

The District's approach when working with Aboriginal people to improve health and wellbeing will recognise the resilience and resourcefulness of Aboriginal communities. This strength-based approach builds on the things that support health such as custodianship of land, language and culture.

The District is committed to working with Aboriginal communities to improve the physical, cultural, spiritual and familial wellbeing of Aboriginal people to improve health and life outcomes. We recognise that:

- Aboriginal Community Controlled Health Services have an important role in providing effective primary health care to Aboriginal people
- Equal access to health services is dependent on Aboriginal people being actively involved in the design and delivery of those services
- Specific measures are needed to improve Aboriginal people's access to health services
- An emphasis on wellness and empowerment is more likely to be successful than approaches that emphasise Aboriginal misfortune

> *Indigenous solutions are more likely to spell out success; Indigenous leaders are more likely to inspire their own people; unleashing Indigenous potential will enable whole populations to flourish; and actively shaping the future will offer opportunities for Indigenous peoples to prosper while retaining culture and homelands.*
>
> *- Professor Mason Durie*

> Health to Aboriginal people is a matter of determining all aspects of their life, including control over their physical environment, of their dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicine or the absence of disease and incapacity. Health is not just the physical well-being of an individual but the social, emotional and cultural well-being of the whole community. This is a whole-of-life view and includes the cyclical concept of life-death-life.
>
> - National Aboriginal Health Strategy 1989

# Focus Area C: **Address the cultural and health needs of Aboriginal people**

The strategies in this focus area are built upon the following evidence-based concepts:

## Building a vibrant and professional Aboriginal workforce

Aboriginal staff bring an expertise, through their identity, skills and experience, that ISLHD needs to be able to deliver effective care to the community.

Our goal of increasing the representation of Aboriginal employees across the District is about ensuring we have a workforce that best represents our local community. Continued commitment to supporting employment for Aboriginal people across the health sector will help ISLHD improve the cultural safety of its services and increase the accessibility of care for Aboriginal community members in this region.

## Continue to build a culturally safe service

There is strong evidence that Aboriginal people often do not have equal access to health services, despite having higher rates of hospitalisation and a higher burden of disease. The differences may be an indication of the cultural competency and accessibility of services for Aboriginal people. Interpersonal racism can be experienced by Aboriginal people through the conduct, attitudes, words or practices of health service staff. Institutional racism is the systemic failure of the organisation to meet the needs of Aboriginal people. This racism has a negative effect on service access and utilisation.

The District will continue to build the structures, policies and processes required for culturally safe work environments, and culturally respectful and secure health service provision.

## Strengths-based approach

> *An emphasis on wellness is more likely to generate Indigenous enthusiasm than approaches that emphasise Indigenous misfortune. The adversity approach runs the risk of generating a stereotype that becomes embedded as an inevitable destination.*
>
> - Professor Mason Durie

## Support the inclusion of local Aboriginal voices at all levels of healthcare through partnerships and engagement

Partnerships are integral as they allow for collaboration in service delivery, including integrated care and responses to health priorities identified through extensive consultation and research. The focus of partnerships will be to enable stronger connections amongst our local service providers – identifying how we can work together collectively to ultimately achieve improved health outcomes for Aboriginal families and communities.

## Recognising the importance of data sovereignty

Data sovereignty of Indigenous people is a global movement concerned with the right of Aboriginal peoples to govern the creation, collection, ownership and application of their data. (Australian Indigenous Governance Institute, 2018)

Exercising Aboriginal data governance allows Aboriginal peoples to accurately reflect their stories. It provides the necessary tools to identify what works, what does not and why. It empowers Aboriginal people to make the best decisions to support self-determination in the ways that meets their needs and aspirations. Aboriginal people have been given little opportunity to contribute to decision making on what data should be collected and why. As a result, data collected has had a deficit focus on difference, disparity, disadvantage, dysfunction and deprivation. (AIGI, 2018)

# Focus Area C: **Address the cultural and health needs of Aboriginal people**

**Strategic Outcome Measures**
- *Improved health outcomes for Aboriginal people living in the Illawarra Shoalhaven*
- *Increased proportion of Aboriginal people working within the health sector*

| Strategies | | Actions |
|---|---|---|
| 1 | Establish mechanisms for inclusion of local Aboriginal voices at all levels of healthcare design and delivery through partnerships and engagement | • Support the Partnership Agreements in place that promote the rights of Aboriginal consumers and ensure that health services are culturally inclusive, available and appropriate<br>• Build trust between partners creating an opportunity to talk and work together to create pathways for clients between different service providers<br>• Incorporate Aboriginal leadership and participation in decision making and governance across the health services<br>• Continue to participate in activities that support local decision making in the interests of the local Aboriginal communities |
| 2 | Recognise the importance of data sovereignty for Aboriginal people | • Support Aboriginal people to govern the creation, collection and ownership of their data and to accurately reflect their stories<br>• Approach the way we describe the health of Aboriginal people with a 'Strengths-based focus', moving away from problem-based descriptions<br>• Invest in research, translation grants and evaluation to inform better models of culturally inclusive care<br>• Identify opportunities for research to focus on the priority health areas, including better cardiac care |
| 3 | Build a vibrant and professional Aboriginal workforce | • Implement a targeted employment strategy identifying and prioritising positions to employ Aboriginal Cadets, trainees and graduates as well as general recruitment<br>• Utilise innovative and flexible recruitment, selection and appointment processes to attract Aboriginal candidates<br>• Promote retention of the Aboriginal workforce through the development and implementation of career pathways, job mentoring, cultural support and capacity building<br>• Develop partnerships with the Aboriginal community controlled health sector and other stakeholders to assist in Aboriginal workforce planning and information sharing |
| 4 | Continue to build a culturally safe health service | • Provide services that are free from racism and discrimination<br>• Provide staff training and education that articulates the impact of colonisation and intergenerational trauma on local health needs<br>• Create welcoming environments using art work, flags displayed, signs of acknowledgement, incorporation of language and events such as smoking ceremonies and NAIDOC week events |

# Focus Area D: **Commit to high value care**

High value care focusses on the healthcare outcomes achieved that matter to patients, relative to the cost of achieving those outcomes. High value care is a significant systemic shift away from the current emphasis on the volume of services provided, to focussing on patient outcomes.

$$\text{Value} \quad = \quad \frac{\text{outcomes (the outcomes that matter to patients)}}{\text{the costs of care}}$$

International evidence suggests that up to 20% of health care spending is wasteful and could be better used to deliver services that provide greater patient outcomes. In addition to the rising costs of health care, there is significant variation in clinical practice, costs and outcomes within and across organisations, regions and nations.

