



NORTHERN SYDNEY  
CENTRAL COAST  
NSW HEALTH

# **Hornsby Ku-ring-gai Health Service**

## **Operational Plan**

**2008/09**

# HORNSBY KU-RING-GAI HEALTH SERVICE

## OPERATIONAL PLAN 2008 – 2009

### FOREWORD

The Hornsby Ku-ring-gai Health Service (HKHS) Operational Plan for 2008 – 2009 contains key strategic and business activities related to the continued provision of efficient and effective health care services. HKHS is one of four health service catchments within Northern Sydney Central Coast Health (NSCCH). The HKHS Operational Plan for 2008-09 is focused on the strategic directions of the State Health Plan (*State Health Plan - A new direction for NSW. Towards 2010*).

HKHS is committed to quality and safety and to improving the health outcomes for the people of Hornsby and Ku-ring-gai local government areas (LGAs). HKHS participates in accreditation by the Australian Council on Healthcare Standards (ACHS). Our health service was granted four years accreditation in 2004, which was confirmed in the alignment survey conducted in December 2006. Our next accreditation survey will be held in March 2009 and we are confident that our ongoing commitment to patient safety and the delivery of high-quality services to our community will once again be evident.

This operational plan addresses a broad range of activities across the continuum of health care and aims to meet the needs of the community by providing clear, comprehensive direction to HKHS as an organisation. Major influences on the health of the Hornsby Ku-ring-gai population have been highlighted in Part I of the document.

I hope you find the information in the Operational Plan useful and that it is helpful in providing direction for us, as an organisation, to tackle the things that will enhance, in partnership with our community and other key agencies, both the provision of health care services and the health of our community.

That together we may achieve Healthy People – Now and in the Future

Greg Flint  
**General Manager**

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# PART I: A SNAPSHOT OF OUR COMMUNITY

## PREAMBLE:

Key issues relating to our community are summarised on this page. Additional details and data are available on pages 6 – 23.

## 1.0 SUMMARY OF KEY ISSUES

*Key factors identified of significance for HKHS include:*

- ➔ The health service covers a large geographic area, which has the potential to create challenges in managing equitable access to health services for the community
- ➔ There are a number of small isolated communities in the northern part of the health service, often with limited access to public transport. This in turn impacts on the opportunity for those communities to fully access health and other services.
- ➔ Projected changes in the population for Hornsby and Ku-ring-gai LGAs are not even across the age ranges. This has implications for service planning.
  - *The projected increases in the adolescent and young adult population may generate increased demand on adolescent and early adult mental health services and on emergency services to deal with the sporting and other activity injuries of young adults.*
  - *The size of the increase in the late working – early retirement age population is expected to put pressure on services for people with early onset heart, lung and cerebrovascular problems.*
  - *Significant impact is anticipated on services for older people, with an anticipated 45% increase in the 85+ age group by 2011.*
- ➔ Within the Hornsby and Ku-ring-gai areas, there are significant culturally and linguistically diverse (CALD) communities. Difficulties may be experienced by CALD communities in accessing health services due to a lack of information about available health services, language difficulties, a lack of culturally appropriate services, inadequate referral systems and transport barriers.
- ➔ Identification of key health risk factors that impact on the health of the community is one of the current challenges facing health care services. Health providers will then be able to develop interventions addressing the identified health risk behaviours or health conditions in order to improve the quality of health in the community.
  - Health behaviours and conditions identified as contributing to the burden of disease (premature death and illness) in Australia include: being overweight, smoking, high blood pressure, physical inactivity, alcohol and drug use, inadequate dietary levels of fruit and vegetables, and unsafe sexual practices.
  - The 2007 Report on Adult Health: Northern Sydney & Central Coast Area Health Service indicated that NSCCH performed better than the population of NSW as a whole for some identified health behaviours. These included: adequate physical activity, lower levels of smoking, more smoke-free households, and less overweight and obesity. This however cannot be seen as a cause for complacency, since levels of some risk behaviours were still unacceptably high and are likely to be contributing to the burden of disease experienced by the community. For example, 59.6% prevalence of adequate physical activity in NSCC area is better than the NSW prevalence, but is a decrease in levels when compared to 2006, and still leaves over 40% of our population reported as having inadequate physical activity. Similarly the overweight & obesity results were better than the NSW average, but with a continuing trend towards greater overweight and obesity, leaving a lot of room for improvement in this indicator.

- In many cases the performance in health behaviours against the NSW rate differed across age and sex ranges. It may therefore be useful to develop specific interventions to assist those groups. This was the case for:
  - ➔ **vegetable consumption** (Young males in the 16-24 years age range reported much lower than state average vegetable consumption where only 2.8% consumed the recommended level. Males in the 35-44, 55-64, 65-74 age ranges also consumed below state average levels; Females in the 25-34 & 35-44 years age ranges also reported significantly lower than state average results, with 5.7% and 2.3%, compared to NSW results of 12.7% and 11.4% respectively);
  - ➔ **alcohol consumption** (Young males aged 16 to 24 years had the highest prevalence of alcohol risk taking behaviour, with 66.7% compared to 49.1% for NSW. Females in aged 16 to 24 years also had a high prevalence of alcohol risk taking behaviour, with 50.4% compared with 41.8% for NSW, as did females aged 25 to 34 also had a prevalence rate above state average, with 46.3% compared to 29.4% )
- NSCCAHS performed worse than NSW in: high risk alcohol drinking and vegetable consumption.
- Divisions of General Practice data (online), 2009 data indicate that Hornsby and Ku-ring-gai have generally lower prevalence rates than NSW and Australia for both premature deaths and chronic diseases. However, 'injury events' were above NSW and Australian rates.
- NSW Cancer Council analysis of cancer incidence in NSW women (over the period 1998 – 2002) indicates that women in Hornsby and Ku-ring-gai LGAs have higher than NSW rates for breast cancer; with Hornsby having lower than NSW rates of lung cancer.
- NSW Cancer Council analysis of cancer incidence in NSW men (over the period 1998 – 2002) indicates that men in Ku-ring-gai have higher than NSW rates for melanoma, but lower than NSW rates of head and neck cancers, lung cancer and stomach cancer. Men in Hornsby have lower than NSW rates of head and neck cancers, and lung cancer.
- It is important to recognise that there is nonetheless an ongoing need to seek enhancements in delivering preventive health services, to improve the health and extend the well-being of our communities.

## 2.0 THE COMMUNITY

### 2.1 GEOGRAPHY

Hornsby Ku-ring-gai Health Service (HKHS) spans the LGAs of Hornsby and Ku-ring-gai and covers an area of approximately 595 km<sup>2</sup>. The HK sector covers the area bounded by the Hawkesbury River (northern boundary), Roseville (within the southern boundary) and Pennant Hills, Cherrybrook and Epping (within the western boundary).

There is a major business and retail hub at Hornsby, with smaller business and retail hubs at Gordon and Pennant Hills. A large proportion of the northern and eastern parts of the Hornsby LGA is forested, with large areas of dedicated open space.

The southern and eastern parts of the sector are well served by rail and road transport (see Figure 1).

There are a number of small isolated communities in the northern part of the sector. These communities have variable, mostly limited, access to public transport.

HKHS provides a wide range of both hospital and community based health services from its main campus of Hornsby Ku-ring-gai Hospital and throughout the community.

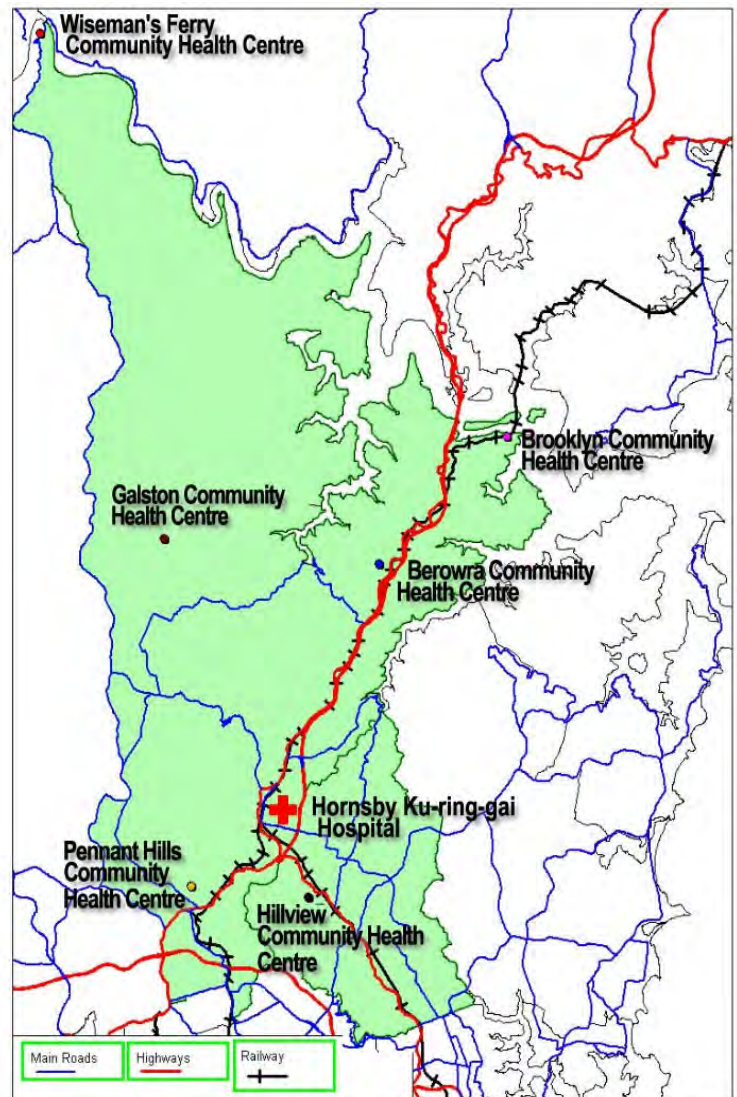


Figure 1: Locations of Hornsby Ku-ring-gai Hospital & Community Health Centres

## 2.2 POPULATION

### 2.2.1 CURRENT AND PROJECTED FUTURE RESIDENT POPULATION

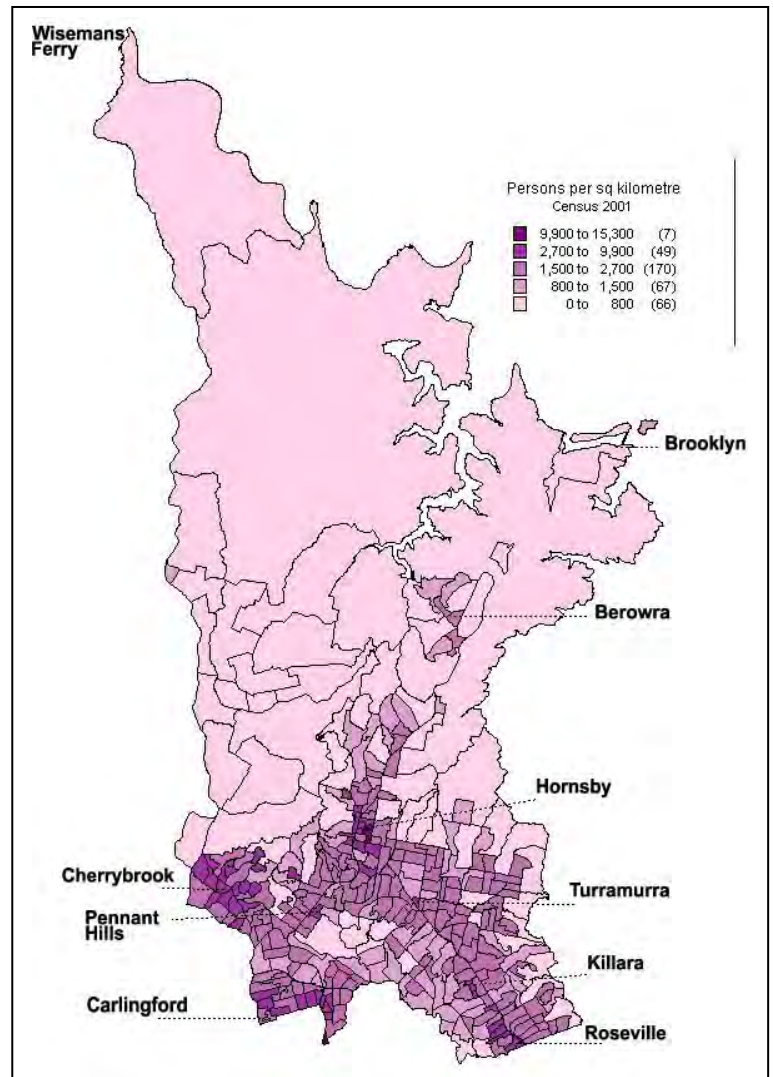
The Northern Sydney Central Coast Health Service comprises four geographic health service catchments, one of which is Hornsby Ku-ring-gai. Among Health Areas in NSW, the Northern Sydney & Central Coast Health Area contains the 3<sup>rd</sup> largest proportion of the NSW population (16.6%) (*The Health of the people of New South Wales – Report of the Chief Health Officer, Data Book – NSW Population, 2008*).

In the 2001 Census, the estimated resident population of the HKH service was 260,855 people. (*ABS, July 2007*)

This represents nearly 24% of the Northern Sydney Central Coast area population and almost 4% of the NSW population.

The HK sector is currently characterised by:

- moderate population density (mostly between 1,000 and 4,000 people per square kilometre) in the southern one-third of the sector;
- low population density (mostly less than 1,000 people per square kilometre) in the northern two-thirds of the sector, with the exception of some localities immediately proximal to the railway line where population density is moderate;
- small pockets of higher population density (greater than 4,000 people per square kilometre) in the Hornsby and Epping localities.



