

Chronic Disease Services Plan 2006 - 2010

October 2006



HNE Health Area Chronic Disease Services Plan-2006-2010

December 2006

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TABLE OF CONTENTS

1. EXECUTIVE SUMMARY	4
2. INTRODUCTION AND BACKGROUND	7
2.1 Definition of Chronic Disease	7
2.2 Scope of Plan	8
2.3 Plan Structure and Relationship to Other Service Plans	8
2.4 Policy Context	8
2.5 Consultation Process	12
3. BURDEN OF DISEASE	13
4. CURRENT SERVICE PROVISION, ISSUES AND NEEDS	16
4.1 General Practitioners	17
4.2 Consumers	18
4.3 Workforce	18
4.4 Child to Adult Service Transition	19
4.5 Issues for Aboriginal People	20
4.6 Issues for People from Cultural and Linguistically Diverse Backgrounds (CALD)	21
4.7 Partnerships	21
5. STRATEGIC DIRECTIONS	25
6. STRATEGIC ACTION PLAN	26
7. APPENDICES	39
Appendix 1 - Stakeholder Consultation List	39
Appendix 2 - Aboriginal Health Impact Statement and Checklist	42
Implementation and Evaluation of the Policy, Program or Strategy	44
Appendix 3 - Draft Corporate Risk Matrix Enhanced with Community, Reputation, Partnership, Equipment and Produce Descriptors	46

1. EXECUTIVE SUMMARY

The impact of death, disability and reduced quality of life for people with chronic disease is significant. In the Hunter New England Health region over half the population's death rate is attributed to chronic diseases such as cardiovascular disease, cancer and diabetes. Over twenty percent of hospital separations are attributed to the same disease groups. The development of a Hunter New England Chronic Disease Plan has been identified as an Area priority.

The Plan will guide the provision of services to adult patients accessing specialist and generalist hospital and community services, youth transitioning from paediatric to adult services and, carers of people with long-term conditions. The Plan encompasses the chronic disease journey from prevention to end stage care.

The Plan has been developed in context of the strategic directions of NSW Health and the Australian government. The principles underpinning the Plan are consistent with the principles of the National Chronic Disease Strategy and NSW Chronic Disease Strategy, they are:

- Adopt a population approach and reduce health disadvantage
- Prioritise health promotion and illness prevention
- Achieve person-centred care and optimise self-management
- Provide the most effective care
- Facilitate coordinated and integrated multi-disciplinary care across services, settings and sectors
- Achieve significant and sustainable change
- Monitor and evaluate progress

Consultation undertaken to develop the plan has facilitated input from a broad range of generalist and specialist services and disciplines across Hunter New England Health, consumers and external stakeholders.

Elements of chronic disease management identified as priorities include:

- Prevention of disease
- Promotion and facilitation of self-management strategies
- Models of care that improve psychological support, ongoing monitoring and coordination of care, and
- Palliative care

Effective partnerships with external service providers are an essential element for improving chronic disease management. The Plan includes strategies that focus on building partnerships with general practice, and other government and non-government agencies.

Aboriginal communities experience a disproportionately high burden of chronic disease, the Plan recognises the need to target interventions to Aboriginal people and includes strategies aimed at redressing this health inequality.

Five focus areas are identified in the Plan's strategy map, these focus areas and objectives for service delivery are:

Patients, Carers and Communities

- Patients, carers and communities are enabled to participate in disease prevention and management
- Reduced health disadvantage

External Partners

- Engaging and supporting GPs and other external partners in improving the prevention and management of chronic disease

Internal Networking and Processes

- Person-centred care and quality health service experience
- Effective integrated service delivery
- Evidence based healthcare safely delivered
- Disease prevention and health promotion across all service areas

Resource Accountability

- Resources and assets are managed effectively to minimise health disadvantage and maximise health benefit

Our People, Culture and Capability

- Skilling staff in the prevention and management of chronic disease
- Effective consultation and communication
- Demonstrating effective leadership and innovation in chronic disease management
- Evidence based strategic workforce planning

A total of sixty-seven strategies are detailed in the Plan. These strategies aim to establish and consolidate an effective framework for chronic disease management across Hunter New England Health. The following table summarises the key strategic actions and initiatives by focus area.

Strategic Direction and Initiative Summary

Focus Area	Strategies
<p>Patients, carers and communities</p>	<ul style="list-style-type: none"> □ Physical activity and wellness programs and infrastructure □ Self management support programs □ Guidelines for culturally appropriate service delivery □ Models of care for disease prevention and management for: <ul style="list-style-type: none"> - Aboriginal people - Socio-economic disadvantaged groups - Rural communities □ Care planning and support models for youth transitioning to adult services

Focus Area	Strategies
External partners	<ul style="list-style-type: none"> ❑ Communication technology and information sharing systems ❑ Integrated models of self management ❑ Models of care in general practice for: <ul style="list-style-type: none"> - Advance Care Planning - Diabetes Management
Internal networking and processes	<ul style="list-style-type: none"> ❑ Evaluation framework for person centred clinical practice ❑ Patient journey re-design, incorporating <ul style="list-style-type: none"> - Discharge planning and support - Risk factor identification and stratification - Clinical standards of practice - Multidisciplinary care ❑ Models of care coordination, preventative care, advance care planning and tele-health ❑ Information management and clinical outcome systems
Resource Accountability	<ul style="list-style-type: none"> ❑ Chronic disease code set ❑ Models for data collection and analysis ❑ Service evaluation framework
Our people, culture and capability	<ul style="list-style-type: none"> ❑ Professional development framework, including: <ul style="list-style-type: none"> - Chronic disease skill set and competencies - Flexible delivery training programs - Professional forums and alliances ❑ Communication structures for staff and consumers ❑ Consumer information resources and education ❑ Consumer representation and consultation ❑ Clinical leadership and performance management ❑ Chronic disease workforce framework

The resource implications of the strategies described in the Plan have been considered and categorised into three levels:

Level 1: initiatives/actions that will be implemented within existing resources

Level 2. initiatives/actions that will be implemented within existing resources, but would require a degree of system redesign

Level 3: initiatives/actions that will require enhancement funding for implementation.

