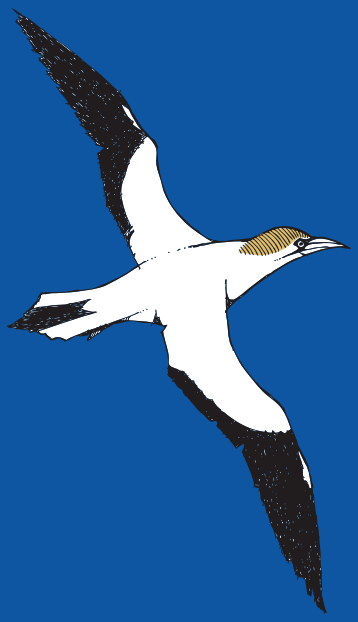


PORTLAND DISTRICT HEALTH

Health Services for Glenelg

Strategic Plan
2023 - 2026

We acknowledge the traditional owners of the lands and waterways in which we live and work, the Gunditjmara people of South West Victoria. We honour and pay our respects to elders, past, present and emerging.

Portland District Health would like to acknowledge the Winda-Mara Aboriginal Corporation and the Budj Bim Rangers for the use of this image.

CONTENTS

MESSAGE FROM THE CHAIR

Portland District Health (PDH) is one of the oldest hospitals in Victoria. It has a proud history of service to its community.

Like health services across the state, the nation, and the world, in the last few years PDH has faced many challenges posed by the COVID pandemic. There will continue to be disruptions and complexities as society makes the necessary adjustments.

PDH has also experienced local challenges as organisational leadership, services, workforce, and culture have been reviewed and are being reframed and revitalised. Progress has been made, but much more is required.

The Board has consulted widely: community, staff, government, and Department of Health. We have listened attentively to the advice of the Executive, those who are closest to the action, those who will implement the plan.

The Board thanks all who have contributed and acknowledges the interest and passion invested by many in PDH. Many voices have expressed their views; as could be reasonably expected there were points of alignment, difference, and diametric opposition.

Health is complex, demanding and critically important to community well-being. The Board is acutely aware of its obligation to navigate through often turbulent waters. The Board does so with great confidence in its executive and staff.

The Board is pleased to present the PDH Strategic Plan 2023-2026 and the positive picture it frames for PDH and its patients, residents, staff, and the community it serves.

Peter Matthews
Chair

MESSAGE FROM THE CEO

The Executive is proud to work on the Strategic Plan 2023–2026 to enable you to get care when and where you need it; care that is best for you; and that you and your family are as healthy as possible.

The strategic plan was developed in consultation with our community, staff, and Board to reflect how we intend to engage with stakeholders now and in the future. PDH's recent history has been a story of improving service for the local community, building a positive culture, creating new leadership pathways, advocating for and delivering better health services, enhanced facilities, creating relevant services and vital referral pathways, while managing responsibly.

Developing a clinical services plan that enables and aligns this work will be the next step in our journey to creating a sustainable health service that supports community needs into the future.

The strategic environment is a challenge in an ever-changing landscape requiring significant thought. We are incredibly optimistic as a service. The critical priority is always safety and quality; this is always our overarching lens to ensure you can return home to your family and live your best life.

On behalf of the staff and volunteers at Portland District Health, I thank the Board and community for the confidence that you have placed in us. It is a privilege to lead such a vital community resource, and I thank you on behalf of the Executive for your ongoing support.

Samantha Sharp
Chief Executive Officer

ABOUT PORTLAND DISTRICT HEALTH

Population Health Profile

PDH serves a catchment population of approximately 12,000 people drawn principally from the Glenelg Shire and increasingly from South East South Australia. Some community services cover an expanded catchment, including the Southern Grampians Shire. While a high proportion of the region's population is concentrated in Portland, many people receiving services from PDH live in smaller townships in the surrounding region and in more isolated cropping, sheep, cattle and dairy farming areas. Population numbers increase by an estimated 2,000 tourists during summer and other peak holiday periods. The community is characterised by a slowly growing population that is rapidly ageing. The prevalence of chronic illnesses such as respiratory disease, cancers, cardiovascular disease, diabetes and mental illness is increasing as our population ages. A relatively high incidence of road accidents, skin cancer, farm injuries and work-related accidents also occur in our region, a characteristic shared with other rural communities.

