Hornsby / Ku-ring-gai Workshop Summary

Principles of Good Neighbours	Identified Opportunity for Improvement	Suggested Solutions / Enablers
Define clear roles	• Clarity around the role of the carer • Clarity around variety of nursing roles (RN, AIN, Practice, etc) • Clarity around the roles of organisations • Different models of care leads to different roles and responsibilities	• Health Pathways • Focus on tasks, not titles • Readily accessible resources • Plain language definitions • Shared care planning • Team meetings • Mini introductions • "I am the person to call when…."
Be accessible	• Waiting lists • Long wait times • Accessibility of after-hours care • Accessibility of home-based services • More bulk-bill GPs and incentives for GPs • Access to discharge information for community health and RACFs • Financial confusion or knowledge of cost-effective options	• Telehealth • Information registries including home-based, after hours and financial information • Standardised processes • Google health • RACGP points for GP neighbourhood work
Enable and empower patients	• Increase patient choice • Non-attendance at follow-up appointments • Access to simple, clear information • Patients confused – need support with coordination	• Simplify processes for patients • Culture change • Encourage consumer participation in health/social/community care events • Provide opportunity for patients to report challenges • Support advocacy groups, community / neighbourhood centres, NGOs, council, clubs, etc.
Ensure continuity of care	• Patients with multiple GPs • Patients with no GP • No consistent protocols for discharge • No shared responsibility / accountability for handovers • Poor communication between specialists, doctors, social care, community care, RACFs • Delays in discharge	• Discuss need for a GP with patient before discharge • Ensure discharge summaries are received • Automated discharge via EMR • Automated recall system to address delays in discharge • When no GP, hospital to link patient to a practice • Fund coordinators / navigators • Fund IT support • Consistent protocols for referral and discharge • Simple instructions for patients on discharge • Secure messaging • Shared care plans • Pre-discharge MDT meetings (skaddle) • ISBar (Identify, Situation, Background, Assessment and Recommendation) and other standard communication tools

Link in to the community	• Social determinants of health issues not managed • Providers unaware of services available • Forums for people to meet / network • Community awareness for providers and patients	• Community transport • Service directories • Include social care into Health Pathways • Community radio / social media to promote services • Formal partnerships with the local council • Clear communication about available resources • Professional forums to overcome competition between providers • Social prescribing
Support your neighbours	• Isolation • Lack of relationships across services	• Peer support programs • Create opportunities to get together • More interdisciplinary services • Health Pathways • Moderated online shared space • Service visits and informal surveys to ensure individuals are happy with 'external' services • Volunteering • Enable/encourage individuals to communicate e.g. meals on wheels alerting GP that someone is not eating meals
Share responsibility for safety and quality	• Discharge summary issues (late, incomplete, not actioned) • Medication needs upon hospital discharge (particularly for nursing homes) • No regular GP • Communication lost between providers • Communication between private and public system	• My Health Record • eMeds • Hospital to provide blister packs or webster packs for patients on discharge • Electronic prescriptions • Automated discharge processes • Encourage regular GP use • System to pick up frequent ED users • Empower patient use of discharge summaries - provide point of delivery education • Secure messaging • Private health funds to incorporate connectivity across neighbourhoods into contracts • Standardise discharge processes with nursing homes
Provide team-based care	• Communication across services • Increase local awareness • Building a team around a patient • Case conferencing • Holistic care	• Shared Care Plan • Neighbourhood networks • Broad accessibility for My Health Record • Patient use and advocacy for My Health Record • Awareness of who is in the team for a patient • A note on the fridge, signed by all team members • HealtheNet • Funding for case conferencing • Telehealth platforms • Service directories (e.g. library) • Health Pathways • Pharmacy reviews