



Health  
Central Coast  
Local Health District

# CENTRAL COAST INTEGRATED CARE STRATEGY

## 2016 **ANNUAL REPORT**



The Central Coast Integrated Care Program is a partnership between Central Coast Local Health District (the District) and Hunter New England and Central Coast Primary Health Network (HNECCPHN) with support and contributions from NSW Department of Family and Community Services (FACS), NSW Ambulance and NSW Department of Education.

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**January 2017**

# Foreword

Entering the third year as a Demonstrator Site of the NSW Integrated Care Strategy, it is with pleasure that Central Coast Local Health District presents the Central Coast Integrated Care – 2016 Annual Report. In 2016, the Integrated Care Program made significant inroads in developing new ways of providing care, changing existing models of care, enabling and seeding change across the Central Coast. This report highlights the District's progress and some of the key achievements of the last year.

This journey began with a bold plan to change how care is delivered on the Central Coast, to integrate the provision of both health and social care to better support vulnerable populations in the region. To enable this change, the District has partnered with Hunter New England & Central Coast Primary Health Network (HNECCPHN), Family & Community Services, NSW Ambulance and NSW Department of Education. The support and involvement of NSW Ministry of Health, Agency for Clinical Innovation, HealthShare NSW and eHealth NSW and collaboration with Hunter New England and Northern Sydney Local Health Districts has also been vital.

2016 was an exciting year for integrated care on the Central Coast. In the proof of concept for vulnerable older people, the District began testing ways of commissioning services that have potential to change how care is delivered across the Central Coast and NSW. In the Family Referral Service (FRS) in Schools and Woy Woy Integrated Care Coordination Pilot, the district is building on work performed on the Central Coast and across NSW to create greater levels of system integration with other government agencies, general practices and non-government organisations. The announcement of a Medical School and Research Institute on the Gosford Hospital campus has created new opportunities in the future to make integrated care a part of how healthcare professionals are educated and for further research into integrated care.

The work of integrated care continues into 2017 as the District seeks to create new partnerships, notably with the University of Newcastle, and to undertake evaluations of the Central Coast Integrated Care Program, including deep dives into specific projects. The focus will remain on creating and refining models of care for vulnerable populations while also looking to embed Integrated Care into the core business of the organisation.

Collectively, the District and partner organisations are committed to the integrated care journey and understand that we still have a lot of work to do as we move toward the strategic direction of the NSW State Health Plan: Towards 2021 - Deliver Truly Integrated Care.

The District would like to acknowledge the community, partner organisations and staff for continuing to support the improvement of health care delivery on the Central Coast, helping to ensure that the community receives the right care, at the right time, in the right place and at the right price.

## **Dr Andrew Montague**

Chief Executive

Chair, Integrated Care Program Steering Committee

Central Coast Local Health District

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# The vision

Central Coast Local Health District's integrated care vision is a ten year journey of transforming the system of care provided to the population of the Central Coast.

Encapsulated in the District's local strategy Caring for the Coast: every patient, every time and it's vision of 'healthy people, vibrant community', the Local Health District aims to play a leading role in making the Central Coast a place where the health of the people is maximised through quality health services, accessible when and where people need them.

Supporting this vision are the following strategic priorities, to ensure:

1. Care is person-centred
2. Care is a seamless and comprehensive continuum
3. Care results in an effective outcome that is desired by the person
4. Care is efficient

Integrated care aims to deliver health and social support services based around the needs of individuals and communities, providing them with the right care, at the right time, in the right place and at the right price. This will make the most efficient use of resources to deliver effective, sustainable care for the people of Central Coast.



The following principles underpin the District's vision for integrated care and the models tested:

1. Projects should be Scalable to support the region.
2. Projects should be Sustainable in impact to the workforce and the District's finances to ensure continuity beyond the life of the program.
3. Projects should be Replicable so that successful models can be implemented across larger population groups.
4. Projects should have shared Governance with partners, sharing goals, decision making and, where possible, risk with partners in providing care.

# Program report

A significant volume of work was undertaken by the Central Coast Integrated Care Program during 2016. Projects progressed across the three streams (Vulnerable Older People, People Living with Complex and Chronic Conditions, Vulnerable Young People) supported by the Business Integration Team.

Investigations began in 2015 with system design implemented across all three streams in 2016. Some key examples include:

- The opening of the Central Coast Multi-Agency Response Centre (CCMARC) for at risk children.
- The completion of the Central Coast Alternative Pathways Initiative (CCAPI) with NSW Ambulance.
- Completing the procurement process to deliver outcomes based care coordination to North Wyong from January 2017.
- Reinvigorating GP antenatal shared care to improve maternal and child wellbeing.
- The program took lessons learned from the previous year to develop new projects:
- The Accelerated Implementation Methodology (AIM) Interagency Capability project used AIM training as the basis of developing a common change language.
- The Requirements Analysis for Shared Care Planning was used to evaluate the Patchwork application which was in turn used to implement Go Share in an eEnabled Patient Education Trial.

A recurring theme in these projects is how their development has stemmed from the building of partnerships over time. This, in turn, has provided a greater sense of the needs of the region and the means by which the District can partner with other organisations to deliver better care. A key component of the Integrated Care Program has been to support the District in responding to changes in the legislative and funding environments and to support other initiatives impacting the region and the care system. The goal is to embed integrated care thinking into the organisation so that it becomes business as usual:

- Providing program support to the Service Delivery Reform trials, in conjunction with the Department of Premier and Cabinet and other Government agencies, targeting the needs of children, young people and their families.
- Providing governance and business integration support to the National Disability Insurance Scheme (NDIS) Steering Committee through Central Coast transition to the NDIS.
- Providing governance support and project resourcing to 16 projects to represent the integrated care strategy and ensure new programs are implemented in consideration of the broader system of care.

The program continues to provide support to the District to equip and support the business to deliver integrated care:

- Mobile devices for all home-visiting, clinicians in aged and chronic care.
- An application, ComCare, built around staff mobility.
- Business intelligence dashboards and reports in Qlik and ComCare to provide insights to community health managers on clinical outcomes and service needs.