The strategies requiring enhancement funding (Level 3) have been prioritised as a low, medium or high priority. A summary of resource requirements and priorities is included in Part C of the Plan.

2. INTRODUCTION AND BACKGROUND

*Most of the burden of disease for Australians is due to chronic disease, and the prevalence of chronic disease is rising. They are estimated to be responsible for 80% of the total burden of disease, mental problems and injury, as measured in terms of disability-adjusted life years (DALYs). Effective responses to this significant health challenge must be found to protect the quality of life and wellbeing of all Australians, and ensure the health system has the capacity to meet the demands placed on it.*¹

The increasing prevalence of chronic disease is attributed to advances in medical technology, ageing of the population and lifestyle risk factors. Approximately one third of chronic diseases are related to modifiable lifestyle risk factors. The Australian Institute of Health and Welfare (AIHW) has identified seven major health behaviours and risks associated with chronic disease²:

- Tobacco smoking
- Risky and high-risk alcohol use
- Physical inactivity
- Poor diet and nutrition
- Excess weight
- High blood pressure
- High blood cholesterol

Management of chronic disease has traditionally been reactive, with disease exacerbation and health deterioration being managed in the acute care setting. It is broadly recognised within Australia and internationally that effective chronic disease management requires a multi-faceted approach incorporating a range of service delivery elements and aspects of the human condition³.

2.1 Definition of Chronic Disease

The term chronic disease, as used in this document, is in accordance with the definition used by NSW Health and the National Health Priority Action Council⁴.

Chronic disease:

- *Has complex and multiple causes*
- *Usually has a gradual onset, although can have sudden onset and acute stages*
- *Occurs across the life cycle, becoming more prevalent with older age*
- *Compromises quality of life through physical limitations and disability*
- *Is long-term and persistent, leading to a gradual deterioration of health*
- *While not immediately life threatening, is the most common and leading cause of premature mortality.*

Both communicable and non-communicable diseases can become chronic, although the term is generally applied to non-communicable diseases. Chronic diseases include diabetes, cardiovascular disease (including stroke and heart failure), cancer, asthma, chronic obstructive pulmonary disease, arthritis and musculoskeletal disease, dementia and mental health problems and disorders.

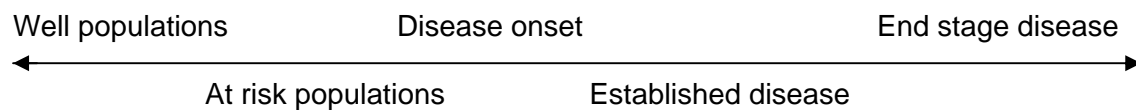
2.2 Scope of Plan

This plan focuses on the health service needs of:

- adult patients accessing specialist and generalist hospital and community services
- youth transitioning from paediatric to adult services
- carers of people with long term conditions

The plan encompasses the chronic disease journey from prevention to end stage care (Figure 1).

Figure 1. : Chronic Disease Continuum



2.3 Plan Structure and Relationship to Other Service Plans

The plan provides a framework for chronic disease management in HNE Health, addressing the issues and interventions that are common across multiple chronic disease categories. Disease specific strategies will be incorporated in a range of service plans to appropriately address the needs of patients, carers and staff working in both generalist and specialist services.

Service plans developed for Clinical Networks should reflect the principles and elements of chronic disease management described in this plan. This will be particularly relevant to the Clinical Networks for Mental Health, Aged Care and Rehabilitation, Cancer, Children and Young People and those Networks coordinating service delivery for people with:

- Cardiovascular disease (acute cardiac syndrome, stroke, angina, heart failure)
- Respiratory disease (Chronic Obstructive Pulmonary Disease (COPD), asthma)
- Diabetes
- Arthritis and musculoskeletal disease (osteo-arthritis, rheumatoid arthritis)
- Neuro degenerative and neuro vascular disease

The disease categories described above reflect current and projected disease burden data and the strategic direction/focus of NSW Health and the Australian Government Department of Health and Ageing⁵.

2.4 Policy Context

The Chronic Disease Service Plan has been developed in the context of HNE Health, NSW Health and Australian government policy. Policy documents of relevance to service development in chronic disease management are:

- Draft NSW Chronic Care Program Phase Three: 2006 – 2009. NSW Chronic Disease Strategy. NSW Health⁶.
- NSW Strengthening Care for People with Chronic Disease, Phase Two (2003-2006)
- NSW Clinical Service Frameworks for Heart Failure, Chronic Respiratory Disease and Cancer^{7,8,9}

- Aboriginal Chronic Conditions Area Health Service Standards¹⁰
- NSW Chronic Disease Prevention Strategy¹¹
- Care of Older People Framework¹²
- Conceptual Framework for Primary and Community Health (PaCH) Services¹³
- Guidelines: Core Functions and Services for Primary and Community Health Services in NSW¹⁴
- Sustainable Access Program¹⁵
- NSW Quality Framework¹⁶.
- National Chronic Disease Strategy¹⁷
- National Service Improvement Frameworks for diabetes, heart, stroke and vascular disease, cancer, arthritis and musculoskeletal disease and asthma^{18,19,20,21,22}
- National Health Priority Initiative²³
- National Chronic Disease Prevention Strategy²⁴.
- Standards for Palliative Care Provision²⁵.

These policy documents establish the framework for the best practice management of chronic disease across the care continuum. In development of this plan HNE Health has adopted the strategic directions of the National Chronic Disease Strategy and the NSW Chronic Disease Strategic Framework.