The rising costs of healthcare and this wasteful spending across health systems has inspired an international focus on high value care.

A system which delivers high value care requires a strong focus on evidence based care, high levels of integration across internal and external health service providers, and strong commitment from clinical staff and the organisation as a whole.



> "*Spending money on curbing the growing burden of chronic disease is high value.*"
> - Consultation Workshop Participant

# Focus Area D: **Commit to high value care**

The strategies in this focus area are built upon the following evidence-based concepts:

## Measuring outcomes

Measuring patient reported outcomes, as well relevant clinical and quality indicators, enables the District to report on what is important to our consumers. Reporting on these outcomes will enable the District to make improvements that are important to the consumer. This is a key requirement for delivering truly patient-centred care.

## Measuring costs

Value is determined by measuring the costs to treat specific medical or mental health conditions, compared to the outcomes achieved. Without being able to clearly link the cost required to deliver services to the outcomes achieved from those services, organisations cannot determine what constitutes high value care.

In regards to high value care, one cost measurement methodology is 'Time Driven Activity Based Costing' (TDABC), which requires the mapping of the typical path that a patient will take in their care cycle, then assigning costs based on the resources used in those steps.

## Benchmarking

Through measuring standardised costs and outcomes of patient care, health organisations are able to benchmark their performance against other organisations. This allows them to respond to any variation, and to exchange lessons from high and low value interventions between organisations.

## Population segments

Care is organised and delivered around specific population groups and their conditions, rather than by clinician specialty. Multi-disciplinary teams help to deliver more coordinated and streamlined care, reducing clinical variation and driving system improvement.

## Health informatics

Underpinning high value care is the need for well-developed IT systems that can allow for the collection and analysis of high quality healthcare data. This data will drive the organisation's ability to measure and communicate patient outcomes and healthcare costs.

## Developing customised interventions

Once value is able to be measured (through outcomes and costs), steps in the delivery of care can be identified as being as high value or low value (or adding no value at all).

# Focus Area D: **Commit to high value care**

**Strategic Outcome Measures**
- *Reduced unwarranted clinical variation*
- *Increased measurement of patient reported and clinical outcomes*
- *Improved patient reported and clinical outcomes*

| Strategies | | Actions |
|---|---|---|
| 1 | Standardise care against evidence based clinical guidelines | • Implement a system-wide program to support consistent use of clinical guidelines to reduce clinical variation<br>   • Promote and implement the Clinical Governance Framework 2017-2020<br>   • Support clinical teams in consensus-based adoption of clinical guidelines<br>   • Promote the use of evidence based clinical decision support tools where appropriate<br>   • Work with the NSW Reducing Unwarranted Clinical Variation (UCV) Taskforce<br>• Continue to leverage the successes of key projects that are driving high value care (eg. Leading Better Value Care Whole of Health, Reducing Clinical Variation, Fit for Frailty Project) |
| 2 | Measure clinical and patient reported outcomes as part of routine care | • Promote the systematic measurement of patient outcomes across all services<br>• Utilise frameworks for standard outcome measurement (eg. ICHOM standard sets or other standard peer reviewed frameworks) starting with demonstration projects<br>• Develop capacity to systematically measure patient reported outcomes in inpatient and community settings |
| 3 | Develop capacity to measure the cost of care for cohorts of patients / consumers | • Investigate the suitability of outcome-based payment models (eg accountable care organisations, co-commissioning) in the District context<br>• Using AIHW's Burden of Disease report as well as local level data to identify the priority disease groups that offer greatest opportunity for value-based interventions.<br>• Improve clinical and administrative staff financial literacy, including understanding of ABM/ ABF practices |

# Focus Area D: **Commit to high value care**

| Strategies | | Actions |
|---|---|---|
| 4 | Implement a coordinated approach to addressing low value and high value interventions currently being provided across the District | • Develop a District-wide approach to addressing low value interventions and prioritise high value interventions |
| 5 | Continue to invest in the use of data and health analytics | • Develop analytics capability which will:<br>  • Build capacity for self-serve online reporting<br>  • Promote integration and sharing of data between key agencies and partnerships<br>  • Enhance clinician involvement to drive health analytics<br>  • Increase access to, and use of, real-time data<br>  • Move towards the use and application of predictive and proactive health analytics |
| 6 | Invest in the teaching, training and research capacity and capability | • Increase the capacity of ISLHD to sponsor and conduct research<br>• Strengthen research partnerships<br>• Enhance research infrastructure to support research across the LHD and in the community<br>• Improve financial sustainability of research<br>• Support clinicians in establishing research projects and competing for external funding<br>• Develop a state-of-the-art clinical trials unit |

# Focus Area E: **Strengthen partnerships and engagement**

One of the central tenets of this Health Care Services Plan is an acknowledgement that the health of the community is a complex picture, shaped by a multitude of social and economic factors. There are a large number of organisations in the Illawarra and Shoalhaven regions doing valuable work which contributes to the improvement of the community's health. The Local Health District will work to better harness and coordinate efforts toward common health and wellbeing goals for our communities.

We need to build on our current partnerships, towards more formalised collaborative approaches. We propose to establish a Health Coalition, which will be a formalised regional partnership with organisations including the Primary Health Network, non-government, local councils, other government agencies and the university. The Health Coalition will work towards the achievement of regional health goals and contribute to the coordination of efforts by the many agencies towards those goals.

In addition, partnering with consumers is a cornerstone of health care delivery and is a key contributor to achieving the organisation's strategic goals.

> "*Aim for sustainability in programs and encourage networking during the programs so participants continue with it once the program finishes.*"
> - Consultation Workshop Participant

# Focus Area E: **Strengthen partnerships and engagement**

The strategies in this focus area are built upon the following evidence-based concepts:

### Regional response to population health needs

A Health Coalition, defined as a high-level strategic regional partnership, would build upon the high-level partnerships currently in place and provide a strong regional and organisational level response to population health needs. Such a partnership would involve key players including the District, Primary Health Network, other government agencies, local councils, NGOs and the University sector.