Population density across the Hornsby & Ku-ring-gai Local Government Areas, persons per square kilometre, 2001  
Source: NSH Planning, 2001

The Estimated Resident Population (ERP) for the HK sector 2001 to 2011 by age range is reviewed in Table 1 and Graph 1

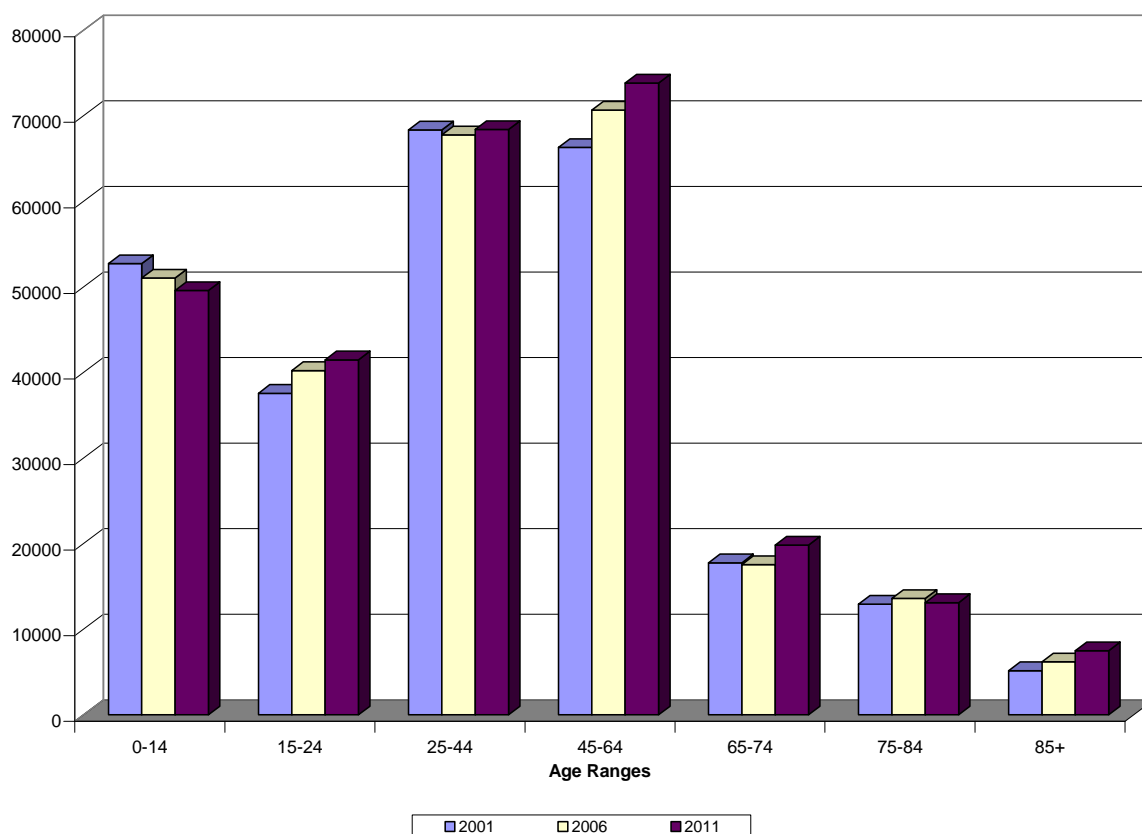
**Table 1 Estimated Resident Population for the Hornsby Ku-ring-gai Sector (2001 to 2011)**

ESTIMATED POPULATION CHANGE					
AGE	2001	2006	2011	2001-2011 CHANGE	
0-14	52729	51050	49,590	-3,139	-5.95%
15-24	37576	40240	41490	3914	10.42%
25-44	68362	67780	68410	48	0.07%
45-64	66307	70,680	73,840	7533	11.36%
65-74	17783	17,560	19,840	2057	11.57%
75-84	12941	13,600	13,110	169	1.31%
85+	5157	6,200	7,500	2,343	45.43%
<b>Grand Total</b>	<b>260,855</b>	<b>267,110</b>	<b>273,780</b>	<b>12,925</b>	<b>4.95%</b>

Source: NSW Health Population Projections & DIPNR Projections 2004

**Graph 1 Hornsby Ku-ring-gai Population Projection**

Hornsby Ku-ring-gai Estimated Resident Population (DIPNR Projections 2004)



Source: DIPNR Projections 2004

Significant identified population trends include:

- between 2001 and 2011, the population is expected to grow from 260,855 to 273,780 people or 4.95%, compared to the anticipated state average of 8.97%;

- the anticipated increases in population are not evenly distributed between age ranges. Groups expected to increase substantially in number between 2001 and 2011 include: those aged 15-24 years (10.42%), 45-64 years (11.36%), 65-74 years (11.57%) and 85+ (45.43%);
- the greatest percentage growth in population will be among people aged 85 years and over. This age group is expected to make increasing demands on acute health care services as well as non-acute services, community and nursing home care and;
- between 2001 and 2011, the number of children the 0 to 14 age group is expected to decrease by 5.95%;
- Ku-ring-gai's population pattern aligns with the Northern Sydney ageing belt, while Hornsby is experiencing more dynamic change and the social and health issues that come with those differences. (*Hornsby Ku-ring-gai Sector, NSCCH Planning Unit, 2005*)

## 2.2.2 POPULATION PROJECTIONS BY LGA

Table 2 identifies the population growth by LGA. A steady population growth of 4.06% is expected in the Ku-ring-gai LGA, over the next period to 2011, while the population of the Hornsby LGA is expected to grow by 5.58% in the same time period.

**Table 2 Population Projections by LGA**

	ESTIMATED POPULATION				ESTIMATED POPULATION CHANGE	
	1996	2001	2006	2011	2001 - 2011	
Hornsby	143,466	153,200	158,730	161,750	8,550	5.58%
Ku-ring-gai	105,225	107,655	108,380	112,030	4,375	4.06%
<b>Total</b>	<b>248,691</b>	<b>260,855</b>	<b>267,110</b>	<b>273,780</b>	<b>12,925</b>	<b>4.95%</b>

*Source: Estimated Resident Population, HOIST 2001; Hornsby Ku-ring-gai Demographic Profile Sector Analysis Discussion Paper, NSCCH Health Planning Unit, 2005; DIPNR Projections 2004*

### 2.2.3 POPULATION PROJECTIONS BY AGE AND SEX

The population of the Hornsby & Ku-ring-gai areas by age and sex is outlined in Table 3. Data provided is based on 'place of usual residence'. Key changes of note in the 2006 census are as follows:

- Hornsby local government area recorded an increase in births (1722 as against 1624 for 2001). For the same period the Ku-ring-gai local government area recorded a slight decrease in births (844 as against 904 for 2001). Births increased slightly overall for the combined area.
- The proportion of older people has increased when compared to the proportion for 2001.
- In the Hornsby & Ku-ring-gai areas the proportion of children and young people aged 0 – 14 is higher when compared to NSW overall (20.2% and 19.8% respectively) and for children aged 15 – 24 (14.2% compared to 13.3%). There are also proportionately more adults 45 – 64 (27% compared to 24.8% for NSW) and more adults aged 80 or over (4.9% compared to 3.9% in NSW). There are fewer adults proportionately aged 25 – 44 years in the Hornsby & Ku-ring-gai areas compared to NSW overall (23.9% and 28.2% respectively), and for those aged 65 – 79 (9.8% and 10% respectively).
- There is a slightly lower proportion of males in the Hornsby & Ku-ring-gai areas (48.2%) than in NSW as a whole (49.3%). This proportion has declined slightly from the 2001 proportion (which was 48.6%), which mirrors a slight decline in the NSW decline from 2001 (49.4%). Figures indicate that in NSW there are more males than females until the over 25 age range, whereas

in the Hornsby and Ku-ring-gai areas females outnumber males with the exception of children and young people aged up to 14 years.

- More than half the population in the Hornsby Ku-ring-gai area (50.9%) is aged from 25 to 64 years. However, this is still lower than the NSW overall rate of 53.3%.
- Almost 27% of the population in the Hornsby Ku-ring-gai area is aged 18 years or younger.

*Table 3 Resident population for Hornsby Ku-ring-gai areas and NSW by age and sex, 2006*

AGE GROUP	HORNSBY & KU-RING-GAI AREAS				NSW			
	MALES	FEMALES	TOTAL	%	MALES	FEMALES	TOTAL	%
0 - 14	26,142	24,732	50,874	20.2%	667,582	631,334	1,298,916	19.8%
15 - 24	18,032	17,809	35,841	14.2%	443,756	427,960	871,716	13.3%
25 - 44	28,466	31,813	60,279	23.9%	907,594	941,294	1,848,888	28.2%
45 - 64	33,220	35,004	68,224	27%	805,765	818,117	1,623,882	24.8%
65 - 79	11,568	13,182	24,750	9.8%	310,634	342,782	653,418	10%
80 +	4,328	8,112	12,440	4.9%	93,120	159,239	252,359	3.9%
<b>Total</b>	<b>121,757</b>	<b>130,653</b>	<b>252,410</b>	<b>100%</b>	<b>3,228,451</b>	<b>3,320,726</b>	<b>6,549,177</b>	<b>100%</b>
<b>Total %</b>	<b>48.2%</b>	<b>51.8%</b>		<b>100%</b>	<b>49.3%</b>	<b>50.7%</b>		<b>100%</b>

*Source: 2006 Census of Population and Housing: Basic Community Profile, 2007 (Based on place of usual residence).*

Projected changes in the population will not be even across the age ranges, with more growth expected among those in the retirement age group, and among those aged 85+. There will be some growth in the adolescent and young adult population, and a decline is expected in the number of young children. (NSCCH Health Services Planning Unit 'Patterns of demography and health service utilisation' 2005; DIPNR projections 2004)

The projected changes in population are likely to generate some increased demand on adolescent and early adult mental health services and on emergency services to deal with the sporting and other activity injuries of young adults. The size of the increase in the late working – early retirement age population is expected to put pressure on services for people with early onset heart, lung and cerebrovascular problems. The major impact will be on services for older people. With a 45% increase in the 85+ age group, the impact on services for people with both chronic and end stage illness will be considerable. (Hornsby Ku-ring-gai Demographic Profile Sector Analysis Discussion Paper, NSCCH Health Planning Unit, 2005)

## 2.2.4 CULTURAL AND LINGUISTIC DIVERSITY

Almost 1 in 3 NSW residents was born overseas and around 1 in 5 speaks a language other than English at home. Overseas-born people generally have good health, but patterns of some health conditions and health risk factors vary with country of birth. (Population Health Division. 2008. *The Health of the people of New South Wales – Report of the Chief Health Officer, Data Book – Country of Birth.* Sydney: NSW Department of Health).

Within the Hornsby and Ku-ring-gai areas, there are significant culturally and linguistically diverse (CALD) communities. These communities and their residents are characterised by great diversity and vary substantially in characteristics such as length of residence, English language proficiency and socioeconomic status.

Some CALD communities experience relative socioeconomic disadvantage, especially in the areas of occupational status, unemployment, income and English proficiency; and in accessing health services due to a lack of information about available health services, language difficulties, lack of culturally appropriate services, inadequate referral systems and transport barriers (*Access to Home and Community Services by the NESB Frail Aged, Younger People with Disabilities and their Carers, 2001*).

Refugee communities may be at a further disadvantage as a result of adverse experiences in their country of origin, during flight, or whilst in their country of asylum. The health experiences and needs of people of refugee background are very different from those of other overseas-born

residents of NSW. Experiences of persecution, psychological trauma, disrupted access to health care and other adverse effects of conflict contribute to their health needs. Health issues commonly identified in resettlement countries include psychological problems, injuries due to hostilities or torture, poor oral health, infectious diseases, under-immunisation, conditions related to under-nutrition, and developmental issues among children. Refugees are also known to face significant barriers to accessing appropriate health care (*The Health of the people of New South Wales – Report of the Chief Health Officer, Data Book – Country of Birth , 2008*). Within the NSCCH in the last five years, refugee communities have tended to settle in the Hornsby, Ryde and Warringah areas.

The primary non-English language groups are Chinese speakers (8.3% speak a Chinese language at home), and Korean (1.9% speak at home while only 1.7% were Korean born) (*ABS Census 2006*). Probably of greater significance is the diversity of ethnic backgrounds represented in the community – there are representatives of widespread cultures with relatively fewer representatives of European cultures than in other parts of NSCCH (*Hornsby Ku-ring-gai Demographic Profile Sector Analysis Discussion Paper, NSCCH Health Planning Unit, 2005*). Hornsby LGA has 24% of the population who speak a language other than English at home (*ABS Census 2006*).

**Table 4 Most common languages other than English spoken at home within Hornsby Ku-ring-gai areas ('usual place of residence')**

LANGUAGE	HORNSBY	KU-RING-GAI	HORNSBY KU-RING-GAI TOTAL	% OF NSW POP. GROUP RESIDENT IN HK AREA
Total est. residents	151,325	101,084	252,409	3.9%
Languages other than English	36,313	17,391	53,704	4.1%
Cantonese	7,740	4,779	12,519	9.7%
Mandarin	5,232	2,308	7,540	7.5%
Korean	3,180	1,560	4,740	12.9%
Hindi	1,590	370	1,960	5.1%
Italian	1,338	593	1,931	2.2%
Arabic (inc. Lebanese)	1,652	248	1,900	1.2%
Persian	1,264	599	1,863	17%
Spanish	941	395	1,336	2.7%
German	627	692	1,319	5.9%
Japanese	507	730	1,237	9.9%
Tamil	889	173	1,062	6.7%
Sinhalese	870	187	1,057	15.8%
Greek	477	392	869	1%
Polish	570	217	787	5.1%
Russian	535	200	735	5.2%
Indonesian	483	244	727	3.8%
Tagalog	598	124	722	2.5%
French	346	344	690	4.6%

Source: ABS: 2006 Census of Population and Housing: Basic Community Profile, 2007 (Based on place of usual residence)

Hornsby Ku-ring-gai has a significant proportion of its population who were born overseas. In Hornsby Ku-ring-gai these people are more likely than in the NSCCH area as a whole to come from Hong Kong (2.5%), Korea (1.3%) and South Africa (2.2%).

In the 2006 census Cantonese, Mandarin and Korean represented the most common languages other than English spoken by Hornsby Ku-ring-gai residents at home. Other languages

commonly reported as spoken at home for the area include Persian, Italian, Hindi and Arabic. It is interesting to note the comparatively lower number of speakers of these languages who report low proficiency in English.

*Table 5 Top 10 Languages Spoken at home by residents who report low proficiency in spoken English*

<b>LANGUAGE</b>	<b>TOTAL HORNSBY KU-RING-GAI RESIDENTS SPEAKING THIS LANGUAGE WHO REPORT LOW ENGLISH PROFICIENCY</b>
Cantonese	1 899
Mandarin	1 583
Korean	1 385
Persian	190
Japanese	186
Italian	180
Arabic (inc. Lebanese)	173
Chinese (not further defined)	111
Spanish	100
Vietnamese	80

*Source: ABS, 2006 Census of Population & Housing: extended community profile (usual place of residence)*

Over one third of all residents in the Hornsby Ku-ring-gai areas were born overseas. This proportion of residents born overseas is much higher than for NSW: 36.5% of residents in the Hornsby and Ku-ring-gai areas compared to 31% for NSW.

*Table 6 Overseas born population in Hornsby & Ku-ring-gai by LGA*

<b>LOCAL GOVERNMENT AREA</b>	<b>NUMBER OF OVERSEAS BORN</b>	<b>% LGA POPULATION</b>
Hornsby *	55,175	36.5 %
Ku-ring-gai *	36,882	36.5 %

\* includes English and non-English speaking countries of birth. *Source: ABS, 2006 Census data (based on 'place of usual residence')*

Amongst the population born in a non-English speaking country, residents born in Hong Kong or China predominate in Hornsby and Ku-ring-gai LGAs. In Hornsby LGA for example, residents born in China make up 3.4% of the population and Hong Kong-born residents make-up 2.4%.