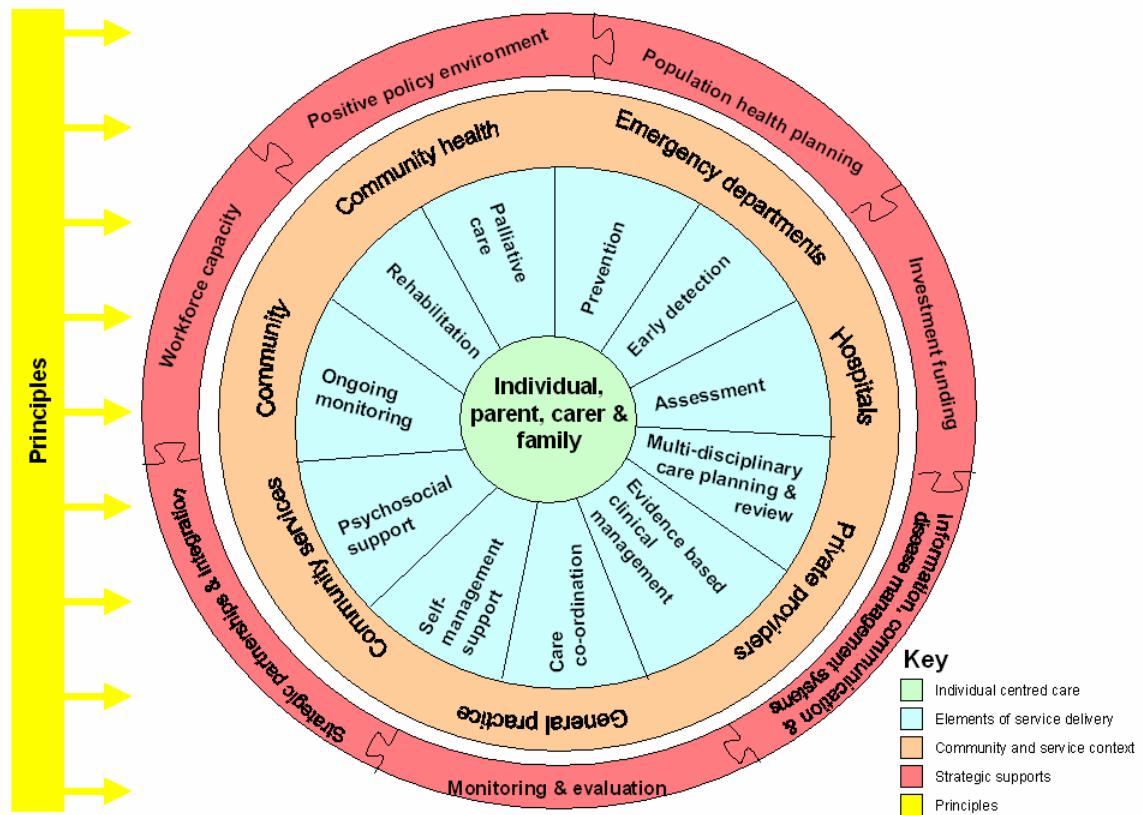
The National Chronic Disease Strategy identifies four key action areas and four development areas to support implementation of effective chronic disease management interventions (Table 1).

Table 1: National Chronic Disease Strategy Action Areas²⁶

Action Area	Implementation Actions
<ul style="list-style-type: none"> • Prevention across the continuum • Early detection and early treatment • Integration and continuity of prevention and care • Self management 	<ul style="list-style-type: none"> • Building workforce capacity • Developing strategic partnerships • Enhancing investment and funding opportunities • Developing infrastructure and information technology

The NSW Chronic Disease Strategic Framework (Figure 2) describes the strategic supports, health care settings and elements of service delivery that together form a foundation for best practice chronic care in NSW²⁷.

Figure 2: NSW Chronic Disease Strategic Framework



The HNE Chronic Disease Service Plan is underpinned by a set of principles adapted from the National Chronic Disease Strategy.

Principles for Chronic Disease Management in HNE Health

1. Adopt a population health approach and reduce health disadvantage

A population health approach aims to improve the health of the whole population and reduce health disadvantage among population groups. It acknowledges the wide range of social, economic and environmental factors that influence the development and progression of chronic disease, as well as the behavioural factors that effect health.

The special needs and challenges for population groups disproportionately affected by chronic disease should be recognised and addressed. Including:

- Aboriginal people
- Older people
- Those with physical or mental disability, and
- The socio-economically disadvantaged

Chronic disease prevention and care should span the age continuum and be responsive to the needs of people from:

- Cultural and linguistically diverse backgrounds
- Diverse social, economic and educational backgrounds, and
- All types of communities, including rural and urban settings.

2. Prioritise health promotion and illness prevention

A significant proportion of the chronic disease burden can be prevented. Health promotion and risk reduction should be prioritised for people at all stages of chronic disease, including people without disease, at risk of disease and with chronic disease at varying stages.

Health promotion should include actions targeted at public health policy, creation of supportive environments, strengthening community and personal capacity, and reorientation of health services.

Using emerging evidence, strategies should be focused on preventable risk factors that impact on the development and progression of chronic disease, such as smoking, excess weight and inadequate physical activity.

Effective disease prevention and health promotion requires a coordinated approach that engages health services with other sectors and settings that impact on the risk and protective factors for chronic disease.

3. Achieve person-centred care and optimise self-management

Person-centred care means that the patient journey, comprising all of a person's interactions with the health system is experienced as consistent over time and settings. Patient centred care is orientated to making a positive difference as determined by the person. The health system is driven by outcomes relevant to the person and their family and carer.

Optimising self-management is essential to achieving person centred care. Self management empowers a person to take responsibility for their own health and, with the support of health care providers, make informed decisions and undertake health actions that maximise their wellbeing and quality of life.

4. Provide the most effective care

People should receive the most effective chronic disease prevention and care across the continuum from detection and diagnosis to ongoing risk reduction, management and end of life care.

The most effective care will have the capacity to delay the progression of disease and the onset of complications, co-morbidities and disabilities. It will achieve outcomes desired by the person including improved quality of life, reducing hospitalisations and maintaining functional capacity, independence and participation in work and social activities.

5. Facilitate coordinated and integrated multi-disciplinary care across services, settings and sectors

Care for people with chronic disease often involves multiple service providers, family and carers.

The integrated provision of chronic disease prevention and care requires a flexible health system that can coordinate care planning across services, setting, sectors and over time. Multidisciplinary care planning must be person centred, incorporate prevention, self-management, and co-morbid conditions and be responsive to the changing needs of the person.

Effective networks which link primary, acute and specialist care within a broader network of allied health and community support services can provide the integrated multidisciplinary care people with chronic disease and complex needs require.

