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CONFERENCE ABSTRACT

Commissioning a Social Work Service to Support GPs and their Patients with Chronic and Complex Diseases

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Debra Clark

Sydney North Health Network, Sydney, NSW, Australia

Introduction: Against a backdrop of strong population growth for our region, an ageing population, potential healthcare workforce shortages and greater numbers of hospitalisations and GP visits over the next 15 years, Northern Sydney Primary Health Network (NSPHN) have been concentrating on innovative and sustainable solutions that shift the focus of care out of the hospitals and supporting the role of primary health.

Practice Change and Aim: To build capacity in general practice and improve patient outcomes, NSPHN commissioned a 'Social Work Service to Support GPs'. These services aim to provide support for patients to stay well and in their own homes, including better support around psychosocial, health, social and welfare needs, in order to reduce the likelihood of admission or readmission to hospital.

Targeted population and stakeholders: The social work service provides timely and flexible access to holistic, practical support to ensure the social determinants of good health are identified and managed to improve outcomes for patient's chronic and complex health conditions. It aims to reduce the workload for primary care health professionals in supporting non-health needs of patients.

Timeline/ Highlights: The social work service was commissioned in July 2016, it has been referred to by over 300 individual GPs and has worked with over 1000 patients. Access to other services or organisations have included Community Transport, Department of Housing, Centrelink, The Guardianship Tribunal and Sydney Home Nursing etc.

Sustainability: The GP Social Work program enhances the relationship between the GP, patient and the services by providing a psychosocial assessment and providing a quick, short term, solution focussed prioritisation of client goals and expectations.

Transferability: The service model allows transfer to other metropolitan locations.

Conclusions (comprising key findings): The modality of service is flexible according to consumer's needs, such as home visits, coffee shops, GP surgeries, this ensures that it a patient centred model. Through effective data collection of the types of multiple services required by a patient with chronic disease, the program highlights the extent of social needs in the management of patient's chronic disease.

Discussions: The needs of people who are referred to the social work services are highly complex and frequently demand multiple providers and funders collaborating, this need has been described as increasing. In the longer term, both health providers and patients have developed a better

understanding of the available health, social and welfare supports, but there continues to be a need of stronger working relationships between community, primary and tertiary care professionals.

Lessons learned: Investment in planning, stakeholder engagement, co-design, monitoring and evaluation is essential to successful commissioning of services and initiatives. Closing the communication gap between GPs and services are imperative. Referral forms need to be refined to ensure optimal information is gathered so that the patient can be triaged more effectively. Waiting times to access services or packages through My Aged Care or the National Disability Services can be time consuming and have the potential impact patient outcomes.