**Table 7 Main country of birth for those from non-English speaking backgrounds by LGA**

<b>RANK</b>	<b>HORNSBY</b>	<b>KU-RING-GAI</b>
1	China	Hong Kong
2	Hong Kong	China
3	India	Korea (South)
4	Korea (South)	India
5	Malaysia	Malaysia

*Source: ABS, 2006 Census (based on 'place of usual residence')*

## **2.2.5 ABORIGINAL AND TORRES STRAIT ISLANDER RESIDENTS**

In the 2006 census there were 109 people in the Ku-ring-gai LGA who identified as being of indigenous origin. This represented an increase of 1 person (1%) since the 2001 census. The result for Hornsby in the 2001 census was 447 people who identified as being of indigenous origin, a figure unchanged since the 2001 census. The number of Aboriginal & Torres Strait Islander residents may be under-reported.

*Table 8 Aboriginal and Torres Strait Islander residents by sex and LGA in Hornsby Ku-ring-gai sector*

<b>LGA</b>	<b>MALE</b>	<b>FEMALE</b>	<b>TOTAL</b>
Hornsby	212	235	447
Ku-ring-gai	53	56	109

*Source: ABS, 2006 Census (based on 'place of usual residence')*

### 3.0 COMMUNITY HEALTH STATUS AND LIFESTYLE FACTORS

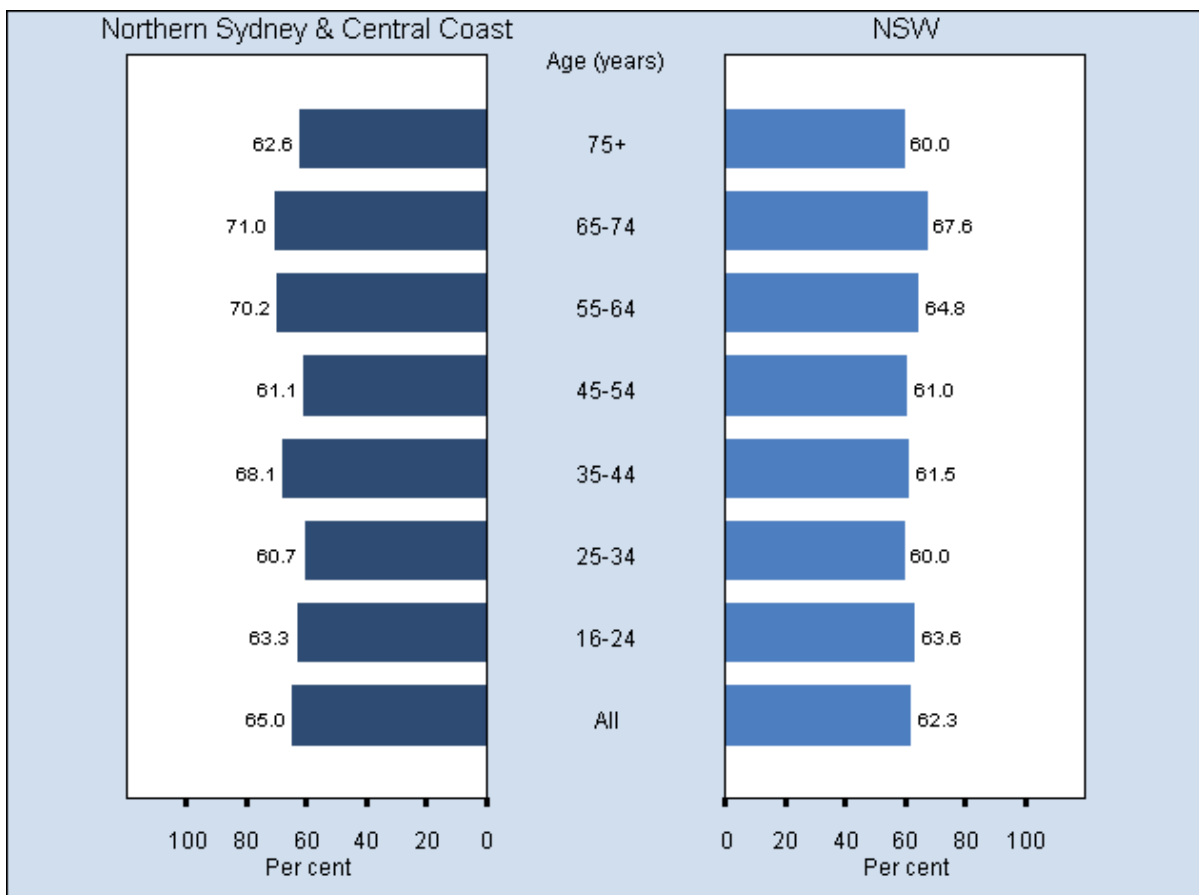
The World Health Organisation defines 'health' as not merely the absence of disease, but also physical, emotional and social well-being (*WHO, 1946*). The factors which determine the health of a given population are complex and inter-related, and include health determinants (such as underlying genetic risk; positive and negative health behaviours), health and environmental interventions, and the availability and accessibility of health resources. Health behaviours identified as contributing to the burden of disease in Australia include: being overweight, smoking, physical inactivity, inadequate nutrition, alcohol and drug use, lack of fruit and vegetables and unsafe sexual practices. (*AIHW 'Australia's Health', 2006*) This section of our Operational Plan reviews information on our community's health behaviours and health status.

#### 3.1 HEALTH RELATED BEHAVIOURS & HEALTH STATUS

##### 3.1.1 SMOKING

Tobacco smoking is the risk factor responsible for the greatest burden of disease in men in Australia, and is just behind obesity in significance when considered for the population as a whole (*AIHW, Australia's Health 2006*). The 2007 Report on Adult Health for Northern Sydney and Central Coast Area Health Service found significantly fewer residents aged were current smokers (11.9% compared to 18.6% in NSW). The NSCCH prevalence rate for smoking dropped from 20.1% in 1997 to 11.9% in 2007. The proportion of smoke free households was higher in NSCCH area (92.9%) in 2007, than in NSW for the same year (88.2%).

Graph 2 Current smoking status by age for persons aged 16 years and over, 2007

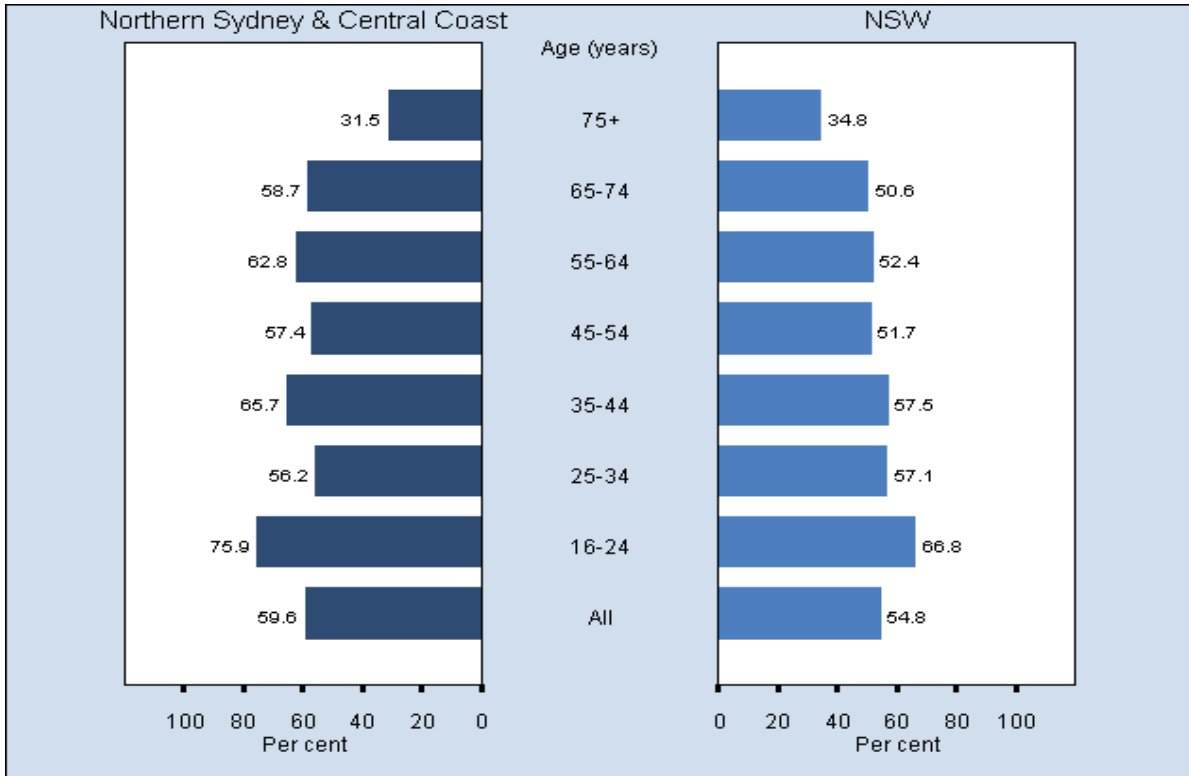


2007 Report on Adult Health: Northern Sydney & Central Coast Area Health. NSW Health, 2008.

### 3.1.2 PHYSICAL ACTIVITY

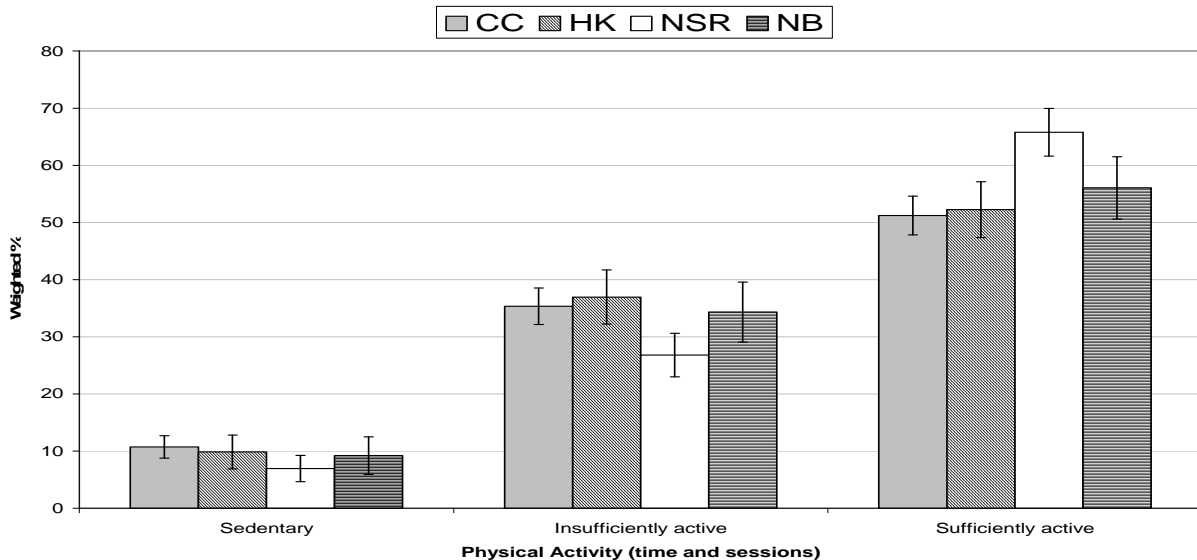
Inadequate physical activity is defined as less than a total of 150 minutes of moderate physical activity per week. This accounts for 7% of the burden of disease and injury across Australia and is known to increase the risk of cardio-vascular disease, cancer, diabetes, injury and mental illness. The overall prevalence of adequate physical activity in Northern Sydney Central Coast area is 59.6%. This is better than the NSW prevalence, which is 54.8%.

Graph 3 Adequate physical activity by age for persons aged 16 years and over, 2007



2007 Report on Adult Health: Northern Sydney & Central Coast Area Health. NSW Health, 2006.

The 2006 Northern Sydney Central Coast Community Health Survey identified Hornsby Ku-ring-gai as performing slightly better than the state average for physical activity. North Shore/Ryde and Northern Beaches areas performed better than the Hornsby Ku-ring-gai area on activity measures.



Source: Profile of Cardiovascular Risk Factors in NSCCA: Analysis of telephone survey 2006

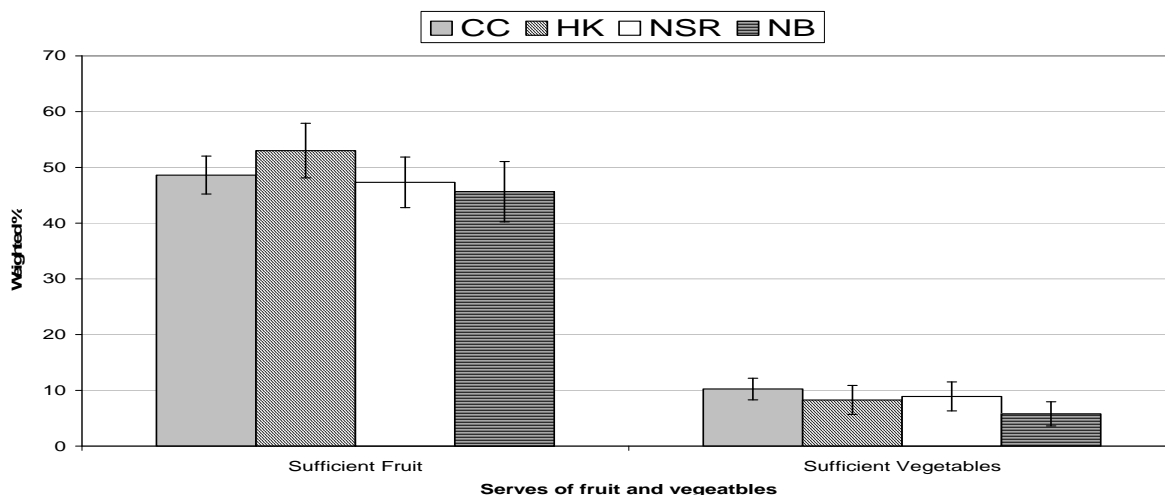
### 3.1.3 NUTRITION (FRUIT AND VEGETABLE CONSUMPTION)

Dietary guidelines recommend between 2 and 3 serves of fruit per day according to age. Northern Sydney Central Coast area residents who responded to had slightly higher rates of fruit consumption than those for NSW overall (60.9% and 54.4% respectively).

The recommended vegetable intake is 5 serves per day for persons aged 16 years and over. The 2007 report on adult health reported that fewer Northern Sydney Central Coast area residents ate the recommended intake of vegetables compared to NSW overall (9.9% and 10.7% respectively). Young males in the 16-24 years age range reported much lower than state average vegetable consumption where only 2.8% consumed the recommended level. Males in the 35-44, 55-64, 65-74 age ranges also consumed below state average levels; Females in the 25-34 & 35-44 years age ranges also reported significantly lower than state average results, with 5.7% and 2.3%, compared to NSW results of 12.7% and 11.4% respectively. (*Centre for Epidemiology and Research. 2007 Report on Adult Health: Northern Sydney & Central Coast Area Health Service. Sydney: NSW Department of Health, 2008*)

Northern Sydney Central Coast Community Health Survey identified Hornsby Ku-ring-gai as performing slightly better than the state average, for consumption of fruit and vegetables. This was still significantly below the levels recommended in dietary guidelines. (*Profile of Cardiovascular Risk Factors in NSCCA: Analysis of telephone survey 2006*)

#### Sufficient serves of fruit and vegetables by health service



### 3.1.4 BEING OVERWEIGHT OR OBESE

In Australia being overweight is now estimated to cause the most premature death and illness. (*AIHW, Australia's health 2006*) Overweight and obesity account for 8.6% of the burden of disease across Australia. Being overweight or obese is becoming an increasing public health problem for both adults and children throughout NSW. In NSW, more than half of all adults aged between 35 and 74 years were classified as overweight or obese.