6. Achieve significant and sustainable change

Sustainable quality chronic disease prevention and care requires effective and ongoing collaboration between service providers both within the Area Health Service and with other government, non-government and private sectors.

Effective leadership at all levels of the health service is required to significantly progress change by supporting implementation of evidence based strategies that can be embedded and sustained within the health and community care systems.

7. Monitor progress

Implementation of the chronic disease plan must include provision for the development, collection and reporting of measures to monitor progress against expected outcomes.

2.5 Consultation Process

The Core Planning Group coordinated the development of the Chronic Disease Service Plan. There has extensive consultation with a range of stakeholders. (See Appendix 1). The consultation process included:

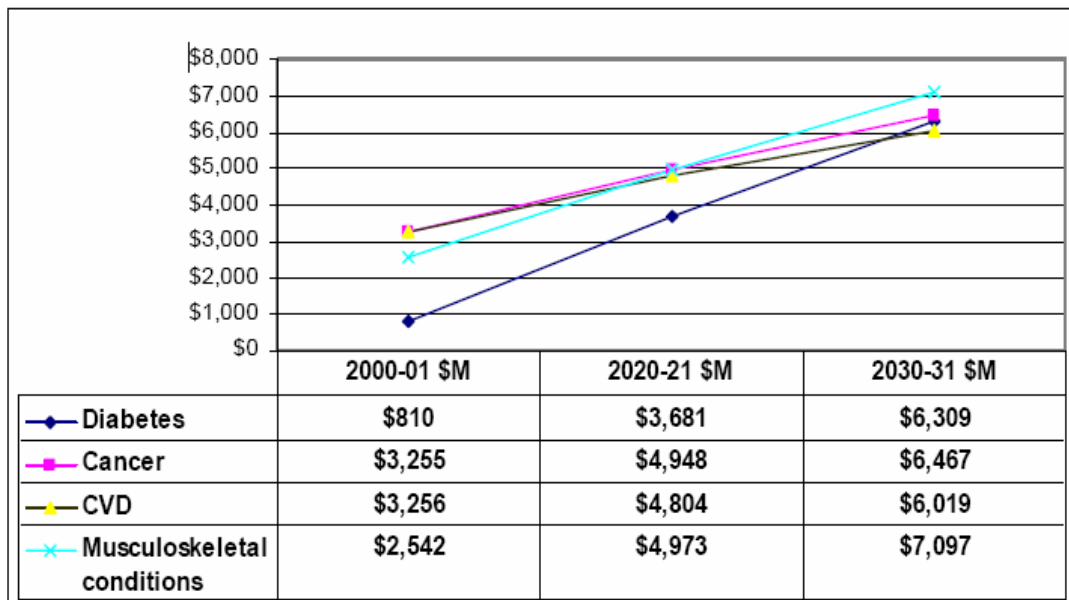
- Review of outcomes from community and staff consultations undertaken in 2005 by the Area Planning Unit
- Strategic planning workshops, meetings and reviews by the HNE Chronic Disease Strategies Group
- Service profiles to identify current practice in chronic disease management in relation to the NSW Health Chronic Disease Strategic Framework
- Workforce survey to identify key issues for clinical staff and managers
- Stakeholder survey to identify priority areas for clinical service development
- Consultation with Divisions of General Practice
- Circulation of draft strategic action plan to non-government organisations for comment/feedback
- Presentation and circulation of draft strategic action plan to Community Forums on Health, with opportunities for written and verbal feedback.

3. BURDEN OF DISEASE

The impact of death, disability and reduced quality of life for people with chronic disease is significant. Over half the burden of chronic disease in Australia is attributed to five major diseases: cardiovascular disease, cancer, chronic obstructive pulmonary disease, musculoskeletal disease and diabetes. The burden of chronic disease is higher in socio-economic disadvantaged and Aboriginal populations.²⁸

Chronic disease accounts for almost a third of health expenditure. It is estimated the cost of chronic diseases such as diabetes, cardiovascular disease and musculoskeletal conditions will increase from approximately \$3.3 billion in 2000/01 to \$6.1 billion in 2020/21 (Figure 3).²⁹

Figure 3: Projected expenditure in Australia (\$m) for admitted patient, medical and pharmaceutical scripts for selected disease groups 2000-01, 2020-21, 2030-31³⁰



In 2002 the most common causes of death in NSW were³¹:

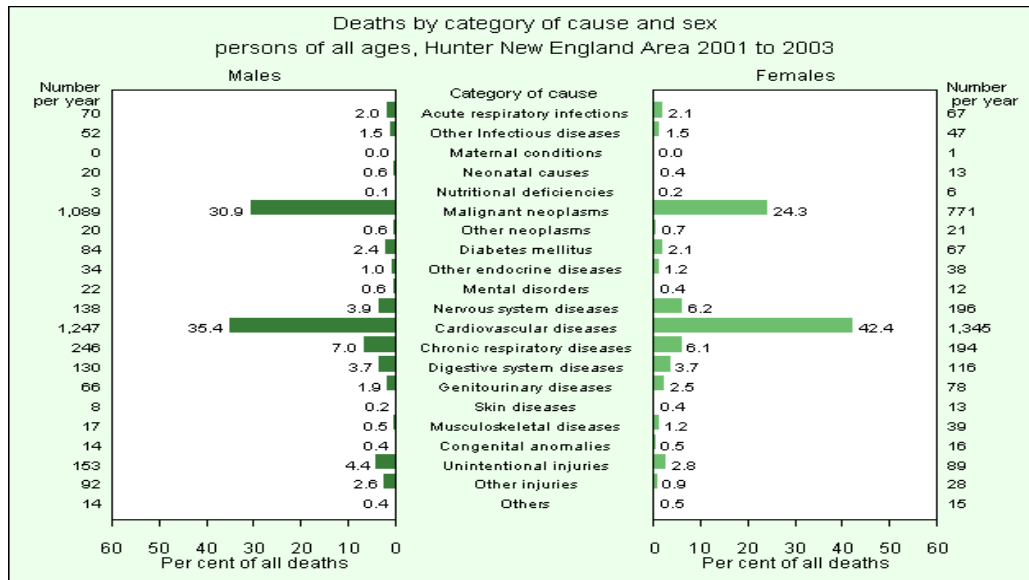
- Cardiovascular disease (40%)
- Cancer (27%)
- Chronic respiratory disease (7%)
- Nervous system diseases (5%)