## Program Evaluations to Occur in 2017

A large amount of resources have been spent developing and testing different ways of providing integrated care for the Community. It will be important to evaluate this through 2017 and the following evaluations are planned:

- Formative program evaluation and deep dives into designated projects
- Economic evaluation of the Outcomes Based Commissioning Proof of Concept in North Wyong

# Focus on vulnerable aged

## *Care coordination for vulnerable older people*

### Care Coordination – Vulnerable Aged Area: North Wyong

- Stratified Population
- Outcomes Based Contract
- Targetted Outcome  
↓ Unplanned Bed Days

### Why North Wyong?

North Wyong is an area of high health need. It is an area of low socio-economic status, high chronicity and lower access to services.

Health data shows a disproportionate number of unplanned admissions from North Wyong.

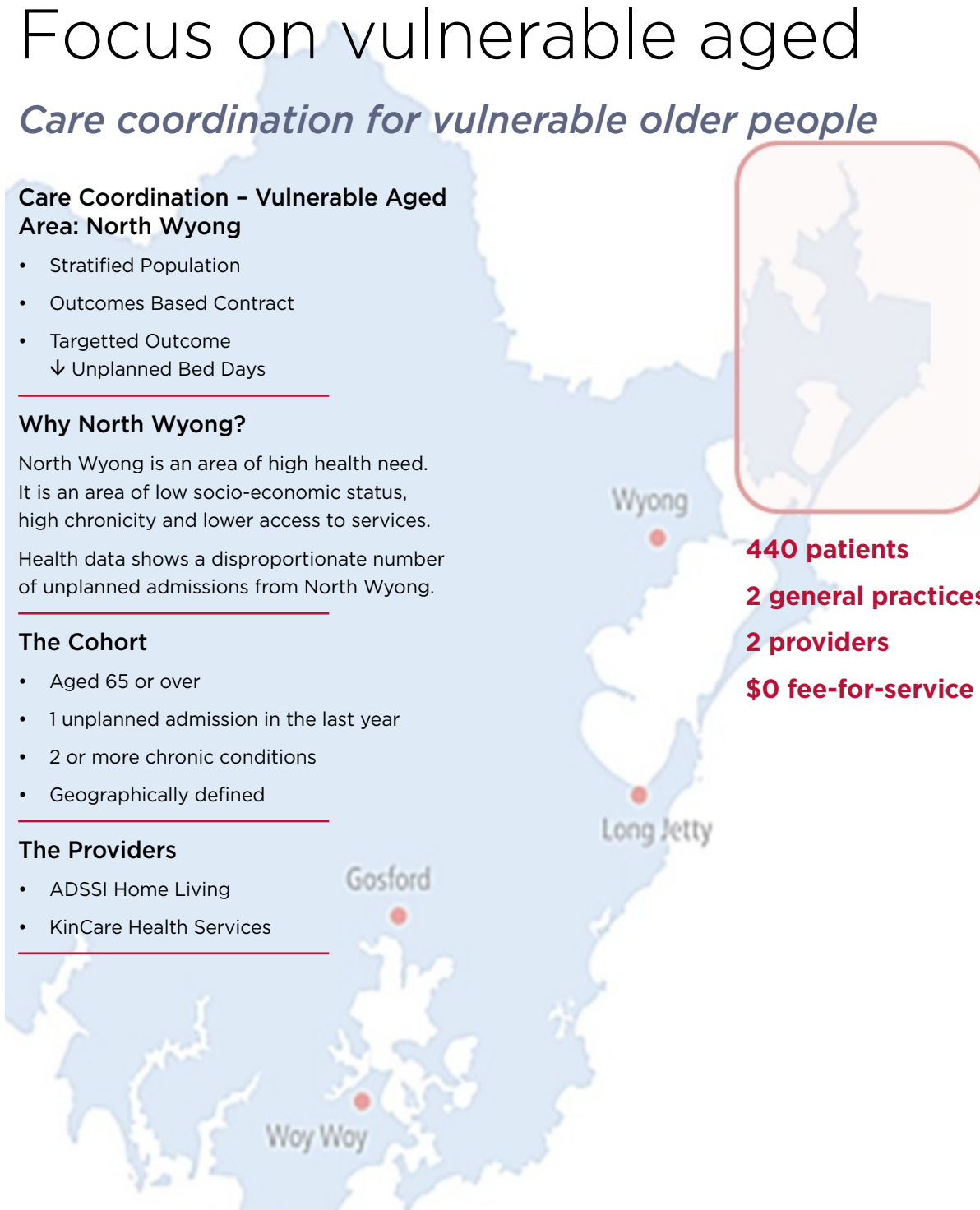
### The Cohort

- Aged 65 or over
- 1 unplanned admission in the last year
- 2 or more chronic conditions
- Geographically defined

### The Providers

- ADSSI Home Living
- KinCare Health Services

**440 patients**  
**2 general practices**  
**2 providers**  
**\$0 fee-for-service**



## First Patients Seen January 2017

Care coordination for the vulnerable aged has commenced in pilot for 440 people identified through risk stratification.

What makes this project unique is the Outcomes Based Commissioning model with two care providers who will be paid for an outcome, bed days saved, rather than for activity. The commissioning approach taken by the Central Coast Integrated Care Program has been based on transparency and on letting the providers determine the care coordination model by which they will keep their patient cohorts out of hospital. The pilot will evaluate the potential for a greater tailoring of care to the needs of each individual, to keep them healthy and at home.

Although this work is commissioned, the District views the care coordination providers as partners, not just contractors.

## The outcomes based commissioning journey

The Central Coast Integrated Care Program commenced with a commitment to integrated Health and Social Care. As a Demonstrator site for the NSW Integrated Care Strategy, the District committed to testing new ways of working that included commissioning, risk stratification and contestability.