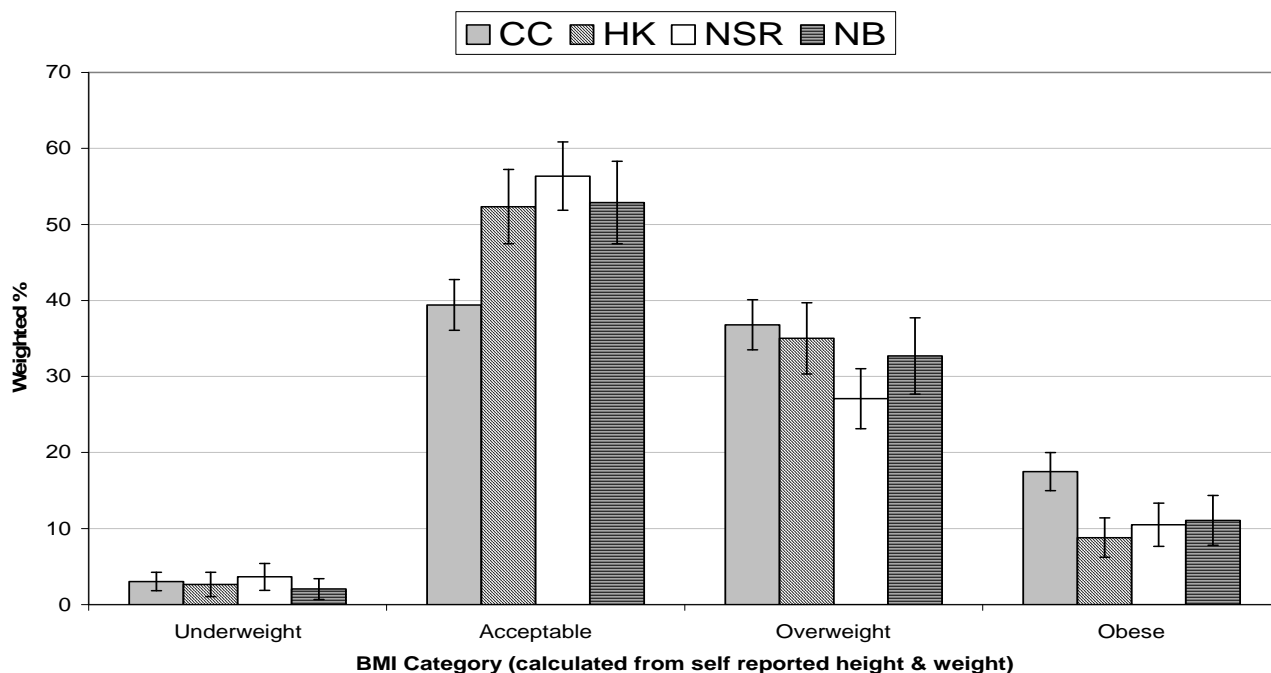
Being overweight is classified as those with a Body Mass Index (BMI) of between 25 and 29 and being obese is classified as those with a BMI of 30 or more. These risk factors are directly associated with hypertension and raised blood cholesterol level, which in turn are risk factors for stroke and cardiovascular disease.

Males in the Northern Sydney Central Coast area were significantly less likely to be overweight than those in NSW (53% compared to 58.8%). At 37.6%, females in the Northern Sydney Central Coast area were well below the rate for females in the whole of NSW (44.7%). Despite the fact that the prevalence rates fall below those of NSW, they still represent a substantial proportion of the community with overweight or obesity problems.

Males and females showed a trend of increasingly being overweight with increasing age but most age groups remained below the state average. Males in NSCCH aged 45 to 54 were slightly above the NSW average rates (71.1% compared to 70%). Trend analysis for NSCCH from 1997 to 2007 indicated an further increase in those classified as overweight or obese, from 47% in 1997 to 53% for males and from 28% to 37.6% for females. (Centre for Epidemiology and Research. 2007 Report on Adult Health: Northern Sydney & Central Coast Area Health Service. Sydney: NSW Department of Health, 2008)

Results from the 2006 Northern Sydney Central Coast Community Health Survey identified Hornsby Ku-ring-gai as performing worse than NSW average for overweight but better than state average for obesity.

### Weight category based on self reported height and weight by health service



Source: Profile of Cardiovascular Risk Factors in NSCCAH: Analysis of telephone survey 2006

### 3.1.5 ALCOHOL CONSUMPTION

Risk taking behaviour in drinking alcohol includes either daily drinking, drinking more than four standard drinks for males and two for females per day or consuming more than six (male) and four (female) standard drinks on any one occasion or day.

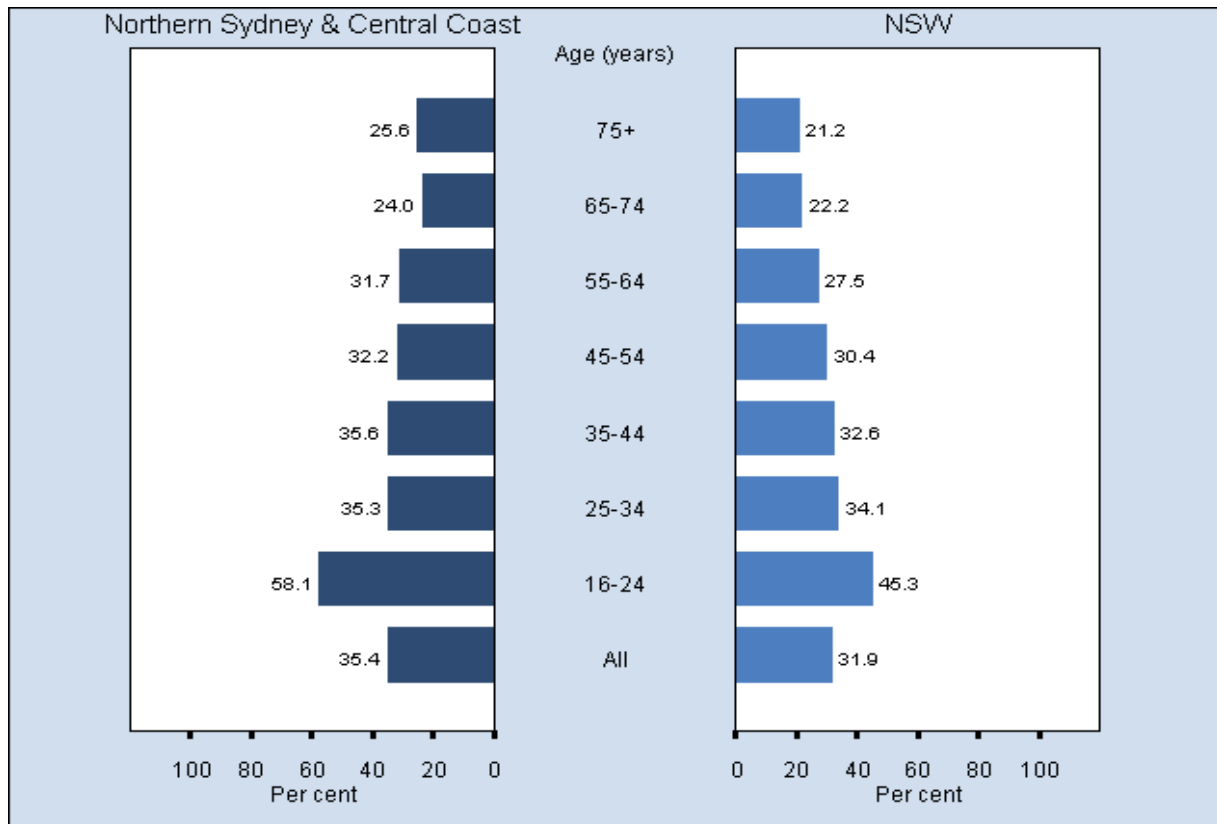
Prevalence rates for males in the Northern Sydney Central Coast area were comparable with, although slightly lower than, NSW overall in alcohol risk taking (35% and 37.2% respectively), while females in the Northern Sydney Central Coast area reported a higher prevalence (35.8%) compared to NSW (27%).

Males in the Northern Sydney Central Coast area aged 16 to 24 years had the highest prevalence of alcohol risk taking behaviour within NSCCH at 66.7% compared to 49.1% for NSW. Females aged 16 to 24 years also had a high prevalence of alcohol risk taking behaviour, with 50.4% compared with 41.8% for NSW, as did females aged 25 to 34 also had a prevalence rate above state average, with 46.3% compared to 29.4%.

The overall trend from 1997 to 2007 showed an improvement in alcohol risk taking for the area, when all ages were included, with a decrease from 46.2% to 35.4%; however the result for 2007

is an increase on both the 2005 result, which was 33.3%, and the 2006 result, which was 35%. This brings Northern Sydney Central Coast area closer to the NSW trend, which declined from 42.3% in 1997 to 31.9% in 2007.

### Overweight and obesity by age, 16 years and over, 2007



Centre for Epidemiology and Research. 2007 Report on Adult Health: Northern Sydney & Central Coast Area Health Service.

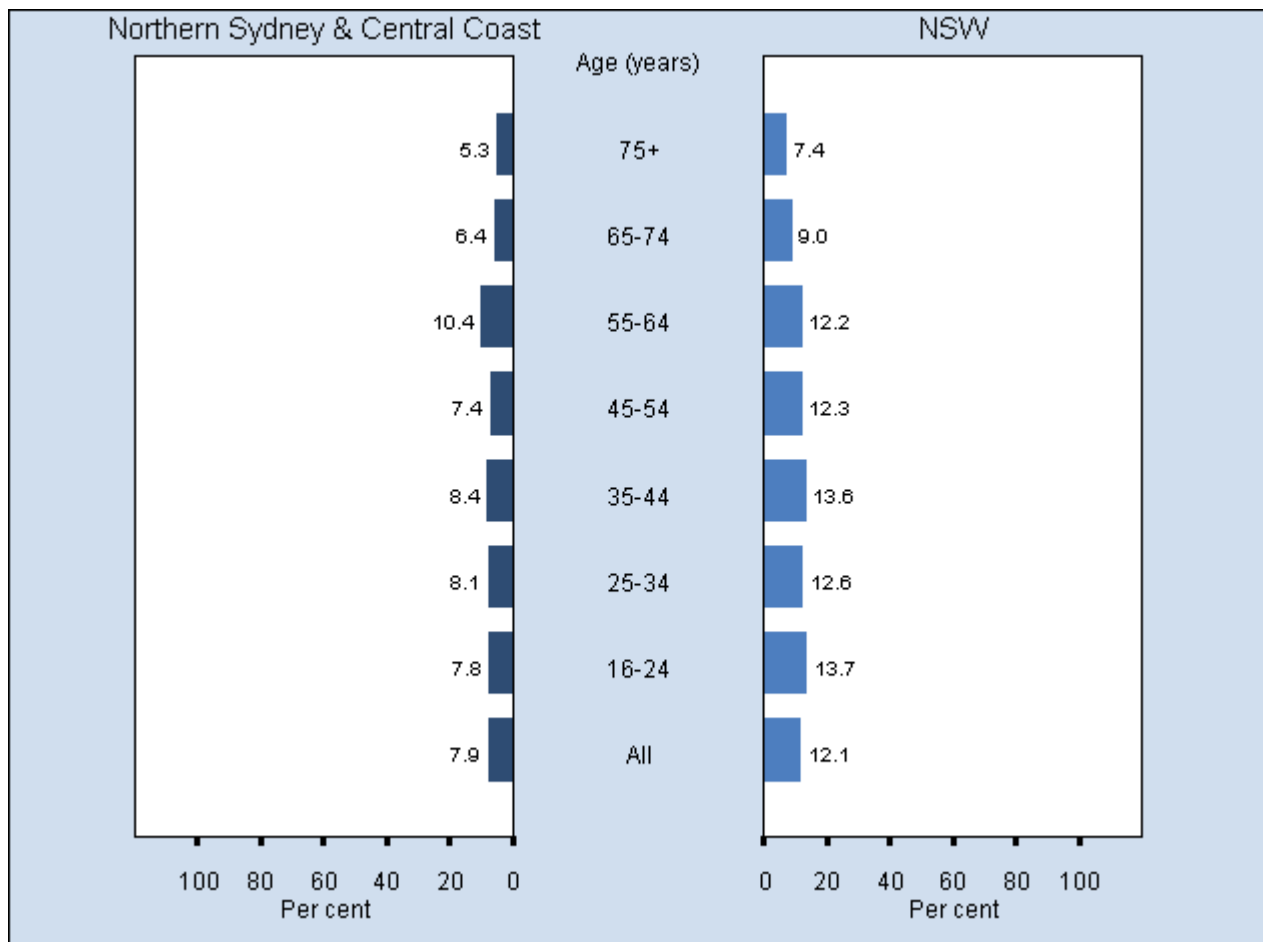
### 3.1.6 IMMUNISATION STATUS

The Public Health Information Development Unit estimated the 2006 rate of child immunisation at 92.2% for the Hornsby LGA. This compares favourably to the estimated NSW rate of 91%, and Australia (90.4%). However the estimated rate for Ku-ring-gai was less favourable, at 88.9%. (Public Health Information Development Unit, DGP Online data, accessed February 2009).

NSCCH performed better than NSW average for adult immunisation against influenza: 77% of residents 65 years and older had been vaccinated in the last 12 months, compared to 72.8% for NSW. Vaccination against pneumococcal disease for persons 65 years and older was also slightly above the NSW average (Centre for Epidemiology and Research. 2007 Report on Adult Health: Northern Sydney & Central Coast Area Health Service).

### 3.17 MENTAL HEALTH INDICATORS

The NSW Population Health Survey reports on indicators of 'high' or 'very high' psychological distress. These are drawn from responses to the Kessler 10 (K10), a 10-item questionnaire that measures the level of psychological distress in the most recent 4-week period. The overall reported prevalence of high or very high psychological distress was somewhat less for NSCCH than the state average. However, once again this trend was not uniform across all sections of the community, with males in NSCCH aged 55 to 64 reporting a significantly higher prevalence compared to state average and females aged 35 – 44 returning a result close to NSW prevalence rates.



Source: 2007 Report on Adult Health- Northern Sydney and Central Coast Area Health Service

Results from the 2006 Northern Sydney Central Coast Community Health Survey indicated that residents aged over 16 years in Hornsby Ku-ring-gai reported high or very high psychological distress less frequently (7.7%) when compared NSW as a whole (10.9%). Within the NSCCH area high or very high levels distress were least reported within Northern Beaches.