NSW Health estimate the following trends in the incidence and prevalence of chronic diseases from 2001 to 2026³² :

- The incidence of cardiovascular disease will decrease by 6%, with the number of people living with these diseases increasing by 2.5%
- The incidence of non-insulin dependant diabetes will increase by 127%, with the number of people living with diabetes increasing by 176%
- The number of people with COPD will decline by 24%, representing a 37% decline in males, but a 7% increase in females
- The incidence of mental disorders will increase by 9%, with a 15% increase in females and a 3% increase for males
- The number of people with musculoskeletal disorders will increase by 79%
- The number of people with dementia will increase by 107%.

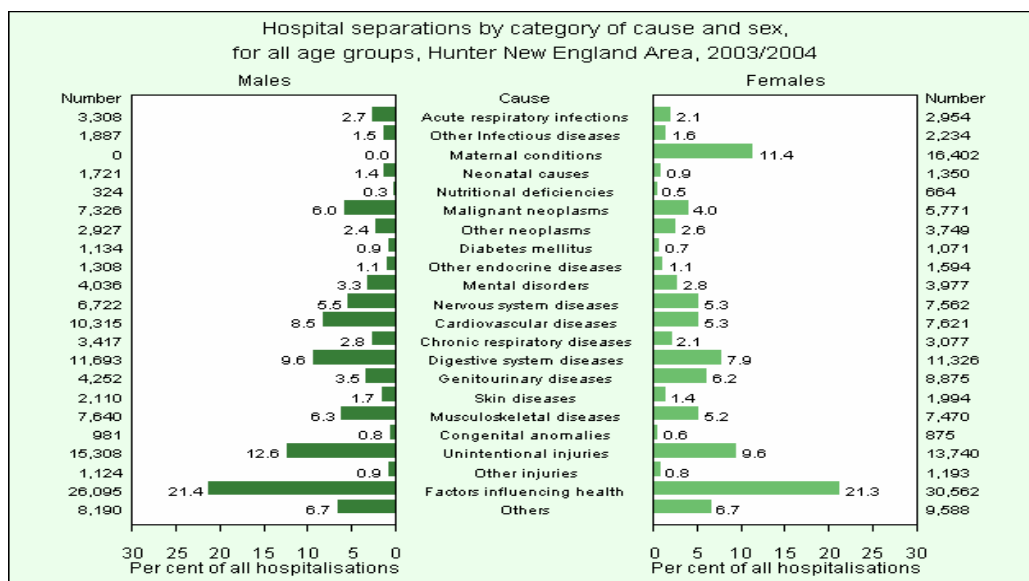
In Hunter New England Health chronic diseases, including diabetes/endocrine, nervous system disorders, cardiovascular disease, chronic respiratory disease and musculoskeletal disorders accounted for 59.2% (female) and 50.2% (male) deaths from 2001 to 2003. (Figure 4³³)

Figure 4: Deaths by category of cause and sex persons of all ages, Hunter New England Area, 2003/2004



For the corresponding time period 24.8% (female) and 20.1% (male) of hospital separations were attributed to the same chronic disease groups in Hunter New England Health (Figure 5³⁴)

Figure 5: Hospital separations by category of cause and sex, for all age groups, Hunter New England Area, 2003/2004



From a demographic perspective, there are a number of issues and challenges that impact on chronic disease and disease management in the Hunter New England area.³⁵:

- 21% of the NSW Indigenous population live in the Hunter New England area
- Hunter New England (14.9%) has a slightly higher proportion of people aged 65 years and over than for the whole of NSW (13.1%)
- SEIFA scores are lower than the mean for NSW as a whole, indicating a more disadvantaged population

There is substantial scope to improve health outcomes for people with coronary heart disease, diabetes, asthma and chronic obstructive pulmonary disease in view of the following trends within the Hunter New England area³⁶:

- The death rate for males from coronary heart disease was the second highest amongst Area Health Services in NSW from 2001 to 2003
- The death rate for coronary heart disease from 1992 – 2003 was higher than Australia as a whole
- Death rates for males with coronary heart disease were highest in Lower Hunter, Mehi and McIntyre Clusters
- People aged 65 years and over accounted for 63% of hospital separations for cardiovascular disease from 1993 to 2004
- The increase in the burden of disability is influenced by the improvement in survival after stroke and the aging population
- Between 1997 and 2003, the death rate for diabetes was higher in Hunter New England than for the rest of NSW
- From 2000 to 2004 the hospitalisation rate for diabetes increased from 123 to 257 per 100,000
- Hospitalisations with diabetes as a co-morbidity increased from 828 to 1384 per 100,000 from 1993 to 2004
- The hospitalisation rates for asthma are significantly higher than the NSW average in the Mehi, McIntyre, Peel and Upper Hunter Clusters
- Chronic Obstructive Pulmonary Disease death rates for males are higher than the NSW average, particularly in Mehi, McIntyre, Tablelands and Upper Hunter Clusters

Chronic disease is associated with high utilisation of community disability and support services³⁷. Lack of appropriate data collection and management systems within the community health setting has limited the ability to determine the effect chronic disease has on community health services. Implementation of the CHIME (Community Health Information Management Enterprise) information system in community health across HNE Health has the potential to enhance availability of data in the future. To meet this need NSW Health Performance Branch has committed funding to further develop CHIME as a primary chronic disease data source from 2006/2007.

It is widely recognised that a significant proportion of work in the community health sector of HNE Health is associated with chronic disease. In 2003 a survey of community health staff in the former Greater Newcastle Sector found:

- 65% of staff estimated they spend greater than 50% of clinical hours caring for people with chronic disease, and
- 35% of staff spend greater than 75% of clinical time with such patients.

The same survey identified diabetes, hypertension, heart disease, chronic pain and musculoskeletal disorders as the five primary chronic conditions for which patients received community health support³⁸.