The journey to complete this first commissioning cycle has been complex and challenging as the Program sought to develop new modes of operation. It is expected that, now market creation and procurement phases have been completed once, they will be faster the next time.



July  
2014

### Needs assessment

North Wyong is identified as an area of need through the development of the Central Coast Integrated Care Strategy.

March  
2015

### Program team established

Integrated Care Program Team is fully established and work begins on development of the Outcomes Based Commissioning Cycle.

April  
2015

### Outcomes Based Commissioning (OBC) Cycle Completed

The OBC becomes the agreed way by which commissioning will occur for the Integrated Care Program.

May  
2015

### Risk Stratification Model is used to identify patients in need

Health data shows degrees of prediction for different factors. A model is chosen that is highly predictive but ensures a substantial patient cohort. Tested and validated through 2015.

May  
2015

### Care design completed with the community

60 community stakeholders, 3 workshops, 2 GP panes and numerous interviews prioritise care coordination as the most effective.

Early  
2016

### Market assessment and creation - 20 EOI submissions

EOI receives significant interest from GPs, NGOs and private providers. 2 industry briefings. The program is transparent about the project aims and funding model.

July  
2016

### Invitation to tender for the proof of concept

2 industry briefings, 7 responses. Positive feedback from all responders on the approach taken to engage all providers.

Dec  
2016

### Contracts finalised and signed

Contracts completed after a robust procurement process!

Jan  
2017

### Outcomes-targeted care begins!

Please contact [CCLHD-IntegratedCare@health.nsw.gov.au](mailto:CCLHD-IntegratedCare@health.nsw.gov.au) if you would like more information on the North Wyong Proof of Concept.



# Focus on vulnerable young people

## *Family referral service in schools*

**Area: 3 school learning communities**  
**Target population of 10,790 student communities with low FOEI scores (indicates increased socio-economic deprivation)**

### Partners

- Family Referral Service
- CCLHD
- Department of Education
- Local School Principles
- HNECCPHN

**5 high schools**

**13 primary schools**

**2 providers**

### The Cohort

Students and their families where there is an identified risk of disengagement from learning and school attendance.

**10 October 2016** – Family Engagement Worker was employed and started work at Brisbane Water High School

**4 November 2016** – Second planning meeting with principals at Lakes Learning Community to plan program start

**5 December 2016** – Brisbane Water Learning Community Governance Meeting

Planned start date for site two, Lakes Learning Community, **week 5/6 of Term 1** (early March 2017)

Planned start date for site three, Wallarah Learning Community, **Term 2, 2017**

The Family Referral Service in Schools Project represents an opportunity to develop Communities of Care around vulnerable families by creating an early intervention program, working up stream to impact health and social vulnerabilities.

Family Engagement Workers will consult with students and their families to connect them with the required school, health and social services.

The project has been developed under the Integrated Care Programs sustainability principle. While some seed funding has been provided alongside governance and implementation support, the aim is to test whether this model of care is something that schools would provide into the long term.

For Health, there is the opportunity to further develop risk stratification models with these schools.

Targeting Success for the Student, Success for the Care-giver, Success for the School and Success for the System. The program will assess the needs of families, understand the health and social care issues faced by families and work with them to prioritise actions that will support the young people to engage with learning.

## The Family Engagement Worker's Story

I was unable to make contact with the young person's (YP) mother and, by the time I began working with the school, the YP had moved back in with her grandparents as the mother had been evicted from the house they were living in and relocated out of area.

YP was struggling with mental health (self-harming and suicidal behaviours) and the grandparents and school were extremely ill-equipped to manage these concerns and behaviours. I identified possible attachment issues between mother and YP with YP's behaviour worsening after visiting her mother.

YP was in crisis with no support services around her. Her grandparents were a really positive protective factor. However, the grandparent's resilience was breaking down as YP's mental health deteriorated and the grandparents also had no support. I linked the grandparents with 'Grandparents Raising Grandchildren' case management to support them in supporting the YP. YP reached crisis point and was admitted to hospital following my advice.

YP picked up case management support from CYPMH that was otherwise unavailable to her. Mental health support for young people in crisis is recognised as a significant gap in service delivery in the area. YP also picked up case management through a Youth Support Service to link her with pro-social activities and social support. I then facilitated a case-coordination meeting so that the school, the family and services involved could communicate and exchange information on how they were supporting the family. Family's support circle was built and family resilience/strength identified.

## Outcomes for Families

- Gap in service identified and escalated
- Linked with relevant support services
- Case coordination ensured all family needs were addressed
- Support circle established
- Supported to identify strengths and build resilience
- Increased communication between the family and school



## Central Coast Multi Agency Response Centre

The Central Coast Multi Agency Response Centre (CCMARC) officially launched 9 February 2016, having begun operations in November 2015.

In attendance were then Minister for Family and Community Services, Brad Hazzard as well as clinicians, managers and executive of both the Department of Family and Community Services (FACS) and the District.

As the first NSW co-located multi-agency child protection information exchange and triage service, Central Coast is leading the way in defining health's role in interagency responses to child protection. Partners are the District, FACS, Department of Education, and Family Referral Service (FRS).

CCMARC has provided a window into the management of child protection concerns across the whole of the health system. The lessons and experiences from this multi agency partnership provide us a platform to build a strategic and integrated strategic approach to child protection concerns within the Central Coast Health District.

CCMARC will provide ongoing challenges and opportunities to influence and implement practice change and service wide realignments. This will enable an effective response to vulnerable families, in all parts of the health system, ensuring the health service response is underpinned by safety frameworks that are also trauma informed.

What next for CCMARC? While there is commitment to the service improvement approach from the Districts senior management, more work needs to be done to determine how it will be achieved, using a rigorous quality improvement framework.

Specifically, a consistent approach will need to be developed where information and recommendations from case reviews are shared with relevant operational managers, who will be asked to adopt these changes within their departments or units, and to monitor that the changes have taken place and that the changes recommended are an improvement.