Issue	Indicator	CC	HK	NSR	NB	NSW
Psychological Distress	High psychological distress	7.1% (±1.7)	<b>6.5%</b> <b>(±2.5)</b>	7.5% (±2.5)	4.5% (±2.2)	<b>7.5%</b> <b>(±0.8)</b>
	Very high psychological distress	2.5% (±1.1)	<b>1.2%</b> <b>(±0.9)</b>	2.3% (±1.5)	2.4% (±2.1)	<b>3.4%</b> <b>(±0.5)</b>

Source: Profile of Cardiovascular Risk Factors in NSCCA: Analysis of telephone survey 2006

The study also highlighted the high level of social participation within Hornsby Ku-ring-gai, with 60-70% of respondents having attended a local community event within the past three months,

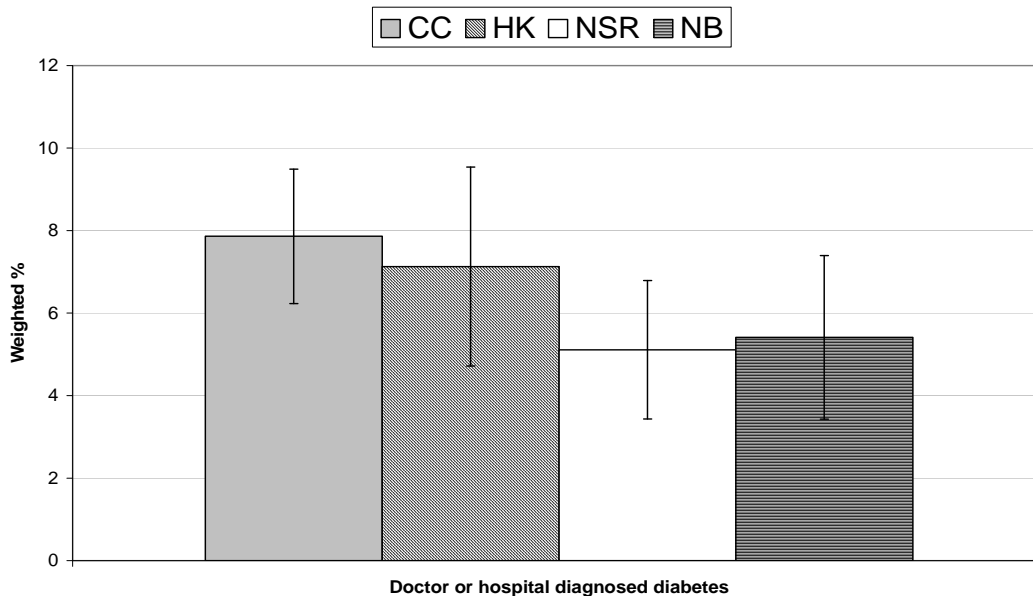
and over 49% having assisted a community group within the past 3 months. *Source: Profile of Cardiovascular Risk Factors in NSCCA: Analysis of telephone survey 2006*

### 3.2 THE IMPACT OF HEALTH CONDITIONS

The Australian Institute for Health and Welfare reported in 2006 that leading conditions associated with profound or severe activity limitations among people aged less than 65 years were back problems and arthritis. For the population as a whole, arthritis, hearing disorders and back problems led the list. Conditions such as attention deficit hyperactivity disorder, autism and dementia, while highly likely to be related to profound or severe activity limitations, were less commonly reported by people because these conditions are generally less prevalent. For older people reporting profound or severe activity limitations the most prevalent conditions included arthritis and related disorders, hearing disorders, hypertension, heart disease, stroke, vision disorders, back problems, diabetes and dementia. (*Australia's Health, 2006*) This data has yet to be confirmed for Hornsby Ku-ring-gai residents.

Results from the 2006 Northern Sydney Central Coast Community Health Survey identified a range of health conditions within the area related to cardiovascular risk. Hornsby Ku-ring-gai residents reported a high rate of diabetes, which was none the less below the state average. Type 1 diabetes was the key driver of the high diabetes rate for the HKHS sector. Hornsby Ku-ring-gai residents also reported a high rate of hypertension, which was above the state average. *Profile of Cardiovascular Risk Factors in NSCCA: Analysis of telephone survey 2006*

#### Self reported diagnosis of diabetes by health service



*Profile of Cardiovascular Risk Factors in NSCCA: Analysis of telephone survey 2006*

2001 data from the National Health Survey suggested that Hornsby and Ku-ring-gai were below the Australian & NSW prevalence rates for premature deaths for a range of conditions including: circulatory system, respiratory, ischaemic heart and cerebrovascular diseases; cancer, diabetes and asthma. These results are also seen in the rates of chronic disease compared to NSW and Australia, with the exception of 'injury', where Ku-ring-gai exceeds the NSW and Australian prevalence rates.

The Standardised Rate (SR) for Australia is 100 and is the baseline, so SR above this figure shows a higher prevalence of disease and SR below this indicates a lower prevalence.

### Estimated Standardised Rate of selected chronic diseases, 2001

	RESPIRATORY SYSTEM	MENTAL & BEHAVIOURAL DISORDERS	CIRCULATORY SYSTEM	DIABETES TYPE 2	MUSCULO-SKELETAL SYSTEM	INJURY
Hornsby	90	80	92	90	89	100
Ku-ring-gai	89	72	91	85	87	<b>103</b>
NSW	93	99	100	104	93	101
<b>Australia</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

PHIDU website, accessed July 2006; based on ABS National Health Survey 2001

In 2007 the Cancer Council NSW issued a report describing cancer incidence and mortality across NSW for the period 1998 to 2002. (*Cancer Maps for New South Wales 1998 to 2002.*)

Cancers for which incidence in Hornsby and Ku-ring-gai LGAs differs significantly from NSW average:

GENDER	CANCER TYPE	SIGNIFICANTLY LOWER THAN NSW	SIGNIFICANTLY HIGHER THAN NSW
Male	All cancers	Hornsby	N/a
	Head & neck	Hornsby & Ku-ring-gai	N/a
	Lung cancer	Hornsby & Ku-ring-gai	N/a
	Melanoma of skin	N/a	Ku-ring-gai
	Stomach cancer	Ku-ring-gai	N/a
Female	Breast cancer	N/a	Hornsby & Ku-ring-gai
	Lung cancer	Hornsby	N/a

*Cancer Maps for New South Wales 1998 to 2002.*

Cancers for which mortality in Hornsby and Ku-ring-gai LGAs differs significantly from the NSW average:

GENDER	CANCER TYPE	SIGNIFICANTLY LOWER THAN NSW	SIGNIFICANTLY HIGHER THAN NSW
Male	All cancers	Hornsby & Ku-ring-gai	N/a
	Lung cancer	Hornsby & Ku-ring-gai	N/a
	Stomach cancer	Ku-ring-gai	N/a
Female	Lung cancer	Hornsby	N/a

*Cancer Maps for New South Wales 1998 to 2002.*

### 3.3 HOSPITAL ADMISSIONS

*Hospital admissions by top 5 diagnostic groups by LGA for Hornsby Ku-ring-gai residents, 2001-2002*

RANK	HORNSBY	KU-RING-GAI
1	Injury	Injury
2	Digestive	Digestive
3	Pregnancy	Nervous System Disorders
4	Nervous System Disorders	Cardiovascular Disorders
5	Cardiovascular Disorders	Mental Disorders

Source: Northern Sydney Central Coast Public Health Intranet site, accessed 2006

## 4.0 FINANCIAL AND ACTIVITY INDICATORS

For the financial year July 2007 – June 2008, HKHS received a total operating budget, including transfer pricing expenses, of \$ 84,256,525

In 2006-07 HKHS experienced very strong growth in the number of people presenting to our emergency department, and significant growth in the number of births at Hornsby Ku-ring-gai Hospital. This trend continued in the 2007-08 financial year. Key features of the performance and activity indicators at HKHS for 2007- 08 were:

- ➔ Emergency department presentations, increased in 2007/08 by 8.6% in comparison to 2006/07
- ➔ Births increased in 2007/08 by 14.1%
- ➔ All emergency triage & access benchmark targets were attained for 2007-08
- ➔ All elective surgery benchmark targets were met for 2007-08

Broad performance and activity indicators at HKHS for the financial year July 2007 – June 2008 were as follows:

INDICATOR	JULY 2007-JUNE 2008	JULY 2006- JUNE 2007
Total Hospital Admissions	14,779	13,881
Total ED Presentations	29,907	27,531
Total Births	1,269	1,112
Total Bed Days	77,161	72,971
Daily average beds occupied	210.8	199.9
Length of stay (days)	5.2	5.3

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\* Denotes the individual in this position is responsible for leading and reporting progress towards the relevant goal

**Goals: To keep people healthy  
To provide the health care that people need**

**SD 1 Make prevention everybody's business**

**HKHS approach to SD 1 Make prevention everybody's business**

<i>No.</i>	<i>WHAT HKHS WILL DO IN 2008/09</i>	<i>KEY PERFORMANCE INDICATORS (KPI)</i>	<i>WHO</i>	<i>TIMEFRAME &amp; REPORTING</i>
1.1	Continue to improve paediatric asthma management through provision of asthma education and outreach	<ul style="list-style-type: none"> <li>Benchmark LOS and readmission rate to ACHS (1.92)</li> <li>Review readmission rate &lt; 28 days</li> <li>Audit Paediatric Asthma admission (compliance to asthma management Plan)</li> </ul>	<i>MWCFS*, DWCFS*, MMEI, Asthma educator, Paediatric &amp; ED staff</i>	June 09
1.2	Continue provision of information for consumers on available services via HKHS Internet site and extend to include health risk reduction information	<ul style="list-style-type: none"> <li>Consumer information &amp; appropriate links provided on HKHS site</li> <li>No. of new risk reduction/healthy lifestyle items added</li> <li>Information on healthy lifestyle projects available on Intranet &amp; Internet</li> </ul>	<i>Area Corporate Communications*, IM*, Div Exec</i>	June 09
1.3	Implement & promote a range of outreach services to reduce falls in the wider community  Review opportunities for partnerships in falls prevention programs in the community	<ul style="list-style-type: none"> <li>Establish DEXA Service for bone density scanning &amp; promote through HKHS website &amp; print media</li> <li>Ongoing promotion of Bone &amp; Balance Clinic, and Tai Chi group for clients with Parkinson's disease</li> <li>Promotion of DEXA service to local GPs through GP Collaboration Unit</li> <li>At least one source of funding / partnership for falls prevention programs in the community is identified</li> </ul>	<i>MRACS*, DRACS, NUM BCRU, DEXA staff, CRM, IM, GP Collaboration Unit</i>  <i>MRACS*, DRACS, Area Falls Coordinator</i>	Oct 08  Dec 08
1.4	Improve information and outreach services available to the community about obesity management	<ul style="list-style-type: none"> <li>'Weight for Health Program' continued in 2008 &amp; 2009</li> <li>Promote 'Weight for Health Program' in print and online services</li> <li>Promotion results in sustained or increased enrolments and enquiries for 08/09</li> </ul>	<i>Manager Nutrition &amp; Dietetics*, CRM*, IM*</i>	Feb 09  June 09

**Goals: To provide the health care that people need  
To deliver high quality health services**

**SD 2 Create better experiences for people using health services**

**HKHS approach to SD 2 Create better experiences for people using health services**

<i>No.</i>	<i>WHAT HKHS WILL DO IN 2008/09</i>	<i>KEY PERFORMANCE INDICATORS (KPI)</i>	<i>WHO</i>	<i>TIMEFRAME &amp; REPORTING</i>
2.1	Implement and evaluate effectiveness of strategies to improve patient-centred care and address LOS and other indicators	<ul style="list-style-type: none"> <li>• Unplanned /unexpected readmissions within 28 days of separation &lt;6.1%</li> <li>• No increase in unplanned readmissions for chronic and older patients within 28 days of discharge</li> <li>• Participate in pilot "Essentials of care" program</li> <li>• Introduction of "protected meal times for patients"</li> <li>• Decrease in the number of SAC 1 and 2 adverse events</li> <li>• Decrease in complaints</li> <li>• Conduct staff focus groups and develop an action plan based on results of November 2008 NSW Health Patient Satisfaction Survey, to build on achievements and improve areas of concern</li> </ul>	<p><i>DNS*, Div Exec*, DMS</i></p> <p><i>DNS*, MMEI*, NUMs</i></p> <p><i>Div exec*, NUMs</i></p> <p><i>Div exec*, NUMs, staff</i></p>	<p>June 09</p> <p>Apr 09 June 09 June 09</p> <p>June 09</p>
2.2	Promote effective care and discharge planning	<ul style="list-style-type: none"> <li>• &gt; 90% patients have a plan of care documented in the healthcare record</li> <li>• &gt;90% patients reviewed by Doctor from the treating medical team</li> </ul>	<i>DNS*,DMS*, Div Exec*, MQS</i>	June 09
2.3	Improve community access to health care through development and enhancement of outpatient and ambulatory models of care	<ul style="list-style-type: none"> <li>• Enhancement of Paediatric Ambulatory Care</li> <li>• Monitor efficiency, gaps, variances of PACS through dashboard</li> <li>• Develop proposal for short stay (23hr)</li> <li>• Explore possibility of registrar clinic</li> <li>• Identify applicability of midwifery practice group (MGP) at HKH</li> <li>• Develop discussion paper regarding MGP</li> </ul>	<p><i>DWCS*, MWCS*</i></p> <p><i>Div staff</i></p> <p><i>Team Midwifery Group, MWCS*, DNS</i></p>	<p>Dec 08 Ongoing</p> <p>May 09 June 09 Mar 09 June 09 Feb 09</p>