4. CURRENT SERVICE PROVISION, ISSUES AND NEEDS

Virtually all service units within HNE Health provide health care to people with chronic disease and their carers. These range from specialist services, such as diabetes education and stroke units, to emergency departments, and generalist community and medical services. Measuring the scope and level of current service provision has proved difficult with existing data management systems and the lack of a consistent approach to identify and account for chronic disease work.

To gain a clearer profile of services, a survey was undertaken in 2005/2006 to identify work levels related to chronic disease in both the generalist and specialist services. Fifty-six services completed the survey that showed:

- 57% identified their service as providing a specialised service
- 44% stated their service provided care to people with a range of chronic diseases i.e. specialisation was related to the type of care provided not the patient group or diseases targeted
- The main chronic disease groups seen by the services were heart disease, respiratory disease, diabetes, stroke/neurological conditions, and musculoskeletal and renal disease
- Multiple co-morbidities and ageing were frequently identified as complicating factors in chronic disease management

Further work is required to clearly define the extent of chronic disease service provision in generalist community and hospital services. Establishment of an agreed code set and improved CHIME data relevant to chronic disease are essential step to progress this process.

All HNE Health services provide some elements of chronic disease management, however, few provide the comprehensive suite of chronic disease interventions described in the NSW Health Chronic Disease Framework.

The elements of a comprehensive chronic disease service are:

- Prevention
- Self-management
- Care coordination
- Psychological support
- Ongoing monitoring, and
- Palliative care

The NSW Health Chronic Care Program provides funding specifically targeted to the development of chronic disease services and strategies in HNE Health. The program has been operational since 2001, with funding currently utilised to fully or partially support:

- Cardiac and pulmonary rehabilitation services
- Psycho-oncology services
- Chronic and complex care coordination
- Nurse consultants and coordinators for cardiovascular disease, respiratory disease and diabetes
- Professional development activities, and
- Practice development and redesign projects

Work has been undertaken to establish mechanisms for best practice chronic disease management including participation in the NSW Chronic Disease

Collaborative (2004/05) and clinical redesign. Even so, establishing appropriate models of care for people with chronic disease remains challenging.

Factors contributing to this challenge include:

- Work processes geared to acute and episodic care
- Fragmented systems that limit capacity for chronic disease management across health care settings and across the disease trajectory
- Limited ability to systematically identify and support patients with complex and multiple conditions, or at risk of developing chronic disease
- Workforce preparedness to manage chronic disease
- Limited access to services such as diagnostics and allied health staff
- Fragmentation of funding arrangements between acute, community and primary care services
- Lack of information systems to monitor chronic disease outcomes and support decision-making
- Limited evidence base to identify effective approaches to chronic disease management.

A stakeholder survey, circulated to a broad range of internal staff members, identified the following four priorities for chronic disease service development over the next five years:

1. Smoking Cessation
2. Advance Care Planning
3. Implementation of the National Service Improvement Frameworks for: diabetes, heart, stroke and vascular disease, cancer, arthritis and musculoskeletal disease and asthma^{39,40,41,42,43}
4. Staff training programs for chronic disease management, including self management

4.1 General Practitioners

General practitioners have a central role in the management of chronic disease. In 2004/05, approximately 50% of general practice encounters were for the management of chronic problems. Significant increases in encounters for diabetes, osteoarthritis and lipid disorders have been noted since 1998/99⁴⁴.

Discussion with Divisions of General Practice in the Hunter New England area identified common areas of work in relation to chronic disease. These specifically include diabetes, cardiac disease and Heart Health. Collaborative projects are currently in progress, including:

- *Strengthening Chronic Disease in General Practice* Diabetes Project with New England Division of General Practice, Barwon Division of General Practice, HNE Health and NSW Health
- an Advanced Care Planning project with Hunter Urban Division of General Practice, New England Division of General Practice and HNE Health.

The potential to achieve a more integrated primary, community and acute care approach to chronic disease management is limited by current national and state funding arrangements. The release of the National Chronic Disease Strategy may provide opportunities to strengthen a collaborative approach to chronic disease. In the interim the strategies developed for this plan are designed to support the work of general practitioners and where possible add value to national and state initiatives.

4.2 Consumers

An extensive process of community consultation across the Area, conducted in 2005, identified chronic disease as a priority issue for people in Hunter New England. Recent feedback from members of Community Forums on Health further endorsed the need to develop appropriate services and systems to support people with a range of chronic diseases. The forums also endorsed the strategies included in the Strategic Action Plan, Section C.

The priority areas identified were for improved:

- Disease prevention strategies, and
- Information and support for advance care planning.

4.3 Workforce

Preparedness of the workforce to manage chronic disease is seen as a significant factor in effective chronic disease management.

Around the world, the rapidly shifting balance between acute and chronic health problems is placing new and different demands on the health care workforce. There is general consensus that to provide effective health care for chronic conditions, the skills of health professionals must be expanded to meet these new complexities⁴⁵.

The World Health Organisation has identified five core competencies for caring for people with chronic diseases⁴⁶:

1. Patient-centred care
 - Interviewing and communicating effectively
 - Assisting health related behaviour change
 - Supporting self management
2. Partnering
 - With patients, other providers and communities
3. Quality improvement
 - Measuring service delivery and outcomes
 - Translating evidence to practice
4. Information and communication technology
 - Using patient registries/databases
 - Using technology such as tele-health systems
5. Public health perspective
 - Providing population based care
 - Working across the care continuum

As part of the planning process a workforce survey was circulated to service units across the Area. The following table summarises the key workforce issues and impact on service provision identified by staff:

Table 2: Workforce Issues and Impact Summary

Workforce Issue	Impact on Service Provision
Recruitment and retention	Challenges in recruitment and retention of staff (nursing, allied health and medical), impacts on: <ul style="list-style-type: none"> • Experience and maturity in teams • Coverage during staff leave of absence • Workloads of remaining staff • Patients having to travel to access services • Waiting lists • Outpatient waiting times • Standards of care delivery • Ageing workforce • Patient and staff safety
Training/education	Challenges in providing education to our workforce in relation to chronic disease impacts on: <ul style="list-style-type: none"> • Staff support/mentoring • Skills assessment • Professional development and training
Funding	Resource levels and availability impacts on: <ul style="list-style-type: none"> • Best practice models of care • Range of provided services • Optimal treatment/intervention levels • Health promotion, early intervention and education services
Specialist services	Challenges in accessing specialist services impacts on: <ul style="list-style-type: none"> • Initiating care at the appropriate clinical time • Need for more intensive interventions at a later date • Duration of intervention/episode of care • Quality of care • Patient safety
Workload	Challenges in managing workload impacts on: <ul style="list-style-type: none"> • Prioritisation of acute phase needs and longer term chronic disease management needs • Frequency of treatments and time spent in treatment • Waiting times for patient assessment prior to commencement of rehabilitation programs and other interventions • Prioritisation of health promotion activities • Follow-up and monitoring activities
Geography and Population Distribution	Challenges in providing care across a diverse geographic area and population distribution patterns impacts on: <ul style="list-style-type: none"> • Models for effective service delivery • Models for staff education and training

Further work is required to better determine the scope of practice and impact of chronic disease on the workforce in generalist community and hospital services.

4.4 Child to Adult Service Transition

Some chronic illnesses, such as asthma and Type 1 diabetes, are most often diagnosed in childhood. Due to advances in medical technology and care, many children with a chronic illness or disability are now living longer. This leads to many young people with a chronic childhood condition surviving into adulthood, requiring them to transition from the paediatric health care setting to adult care. With an increasing number of young people who will require adult health care, well-planned transition, occurring over a number of years is an essential component in a young person's management. The transition should be seamless and well coordinated, and will require service integration from both paediatric and adult health care services⁴⁷.

The literature currently states that the majority of young people will face obstacles during transition, often arising from a lack of transition coordination. Without a well-planned coordinated move to adult services young people may stay in the paediatric setting longer than is appropriate or be abruptly transferred to adult services potentially leading to a lack of engagement with the adult service and resulting in the young person opting out of care.

There are unique challenges to providing integrated care for young people during the period of transition in health service provision, including:

- Meeting young people's developmental needs,
- Support for young people to develop their ability to self manage and communicate independently with health care staff.
- The changing role of parents/carers as the young person demonstrates increasingly independent health care behaviour.
- The young person and parent/carer knowledge of the difference in service provision between paediatric and adult health care.
- Establishment of paediatric and adult services' relationships and common transition pathways to support seamless services for young people.
- Education needs of staff in adult services that historically have not had to engage with young people.
- Identification of gaps in the provision of adult health care for young people, i.e. adult services may not exist for some conditions that young people experience.

4.5 Issues for Aboriginal People

Of particular note is the disproportionately high burden of chronic conditions in the Aboriginal community. Diabetes-related death and illness is 10 times more for Aboriginal people than non-Aboriginal people. Aboriginal people die six years before their non-Aboriginal counterparts from cardiovascular disease.

Most of the increased morbidity and premature mortality is due to the increased prevalence of chronic conditions such as cardiovascular disease, diabetes, kidney disease, respiratory disease and cancer. The uneven burden of social, economic and environmental circumstances in which many Aboriginal people live (poverty, poor housing and inadequate food supply) place Aboriginal people at greater risk for chronic conditions. The health disadvantage begins early in the life cycle continuing into childhood and throughout adult life.

Risk factors for chronic conditions such as high blood pressure, smoking, physical inactivity and poor nutrition continue to occur at higher rates in Aboriginal populations. In addition Aboriginal people have had a consistently poor level of access to appropriate health care services.....⁴⁸

Twenty-one percent (21%) of the Aboriginal population of NSW reside in the Hunter New England area. Service profiles identified a significant gap in the availability of culturally appropriate chronic disease interventions. Programs specifically designed for Aboriginal people are predominately provided by the Aboriginal Health Services. Some mainstream services, such as Regional Health Services, have implemented strategies to address the needs of Aboriginal people. However, there is an identified need to build the capacity of all services providing chronic care to improve cultural appropriateness.

In 2005, NSW Health released the NSW Aboriginal Chronic Conditions Area Health Service Standards. These standards provide the platform for development of a health system better designed to meet the needs of Aboriginal people. Working parties have been formed across Hunter New England Health to progress implementation of the standards.

Ensuring improved health outcomes for Aboriginal people particularly in relation to preventing chronic disease and access to services for those with a chronic disease is a significant challenge within HNE Health. In the development of the Chronic Disease Service Plan, the health needs and interests of Aboriginal people have been considered, and where relevant, incorporated and appropriately addressed.

(Aboriginal Impact Statement – included as Appendix 2)

4.6 Issues for People from Cultural and Linguistically Diverse Backgrounds (CALD)

In general, overseas-born residents have better health than Australian-born residents. This reflects the 'healthy migrant effect', whereby people in good health are more likely to meet eligibility criteria, and to be willing and economically able to migrate. However, certain diseases and health risk factors are more prevalent among some country-of-birth groups. This reflects diverse social, economic, environmental, cultural, and genetic influences⁴⁹.

It is important to note there are areas for concern amongst CALD populations in relation to chronic disease. Changes to cultural mores have the potential to impact the health status of many people from cultural and linguistically diverse backgrounds.

Key issues for CALD populations:

- Exposure to chronic disease risk factors such as physical inactivity, malnutrition, tobacco and alcohol use. In the Hunter New England area, the incidence of smoking is higher amongst CALD groups than the general population⁵⁰
- Issues related to aging, including loss of English speaking skills
- Social and economic disadvantage, particularly for refugee groups, and
- Language and cultural barriers to accessing health services in a timely manner and maximising potential for self-management

The challenge for care providers is to ensure people from culturally and linguistically diverse backgrounds receive appropriate information about the risk factors for chronic disease, information about their disease and the skills to manage their disease effectively.

In development of the Chronic Disease Service Plan, the health needs and interests of people from culturally and linguistically diverse groups have been considered. HNE health is committed to delivering services that best meet their needs and there are specific strategies included in the Strategic Action Plan demonstrating that commitment.