The Health Coalition will facilitate:

- Communication and trust between organisations

- Formalised commitment in response to our local health needs

- Regional health goals and joint planning towards achieving goals

- Strong joint advocacy about regional health issues

- Partnered service delivery and co-commissioning of services into the future

### Partnering with consumers in all aspects of health care delivery and planning

Meaningful partnerships with consumers ensure that consumers are involved as partners in planning, design, delivery, measurement and evaluation of health systems and services. Patients should also be partners in their own care to the extent that they choose.

## Focus Area E: **Strengthen partnerships and engagement**

**Strategic Outcome Measures**
- *Increased formal partnerships across the region*
- *Increased number of consumers involved in the planning and design of services*

| Strategies | | Actions |
|---|---|---|
| 1 | Build on existing strategic partnerships and alliances to develop a Health Coalition in the Illawarra Shoalhaven Region | • Build support for and establish a Health Coalition in the Illawarra Shoalhaven region which:<br>  • Formalises a regional partnership approach to improving the health of the community<br>  • Develops priorities for joint action<br>  • Invests in existing partnerships and networks (rather than creating new networks)<br>  • Focusses efforts towards vulnerable and "at risk" populations and burdens of disease<br>  • Builds in evaluation and research<br>  • Incorporates capacity building |
| 2 | Improve ISLHD's organisational capacity to partner with general practice and other organisations in the region | • Develop a Partnership Framework which clearly:<br>  • Outlines the strategic importance of partnerships to ISLHD achieving its vision<br>  • Sets out our approach to partnerships – including the governance structure and performance metrics<br>  • Addresses structural and cultural barriers to successful partnerships<br>  • Embeds a culture that supports formal and information partnerships between organisations and between staff on the ground. Staff and services should be encouraged to work with others when caring for patients<br><br>• Continue investment in the Primary Health Network / ISLHD strategy including expanding co-commissioning, shared planning, consumer literacy and engagement and ICT investment. |
| 3 | Utilise commissioning and co-commissioning to provide targeted services | • Pool resources / co-commission with other organisations to deliver targeted services aimed at high risk groups, geographically isolated communities or disease-specific programs<br>• Review the current grants program (MOH grants) and work with partners to better align funding and outcomes to support at-risk and high-need groups<br>• Review current programs for specific cohorts e.g. aged care, and re-design them to deliver coordinated referral processes and improved governance and outcomes |
| 4 | Partner with consumers and communities in all aspects of health care delivery and planning | • Embed partnering with consumers into clinical governance and quality improvement systems<br>• Continue to promote the importance of partnering with patients and carers in their own clinical care<br>• In partnership with others, improve the health literacy of the community<br>• Partner with consumers in organisational design and governance of ISLHD<br>• Partner with consumers in planning future clinical services |

# Infrastructure to support our vision

# Our future capital footprint

Our capital infrastructure must respond to the health needs of local communities. Reconfiguring our capital assets to be fit-for-purpose is a prerequisite to the provision of evidence-based patient-centred care.

Investing in community health and ambulatory care infrastructure will enable us to deliver one of the key platforms of the plan - to keep people healthy in their communities. Community health centres need to be located according to need, and should also maximise accessibility through good access to public transport and other services people may visit (eg. shopping centres). Dapto and Ulladulla Community Health Centres are currently undergoing redevelopment which will facilitate the delivery of contemporary community based care.

Our vision is for community health centres to support partnered service delivery with the integration and collocation of other health care providers and government agencies to deliver coordinated approaches to supporting our communities.

*Artist's impression of the future Ulladulla HealthOne Centre*



The future Community Health capital footprint is depicted in Figure 5, and is based on the specific needs of the local population and areas of disadvantage.

**Figure 5: Future Footprint for Community Health Centres**

# Our future capital footprint

Hospitals play an important role in supporting patients with complex and high level clinical needs as well as trauma and routine surgical care. The District's hospital services must be configured to respond to the community's growing needs and support the new models of care, emerging technologies and scientific breakthroughs of the future. This includes consideration of the optimal placement of services across the District and networked arrangements with other services and hospitals in NSW to facilitate effective and efficient care for patients.

Significant investment is planned across the District's hospitals, to enable them to play their roles in supporting the health of the community.

- Bulli Aged Care Centre will open in early 2020, providing an innovative collaborative aged care service model in partnership with the Illawarra Retirement Trust.

- Shellharbour Hospital is currently being redeveloped to enable it to meet the needs of Shellharbour and Kiama residents and provide innovative models of care within the District's networked service model.

- A major redevelopment is planned for Shoalhaven District Memorial Hospital, which will deliver increased service capacity to meet the future needs of the local Shoalhaven population.



*Artist's impression of the future Bulli Aged Care Centre*

Shoalhaven Hospital's role will continue as a major non-metropolitan hospital for the region, providing a comprehensive range of acute services.

- Both Shellharbour and Shoalhaven Hospital redevelopments will deliver state of the art facilities, designed to support increased ambulatory care and facilitate better patient and carer experiences.

- Wollongong Hospital is the District's principal tertiary referral hospital, providing a comprehensive range of secondary and tertiary services on a District basis as well as servicing the local Illawarra community. Planning is underway to support Wollongong Hospital's development and position it with the optimal configuration of services to deliver the District's vision for the future and meet the growing needs of the community.

**Figure 6: Footprint for Hospitals**
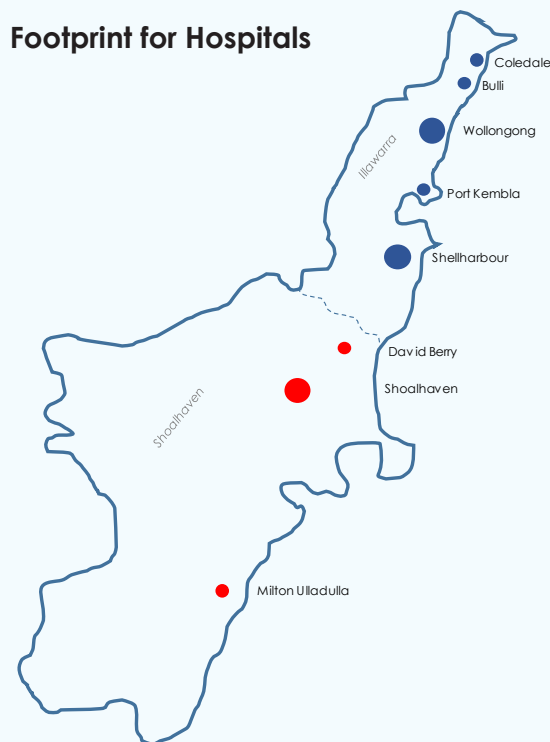
**Table 2: Services available across all hospital sites**