	<p>Develop guidelines for occupational therapy provision across acute, rehabilitation &amp; adult community areas to ensure all referred patients receive an effective service</p> <p>Seek funding to improve community access to key clinical outpatient clinics</p>	<ul style="list-style-type: none"> <li>Extend availability of Medical Imaging to improve flow from ED</li> <li>Department Occupational Therapists surveyed</li> <li>System of service access priority guidelines developed</li> <li>System of service provision priority guidelines ratified</li> <li>Lobby to increase HACC funding for HKHS podiatry</li> <li>Increased staff hours &amp; episodes of care</li> </ul>	<p><i>DMS, DNS, Medical Imaging</i></p> <p><i>MMEI*, Div exec, Manager Occupational therapy &amp; staff</i></p> <p><i>MPCC*, Podiatry staff</i></p>	<p>Dec 08</p> <p>Dec 08 April 09 June 09</p> <p>Dec 08 June 09</p>
2.4	<p>Ensure ongoing process for review of standards of care for key risk areas, e.g. pressure areas, falls, medication errors, infections &amp; aspiration</p>	<ul style="list-style-type: none"> <li>Participation in area Pressure Ulcer point prevalence survey- improve against previous benchmark &amp; achieve NSCCH wound care program action plan strategies</li> <li>Incident Management Quarterly reports tabled at Q&amp;S committee and Divisional Executive meetings: IIMS management, falls, pressure areas, complaints, medication errors, clinical management.</li> <li>Quality &amp; Safety Action Plan 2008/09 developed addressing key risk areas. At least 75% of strategies achieved as at December 2008.</li> <li>Falls committee meets regularly &amp; audits are submitted monthly by wards and tabled 6 monthly at meetings. <ul style="list-style-type: none"> <li>Number of inpatient falls leading to SAC 2 incidents</li> <li>Falls prevention education ongoing for staff</li> </ul> </li> <li>HKHS Quality Use of Medicine committee meets regularly, with trended incident data tabled by NSCCAHS Medication Safety Officer.</li> <li>HKHS Infection Prevention and Control Committee meets regularly and reports to Pt Safety and CRC and Q&amp;S committee, with NSW health clinical Indicator and KPI data, MRSA trended data presented</li> <li>Improved M&amp;M / death review processes established</li> </ul>	<p><i>MQS*, Div. exec, DMS, DNS, Chairs of key clinical committees (e.g. Falls, Wound Care, QuM, IPCC)</i></p>	<p>Annually</p> <p>July 08 &amp; ongoing</p> <p>Dec 08</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Dec 08</p>
2.5	<p>Embed continuous quality improvement</p>	<ul style="list-style-type: none"> <li>Risk management and IIMS education conducted</li> </ul>	<p><i>MQS*, Div. exec, DMS,</i></p>	<p>Ongoing</p>

	approach to care through ongoing quality and patient safety education & assist staff to establish CPI projects that address incidents and minimise identified risks through ongoing facility run clinical practice improvement education	<ul style="list-style-type: none"> <li>• Open disclosure training education for senior clinicians</li> <li>• No. staff trained in risk management/identification process/ CPI process</li> <li>• &gt;75% registered quality improvement projects successfully completed</li> </ul>	<i>DNS</i>	Mar 09 June 09
2.6	Improve recognition of and resources for issues, including mental health, that affect clients of DWCFS, particularly adolescents, and mothers of infants, in the both community and acute settings.	<ul style="list-style-type: none"> <li>• Conduct CPI on Antenatal Booking system</li> <li>• Implement gynaecology booking</li> <li>• Recommence Adolescent mother antenatal education</li> <li>• Finalise Early Parenting Support Groups - five year review</li> <li>• Develop improved communication strategies between services through IPC</li> <li>• Audit effectiveness of early referral to speech pathology by ECH nurses</li> </ul>	<i>MWCFS*, DWCFS, WCFS staff, MH,</i>	Aug 08 Jan 09  June 09
2.7	Maintain and improve performance in Sustainable Access Program (SAP) with ongoing management of access block, triage & OST  Redesign low activity periods for surgery to improve efficiency & reduce bed block	<ul style="list-style-type: none"> <li>• EAP above 80% as a monthly average</li> <li>• OST problems identified</li> <li>• Meeting re achieving OST improvements (Station Officers, NUM ED, CNEs, Area Ambulance liaison, Bed manager)</li> <li>• Achieve benchmark in all triage categories</li> <li>• Schedule low surgical activity during the winter period rather than the traditional summer period</li> <li>• Reduced number of surgical cancellations on day of surgery due to no bed available.</li> </ul>	<i>DNS*, Div Exec, DDNS, Bed Manager MMEI*, ED NUM* &amp; staff, Bed Manager  MAS*, DAS, Admissions &amp; perioperative staff, VMOs, DNS</i>	Ongoing Feb 09  Ongoing June 09
2.8	Ongoing clinical service redesign (CSR) and review of surgical MOC to improve patient safety and experiences for HKHS surgical patients, including: preadmission clinic, ECT bookings & management, ambulatory care, "time out" procedures in line with PD2007_079 and introduction of priority categories for booking surgical cases as per DoH KPIs	<ul style="list-style-type: none"> <li>• Pre-admission assessment clinic set up that includes a revenue stream for PAC diagnostics</li> <li>• Development and implementation of protocol driven discharges with clinical pathways</li> <li>• 80% Patients admitted as Extended Day Only and Day Only (for target EDO DRGs)</li> <li>• Development of procedure for ECT bookings, including MHICU patients</li> <li>• Achievement of targets for surgical waitlist for U1 and</li> </ul>	<i>DNS*, MAS*, VMOs, DAS, MDSU, DMS, PaLMS, Waitlist coordinator</i>	June 09  June 09  May 09  Ongoing

		<p>U2 and for long waits</p> <ul style="list-style-type: none"> <li>• 100% of surgical patients have "time out" undertaken and correct</li> <li>• "Time out" procedure includes the assessment for antibiotic prophylaxis and assessment for venous thromboembolism prophylaxis</li> <li>• Introduction of system to acquit against DoH priority categories for booking surgical cases</li> <li>• Urgency category requested &amp; documented at time of booking of the surgical patient &amp; data entered on OTIS <ul style="list-style-type: none"> <li>○ Cat 1 = &lt;15mins Cat 2 = &lt;1 hour</li> <li>○ Cat 3 = &lt; 4 hours</li> <li>○ Cat 4 = &lt; 8 hours</li> <li>○ Cat 5 = &lt; 24 hours</li> <li>○ Cat 6 = &lt; 72 hours</li> </ul> </li> </ul>	<p><i>MAS*, DAS, VMOs, Perioperative staff, CGU auditors</i></p>	<p>Ongoing Monthly audits</p> <p>July 08</p> <p>Ongoing</p>
<b>2.9</b>	Manage increase in maternity booking (Clinic)	<ul style="list-style-type: none"> <li>• System in place for booking out of area women</li> <li>• Sustain and maintain Student midwives Clinic</li> <li>• Review GP shared care collaboration</li> <li>• Conduct CPI- (Antenatal booking system)</li> </ul>	<p><i>MWCS*, DWCS Heads of Dept/Div/NUM GP Collaboration Unit</i></p>	<p>Mar 09 June 09</p>
<b>2.10</b>	<p>Improve health outcomes for the CALD community</p> <p>3 year plan to identify and address needs of CALD communities, in consultation with appropriate communities and area services</p> <p>Improve access to interpreter service for surgical patients</p>	<ul style="list-style-type: none"> <li>• Multicultural Access Committee reconvened at HKHS</li> <li>• Number of staff accessing training and participation in EAPS processes</li> <li>• Working party established and progress monitored, through identification of key issues, strategies and outcomes</li> <li>• Progress reported annually through the EAPS process throughout the 3 year timeframe'</li> <li>• Educate perioperative staff on interpreter services and DoH policy directive.</li> <li>• Audit of three-way telephone in department</li> <li>• New telephones ordered</li> <li>• Improved compliance with use of interpreter service</li> </ul>	<p><i>MPCC*, Divisional Executive, Department managers, staff and area services</i></p> <p><i>MAS*, DAS, Perioperative staff, Interpreter service</i></p>	<p>July 08</p> <p>Quarterly</p> <p>Sep 08</p> <p>Annually</p> <p>Ongoing Mar 09</p> <p>June 09</p>
<b>2.11</b>	Reconfigure surgical services and define roles of HKHS to reflect its delineated role	<ul style="list-style-type: none"> <li>• HKHS participation in final development and review of Area Clinical Services Plan</li> </ul>	<p><i>GM*, Exec, staff</i></p>	<p>July 08</p>

	under the Clinical Services Plan	<ul style="list-style-type: none"> <li>• Ongoing Executive planning for, and roll-out of, recommendations for HKHS</li> <li>• Executive and key staff participation in clinical networks</li> <li>• GM participation on Area Clinical Council.</li> </ul>		Ongoing
2.12	Ensure identification and appropriate management of obese women in maternity unit.	<ul style="list-style-type: none"> <li>• Develop maternity bariatric policy for pregnant women</li> <li>• Identification and appropriate management of obese women in maternity unit.</li> </ul>	<b>CMC Midwifery*</b> , <b>Maternity staff, DWCS, MWCS</b>	Mar 09
2.13	Ensure Stroke pathway utilisation through ongoing education of medical and nursing staff in ED and stroke unit	<ul style="list-style-type: none"> <li>• Admission demonstrates adherence to Acute Stroke Pathway</li> <li>• Transfer within 6 hrs to Stroke Unit</li> <li>• Monitoring, elevation of head of bed; DVT, pressure area and shoulder-subluxation prevention commences on day 1.</li> <li>• Aspirin given &lt; 24 hrs post-onset after CT scan (Ischaemic stroke).</li> <li>• 12 hrs bed-rest for ICH.</li> <li>• Family and carers are informed in a timely fashion of changes in condition and/or expected outcome, diagnosis, management and strategies to assist the patient in therapy and discharge</li> </ul>	<i><b>MMEI*</b></i> , <i><b>DMEI</b></i> , <i><b>Stroke CNC*</b></i> , <i><b>ED &amp; Stroke Unit staff</b></i>	Sep 08 Ongoing

**Goals: To provide the health care that people need  
To deliver high quality health services**

***SD 3 Strengthen primary health and continuing care in the community***

**HKHS approach to SD 3 Strengthen primary health and continuing care in the community**

<i>No.</i>	<i>WHAT HKHS WILL DO IN 2008/09</i>	<i>KEY PERFORMANCE INDICATORS (KPI)</i>	<i>WHO</i>	<i>TIMEFRAME &amp; REPORTING</i>
3.1	GRACE project - develop & implement activities for 08/09 to further improve patient journey for residents of ACFs and reduce ACF admissions, through a program of enhanced management for residents, increased education to ACF staff	<ul style="list-style-type: none"> <li>No. of admission avoidances</li> <li>Launch educational/avoidance tool (NHHEDI)</li> <li>Continued education in ACFs by GRACE</li> <li>No. visits to ACFs for education &amp; avoidance strategies</li> <li>Implement fast-track radiology for ACF patients</li> <li>Evaluate feasibility of protocol-driven discharge for ACF patients in EMU</li> </ul>	<i>MRACS*, DRACS*, GRACE &amp; ASET teams</i>	Nov 08 Ongoing June 09 Oct 08  June 09
3.2	Evaluate the outcomes of the Healthy at Home (formerly SAFTE) program at HKHS & assess options for continuation of program in conjunction with NSW Health	<ul style="list-style-type: none"> <li>Ongoing funding secured</li> <li>Audit work flow information reported to NSW Health</li> <li>Review services in line with new DoH directions &amp; assess availability of outcome data</li> <li>Develop patient satisfaction process &amp; trial</li> </ul>	<i>MRACS*, DRACS, H@H team, IM</i>	July 08 Oct 08 March 09  June 09
3.3	Continue to Implement Families First	<ul style="list-style-type: none"> <li>Meet target for &lt;2 weeks home visiting</li> <li>Implement Centralised intake and phone counselling at Pennant Hills and Hornsby ECHC</li> </ul>	<i>MWCFS*, DWCFS, Community paediatrics NUM &amp; staff</i>	June 09
3.4	Ongoing review of ACAT waiting times for initial assessment	<ul style="list-style-type: none"> <li>Improve KPI performance for private hospital ACAT assessments to meet Department of Health and Ageing benchmark</li> <li>Waiting times reported &amp; strategies identified to reduce waiting times where required</li> </ul>	<i>MRACS*, ACAT manager and staff</i>	Aug 08  Quarterly
3.5	Establish outreach geriatric services in a community setting to promote early assessment & management of geriatric syndromes and reduce avoidable admissions for the 65+ age group	<ul style="list-style-type: none"> <li>Geriatric Clinic established by HKH at Anglican Retirement Village</li> <li>No. of clients</li> </ul>	<i>MRACS, DRACS*, GRACE CNC, RACS staff specialists</i>	Dec 08  Quarterly

3.6	Decrease waiting times for memory clinic assessments, in order to improve client & family access to appropriate treatment and support	<ul style="list-style-type: none"> <li>• Wait time to initial assessment audited</li> <li>• Process for scheduling of assessments reviewed &amp; streamlined</li> <li>• Waiting times decreased cf audit benchmark</li> </ul>	<i>MRACS*, DRACS, NUM BCRU, RACS staff</i>	Aug 08 Sep 08 Dec 08
3.7	Local review of community health models of care in conjunction with area review– with particular regard to mental health services & unmet community health needs	<ul style="list-style-type: none"> <li>• Unmet community need re Day Respite services in Galston, Berowra, Brooklyn raised with DADHAC - funding made available for new services</li> <li>• Area P&amp;CC planning day – youth and mental health unmet needs identified for Galston/ Berowra areas</li> <li>• Programs to address unmet needs to be included in Area P&amp; CC Plan</li> </ul>	<i>MPCC*, CH staff, Area MPCC, MH</i>	Dec 08 Mar 09 Jul 09
3.8	Develop and implement programs for patients with respiratory chronic / complex care needs, to support monitoring and management of extended and ongoing illness in the community and reduce the need for hospital admission	<ul style="list-style-type: none"> <li>• 'Hornsby Hufflers' group established in partnership with RRRS for patients with respiratory disease residing in the community who have already completed the respiratory rehabilitation program</li> <li>• Establishment of links with Area Healthy Lifestyle to promote course</li> <li>• Investigate methods to increase communication between Hospital and GPs for chronic medical patients</li> <li>• GPs to be informed of their patient's care</li> </ul>	<i>MRACS*, MRACS*, RRRS, Area Healthy Lifestyle</i>  <i>MMEI*, DMEI, NUMs &amp; staff 1A &amp;1B, MPCC, GP Collaboration Unit</i>	Nov 08 Mar 09 June 09 June 09
3.9	Assess performance of Maternity Service against benchmarks	<ul style="list-style-type: none"> <li>• Antenatal visits – 1<sup>st</sup> visit before 20 weeks gestation- Aboriginal women &gt;84.8%</li> <li>• Antenatal visits – 1<sup>st</sup> visit before 20 weeks gestation- Non-Aboriginal women &gt;94%</li> <li>• Low birth weight babies (&lt; than 2,500g at term)- Aboriginal women &lt;13.1%</li> <li>• Low birth weight babies (&lt; than 2,500g at term)-Non-Aboriginal women ≤5.5%</li> </ul>	<i>MWCFS*, DWCFS, NUM, CMC, Team Midwives</i>	Quarterly
3.10	Enhance social and health support services for older and disabled people in the community	<ul style="list-style-type: none"> <li>• Berowra &amp; Galston area <ul style="list-style-type: none"> <li>○ Improve utilisation of HACC funding, staff &amp; volunteers</li> <li>○ New Home Visiting service established</li> <li>○ Number of occasions of service</li> </ul> </li> <li>• Wisemans Ferry <ul style="list-style-type: none"> <li>○ Provision of additional nursing staff hours within existing budget</li> </ul> </li> </ul>	<i>MPCC*, CH staff, HACC staff</i>	Sep 08 Dec 08 June 09 Dec 08

**Goal: To manage health services well  
To provide the health care that people need  
To deliver high quality health services**