About Portland District Health

PDH is a public hospital under the Health Services Act 1988. Our role is to provide quality, safe health services to people in the Glenelg Shire. To fulfil this role, Portland District Health offers a range of services, including; acute care through specialised medicine and surgery, urgent care, maternity services and limited children's services. As an integrated Healthcare organisation, PDH provides a range of services in sub-acute and aged care, population health, primary and community care.

WHERE WE WORK

WHAT WE DO

1 Portland District Health

2 Western District Health Services

3 South West Health Services

4 Barwon Health

5 Metropolitan Tertiary Hospitals

We deliver locally:

- Urgent care
- Maternity
- Residential aged care
- General medical and surgical
- Home based care
- Prevention and health promotion
- Alcohol and drug services
- Participation in research / clinical trials
- Acute Aboriginal Health
- Allied health / community health

In partnership with others, this is what services we deliver:

- Mental health services
- Disability support
- Outpatient specialist services
- Rehabilitation
- Aboriginal & Torres Straits Islander health
- Critical care
- General medical
- Local Public Health Unit
- Pharmacy
- Administrative support

We refer:

- Outpatients / Specialist Services
- Tertiary and complex care

STRATEGY ON A PAGE

Our purpose

You as a consumer, have lifelong care when and where you need it

You get care that's best for you

You and your family are the healthiest possible

Our values

ORGANISATIONAL (What we stand for)

Togetherness
We work with community, staff and partners

Courage
We change, adapt and innovate

Optimism
We strive for the best and see strengths in our community and the people we serve

OPERATIONAL (How we do our work)

C Compassion

A Accountability

R Respect

E Excellence

Our objectives

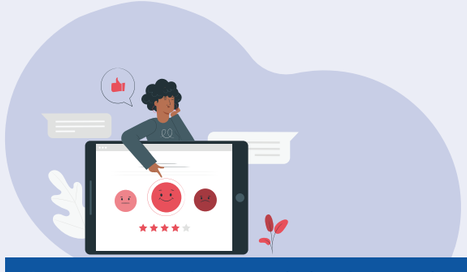
OBJECTIVE 1:
Enhancing services for our community

Our intent: In order to deliver and facilitate the services the community wants and needs, at acceptable cost...

We will...

- Define and stabliise our core services
- Build a strong suite of clinical partnerships to grow comprehensiveness and responsiveness of care options
- Develop sound referral networks for care unable to be provided locally (for those requiring complex, high-risk or tertiary care)

OBJECTIVE 2:
Enhancing our community's experience



Our intent: In order to maximise the experience of care for patients, families and carers and our repute and connection to our communities and our places...

We will...

- Rigorously and regularly measure patient experience
- Use insights from measurement, along with other sources, to continuously improve the experience of patients and carers and enhance access to, and safety of care
- Connect to, and engage with, our diverse communities

OBJECTIVE 3:
Workforces of the future

Our intent: In order to secure capable and engaged workforces for our future...

We will...

- Attract and retain high performing staff, including clinical and support workforce
- Develop a leadership group who can build a strong culture of togetherness, courage and care
- Optimise health and wellness of all staff

OBJECTIVE 4:
Evidence-based & sustainable systems

Our intent: In order to maximise the effectiveness, responsiveness and sustainability of all we do...

We will...

- Continually monitor and improve financial performance
- Develop information systems to inform timely, quality clinical decision making, performance monitoring and business operations
- Heighten our environmental sustainability

Social and population trends

The population of Victoria's South West Coast is 66,000, projected to grow to 69,000 by 2030. Our specific catchment of Glenelg Shire is, at 2023, approximately 20,000 and predicted to remain stable.