| Service | Wollongong | Shellharbour | Shoalhaven | Milton Ulladulla | Coledale | Bulli | Port Kembla | David Berry |
|---|---|---|---|---|---|---|---|---|
| Emergency Department | ✓ | ✓ | ✓ | ✓ | | | | |
| Paediatric Emergency | ✓ | ✓ | ✓ | | | | | |
| Trauma | ✓ | | | | | | | |
| Intensive Care | ✓ | ✓ | ✓ | | | | | |
| Emergency Surgery | ✓ | | ✓ | | | | | |
| Planned Surgery | ✓ | ✓ | ✓ | ✓ | | | | |
| Cancer Services | ✓ | | ✓ | ✓ | | | | |
| Ante & Postnatal care | ✓ | ✓ | ✓ | ✓ | | | | |
| Birthing Services | ✓ | | ✓ | | | | | |
| Neonatal Services | ✓ | | ✓ | | | | | |
| Paediatric Inpatient | ✓ | | ✓ | | | | | |
| Specialist Cardiology | ✓ | | ✓ | | | | | |
| Specialist Respiratory | ✓ | | ✓ | | | | | |
| Specialist Neurology | ✓ | | ✓ | | | | | |
| General Medicine | ✓ | ✓ | ✓ | ✓ | | | | |
| Mental Health | ✓ | ✓ | ✓ | | | | | |
| Rehabilitation | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ |
| Palliative Care | ✓ | | | ✓ | | | ✓ | ✓ |
| Acute Aged Care | ✓ | ✓ | ✓ | ✓ | | ✓ | | |

# References

In preparing this plan, a review of international and national evidence in relation to the key focus areas and strategies was undertaken. Each section has been underpinned by this evidence and has included:

**Section 1 - Introduction**

1. NSW Government 2018, Health Services Act 1997 No 154, viewed 22 January 2019, < https://www.legislation.nsw.gov.au/#/view/act/1997/154>

2. NSW Health 2014, NSW State Health Plan: Towards 2021, viewed 24 September 2018, <https://www.health.nsw.gov.au/statehealthplan/pages/nsw-state-health-plan-towards-2021.aspx>

3. Illawarra Shoalhaven Local Health District 2017, Strategic Directions for Illawarra Shoalhaven Local Health District 2017 – 2020, viewed 24 September 2018, <https://www.islhd.health.nsw.gov.au/Strategic_Directions/>

4. Canterbury DHB 2012, Transition 2012 – We need the whole system to be working for the whole system to work, viewed 7 January 2019, <https://www.cdhb.health.nz/wp-content/uploads/577ca7ac-canterbury-dhb-transition-plan-2012.pdf>

5. South Eastern Sydney Local Health District Journey to Excellence Strategy 2018-2021, viewed 27 August 2018 < https://www.seslhd.health.nsw.gov.au/sites/default/files/groups/Planning_Population_and_Equity/Health_Plans/JourneytoExcellence_v13.pdf>

6. NSW Health 2018, Leading Better Value Care, viewed 24 September 2018, < https://www.health.nsw.gov.au/Value/Pages/leading-better-value-care.aspx>

7. Australian Institute of Health and Welfare 2018, Australia's health 2018, viewed 12 November 2018, https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-of-contents

8. MinterEllison 2019, Shifting consumer expectations in healthcare – it's an empowerment game, viewed 6 December 2018, <https://www.minterellison.com/articles/shifting-consumer-expectations-in-healthcare-its-an-empowerment-game>

9. Department of Environment and Conservation 2005, A History of Aboriginal People of the Illawarra 1770 to 1970, viewed 19 December 2018, <https://www.environment.nsw.gov.au/resources/cultureheritage/illawarraAboriginalHistory.pdf>

10. NSW Health 2019, The First 2000 Days Framework, PD2019_008, February 2019

11. NSW Health – CaSPA Portal 2019,  HealthAPP, accessed November 2018

12. NSW Government 2019, HealthStats NSW, accessed June – December 2018, <http://www.healthstats.nsw.gov.au/>

**Section 2 - Health of the community**

13. NSW Health 2019, The First 2000 Days Framework, PD2019_008, February 2019

14. South Eastern Sydney Local Health District 2015, South Eastern Sydney Local Health District Equity Strategy, viewed 2 July 2018, <https://www.seslhd.health.nsw.gov.au/sites/default/files/migration/HealthPlans/documents/2016/SESLHD%20equitystrategy%20FINAL.pdf>

15. NSW Health – CaSPA Portal 2019,  HealthAPP, accessed November 2018

16. Australian Institute of Health and Welfare 2019, AIHW Health Expenditure 2015-16, viewed 22 January 2019, < https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2015-16/contents/summary>

17. NSW Government 2019, HealthStats NSW, accessed June – December 2018, <http://www.healthstats.nsw.gov.au/>

18. Illawarra Shoalhaven Local Health District 2018. ISLHD Community Needs Assessment. Planning and Strategic Commissioning Unit.