***SD 4 Build regional and other partnerships for health***

**HKHS approach to SD 4 Build regional and other partnerships for health**

<i>No.</i>	<i>WHAT HKHS WILL DO IN 2008/09</i>	<i>KEY PERFORMANCE INDICATORS (KPI)</i>	<i>WHO</i>	<i>TIMEFRAME &amp; REPORTING</i>
4.1	Develop programs for GPs in the HKHS LGAs to improve collaboration & communication with GPs, to enhance patient care through shared care arrangements	<ul style="list-style-type: none"> <li>• GPs &amp; GP Unit staff represented on HKHS committees</li> <li>• GP Network Northside &amp; HKHS Executive Liaison Committee established &amp; HKHS GM, DMS and DNS attend regular Division of General Practice Meeting</li> <li>• GM attends Area GP Liaison Committee</li> <li>• Application for Australian Better Health Initiative funding to enhance GP role / communication with health service</li> <li>• Funding received &amp; governance for project established</li> </ul>	<p><i>MPCC*, GM, GPCU, Div Exec, DMS</i></p> <p><i>MPCC*, GP Unit, MMEI, NUMs, GPCU</i></p>	<p>Sep 08 Ongoing</p> <p>Dec 08 Mar 09</p>
4.2	Maintain effective Community Participation Committee & extend levels of consumer involvement in key committees	<ul style="list-style-type: none"> <li>• Number of CPC meetings held</li> <li>• HKHS committee members participate in area CPC evaluation process</li> <li>• Process developed to increase number of consumer and community reps in locally based redesign projects &amp; HKHS 'tier 1' committees &amp; other consultations with consumers re redesign projects- e.g. focus groups, surveys</li> <li>• HKHS CPC includes Council representative</li> </ul>	<p><i>GM*, MPCC, MQS, DMS, DNS, Div Exec</i></p>	<p>Ongoing Nov 08 May 09</p>
4.3	Build and nurture effective relationships with our community, including supporters and donors	<ul style="list-style-type: none"> <li>• No. of personal contacts with community &amp; supporters including attending community group functions, written correspondence, phone calls and inpatient visits to donors</li> </ul>	<p><i>FRM*, GM, DSU, Div Exec</i></p>	<p>Quarterly</p>
4.4	Develop community partnerships with stakeholders, including NGOs and government	<ul style="list-style-type: none"> <li>• Establishment of community working party to address the needs of young people living in the Galston/Wiseman</li> </ul>	<p><i>MPCC*, CHC coordinators</i></p>	<p>Mar 09</p>

	agencies, to address unmet needs in the community	Ferry areas <ul style="list-style-type: none"> <li>○ Participants include community centre coordinators, non-government and government agencies and community members</li> <li>○ New programs for young people identified</li> <li>● Review of the needs of Brooklyn homeless community             <ul style="list-style-type: none"> <li>○ Participate in local task force</li> <li>○ Programs identified</li> </ul> </li> </ul>		June 09
				Dec 08
				June 09

## Goal: To manage health services well

### SD 5 Make smart choices about the costs and benefits of health services

#### HKHS approach to SD 5 Make smart choices about the costs and benefits of health services

<i>No.</i>	<i>What HKHS will do in 2008/09</i>	<i>Key Performance Indicator (KPI)</i>	<i>WHO</i>	<i>TIMEFRAME &amp; REPORTING</i>
5.1	Implement divisional, clinical and other network structures and ensure effective governance & reporting structures with HKHS Executive	<ul style="list-style-type: none"> <li>● HKH organisational structure revised to meet new area requirements</li> <li>● Committee structure and reporting evaluated and refined as necessary</li> </ul>	<i>GM*, Div Exec</i>	Mar 09
				Apr 09
5.2	Continue development of 'efficient performance' culture for HKHS Executive & cost centre managers to align activity/performance targets with budget, whilst promoting benchmarking and best practice	<ul style="list-style-type: none"> <li>● Whole of service saving strategy- allocate Executive portfolio holders</li> <li>● Executive portfolio holders lead staff focus meetings to identify savings measures</li> <li>● Identified inventory, ordering and usage measures communicated to staff through email, newsletter and department meetings</li> <li>● Ongoing strategies identified and rolled out</li> <li>● Savings in food costs, stationery, pharmacy, prosthetics, medical supplies, linen</li> </ul>	<i>GM*, Div exec*, DMS, DNS, MDSU</i>	Sep 08
				Oct 08
				Dec 08
				Ongoing

	Encourage innovation that delivers improved value for money	<ul style="list-style-type: none"> <li>• Review ambulance costing for HKHS</li> <li>• Monthly distribution of monthly financial, performance &amp; FTE reports for analysis by DSU and Divisional Executives</li> <li>• Monthly Finance &amp; Performance meeting to review organisational performance and develop strategies to address areas of concern</li> <li>• Monthly meetings with between Divisional Managers and DSU to review financial performance</li> <li>• Distribution of most recent Episode Funding &amp; Health Round Table results combined with presentations to senior Medical Forums (eg Section of Physicians).</li> </ul>	<p><i>DNS*, MMEI, NUM ED</i></p> <p><i>MDSU* &amp; DSU staff, Div exec</i></p>	<p>Mar 09</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>May-09</p>
5.3	Delivery of Financial Plan for 08/09 including implementation of Area-wide Savings Strategies	<ul style="list-style-type: none"> <li>• Allocate Executive Portfolios for each Area Wide Savings Strategy</li> </ul>	<p><i>GM*, Div Exec, DMS, DNS, MDSU</i></p>	<p>Sep 08</p>
5.4	Reduce the cost of medical and surgical supplies through improved inventory management and usage practices.	<ul style="list-style-type: none"> <li>• Reduce waste in medical stores</li> <li>• Streamline returns and journals for incorrect deliveries</li> <li>• Work with Stores focus group on strategies to improve inventory and stores management</li> <li>• Methods and improvements rolled out through HKHS divisions</li> </ul>	<p><i>MMEI*, DNS, MDSU, ED NUM and staff, Stores staff</i></p> <p><i>Div Exec*</i></p>	<p>Feb 09</p> <p>Feb 09</p> <p>Ongoing</p> <p>June 09</p>
5.5	Consolidation of consignment prosthesis to reduce expenditure	<ul style="list-style-type: none"> <li>• Consultation with surgical VMOs on preferred prostheses</li> <li>• Choice of consignment stock limited as per consultations</li> <li>• Reduction in prosthetic costs</li> </ul>	<p><i>MAS*, DAS, VMOs</i></p>	<p>Mar 09</p> <p>June 09</p>
5.6	Ensure effective management and financial control of community health services in the HKHS sector	<ul style="list-style-type: none"> <li>• Financial audit community health services by NSCCH internal audit team</li> <li>• Action plan developed</li> <li>• Negotiation of appropriate leases for Brooklyn and Wisemans Ferry CHCs</li> </ul>	<p><i>MPCC*, CHC managers, Internal audit team</i></p>	<p>Dec 08</p> <p>Mar 09</p> <p>Dec 08</p>
5.7	Ensure accurate data for OST and other key ED	<ul style="list-style-type: none"> <li>• Problems in EDIS data management identified</li> </ul>	<p><i>MMEI*, ED</i></p>	<p>Jan 09</p>

	KPIs through improved EDIS data management	<ul style="list-style-type: none"> <li>• Education of medical, nursing and clerical staff streamlined</li> <li>• EDIS data management improved</li> </ul>	<i>NUM, ED CNEs &amp; clerical, MDSU,</i>	June 09 June 09
5.8	Reduce ward nursing FTEs (including overtime) to match agreed Reasonable Workload Tool levels in relation to the individual 'specialling' of patients.	<ul style="list-style-type: none"> <li>• Develop agreed procedure for ordering of Individual Patient Specials at HKH, aligned with area policy</li> </ul>	<i>DNS*, Div Exec, ADNS, NUMs</i>	May 09
5.9	Reduce the overtime costs of medical staff	<ul style="list-style-type: none"> <li>• Development, implement and enforce policy-driven restrictions on claims for payment of non-rostered overtime and call-backs.</li> </ul>	<i>DMS*, Div Exec, RSU Manager</i>	June 09
5.10	Co-locate EMU and surge beds to ensure optimal patient safety and resource utilisation	<ul style="list-style-type: none"> <li>• Space identified</li> <li>• Funding secured</li> <li>• Business case for refurbishment submitted</li> <li>• Refurbishment commenced</li> </ul>	<i>MMEI*, DMEI, NUM EMU, DNS, DMS,</i>	Jan 09 Feb 09 May 09
5.11	Continue development of integrated HKHS risk management process & facility quality plan	<ul style="list-style-type: none"> <li>• Major HKHS risks formally identified &amp; reported to HKHS executive and Area DCG</li> <li>• Clinical Governance Framework &amp; Quality plan developed and available on to all staff on HKH Intranet</li> <li>• Risk management process &amp; facility quality plan align with area processes and CGU plans as developed.</li> </ul>	<i>MQS*, DMS, Div exec</i>	Ongoing Nov 08 Ongoing
5.12	Achievement of accreditation by the ACHS in March 2009	<ul style="list-style-type: none"> <li>• Coordinate completion of ACHS pre-survey documentation</li> <li>• Support executive and managers in highlighting achievements and demonstrating compliance with EQuIP standards</li> <li>• ACHS maintains HKHS accreditation status, indicating high level of accreditation standards</li> </ul>	<i>MQS*, HKHS Exec,</i>	Feb 09 Ongoing Mar 09
5.13	Continue to implement revisions of NSCCH delegations manual	<ul style="list-style-type: none"> <li>• Cost centre managers informed &amp; aware</li> <li>• Appropriateness of allocated delegations evaluated</li> </ul>	<i>MDSU*, Div exec</i>	July 08 Ongoing
5.14	Timely and relevant performance reports for HKHS Executive drive improvements  Effective business support is extended to the	<ul style="list-style-type: none"> <li>• Divisional Dashboards in use for each Clinical Division, which include relevant KPIs</li> <li>• Divisional Financial, FTE &amp; Performance reports</li> </ul>	<i>MDSU*, Div exec</i>	Aug 08 On-going

	resources	<ul style="list-style-type: none"> <li>• DSU meet with All Divisional Managers Monthly to review finance &amp; performance</li> <li>• DSU membership on all Clinical Divisional Executives</li> </ul>		On-going
5.15	Ongoing management of HKHS capital asset replacement plan, based on priorities identified by HKH executive.  Participation in area capital process	<ul style="list-style-type: none"> <li>• HKHS Capital Plan updated &amp; prioritised</li> <li>• HKHS Capital items list revised and submitted to Area</li> <li>• Fundraising Priority List derived from Capital List and given to Fundraising Department biannually</li> <li>• HKHS GM is a member of Area Capital Works Committee</li> </ul>	<i>GM, MDSU*, Executive,</i>  <i>GM*</i>	Dec 08 Jan 09  Ongoing
5.16	Gain approval for the development of site master plan for further development & refurbishment at HKHS	<ul style="list-style-type: none"> <li>• Approval to develop plan</li> <li>• Budget proposal for 07/08 address Stage II needs</li> </ul>	<i>GM*, MDSU</i>	June 09
5.17	Manage ongoing issues related to IM&T & facilitate implementation of PAS/Cerner and electronic discharge at HKHS	<ul style="list-style-type: none"> <li>• Ongoing training of relevant staff trained in eMR</li> <li>• eMR Phase 2 planning is supported if project is re-scoped</li> <li>• Upgrade of Hospital paging system to BAE 'hybrid 2' system</li> </ul>	<i>MDSU*, Exec, EQUIP IM team</i>	Ongoing Jun 09  Mar 09

## Goal: To manage health services well

### SD 6 Build a sustainable health workforce

#### HKHS approach to SD 6 Build a sustainable health workforce

<i>No.</i>	<i>What HKHS will do in 2008/09</i>	<i>Key Performance Indicator (KPI)</i>	<i>WHO</i>	<i>TIMEFRAME &amp; REPORTING</i>
6.1	Increase the effectiveness and efficiency of graduate on-the-job training for graduate, improve rostering of trainee nurses (TENS) and improve availability of ongoing education for	<ul style="list-style-type: none"> <li>• Number of graduate nurse rotations reduced from 4 rotations to 2</li> <li>• Revise programs for graduate nurses available in line with feedback from new graduates</li> </ul>	<i>DNS*, Div Exec, ADNS, NUMs</i>	Dec 08  June 09

	HKH nurses	<ul style="list-style-type: none"> <li>• Rosters of TENs revised to incorporate annual leave within the twelve month program.</li> <li>• New education sessions delivered for specific staff groups (CNEs, CNS) to meet identified needs</li> </ul>		Dec 08 June 09
6.2	Support staff undergraduate and post-graduate learning activities, in accordance with NSW Health policy directive PD2006_066	<ul style="list-style-type: none"> <li>• Learning &amp; development leave taken (in hours) for external learning activities</li> <li>• Learning &amp; development activities undertaken on an on-duty basis (in hours)</li> </ul>	<i>DMS*, DNS*, Div exec</i>	Quarterly
6.3	Develop HKH Executive leadership & management through effective participation in area, DoH and HKH Executive processes; including delegating to build the capacity of the organisation	<ul style="list-style-type: none"> <li>• Allocated ministerial related matters submitted by due date</li> <li>• Allocated executive correspondence matters submitted by due date</li> <li>• Undertake annual performance development review process with each direct report</li> <li>• Implement one new local initiative with a view of improvising staff morale</li> </ul>	<i>GM*, Divisional Exec</i>	June 09
6.4	Formalise provision of supervision within the Occupational Therapy Department to ensure all level 1 & 2 Occupational Therapists have a clear and appropriate line for clinical supervision	<ul style="list-style-type: none"> <li>• Allied Health award translation – applied for senior staff levels</li> <li>• Senior staff levels obtained</li> <li>• Supervisors for Level 1 / 2 OT staff decided</li> <li>• Formal supervision commenced</li> <li>• Supervision process evaluated</li> </ul>	<i>MMEI*, Occupation therapy manager &amp; staff</i>	Aug 08 Aug 08 Oct 08 Feb 09 May 09
6.5	Ensure effective management of quinquennium processes	<ul style="list-style-type: none"> <li>• Planning ongoing</li> <li>• HKHS in line with area processes</li> </ul>	<i>DMS*, Clinical Div Directors*</i>	July 08 Ongoing
6.6	Develop strategies in response to workplace problems identified by staff in appropriate forums, eg. Staff Consultative Committee	<ul style="list-style-type: none"> <li>• % strategies / recommendations implemented compared to problems identified</li> <li>• Compliance with relevant industrial awards and policies</li> </ul>	<i>HRM*, GM, Div exec</i>	Ongoing
6.7	Develop & implement HKHS OH&S plan for 2008-2010 which reflects area OH&S Strategic Plan (2008-2011) & local requirements	<ul style="list-style-type: none"> <li>• OHS&amp;IM 2 year plan developed in response to June 2008 OHS&amp;IM profile report recommendations</li> <li>• % priorities implemented</li> <li>• Employer representation on OHS Committee strengthened in line with OHS legislative requirements</li> </ul>	<i>OHSM*, GM</i>	Feb 09

6.8	Manage performance monitoring and credentialing program for all medical staff	<ul style="list-style-type: none"> <li>• % Staff medical specialists have annual performance review</li> <li>• % VMO reappointments and performance reviews at quinquennium</li> <li>• % non-specialist medical staff have appraisal / performance review</li> <li>• Scope of clinical practice developed for Senior Medical Practitioners and Advanced Trainees</li> </ul>	<i>DMS*, Clinical directors*, Director Clinical Training, RSU</i>	<p>June 09 Quarterly</p> <p>Dec 08</p>
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**Goal: To manage health services well**  
**To provide the health care that people need**  
**To deliver high quality health services**  
**To keep people healthy**

**SD 7 Be ready for new risks and opportunities**

**HKHS approach to SD 7 Be ready for new risks and opportunities**

No.	WHAT HKHS WILL DO IN 2008/09	KEY PERFORMANCE INDICATORS (KPI)	WHO	TIMEFRAME & REPORTING
7.1	Encourage a culture of innovation and awareness of strategic trends	<ul style="list-style-type: none"> <li>• Demonstrated ongoing professional development for members Executive</li> <li>• Executive and senior staff participate in steering groups, meetings and planning committees at State level</li> <li>• Executive identify possible research programs, DOHA, NSW Health and other funding opportunities</li> </ul>	<i>GM*, Executive, HKHS staff</i>	<p>June 09</p> <p>Ongoing</p> <p>Ongoing</p>

## PART III: PERFORMANCE DASHBOARDS AT HKHS

To evaluate the success of our strategies and goals, this year we have continued the use of our “Divisional Dashboards” to monitor and improve our performance.