### CCMARC has...

- Increased the specificity and relevance of information exchange while maintaining patient privacy requirements
- Enacted Service Improvement Processes in data collection and agency interactions
- Identified gaps in treatment responses



Staff from FACS and Central Coast Local Health District at the opening of CCMARC



Former Minister for Family and Community Services, now Minister for Health and Medical Research, the Hon Brad Hazzard (centre), with former CCLHD Chief Executive, Matt Hanrahan, and CCLHD Child Protection Services Manager, Donna Curtis

## Patchwork Trial

## Background

Patchwork was introduced through the Central Coast Youth Safety and Wellbeing Forum (CCYSAW) as a solution to improve coordination between health and social care agencies on the Central Coast in 2014.

The identified need for this approach was the lack of coordinated case management for complex and vulnerable children and families, and the continued experience of fragmentation in service deliver both within and across agencies.

## Process

FACS and the District partnered in the trial with service participation from Youth Health Service, Children and Young People's Mental Health and Headspace.

An Integrated Care Project Manager worked with trial teams to familiarise them with the tool through face to face training and phone support. This included the development of appropriate resources including FAQs, Operational Manual, and patient information sheets. A process improvement cycle (Plan, Do, Study, Act) was implemented to address barriers to implementation of the tool.

## Findings

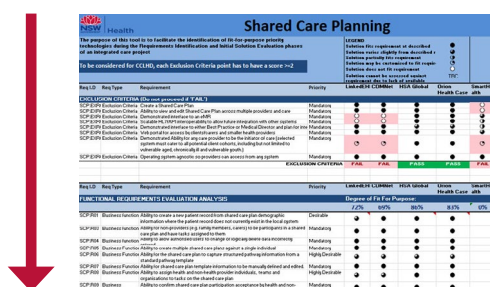
The project identified significant variation in clinical staff practice when sharing clinical information, and in their knowledge and application of appropriate health policy (Privacy Manual for Health Information) and legislation (Chapter 16A Children and Young Persons Care and Protection Act 1998).

The Patchwork Trial is completed and final lessons will inform the future direction. It is clear that tools like Patchwork can support care coordination only when combined with structured care coordination approaches agreed across agencies (and capacity for staff to actively collaborate). In this trial, presence of Patchwork as a tool did not appear to influence or change approaches to collaboration and care coordination across agencies.

It is anticipated that the review of the Patchwork Trial will be based on the findings of the project and take into consideration the requirements identified by Central Coast Integrated Care and the broader range of collaboration tools available.

## Building Blocks...

*The works performed with eHealth NSW to assess requirements for Shared Care Planning*



*Inform the CCLHD review of Patchwork*



Which in turn informs the testing and trial of  
GoShare for Health in the Chronic Disease Program





## Out of Home Care Health Access

**Area:** Whole of Central Coast

**Target population:** Central Coast children and young people in out of home care (0 – 18 years)

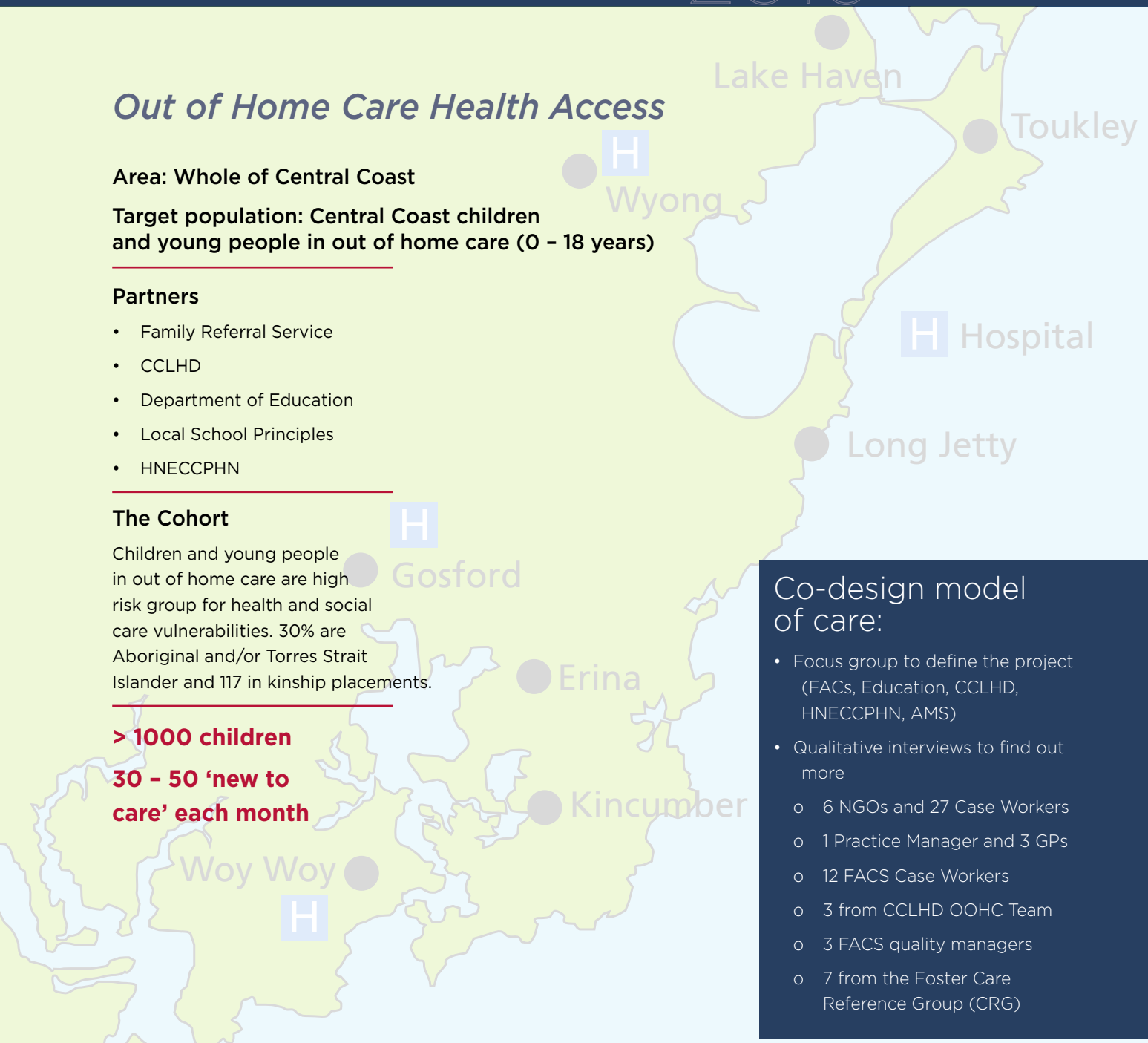
### Partners

- Family Referral Service
- CCLHD
- Department of Education
- Local School Principals
- HNECCPHN