Significant differences

	Glenelg or South West	Victorian average
Median age	47	37
Aged 65 or over	25.8%	16.8%
Young workforce (under 35)	8.5%	14.2%
Life expectancy	76.9 (M) / 81.5 (F)	80.3 (M) / 84.4 (F)
First Nations	2.9	1.0%
Lone person household	29.4%	23.3%

Positive social factors

Homelessness	32 per 10,000	41.3 per 10,000
Food insecurity	2.6%	4.6%
English language barriers	0.2%	4.4%
Feels connected to community	78.4%	72.3%

Social risk factors

Internet access amongst 65+	63%	70%
Low income household	44.6%	40.9%
Violence in the home	Family violence 18.2 per 1,000 Alcohol related FV 290 per 100,000 Substantiated child abuse 10.4 per 1,000	Family violence 16 per 1,000 Alcohol related FV 128 per 100,000 Substantiated child abuse 6.7 per 1,000

Data sources:
- Western Victoria Primary Health Network (2022) Health data table for Glenelg Shire
- Southwest PCP (2020) Health and Wellbeing Trends for Great South Coast, October 2020
- Western Victoria Primary Health Network (2020) Great South Coast Health and Wellbeing Profile, May 2020
- Glenelg Shire (2021) Municipal Public Health and Wellbeing Plan
- Southwest PCP (2020) Rural Liveability for the Aged, November 2020

Health access trends

LESS than average

	Glenelg or South West	Victorian average
Access to allied health	5.0 psychologists per 10,000 8.6 pharmacists per 10,000 4.9 dentists per 10,000	11.4 psychologists per 10,000 9.8 pharmacists per 10,000 7 dentists per 10,000
Private health insurance	33.9%	48%

SAME as average

Type of hospital admissions	Acute conditions 130 per 100,000 Chronic conditions 152 per 100,000 Preventable conditions 299 per 100,000	Acute conditions 121 per 100,000 Chronic conditions 152 per 100,000 Preventable conditions 298 per 100,000
General practitioners	1.4 per 1,000	1.2 per 1,000
NDIS recipients	2.3%	2.1%

MORE than average

ED presentations	3159 per 10,000	2654 per 10,000
Cost barrier to accessing healthcare	1.9 per 100 people	1.6 per 100 people

OUR COMMUNITY

Health status trends

BETTER than average

	Glenelg or South West	Victorian average
Unvaccinated children	2.7%	4.7%
Self reported health good or better	45.7%	41.6%
Lifetime experience of asthma	16.7%	20.0%

SAME as average

Low or no exercise	67.9 per 100	65.7 per 100
Cancer screening	Cervical 60.8% Bowel 45.9% Breast 59.6%	Cervical 57.1% Bowel 43.2% Breast 54.1%
Two or more conditions in 65yo+	27.2%	27.6%
Type 2 Diabetes	5.5%	5.5%
Poor fruit & vegetable consumption	49.8%	51.5%

WORSE than average

Smoking	23%	15.6%
Risky alcohol	18.4 per 100	15 per 100
Obesity	40% (Adult) / 43.1% (Child)	31% (Adult) / 25% (Child)
1 or more long-term health conditions	34.9%	27.4%
Children developmentally vulnerable	11.7%	10.2%
Cardiovascular disease	39.2 per 100,000	33.8 per 100,000
Arthritis	27%	19.8%
Respiratory disease	11.1 per 100,000	7.6 per 100,000
Suicide & self-inflicted injuries	13.2 per 1,000	9.4 per 1,000
Registered mental health clients	24.9 per 100,000	11.9 per 100,000
Premature deaths of 70 year olds	32.4 per 10,000	22 per 10,000

OUR COMMUNITY

What people say they want and need from their health service

In August 2022 extensive community consultation was undertaken and, from over 800 local respondents (residents and staff), the following strong themes emerged:

Services aligned to community needs	• Shorter wait times • Referral to other services • Knowledge of what's available locally (and elsewhere) • Support with transport and accommodation to other health and support services
Specific services emphasised by community	• Access to Urgent Care 24/7 • Urgent care locally, reducing need for transfers outside PDH • Surgical services that are low to medium risk, but high volume • Diagnostic services • Telehealth for 'non touch' specialist consultations • Cardiac care • Fracture clinic • Maternity services for low risk births • GP access, including admitting rights to the hospital • Gerontology to support residential and community aged care • Cancer care, including support outside of clinical services
Workforce and people	• Clinicians who listen and work towards patient's own goals • Reduce turnover so that continuity of care improves • More nurse practitioners and allied health • More medical staff employed locally • Capacity to assist patients with service choice & navigation

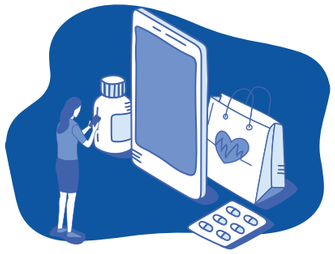
A CHANGING WORLD

Health and healthcare are changing rapidly, in line with community expectation. This means that, over the life of this plan, we will assume that those we serve will expect of us:

More care close to home

More care delivered virtually

Data-driven decision making



Growing health literacy of consumers

Focus on prevention

Meeting a wide diversity of need and expectation

Emphasis on outcomes not just activity

Working in partnership as a default

STRATEGIC PRIORITIES IN DETAIL

OBJECTIVE 1:

Enhancing services for our community

Our intent: In order to deliver and facilitate the services the community wants and needs, at acceptable cost . . .

We will...

- Define and stabliise our core services
- Build a strong suite of clinical partnerships to grow comprehensiveness and responsiveness of care options
- Develop sound referral networks for care unable to be provided locally (for those requiring complex, high-risk or tertiary care)

INITIATIVES

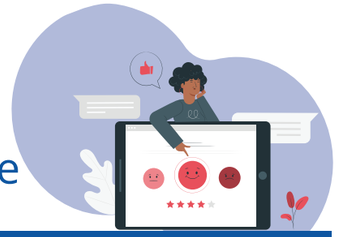
- With our community, co-develop a service plan that defines our scope of service relative to need.
- Investigate and develop strong community partnerships with other health services, education, local government, industry, GPs and primary health providers to strengthen the continuum of care.
- Explore long-term opportunities to provide support to those who are vulnerable.

ASSURANCES	RESULTS AREAS	MEASURE	TARGET
Our services are effective comparable to similar sized services	Service effectiveness against benchmark	Service specific benchmarks	All PDH services are equal to or better than statewide against comparable services (rurality + size)
	Quality standards against benchmark	PDH Care (Model of care)	TBD
Our services are delivered in a financially responsible way	Services are cost effective	Financial performance of clinical services	80% of services break-even
		Financial efficiency of clinical services	80% of services at or above benchmark (rurality + size)
Capable partners willing to work with us	Ability to enlist suitable partners	Number of effective agree-ments with strategic partners	20
	Partner effectiveness against agreements	Partner appropriateness review against Service Plan	Minimum of 10 effective strategic partnerships developed are reviewed annually for effectiveness (rurality + size)
We can refer appropriately when complex or tertiary care is required	Referral appropriateness in line with capability framework	Referral acceptance	Referrals not accepted as close to zero as possible
Health of our population improves as a consequence of our services	Major contributors to ill-health are reduced	Top 5 burden of disease metrics improve over 5 years	Burden of disease metrics improve by 2% year on year

You as a consumer, have lifelong care when and where you need it | You get care that's best for you | You and your family are the healthiest possible

OBJECTIVE 2:

Enhancing our community's experience



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We will...

- Rigorously and regularly measure patient experience
- Use insights from measurement, along with other sources, to continuously improve the experience of patients and carers and enhance access to, and safety of, care
- Connect to, and engage with, our diverse communities

INITIATIVES

- Design a system to track experience across continuum of care, for each service stream, including for vulnerable groups or those with communication limitations.
- Develop systems that communicate information consumers deem helpful, in real time (e.g., urgent care wait times).
- Establish expectation measures and methods for responding to consumer requests (e.g., call backs).
- Develop staff, during induction and subsequently, to deliver strong person-centred approaches in every interaction.
- Embed consumer voice in PDH governance structures and key decision processes.
- Heighten PDH's cultural relevance through engagement and formal planning with First Nations people and other culturally specific groups.
- Embed PDH into relevant community activities, programs and groups.

ASSURANCES	RESULTS AREAS	MEASURE	TARGET
People choose us (community + referrers)	Services fully subscribed / utilised	Service utilisation	95% target of operational bed utilisation 95% target of clinical consulting hours
	Our patient groups mirror representation in the population	Demographic data report	No demographic group is less than 50% proportionally represented
	Local referrers refer to PDH (within capability)	For 3 key service types (maternity/ orthopaedic surgery) % of referrals to PDH	TBD x baseline
Customer experience is positive	Patient reported outcomes	Patient / consumer satisfaction survey	TBD x baseline
	Patient reported experience	Victorian Health Experience Survey	Achievement x SOP 100% VHES indicators meet target?
Repute in the community is high	Community knows what we do	Community pulse checks	75 percent overall positive response
	Community rates us highly		75% overall positive response + issues of concern highlighted

OBJECTIVE 3:

Workforces of the future

Our intent: In order to secure capable and engaged workforces for our future . . .