The dashboards, which help simplify the reporting process, have been developed by the Divisional Executive in consultation with their staff, and the assistance of the Decision Support Unit.

Key performance indicators and outcome measures that are highlighted in the dashboards cover the domains of:

- quality and safety,
- access & activity,
- human resources and
- financial performance.

There is capacity within the dashboard structure to report on additional focused clinical indicators and reflect performance in clinical redesign project outcomes. The flexibility of design promotes the ongoing enhancement of the efficient performance culture at Hornsby Ku-ring-gai Health Service.

# Women's , Children & Family Health Dashboard



**Work in Progress link to Historical monthly info**

<b>Paeds</b>	Yesterday	Prev	Current Mth Avg - June	Mth Avg - May
Total Presentations			15.0	12.8
Patients >8hrs In ED for Ward Adm				
% Emergency Access Performance			96%	91%
% Ward Admits			17%	15%
ED Admits				
PACs (Paed Amb Care) Admission				
PACs (Paed Amb Care) Assessment				
Trfr from PAC's to Inpat				
Total in Unit (all Inpatients)				
	Today	Yesterday		
Planned Admits				
Planned Discharges				
No. of Patients with EDD				
<b>Obstets</b>				
Planned Admits				
Planned Discharges Today				
Planned Discharges Tomorrow				
Emergency LSCS				
Planned LSCS				
Patients In Unit				
DAU Patients Not Admitted				
DAU Patients < 4 hrs				
Complication in Month	0	0		
	0	0		

<b>Jul-06</b>	Jul-06	Last Month	Target
Births	90	88	100
Booked Deliveries			0
MSP Bookings			0
% MSP			0
GP Shared Care %			10%
LSCS Elective			
Miscellaneous	1	1	0
Child & Family Health Indicators			

**Focused Clinical Indicators** [Demand Mx plan](#)

	Monthly	YTD	Target	Outcome Comment
% Normal Vag Del <2 days			60%	
% FTS by GP			100%	
% Midwifery Led care			60%	
% Asthma LOS < 1.9 days			100%	
% Follow up < 2 weeks			65%	
% Breast feeding			80%	
Special Proj 2			25%	
% Planned CW discharges			80%	
% Planned Maternity disch			80%	

**Summary Bed Snapshot**      **25-June-2007**      **26-June-2007**

Staff Resource Comment:	
Birthing Unit Access :	
Paeds Inpatients:	0
Paeds ED Comment:	
OTHER ISSUES:	

# Division of Medicine , Emergency & Intensive Care



Ward Drq's 2005-06 to 2006-07

Winter 2007 Presentation

Jugglers 2006 Powerpoint

Date Selector →

26-June-2007

Tuesday

Emergency	Yesterday	Prev	Current Mth Avg - June	Mth Avg - May
Total Presentations				
Patients >8hrs In ED for Ward Adm				
% Emergency Access Performance				
% Ward Admits				
ED Admits				
EMU / Surge				
No. of Patients Waiting for General Beds				
EMU ward Inpatients				
EMU X Outliers (not meeting Adm criteria)				
Planned Emu Discharges / Tfrs Out				
No. of EMU > 48 hrs				
No. Surge Beds Utilised				
Grace patients > 5 days				
Acute Wards <span style="color: #000080;">(1A &amp; 1B)</span>				
No. of Patients Waiting Telemetry (L1A)				
L1A Inpatients			22.9	22.4
L1A Planned Discharges Today				
L1A No. of Patients with EDD				
No. of Patients Waiting Telemetry (L1B)				
L1B Inpatients			23.0	22.4
L1B Planned Discharges Today				
L1B No. of Patients with EDD				
Total Patients Waiting for Rehab				
Total Patients Waiting for Hostel				
Total Patients Waiting for N/Home				

Summary Bed Snapshot	25-June-2007
Staff Resource Comment:	
ICU /HDU Access Comment:	
ED Access & Perf Comment :	
EMU / Surge Comment :	
Acute Ward Comments:	

ICU / HDU	Yesterday	Prev	Current Mth Avg - May	Current Mth Avg -Apr
Current No. of Patients ICU				
Planned Tfrs in ICU				
Planned Tfrs out ICU				
Anticipated ICU Inpats at End				
Pats waiting for ICU (Inability to admit)				
Current No. of Patients HDU				
Planned Tfrs in HDU				
Planned Tfrs in HDU				
Anticipated HDU Inpats at End				
Pats waiting for HDU (Inability to admit)				
Emergency/Not Planned ICU Admits				
Total In Unit				
Total Anticipated In Unit				
Focused Clinical Indicators				
	Monthly	YTD	Target	Outcome Comment
Delays in Transport ( Across Div & Ward)				
ICU Central Line Assoc Infects (CLAB)				
ICU peripherally inserted (CLAB) infections				
% Discharges Lumby < 12am				
% Weekend Disch Lumby				
Medication incidents per 1,000 bed days				
Project 7				
Project 8				
Project 9				

Predicitive Comments	26-June-2007
Staff Resource Comment:	
ICU /HDU Access Comment:	
ED Access & Perf Comment :	
EMU / Surge Comment :	
Acute Ward Comments:	



Emergency	Yesterday	Prev	Current Mth Avg - June	Mth Avg - May
Total Presentations >= 70 yrs				
Patients >8hrs In ED for Ward Adm				
% Emergency Access Performance				
% Ward Admits				
ED Ward Admits >=70yrs				
EMU / GRACE /ASET				
No. of Patients Waiting for General Beds				
Total EMU ward Inpatients				
EMU X Outliers (not meeting Adm criteria)				
Planned Emu Discharges / Tfrs Out				
No. of EMU > 48 hrs				
Grace patients to Surge Beds				
Grace patients > 5 days				
Wards (GER & MGW)				
No. Waiting for MGW in Acute Wards				
MGW Inpatients				
MGW Planned Discharges Today				
MGW No. of Patients with EDD				
No. Waiting for GER in Acute Wards				
GER Inpatients				
GER Planned Discharges Today				
GER No. of Patients with EDD				
Total Patients Waiting for Rehab				
Total Patients Waiting for Hostel				
Total Patients Waiting for N/Home				

SAFTE	Last week	Prev	Current Mth Avg - May	Current Mth Avg - Apr
Total Safe Registrations	0	0		
Total Safe Comm Visits				
Direct Admissions to Rehab	0	0		
Facilitated Ed Admissions	0	0		
No. of Front End Compacts				
RDT				
Total RDT Registrations	0	0		
Total RDT Comm Visits	0	0		
Direct Admissions to Rehab	0	0		
Facilitated Ed Admissions	0	0		
ASET / GRACE Avoids				
Nursing Home Avoids	0	0		
Hostel Avoids	0	0		
Focused Clinical Indicators				
	Monthly	YTD	Target	Outcome Comment
Delays in Transport ( Across Div & Ward)	0	0		
Racs patients in Acute Care/EMU	0			
NHP/Hostel Patients placed	0	0		
No. of ASET patients seen (wkly)	0	0		
No. of GRACE patients seen (wkly)	0	0		
ACAT waiting List	0	0		
ACAT Avg. Waiting Time	0	0		
NHP waiting > 7 days				

Falls prevention > 65 yrs , Hospital Admiss Avoids				In Conjunct with Prim & Community
--	--	--	--	-----------------------------------

Summary Bed Snapshot	21-June-2007
Staff Resource Comment:	
GER/MGW Access Comment:	
> 70yrs ED Access & Perf Comment :	
EMU / Surge Comment :	
Acute Ward Comments:	

Predictive Comments	22-June-2007
Staff Resource Comment:	
GER/MGW Access Comment:	
> 70yrs ED Access & Perf Comment :	
EMU / Surge Comment :	
Acute Ward Comments:	

Ward Drg's 2006-06 to 2006-07  
 Winter 2007 Presentation  
 Jugglers 2006 Powerpoint

# Division of Anaesthetics & Surgery

Date Selector → **31-May-2007** **Thursday**



Planned Activity	Yesterday	Prev	Current Mth Avg - June	Mth Avg - May
Total Surgical Procedures				
Day Only Planned				
Overnight Planned				
EDD Patients identified				
Unplanned Overnight Stays				
IBU Indicators				
Pre Admission Attendances				
Pre Admission (FTA's) No Shows				
PAC completed via Phone				
Cancelled Procs on Day of Surgery				
No of RFA's processed				
% RFA's with Min Data Set Complete				
Acute Wards <small>(2A &amp; 2B)</small>				
No. of Patients Waiting Telemetry (L2A)				
L2A Inpatients				
L2A Planned Discharges Today				
L2A No. of Patients with EDD				
No. of Patients Waiting Telemetry (L2B)				
L2B Inpatients				
L2B Planned Discharges Today				
L2B No. of Patients with EDD				
Total Patients with EDT Assess				
Total Surgical Pats Waiting for Rehab				
Total Patients >LOS B'mark Out of Area				

Operating Suite	Yesterday	Prev	Current Mth Avg - May	Current Mth Avg -Apr
No of Sessions Commenced >20 mins				
No of Sessions overrun >20 mins				
% utilisation Core ( Target ? 75)				
Hrs utilised Clearing List				
Proc Hrs Utilised > 7pm				
Anticipated Emerg req. Surgery				
Access Block in Recovery				
Cancelled Procs in Op Suite				
Total Patients				
Emergency/Not Planned ICU Admits				
Total Anticipated In Unit				

Focused Clinical Indicators				
	Monthly	YTD	Target	Outcome Comment
Delays in Transport ( Across Div & Ward)				
% Same Day Surg for Lap Chol				
% Same Day Surg for Inguinal Hernia				
% Wk end Discharges - Acute Ward				
Project 5				
Project 6				
Project 7				
Project 8				
Project 9				

**Summary Bed Snapshot** **30-May-2007**

Staff Resource Comment:|  
 OP Suite KPI's Comment:|  
 ED Access & Perf Comment :|  
 Surge Comment :|  
 Acute Ward Comments: |

**Predicitive Comments** **31-May-2007**

Staff Resource Comment:|  
 OP Suite KPI's Comment:|  
 ED Access & Perf Comment :|  
 Surge Comment :|  
 Acute Ward Comments: |

## Appendix I: Abbreviations used in the Plan

Abbrev.	Position	Abbrev.	Position
CRM	Community Relations Manager		
DDNS	Deputy Director of Nursing & Midwifery Services	Div Exec	All HKHS divisional executive
DMEI	Clinical Dir. Medicine, Emergency & ICU	DMS	Director of Medical Services
DNS	Director of Nursing and Midwifery Services	DRACS	Clinical Dir. of Rehabilitation & Aged Care Services
DAS	Clinical Director Anaesthetics & Surgery	DWCFS	Clinical Director of Women's, Child & Family Services
GM	General Manager	HRM	Human Resources Manager
IM	Information Manager, Clinical Evidence Service	MDSU	Manager, Decision Support Unit
MH	Mental Health Manager	MPCC	Manager Primary & Community Care
MQS	Manager Quality & Safety	MAS	Divisional Manager Anaesthetics & Surgery
MMEI	Manager Medicine, Emergency & ICU	MRACS	Divisional Manager RACS
MWCFS	Divisional Manager Women's, Child & Family Services	OHSM	Occupational Health & Safety Manager
Pt Rep	Patient Representative	Study Co-ord.	Study Co-ordinator RACS

\* Denotes the individual in this position is responsible for leading and reporting progress towards the relevant goal

### Other abbreviations used in the plan

Abbrev.		Abbrev.	
ACAT	Aged Care Assessment Team	ACHS	Australian Council on Healthcare Standards
AHAC	Area Health Advisory Council	APAC	Acute Post Acute Care
ASET	Aged-care Services in Emergency Team		
CALD	Cultural and Linguistic Diversity	CC	Central Coast Health Service
CGU	Clinical Governance Unit	CH	Community Health
CPC	Community Participation Committee	CSR	Clinical Service Redesign
DOH	Department of Health	DRGs	Diagnosis Related Groups
DSU	Decision Support Unit		
ECT	Electroconvulsive Therapy	ED	Emergency Department
EDD	Estimated Day of Discharge	eMR	Electronic Medical Record project
EMU	Emergency Medical Unit	DIPNR	Department of Infrastructure Planning & Natural Resources

Abbrev.		Abbrev.	
FTE	Full-time Equivalent (employees)		
GPCU	GP Collaboration Unit	GRACE	Geriatric Rapid Acute Care & Evaluation
HaH	Healthy at Home (formerly SAFTE)	HDU	High Dependency Unit
HKHS	Hornsby Ku-ring-gai Health Service	HOPE	Hornsby Obstetrics Paediatrics Emergency
ICU	Intensive Care Unit	IM&T	Information Management & Technology
IIMS	Incident Information Management System	IRT	Internal Response Team
KPI	Key Performance Indicator		
LGA	Local Government Area	LOS	Length of stay
MHICU	Mental Health Intensive Care Unit	MOC	Model of care
MSP	Maternity services Program		
NBHS	Northern Beaches Health Service	NSCCAHS NSCCH	Northern Sydney Central Coast Area Health Service Northern Sydney Central Coast Health
NSR	North Shore/ Ryde Health Service	NUM	Nursing Unit Manager
OH&S	Occupational Health & Safety	OST	'Off-stretcher time'
PAC	Paediatric Ambulatory Care	PECC	Psychiatric Emergency Care Centre
RACS	Rehabilitation & Aged Care Service	RDF	Resource Distribution Formula
RSU	Resident Support Unit		
SAC	Severity Assessment Code	SAFTE	Sub-Acute Fast Track Elderly-care
SAP	Sustainable Access Program	SR	Standardised Rate
TNA	Training Needs Analysis	TOR	Terms of Reference

## Appendix II: NSCCH Strategy Map