19. Australian Human Rights Commission 2015, Face the Facts: LGBTI People, <https://www.humanrights.gov.au/our-work/education/face-facts-lesbian-gay-bisexual-trans-and-intersex-people>

20. NSW Parliament 2018, Homelessness in NSW: Electorate Statistics 2018, <https://www.parliament.nsw.gov.au/researchpapers/Documents/NSW%20Homelessness%20by%20SED%20-%20Key%20Statistics.pdf>

21. Australian Institute of Health and Welfare 2018, Australian Burden of Disease Study 2011, viewed 4 June 2018, < https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/burden-of-disease/overview>

22. The Australian Kidney Foundation 2016, Kidney Health Australia State of the Nation 2016, viewed 22 October 2018, <https://kidney.org.au/cms_uploads/docs/state-of-the-nation--kidney-health-week-2016--chronic-kidney-disease-hot-spots.pdf>

23. Australian Institute of Health and Welfare 2018, Australia's health

# References

2018, viewed 12 November 2018, <https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-of-contents>

**Section 3 - Our future health system**

24. NSW Health 2019, The First 2000 Days Framework, PD2019_008, February 2019

25. CSIRO 2018, Future of Health Shifting Australia's focus from illness treatment to health and wellbeing management, viewed 12 November 2018, https://www.csiro.au/en/Showcase/futureofhealth

26. Canterbury DHB 2012, Transition 2012 – We need the whole system to be working for the whole system to work, viewed 7 January 2019, <https://www.cdhb.health.nz/wp-content/uploads/577ca7ac-canterbury-dhb-transition-plan-2012.pdf>

27. South Eastern Sydney Local Health District Journey to Excellence Strategy 2018-2021, viewed 27 August 2018 < https://www.seslhd.health.nsw.gov.au/sites/default/files/groups/Planning_Population_and_Equity/Health_Plans/JourneytoExcellence_v13.pdf>

28. Adapted from Source: Hendry, A., Taylor, A., Mercer, S., and Knight, P. "Improving Outcomes through Transformational Health and Social Care Integration - The Scottish Experience." Healthcare Quarterly Vol. 19, No. 2, 2016.

29. World Health Organisation 2018, The Transformative Role of Hospitals In The Future of Primary Health Care, viewed 22 October 2018, <https://www.who.int/docs/default-source/primary-health-care-conference/hospitals.pdf?sfvrsn=5d7e8137_2>

**Section 4 - Our focus areas**

30. Government of Western Australia, Department of Health 2011, WA Chronic Health Conditions Framework 2011–2016, viewed 6 December 2018 , <https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Health%20Networks/Chronic%20conditions/Chronic-Health-Conditions-Framework.pdf>

31. ACT Government Health 2018, viewed 22 October 2018, https://www.health.act.gov.au/sites/default/files//Population%20Health%20Strategic%20Framework.pdf

32. ACI & ISLHD. 'Figtree Caravan Park Health Living Project.' viewed 13 February 2019, <https://www.aci.health.nsw.gov.au/resources/chronic-care/social-determinants-of-health/sdoh/initiatives/figree-caravan>

33. Australians Together. 'Intergenerational Trauma.' viewed 19 March 2019, <https://australianstogether.org.au/discover/the-wound/intergenerational-trauma/>

34. National Aboriginal and Torres Strait Islander Health Council 2003, National Strategic Framework for Aboriginal and Torres Strait Islander Health, viewed 7 January 2019, https://www.health.gov.au/internet/main/publishing.nsf/Content/12B50420F5E0006DCA257BF000199D6C/$File/nsfatsihcont.pdf

35. National Aboriginal Health Strategy Working Party 1989, National Aboriginal Health Strategy, viewed 6 January 2019, <https://catalogue.nla.gov.au/Record/668993>

36. Indigenous Data Sovereignty 2018, Communique Indigenous Data Sovereignty Summit, viewed 7 January 2019, <http://www.aigi.com.au/wp-content/uploads/2018/07/Communique-Indigenous-Data-Sovereignty-Summit.pdf>

37. McFarlane, K, Devine, S, Judd, J, Nichols, N & Watt, K 2017, 'Workforce insights on how health promotion is practise in an Aboriginal Community Controlled Health Service', Australian Journal of Primary Health, vol. 23, p. 243-248

38. Fogarty, W., Lovell, M., Langenberg, J. & Heron, M-J. 2018, Deficit Discourse and Strengths-based Approaches: Changing the Narrative of Aboriginal and Torres Strait Islander Health and Wellbeing, The Lowitja Institute, Melbourne

39. Australian Institute of Health and Welfare 2014, Australia's health 2014, viewed 12 November 2018, < https://www.aihw.gov.au/getmedia/6c8ffb4a-a0f6-49f8-9b05-01f2157b822c/8_1-health-prevention.pdf.aspx>

40. Australian Government Preventative Health Taskforce 2008, Australia: The healthiest country by 2020 – national preventative health strategy, viewed 12 November 2018, <https://extranet.who.int/nutrition/gina/sites/default/files/AUS%202009%20National%20Preventative%20Health%20Strategy.pdf>

41. Canterbury DHB 2012, Transition 2012 – We need the whole system to be working for the whole system to work, viewed 7 January 2019, <https://www.cdhb.health.nz/wp-content/uploads/577ca7ac-canterbury-dhb-transition-plan-2012.pdf>

42. Gullery, C & Hamilton, G 2015, 'Towards integrated person-centred health care – the Canterbury journey', Future Hospital Journal, vol. 2, no 2, p. 111–116, viewed 12 November 2018 <http://futurehospital.rcpjournal.org/content/2/2/111.full>

43. Health risks, present and future, from global climate change, BMJ

# References

2012;344:e1359 <https://doi.org/10.1136/bmj.e1359> (Published 19 March 2012)

44. NSW Government Climate Change policy <https://www.environment.nsw.gov.au/-/media/OEH/Corporate-Site/Documents/Climate-change/nsw-climate-change-policy-framework-160618.pdf>

45. Brown, L & Oliver-Baxter, J 2016, 'Six elements of integrated primary health care', Australian Family Physician, vol. 45, no. 3, p. 149-152

46. Harris, L, Fintan, T, Dey, A et al 2016, 'When chronic conditions become emergencies – a report from Regional Queensland', Australian Journal Rural Health, vol. 24, no. 392-401

47. Summerfelt, T, Sulo, S, Robinson, A, Chess, D, Catanzano K 2015, 'Scalable Hospital at Home with Virtual Physician Visits: Pilot Study', The American Journal of Managed Care, vol. 21, no. 10, p. 675-684

48. Caplan, G, Sutalman, N, Mangin, D, Ricauda, N, Wilson, A & Barclay, L 2012, 'A meta-analysis of "hospital in the home"', Medical Journal of Australia, vol. 197, no. 9, p. 512-519

49. Lawn, S., Zabeen, S., Smith, D, Wilson, E, Miller, C, Battersby, M & Masman K, 2018, 'Managing chronic conditions care across primary care and hospital systems: lessons from an Australian Hospital Avoidance Risk Program….' Australian Health Review, vol. 42, p. 542-549