### The Cohort

Children and young people in out of home care are high risk group for health and social care vulnerabilities. 30% are Aboriginal and/or Torres Strait Islander and 117 in kinship placements.

**> 1000 children**  
**30 – 50 'new to care' each month**



Aiming to provide a better integrated approach to health assessment and treatment, the Central Coast Integrated Care Program has supported a multi-agency partnership review of Out of Home Care with HNECCPHN, FACS, Department of Education and NGO agencies. The project has identified key opportunities for efficiencies, which require a greater degree of multi-agency integrated responses to assessment and management of the health needs of these vulnerable young people.

The Desired Future State identified 5 key opportunities for consideration:

1. New Medicare Cards should only be issued where there is identified risk
2. Health care is a key part of “new to care” planning meeting checklists. Medicare number, immunisation record, GP Health Records and My Health Record registration ideally go with the child.
3. Children and families are enabled to have strong connections with General Practice as the gate opener of health care. Health only facilitates those with significant identified health needs.
4. “1000 days of care” Framework is considered and designed with partners.
5. Opportunities for joint working are enabled through formal and informal partnership arrangements.

These opportunities have been presented for review to the business so that the way forward can be planned.

# Focus on complex and chronic care

## *Central Coast Alternative Pathways Initiative*



John Sillince, NSW Ambulance, meets with Colleen Cooper (HNECCPHN) as well as Mick Napoli and Michael Bishop from the Integrated Care Program.

*I do P5's (alternative pathways) a lot and I hear about them being done every day.... Personally, I think it's one of the best things we have done... Before alternate pathways there was no other way. It was either refuse transport or transport to ED.*

*We had a 94 year old lady in Erina Fair. She came out shopping and was withholding her diuretic so that she could shop for longer without interruption. She became breathless and ambulance was called. I begin talking to her, asking her story and find she is able to walk and look after herself. She chose not to take her meds that day. We knew why she was short of breath and what fixes it. We took her home and made sure she was ok. I called the GP and he was happy with our approach. If we took her to ED, we might be there for hours. It's a no brainer.*

*John Sillince, NSW Ambulance*

### Background

NSW Ambulance patient transportations of triage categories 4/5 to emergency departments had been increasing over time.

A proof-of-concept was conducted Jan - July 2014 by Central Coast NSW Medicare Local. It identified change required to reduce unnecessary hospital transports of low acuity patients and to reduce Ambulance turnaround time at hospitals.

The role of an Ambulance liaison officer is essential to the successful collaboration with patients, usual care providers or available GP practices. Patients assessed by qualified paramedics as suitable for alternative referral options do not require transport to the Emergency Department via ambulance

### Process

The Central Coast Alternative Pathways Initiative (CCAPI) was run as a partnership between HNECCPHN, CCLHD and NSW Ambulance.

**108 NSW Ambulance Paramedics were trained** to implement low acuity protocols to manage alternate pathway referrals for appropriate patients. The training occurred between December 2015 and June 2016.

### Findings

Data for September 2016 indicates 34.5% of total NSW Ambulance incidents on the Central Coast were managed as non-transports and patients were provided an alternative pathway referral instead of presenting to hospital (28.7% in June 2016).

## Woy Woy Integrated Care Coordination Pilot

### Care Coordination – Chronic Care Area: Woy Woy

- Testing transition from the Chronic Disease Management Program (CDMP) to a model focused on general practice

### Care breakdown

- 30 clients are serviced with intensive case management
- 59 clients are serviced with telephonic health coaching support
- 20 clients are serviced with a monitoring and review phone call every 3 months

### Why Woy Woy?

CCLHD is an early implementer of the state-wide redesign on CDMP.

Woy Woy has been identified as an area with a range of issues: accessing health care, socio-economics, age and culture.