We will...

- Attract and retain high performing staff, including medical workforce
- Develop a leadership group who can build a strong culture of togetherness, courage and care
- Optimise health and wellness of all staff

INITIATIVES

- Renew and formalise commitments to organisational values and behaviours, including measuring progress towards desired culture settings.
- Develop PDH leadership capability, and provide emerging leaders with appropriate tools and practices.
- Develop a future-focussed Employee Value Proposition that attracts staff to Portland and provides succession + career pathways.
- Develop systems that incorporate and optimise rotational staff and virtual service delivery to staff.
- Design and implement a sustainable medical workforce model based on a rural generalist approach customised for PDH's size and scope of service.
- Formalise wellness processes for staff, including a Culture and Wellbeing Committee, and wellness resources and supports.
- Increase community-responsive contributions to PDH: number and scope of volunteer efforts, disability employment.

ASSURANCES	RESULTS AREAS	MEASURE	TARGET
Supply of capable staff	Attraction	Vacancy rate Length of time to complete end to end	<5% Average < 30 days
	Retention	Turnover rates of permanent staff	<15%
	Advancement	Within past year, opportunity for higher duties, secondment, acting up and across	No. of opportunities No. of opportunities taken up
		Above base level vacancies, number of PDH applicants + % successful	No. of jobs advertised, internal applicants and internal applicants that are successful
Safe, inclusive culture	Progress towards desired culture	TOOL based metrics Imbed aspiration culture metrics	2 Reviews of culture matric within the life of the Strategic Plan
	Staff engagement	People Matters Survey metrics	Increase participation rate by 5%
Capable people	Performance within expectations	Percentage of staff with defined performance (KPIs)	Y1: 20%; Y2: 50%; Y3: 90%
	Partner effectiveness against agreements	Percentage of staff under formal performance review	<15%
Strong leadership	Leaders highly valued by staff	Percentage of staff having performance conversation with their leaders in the past 6 months	80%
		Engage a consultant to evaluate Student program	Mid point and end of program

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OBJECTIVE 4:

Evidence-based & sustainable systems

Our intent: In order to maximise the effectiveness, responsiveness and sustainability of all we do . . .

We will...

- Continually monitor and improve financial performance
- Develop information systems to inform timely, quality clinical decision making, performance monitoring and business operations
- Heighten our environmental sustainability

INITIATIVES

- Continue to implement disciplined financial optimisation processes to restore and retain sound financial state.
- Improve organisational governance through enhanced risk management processes.
- Map and identify data assets, and technology and supports, including those provided through SWARH, and evaluate 'fit for purpose'.
- Co-design requirements for future-focussed information management and governance.
- Improve performance monitoring of our operations and make results available to individuals, community, and funders, as appropriate.
- Develop methods to minimise our environmental impact and associated costs by reducing waste and energy inputs.

ASSURANCES	RESULTS AREAS	MEASURE	TARGET
Financially sound operations	Solvency	Financial Management Improvement Plan parameters	$5 million over 3 years
	Funding obligations met	Acquit in conformance with requirements	100%
	Alternate funding sources	% of revenue extra-budget (non-recurrent) applied to value-add priorities	3% per year
Secure and defensible data and compliance processes	Data security	Internal and external audits	100% compliant with audit recommendations
Processes yield effectiveness + efficiency	New approaches yield cost / time savings	Adopted process + technologies use less staff hours	Number of processes reviewed and changed to increase time efficiencies
Environmental footprint minimised	Energy use	Reduced use of fossil fuel derived power + gas + fuel	TBD x DH requirements 1 new major recycling project per year 10% reduction from baseline
	Circularity and waste	Reduction of non-infectious waste disposed of in infectious waste	

PORTLAND
DISTRICT HEALTH

PORTLAND DISTRICT HEALTH

141 - 151 BENTINCK ST, PORTLAND VIC 3305 AUSTRALIA

Telephone: 03 5521 0333 Facsimile: 03 5521 0559

Email: pdh@swarh.vic.gov.au Website: www.pdh.net.au