50. Bradford N, Caffery, I & Smith, A 2016, 'Telehealth services in rural and remote Australia: a systematic review of models of care and factors influencing success and sustainability', Rural and Remote Health, vol. 16, p. 3808

51. Wang, M, Gallivan, L, Lemon, S, Borg, A, Ramirez, J, Figueroa, B, McGuire, A & Rosal, M 2015, 'Navigating to health: Evaluation of a community health centre patient navigation program', Preventative Medicine Reports, vol. 2, p. 664-668

52. Porter, M & Lee, T 2013, The Strategy that Will Fix Health Care, Harvard Business Review, viewed 19 November 2018, < https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>

53. Organisation for Economic Co-operation and Development (OECD) 2017, Tackling Wasteful Spending on Health, viewed 19 November 2018, < http://www.oecd.org/health/tackling-wasteful-spending-on-health-9789264266414-en.htm>

54. World Economic Forum (WEF) Insight Report 2015, Future of Healthy How to Realize Returns on Health, viewed 5 November 2019, https://www.bain.com/insights/world-economic-forum-future-of-healthy-how-to-realize-returns-on-health/

55. Blackmore, C, Mecklenburg, R, Kaplan, G. 2011. 'At Virginia Mason, Collaboration Among Providers, Employers, and Health Plans to Transform Care, Cut Costs and Improved Quality.' Health Affairs, vol. 30, no. 9, p. 1680-1687

56. Harris, C, Waltz, T, O'Neal, J, 2018, 'Conceptualization of a Health Care Coalition Framework in Georgia Based on the Existing Regional Coordinating Hospital Infrastructure', Disaster Medicine and Public Health Preparedness, viewed 19 November 2018, <https://www.cambridge.org/core/journals/disaster-medicine-and-public-health-preparedness/article/conceptualization-of-a-health-care-coalition-framework-in-georgia-based-on-the-existing-regional-coordinating-hospital-infrastructure/A6D30058B51A3AA8C2790D019A9FF53A>

57. Australian Commission on Safety and Quality in Health Care 2017, NSQHS Standards, viewed 22 October 2018, <http://nationalstandards.safetyandquality.gov.au/>

58. Victoria State Government PCP Development Program 2008, Strengthening Partnerships - Evaluation Report Appendix 1, viewed 12 November 2018, <https://www2.health.vic.gov.au/about/publications/ResearchAndReports/strengthening-partnerships-evaluation-report-2008>

59. Christens, B, Inzeo, P & Meinen, A 2016, 'Community-Led Collaborative Action to Prevent Obesity', Obesity Prevention Interventions, vol. 115, no. 5, p. 259 – 263

60. Australian Government 2016, PHN Commissioning, Designing and Contracting Services Guidance, viewed 3 December 2018, <https://health.gov.au/internet/main/publishing.nsf/Content/E11D6513E6583EA1CA2580D4000F0A70/$File/PHN%20Designing%20and%20Contracting%20Services%20v0.1.pdf>

61. British Medical Association (BMA) 2018, What is co-commissioning?, viewed 15 October 2018, <https://www.bma.org.uk/advice/employment/commissioning/commissioning-guide/co-commissioning>

# Appendices

## Appendix 1: Health-Disease Continuum

| Stage of disease continuum | Well | At Risk / Early Identification | Established Disease | Acute Conditions & Consequences | Chronic Conditions & Consequences | Predictable End of Life |
|---|---|---|---|---|---|---|

*Promote, protect and maintain the health of the community* ←

| | Primary Prevention | Secondary Prevention | Tertiary Prevention | | | |
|---|---|---|---|---|---|---|
| **Objective** | Prevent disease or injury before it occurs by preventing exposures to hazards or altering behaviours | Slow, halt or reverse the progression of early disease or reduce impact of disease that has already occurred | Support self-management, prevent health deterioration, limit disability after harm has occurred and prevent avoidable hospitalisations | | Support self – management, promote highest possible level of functioning, minimise acute exacerbations and hospitalisations / readmissions | Support informed planning & decision making, safe high quality care |
| **Types of prevention** | Health promotion through population wide:<br>• Legislation<br>• Education<br>• Immunisation | Prevention & early detection through:<br>• Regular exams<br>• Screening<br>• Programs | Intervention by managing long-term effects of complex health problems in order to improve ability to function, quality of life and life expectancy through:<br>• Chronic disease management programs<br>• Medications, treatments etc.<br>• Support & vocational groups | | | |
| **Coordinated Care** | | Largely self-managing | Self-management with some care coordination | | High level of clinical coordinated care | |
| **Nature of Intervention** | • Promotion of healthy behaviours & environments<br>• Universal & targeted approaches | • Screening<br>• Case finding<br>• Periodic health examinations<br>• Early interventions<br>• Controlled risk factors (lifestyle & medication) | • Treatment & acute care<br>• Complications management | • Continuing Care<br>• Maintenance<br>• Rehabilitation<br>• Self-management | • Treatment & acute care<br>• Complications management<br>• Continuing Care<br>• Maintenance<br>• Rehabilitation<br>• Self-management | • Pain and symptom management<br>• Preparation for the end of life<br>• Support family<br>• Spiritual care |

*Focus on high value care*

| **Responsible Services** | • Public Health<br>• Primary Health | Primary Health | Community | Specialist | Hospital | |
|---|---|---|---|---|---|---|