### Next Steps

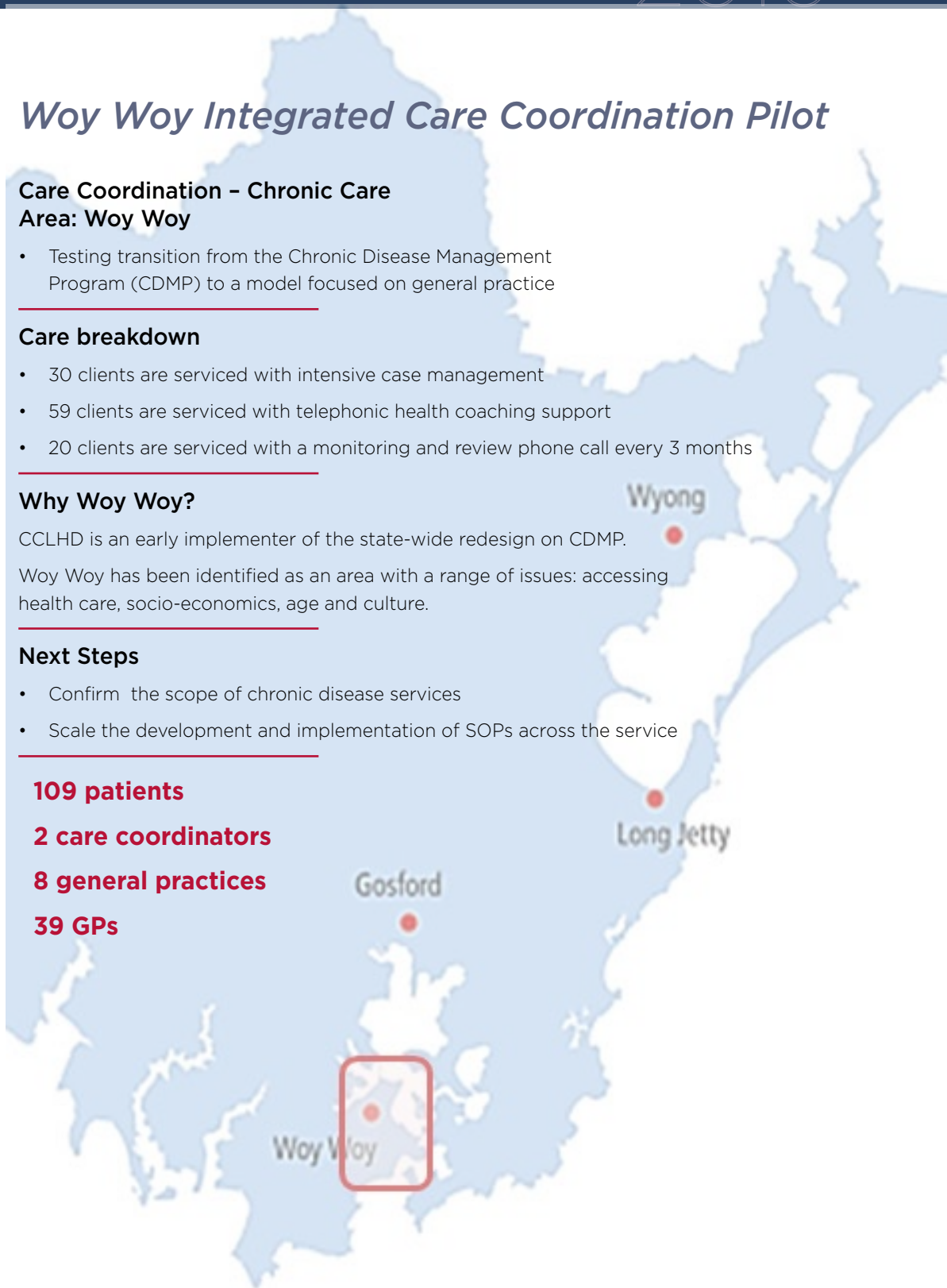
- Confirm the scope of chronic disease services
- Scale the development and implementation of SOPs across the service

**109 patients**

**2 care coordinators**

**8 general practices**

**39 GPs**



## Enabling New Models

- eEnabled Patient Education
- Patient story videos developed with the Agency for Clinical Innovation;
  - o Kay's Story <https://vimeo.com/196507016>
  - o Ian's Story <https://vimeo.com/196506978>
- 8 new Standard Operating Procedures (SOPs) to define appointment scheduling routines and standard duration of service.

## *Self-Management Support Service Review*

In 2016, a review of the Self-Management Support Service (SMSS) was conducted with a view to expand the reach of self-management support services across the Central Coast. SMSS is a small service and the aim was to investigate how the District might be able to provide self-management support to the >30,000 residents estimated to have a chronic disease.

### **Process**

Stakeholders formed a project working party that included staff from SMSS, Integrated Care and Ongoing and Complex Care. An audit tool was developed in March 2016 to identify how self-management support strategies have been embedded into routine care and where SMSS could strengthen systems, processes and develop staff skills.

### **Outcomes**

Through communication with Stanford University, the Integrated Care Program team negotiated to trial more flexible licencing arrangements for other organisations to deliver Stanford's Better Health Self-Management (BHSM) under the CCLHD licence until 1 December 2018.

Four non-CCLHD venues were trialled, with three of these venues doing 75% of the promotion, reducing resource allocation of District staff. A Memorandum of Understanding and Service Level Agreement was finalised to allow one NGO aged and disability service to provide BHSM program for their clients.

## *E-enabled Patient Education Trial*



**5 services involved  
in the pilot**

**642 education  
bundles sent**

**45% bundle opening  
rate**

Central Coast Local Health District is trialling the RealTime Health Secure GoShare platform to deliver patient education and patient stories to community clients and their carers. The trial runs until July 2017 and allows the District to test different communication media.

Services involved in the pilot have been given the opportunity to create education bundles for their clients as well as regimes that allow a scheduled series of information packs to be sent out over a period of time. Community clients and their carers are able to receive information as an email or SMS.

A unique feature of this method of communication is the ability to see who has opened an education bundle. This is not discernible for paper communications.



# District wide integrated care initiatives

## *General Practitioner Antenatal Shared Care Project*

Aside from general project work, a key component of the Integrated Care Program has been to sponsor and seed projects across the District. As a part of this GP Collaboration Unit has moved into the Integrated Care Program. One of the key focuses of the GP Collaboration Unit in 2016 was the GP Ante-Natal Shared Care (GPANSC) project.

### Background

This project examined the causes of a substantial decline in general practitioner (GP) antenatal shared care (ANSC) on the Central Coast over the last 15 years and is implementing solutions to reinvigorate the model of care.

### Process

A registered midwife was allocated as a dedicated central contact. They provide personalised GP visits, assists to coordinate GP antenatal education evenings, will develop online education for GPs and coordinates communication between GPs and antenatal services. This communication includes regular newsletters and HealthPathways promotion.

Prior to the project, GPs were required to register on a list that would allow them to participate in ANSC and professional development activities related to antenatal and women's health. There was no perceived benefit to this registration, as the list could not be shared and registration was not accredited or monitored. Many GPs were confused about the requirement, or found it onerous and unnecessary. To address this problem, the registered list of GPs providing ANSC was removed.

### Results

- 18 new GP's offering GPANSC
- Increase of participants in GPANSC from < 2% in January 2016 to 5.2% in January 2017

### Next Steps

- Planning for a category 1 education event for GPs and midwives in April 2017
- Promotion of ANSC to community members / expectant mothers via Facebook / twitter / social media and other websites that families and expectant mothers may view
- Promotion of ANSC to GPs via posters and HealthPathways newsletter, regular ANSC newsletters, education events, links with HNECCPHN practice support team



*Above: A patient and GP from the project.*

*Below: Former Health Minister, the Hon Jillian Skinner, with the CCLHD GP Ante-Natal Shared Care Project Team at the ACI's Redesign School Graduation.*

<2%

Proportion  
of women in  
GP ante-natal  
shared care at  
January 2016

5.2%

Proportion  
of women in  
GP ante-natal  
shared care at  
January 2017

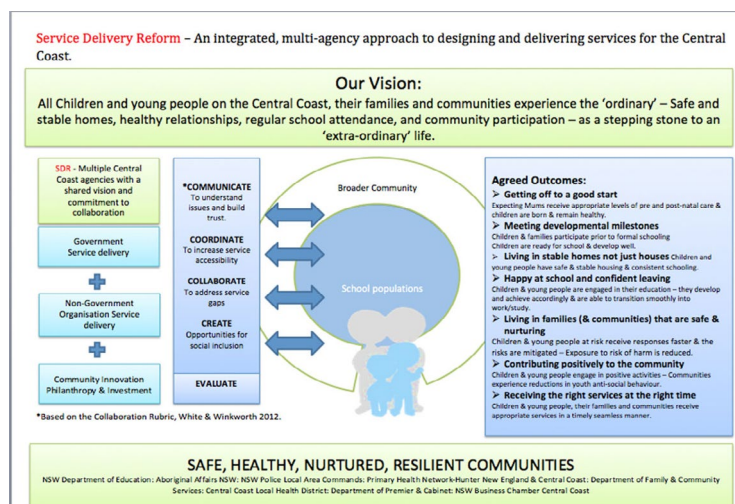
## Service Delivery Reform

### Background

- An integrated, multi agency approach to designing and delivering services in the district.
- The Central Coast is one of four Service Delivery Reform (SDR) trial sites led by the Department of Premier and Cabinet (DPC) and supported by the NSW Government.
- The needs of children, young people and their families are at the heart of these reforms.
- Shared data analysis has led to an initial focus on the North Wyong area and more specifically school populations in this area (2 high schools, 5 primary schools).

### Progress

- On 30 June 2016, The NSW Advocate for Children & Young People undertook consultations with 158 children and young people aged from 10-18 years living in North Wyong.
- Responses not only inform the work of the SDR but have contributed to the 4,000 plus consultations conducted with Children and Young people across NSW to develop the first NSW Strategic Plan for Children and Young People.
- In August 2015 Guardian Actuarial was engaged by the Department of Family and Community Services (FACS) Central Coast to develop the Reporting Framework for SDR. Work continues on the development and monitoring of population based data.
- In August and September 2016 the Department of Family and Community Services (FACS) Central Coast invited Second Road to facilitate a co-design process to explore ways to improve the service ecosystem in North Wyong.
- 24 Government and non-government organisations participated.
- There are 5 projects currently underway as a result of this work
  - Shared Services Directory
  - True Community Schools
  - Cultural Competence
  - Mobile Services/Pop Ups
  - Strengthened Local Hubs
- On October 21, 2016 member agencies signed the Service Delivery Reform Compact which formalises the shared vision and commitment of all members to continue the SDR agenda and program of works for the benefit of the Central Coast community.
- Agencies continue to apply the SDR philosophy to new collaborative initiatives.



## Redesigning Services - Aboriginal Mothers and Children

A partnership with Yerin Aboriginal Health Service Inc and Central Coast LHD.

	Aboriginal and/or Torres Strait Islander Women	All Central Coast Women
Teenage pregnancies	15.9%	4.4%
Smoking during pregnancy	42%	15.8%
Low birth-weight babies	9.9%	4.9%
At least 1 antenatal visit in the 1st trimester	73.5%	83%

Source: Hunter New England & Central Coast Primary Health Network Aboriginal Health Profile 2016. [www.hneccpnh.com.au](http://www.hneccpnh.com.au)

### Background

The need for Targeted interventions to address the health needs of Aboriginal communities is well documented (Closing the Gap literature 2005 to present). There are currently 3 different services on the Central Coast that are targeted and resourced to support Aboriginal mothers and children during pregnancy and early childhood - Ngilyang (CCLHD), Nunyara (CCLHD) and Yerin Aboriginal Health Service Inc.

In 2014/15 Only 26% of mothers and children identified as Aboriginal received a Targeted Model of Care (Ngilyang AMIHS) from first contact with the Local Health District.

Diagnostics identified system constraints in relation to 4 key areas:

1. Access to care
2. Cultural Support
3. Patient Information and education
4. Care Coordination and Integration

Key Solutions developed include:

1. Revising the way the question regarding Aboriginality is asked.
2. Developing a Maternity and Early Childhood information package for Aboriginal families.
3. Revision of the maternity intake process to include 1 and 2 plus all care options for Aboriginal families.
4. The most significant body of work will be the Development of an integrated model of service delivery for Aboriginal families that ensures equitable access to care, informed decision making, cultural support and seamless care coordination.

### Goal

Aboriginal Women and children will have access to culturally safe and clinically appropriate maternal and child health care on the Central Coast irrespective of where they live.

### Objectives

1. To increase the number of Aboriginal mothers and children offered cultural support through pregnancy and early childhood from 54% to 100% by July 2017.
2. 100% of parents who identify as Aboriginal will be aware of Health services available to support Aboriginal families on entry to the service by 2017.
3. To increase the number of mothers and children who identify as Aboriginal at Maternity Booking in from 66% to 80% by July 2018

### Progress

The project is currently in the Implementation phase with project team support to continue through to June 2017.