←

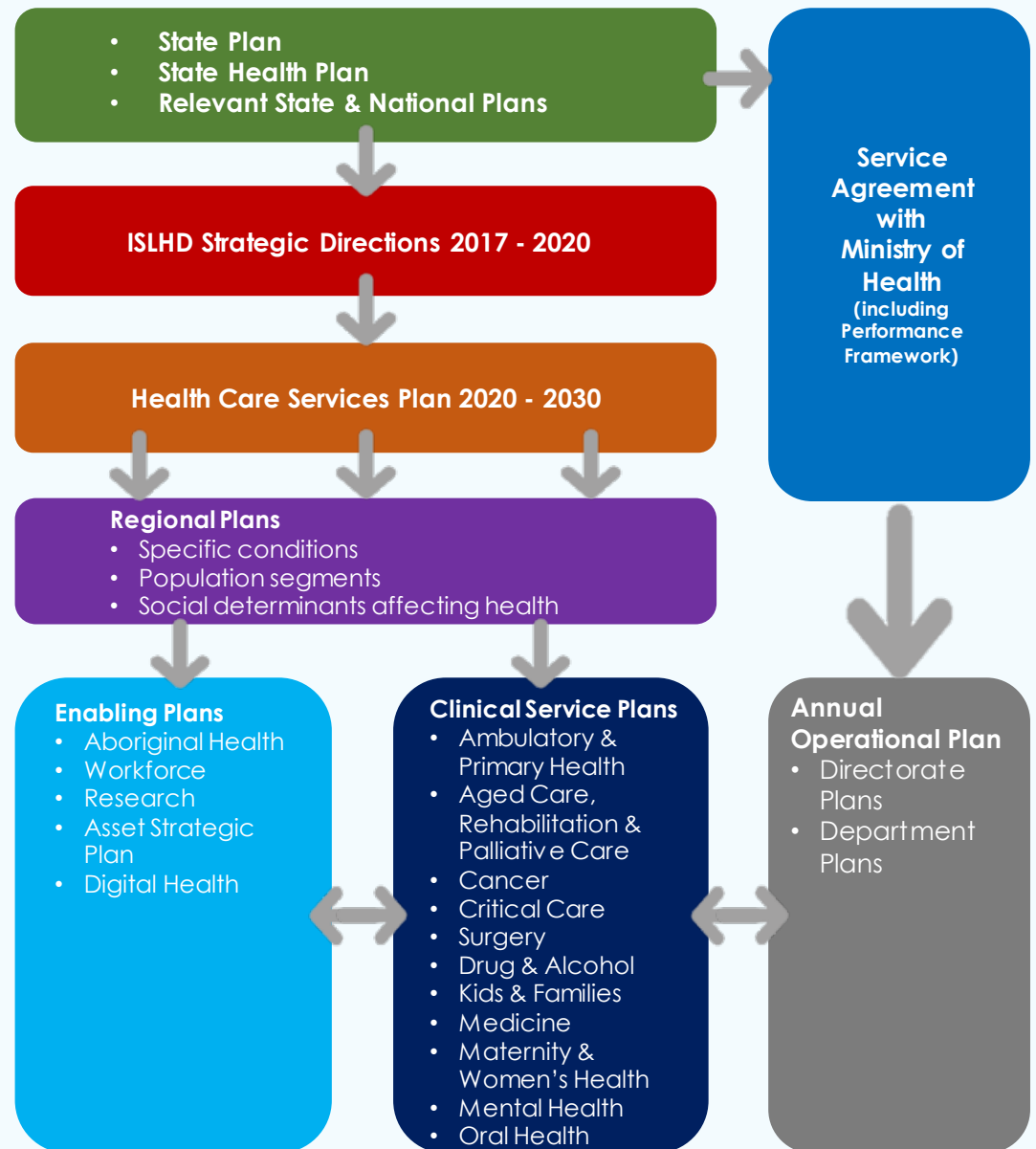*Strengthen partnerships and engagement*

# Appendices

## Appendix 2 - Planning Context

The New South Wales Ministry of Health requires each Local Health District to develop a Plan that will drive the delivery of its health care services. Ours is the Health Care Services Plan, which details the future roles of health services and the broad directions within our organisation over the next 10 years. A number of national, state and local strategic plans have influenced the development of this plan, including:

- Council of Australian Government's National Health Reform
- NSW State Health Plan: Towards 2021
- NSW Health Resource Efficiency Strategy 2016 – 2023
- Annual Service Agreement with the Ministry of Health
- ISLHD Strategic Directions 2017- 2020

This Plan, along with ISLHD Strategic Directions 2017 - 2020 will guide the development of Clinical Division service plans and other enabling plans.

We acknowledge that our renewed focus on supporting the overall health of individuals and populations in a meaningful way can only occur in partnership with other organisations. These partnerships must be built on trust and common goals.

- • State Plan
- • State Health Plan
- • Relevant State & National Plans

**ISLHD Strategic Directions 2017 - 2020**

**Health Care Services Plan 2020 - 2030**

**Regional Plans**
- Specific conditions
- Population segments
- Social determinants affecting health

**Service Agreement with Ministry of Health**
(including Performance Framework)

**Enabling Plans**
- Aboriginal Health
- Workforce
- Research
- Asset Strategic Plan
- Digital Health

**Clinical Service Plans**
- Ambulatory & Primary Health
- Aged Care, Rehabilitation & Palliative Care
- Cancer
- Critical Care
- Surgery
- Drug & Alcohol
- Kids & Families
- Medicine
- Maternity & Women's Health
- Mental Health
- Oral Health

**Annual Operational Plan**
- Directorate Plans
- Department Plans

# Appendices

## Appendix 2 - Planning Context

The **National Disability Insurance Scheme** (also called the NDIS) is a scheme designed to provide disability support. The NDIS is for people who have their functional ability impacted by a disability including physical, intellectual, sensory, neurological or psychosocial disabilities. The scheme will fund a wide range of services for people under the age of 65 years. The NDIS replaces traditional disability systems with a new insurance scheme that takes a lifetime approach to support and investing in people with disability early to improve their outcomes later in life (to do this the NDIS will also include an Early Childhood Early Intervention approach).

The NDIS intersects with the health system on a number of levels. To ensure the NDIS does not lead to fragmented care for participants, the District needs to work closely to monitor and resolve any issues that arise. This requires active, joint collaboration to develop appropriate responses.

The District has recently undertaken some significant planning in regards to **Aboriginal Health**. A number of strategies have been developed and provide strategic advice to support the development of a culture across the District which embraces an 'Aboriginal Health is everybody's business'. These strategies include:

- Statement of Commitment: acknowledges, regrets and apologises for past injustice and commits to practical actions to Close the Gap on life expectancy.
- Aboriginal Health Partnership Agreement: formal partnership with Aboriginal Community Controlled Health Services and Aboriginal NGO partners to facilitate ongoing collaboration, engagement and monitoring of the District's outcomes
- Closing the Gap Aboriginal Health Plan: to identify key outcomes, roles and responsibilities, and an accountability and monitoring framework

- Respecting the Difference: Improving appreciation, understanding and knowledge of Aboriginal culture, customs, heritage and protocols in Aboriginal families and communities.
- Aboriginal Employment Strategy: to improve Recruitment Retention and Recognition of Aboriginal employees across the Local Health District.