There is a strong focus on sustainability with findings to be incorporated into The trilateral Aboriginal Health Agreement and The Aboriginal Health Plan.

# Building Capability

## *Multi-Agency Accelerated Implementation Methodology Training*



The Central Coast Integrated Care Program (CCICP) has identified workforce change management skills as a main barrier of successful project implementation. Having a common change language across partner organisations and managing resistance were two of the main issues experienced.

The evidence has identified joint training in the use of a consistent framework and change management approach as enablers to support effective interagency working.

Multi-agency training in Accelerated Implementation Methodology (AIM) has been trialled to build the region's capability to deliver partnered change. AIM is an internationally recognised change management methodology, supported and promoted by the Agency for Clinical Innovation (ACI) and the Health Education and Training Institute (HETI).

Throughout 2016, the District has facilitated six AIM training programs, reaching 90 participants across six organisations. Overwhelmingly, feedback from participants has been positive, leading to more enrolments.

Two day AIM training sessions were offered to partner agencies as part of the program:

- Hunter New England and Central Coast Primary Health Network (HNECCPHN)
- Department of Family and Community Service (FACS) – Hunter and Central Coast Districts
- Department of Education
- NSW Ambulance
- Family Referral Service (FRS) – Benevolent Society

The program has been a success, both in terms of the number of participants and the number of agencies involved.

The District's Directorate of Workforce and Culture have now added AIM to the training calendar and have engaged two additional trainers to meet local demand for AIM training and deliver planned programs throughout 2017. At January 2017, demand for the AIM programs is very high.

## Creating Value in Integrated Care

In November 2016, the Central Coast hosted six international experts in integrated care as part of the 'Creating Value in Integrated Care - Whole System Approaches' workshop. The event was hosted by CCLHD in partnership with University of Newcastle (UoN), Centre for Rural and Remote Mental Health (CRRMH), International Foundation for Integrated Care (IFIC) and Hunter New England and Central Coast Primary Health Network (HNECCPHN).



*Dr Anne Hendry hosts a breakout session at the workshop.*



*Above: Prof. David Perkins leads a panel with Dr Viktoria Stein, Dr Robin Miller and Dr Nick Goodwin.*

*Below: CCLHD Chief Executive, Dr Andrew Montague addresses the workshop.*

Participants had the opportunity to discuss and hear international perspectives from Dr Nick Goodwin (Co-founder and Chief Executive of International Foundation for Integrated Care - IFIC), Dr Viktoria Stein (Head of Education and Training IFIC), Dr Robin Miller (Director of Evaluation, Health Services Management Centre University of Birmingham UK), Dr Anne Hendry (Clinical Lead for Integrated Care Scotland), Dr Richard Antonelli (Medical Director of Integrated Care, Boston Children's Hospital USA) and Professor David Perkins (Director CRRMH UON). It was both a great learning experience and a chance to share ideas about how to manage the challenges of integrated care.

District staff, Dr Rachel Sheather-Reid, Dr Peter Lewis, Anthony Critchley and Catherine Turner presented on integrated care experiences and work underway locally. There was positive feedback from the international guests regarding the way patient cohorts have been identified, care requirements designed and care providers engaged on the Central Coast to develop person-centred care.

District Board Member, Emeritus Professor Maree Gleeson OAM, from University of Newcastle (UoN), led discussions on how integrated care will impact the development of the research plan. Professor John Aitken, Pro Vice-Chancellor Biological Sciences, UoN, discussed the potential opportunities in working with UoN, particularly in the development of courses centered around integrated care and bio-analytics.

In summing up the two-day conference District Chief Executive, Dr Andrew Montague, identified two key next steps for integrated care in our region: to take our experience of Integrated Care to build a vision which we can embed into our clinical operations and to continue to build the Central Coast Medical School and Research Institute.



# Looking ahead 2017 – next steps

The work of integrated care continues apace on the Central Coast in 2017. With projects wrapping up and entering evaluation, 2017 will provide the Central Coast the opportunity to stop and assess the District's goals and set new priorities for the coming years.

## **Strategic Review – February 2017**

Having had the chance to evolve the thinking and processes around integrated care, the Program's Governance Committee will hold a Strategic Review of the program in February 2017.

The strategic review will allow all partner organisations to assess what has been achieved and what else needs to be prioritised.

It's anticipated that the review will not only look at particular focal areas in terms of patient cohorts but also at what partnerships require further development and the role of this program in creating system level integration.

Initiatives at both the state and federal levels will also be taken into account when identifying focus populations.

## **Transitioning to “Business as Usual”**

While a lot of work has been done to transform the thinking and mode of operation of the District and partner organisations, more needs to be done to embed integrated care into business as usual.

It is anticipated that there will be an increased effort at setting a vision for the District of how integrated care fits into the bigger picture of providing care to the people of the Central Coast.

## **Central Coast Medical School and Research Institute**

The development of the Central Coast Medical School and Research Institute will take shape over 2017.

How that institute develops, with integrated care being one of the areas of focus, will be formative in the ongoing development of integrated care practices and culture within the Central Coast region.

This should be clearer by the end of 2017.

## **Gosford Redevelopment and Health and Wellbeing Precinct**

The development of Gosford Hospital and the new Health and Wellbeing Precinct creates opportunities for the District to review its models of care and levels of service provision at the Gosford site.

This is an opportune moment to build integrated care across all of the models of care in the hospital. As project officers come in to create these new models of care for the hospital, they will be connected with the Central Coast Integrated Care Program to equip them with concepts of how integration can be built into their work streams.

Thank you to all of our staff and partners for your collaboration and patience in 2016. We look forward to continuing to work together to build Integrated Care across the Central Coast in 2017.

*If you have any questions or would like further information, please contact the Central Coast Integrated Care Program Team on [CCLHD-IntegratedCare@health.nsw.gov.au](mailto:CCLHD-IntegratedCare@health.nsw.gov.au).*



**Health**  
Central Coast  
Local Health District

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