Our operational plans will translate our long term goals into day to day operations, which are also informed by the annual Service Agreements with the NSW Ministry of Health. At an operational level, we have committed to prioritise:

1. Access and flow
2. Service redesign
3. Integrated care
4. Aboriginal Health (Closing the gap)
5. Workforce safety and engagement
6. Research
7. Value for money

# Appendices

## Appendix 3 - Aboriginal Health Impact Statement

This Aboriginal Health Impact Statement aims to ensure the health needs and interests of Aboriginal people have been incorporated into the development of the Health Care Services Plan 2020-2030. Aboriginal people are the first peoples of Australia and have strong cultures and communities. We are committed to Closing the Gap in health outcomes between Aboriginal and non-Aboriginal people.

**Who are the Aboriginal people that will likely be affected by the initiative?**

The Illawarra Shoalhaven Local Health District (ISLHD) services fall into the land of the Dharawal and Yuin Nations (the area of the Nations however, far exceed ISLHD boundaries) and the people of the traditional language groups within these Nations including Wadi Wadi, Dharawal, Wandandian, Walbanga and Yuin. The District has a greater proportion of Aboriginal people living in our communities (NSW 2.9% compared to ISLHD 3.5%) (ABS Census 2016). Furthermore, compared to NSW, the Shellharbour and Kiama LGA's combined has a greater proportion of Aboriginal people living in our communities with 3.2% of the catchment populations identifying as Aboriginal (ABS Census 2016).

**What is the burden of ill health and/or health priorities for this group of Aboriginal people? What issues may potentially affect access to services for this group of Aboriginal people?**

The District acknowledges the health gap that exists between Aboriginal and non-Aboriginal people. The Aboriginal population experience 2.3 times the rate of disease burden when compared with the non-Aboriginal population (AIHW 2011). Chronic diseases and injuries contribute a significant proportion of the total disease burden, with mental and substance use causing the most total burden of disease (AIHW 2011).

The gap in disease burden between Aboriginal and non-Aboriginal people is primarily attributable to chronic diseases that are responsible for 70% of the disease burden gap (AIHW 2011). The analysis is supported by information provided in publications produced by government and non-government, Aboriginal and non-Aboriginal organisations.

The high proportion of Aboriginal residents in the District reinforces the need to embed tailored responses to the specific health needs of Aboriginal communities. In this planning process, ISLHD endeavoured to ensure that this has, and will occur in the development and delivery of all our services. The Health Care Services Plan focuses on addressing the health needs of the community with the primary intention of addressing the cultural and health needs of the Aboriginal.

**How does the initiative link to existing Aboriginal health policies, programs or strategies?**

This Plan gives consideration to and incorporates the strategic directions stated in the NSW Aboriginal Health Plan 2013 -2023 as well as the initiatives and research provided by the AIHW 2011 Burden of Disease report, Closing the Gap strategy and ISLHD Aboriginal Health Action Plan 2017-2020. ISLHD is a signatory to the Illawarra Wingecarribee Local Decision Making Accord (May 2018), which includes specific strategies to ensure our services are culturally welcoming.

**How will this initiative impact on Aboriginal people and will the impact be different for Aboriginal people compared to non-Aboriginal people? How can the initiative be designed to reach Aboriginal people? What might be the unintended impacts (including potential negative impacts) for Aboriginal people and what are the actions that will be taken to mitigate or prevent them?**

The Health Care Services Plan includes five key focus areas which aim to support the District to deliver its vision of excellent services, quality partnerships, and healthy communities. Focus Area C is dedicated to addressing the cultural and health needs of Aboriginal people.

# Appendices

## Appendix 3 - Aboriginal Health Impact Statement

The District is committed to working with Aboriginal communities to improve the physical, cultural, spiritual and familial wellbeing of Aboriginal people to improve health and life outcomes, recognising that:

- Aboriginal Community Controlled Health Services have an important role in providing effective primary health care to Aboriginal people
- Equal access to health services is dependent on Aboriginal people being actively involved in the design and delivery of those services
- Specific measures are needed to improve Aboriginal people's access to health services
- An emphasis on wellness and empowerment is more likely to be successful than approaches that emphasise Aboriginal misfortune

**How will the impact of the initiative on Aboriginal people be actively monitored and evaluated?**

Focus Area C has four strategies towards addressing the cultural and health needs of Aboriginal people. These include:

- Establish mechanisms for inclusion of local Aboriginal voices at all levels of healthcare design and delivery through partnerships and engagement
- Recognise the importance of data sovereignty for Aboriginal people
- Build a vibrant and professional Aboriginal workforce
- Continue to build a culturally safe health service.

The Plan includes example actions towards achieving these strategies and has a set of Strategic Outcome Measures which can be monitored and evaluated over time. Many of the strategies and outcome measures already align to KPIs the District reports against in its annual Operational Plans.

**Based on the anticipated impact of the initiative on Aboriginal people, what level and nature of engagement with Aboriginal stakeholders is appropriate? Are there potential barriers that might impact the ability of Aboriginal people to be meaningfully engaged?**

The consultation process for developing this Plan involved seeking input from Illawarra Shoalhaven community members and partner organisations to contribute to determining what the future will look like. All Aboriginal Medical Service staff were invited to contribute to consultations, and separate consultations were held with the Aboriginal staff "Talking Circle". Local land councils were also invited to participate in consultations.

ISLHD also presented the Plan to the Aboriginal Health Partnership Committee for feedback.

**To ensure coordination and avoidance of duplication, what existing governance mechanisms such as committees, networks or partnerships exist that could be used to support engagement with Aboriginal people? What information will be provided back to Aboriginal stakeholders and how will continued engagement through the implementation and evaluation of the initiative be facilitated?**

Engagement with stakeholders and the wider Aboriginal communities within ISLHD will be via existing information channels, to be led by the ISLHD Director Aboriginal Health Strategy. ISLHD has used current published data and commentary wherever possible. In addition, we have leveraged the existing Aboriginal Health Partnership which includes the Illawarra Aboriginal Medical Service, South Coast Medical Service Aboriginal Corporation and Waminda South Coast Women's Health and Welfare Aboriginal Corporation as means of further consultation. ISLHD is a member of the governance structures in place to monitor implementation of the Illawarra/Wingecarribee LDM Accord.

**Pauline Brown - Director of Aboriginal Health Strategy**