4.7 Partnerships

Effective chronic disease management requires an approach that integrates the work of various government and non-government organisations. In addition to the work of general practitioners, external stakeholders to chronic disease management include, but are not limited to:

- Residential aged care sector
- Department of Ageing and Disability
- Home and Community Care providers
- Education and training organisations

Strategies in this plan have been developed to incorporate a multi-sectorial approach aimed at building partnerships to support patients and carers across the care continuum and settings. Of particular note is the need to promote chronic disease research and establish mechanisms to facilitate the translation of research into clinical practice and models of care. There is an identified need for further assessment of current strengths and weaknesses in evidence; workforce needs; infrastructure requirements and opportunities to attract funding in partnership with education organisations.

The following pages present the Chronic Disease Services Strategic Objectives and our Strategic Action Plan. The plan details the strategic initiatives that will be implemented to ensure we achieve our Strategic Objectives.

CHRONIC DISEASE SERVICES STRATEGY OBJECTIVES

Our Vision, Purpose, Key Focus Areas and Strategic Objectives are presented as a one-page summary.

Our Key Focus Areas are those areas that we consider are critical to achieving our Vision. For each Key Focus Area, Strategic Objectives are identified to ensure that Chronic Disease services remain focussed on the most important issues and needs.

CHRONIC DISEASE SERVICES STRATEGIC ACTION PLAN

Our Strategic Action Plan identifies performance measure/s for each of the key objectives and presents the strategic initiatives (the actions, activities or projects) that we will implement over the next five years to improve our performance, reach our targets and achieve our key objectives.

We have also related NSW Health's Strategic Directions and Objectives to each of our Strategic Objectives.

Each Objective is risk-rated using the HNE Health Risk Matrix (see Appendix 3), which is based on the NSW Health Severity Assessment Code (SAC). In rating the strategic objectives the consequences and likelihood of not achieving an objective and the impact on service provision and outcomes for the community were considered. The risk ratings identified for each strategic objective signify the priority placed on achieving each objective and indicate where we want to be as an organisation in relation to the objective in five years time. A current risk rating (based on what we are doing now) and a target risk rating (what the risk will be once we have implemented the strategic initiatives) is assessed for each objective.

4.8 References

- ¹ Australian Government Department of Health and Ageing. 2006. *National Chronic Disease Strategy*. Australian Government DOHA, Canberra.
- ² Australian Institute of Health and Welfare (2002) *Chronic Diseases and Associated Risk Factors in Australia, 2001*. Canberra: AIHW
- ³ Australian Government Department of Health and Ageing. 2006. *National Chronic Disease Strategy*. Australian Government DOHA, Canberra.
NSW Department of Health. 2005. *Draft NSW Chronic Care Program Phase Three: 2006 – 2009. NSW Chronic Disease Strategy*. NSW Department of Health, Sydney.
- ⁴ Australian Government Department of Health and Ageing. 2006. *National Chronic Disease Strategy*. Australian Government DOHA, Canberra.
- ⁵ Population Health Division, *The Health of the people of New South Wales - Report of the Chief Health Officer*. Sydney: NSW Department of Health. Available at: <http://www.health.nsw.gov.au/public-health/chorep/toc/choindex.htm>. Accessed January 2006.
- ⁶ NSW Department of Health. 2005. *Draft NSW Chronic Care Program Phase Three: 2006 – 2009. NSW Chronic Disease Strategy*. NSW Department of Health, Sydney.
- ⁷ NSW Department of Health. 2003. *NSW Clinical Service Framework for Heart Failure: Overview of the framework and its standards – Volumes 1 and 2*. NSW Department of Health, Sydney.
- ⁸ NSW Department of Health. 2003. *A Clinical Service Framework for Optimising Cancer Care in NSW 2003*. NSW Department of Health, Sydney.
- ⁹ NSW Department of Health. 2003. *NSW Clinical Service Framework for Chronic Respiratory Disease – Volumes 1 and 2*. NSW Department of Health, Sydney.
- ¹⁰ NSW Department of Health. 2005. *NSW Aboriginal Chronic Conditions Area Health Service Standards*. NSW Department of Health, Sydney.
- ¹¹ NSW Department of Health. 2003. *NSW Chronic Disease Prevention Strategy 2003-2007*. NSW Department of Health, Sydney.
- ¹² NSW Department of Health. 2004. *Framework for integrated support and management of older people in the NSW health care system 2004-2006*. NSW Department of Health, Sydney.
- ¹³ Centre for Health Equity Training, Research and Evaluation (CHETRE) 2005 *Conceptual Framework for Primary and Community Health (PaCH) Services*. CHETRE University of New South Wales, Sydney, January 2005
- ¹⁴ Centre for Health Equity Training, Research and Evaluation (CHETRE) 2004 *Guidelines: Core functions and services for Primary and Community Health Services in NSW*. CHETRE University of New South Wales, Sydney, December 2004
- ¹⁵ NSW Department of Health. 2005. *Clinical Services Redesign Program – At a glance*. NSW Department of Health, Sydney.
- ¹⁶ NSW Department of Health. 1999. *A Framework for Managing the Quality of Health Services in New South Wales*. NSW Department of Health, Sydney.
- ¹⁷ Australian Government Department of Health and Ageing. 2005. Op Cit.
- ¹⁸ Australian Government Department of Health and Ageing. 2005. *National Service Improvement Framework for Asthma*. DOHA, Canberra.
- ¹⁹ Australian Government Department of Health and Ageing. 2005. *National Service Improvement Framework for Diabetes*. DOHA, Canberra.
- ²⁰ Australian Government Department of Health and Ageing. 2005. *National Service Improvement Framework for heart, stroke, vascular disease*. DOHA, Canberra.
- ²¹ Australian Government Department of Health and Ageing. 2005. *National Service Improvement Framework for cancer*, DOHA, Canberra.
- ²² Australian Government Department of Health and Ageing. 2005. *National Service Improvement Framework for Osteoarthritis, Rheumatoid Arthritis and Osteoporosis*. DOHA, Canberra.
- ²³ National Health Priority Action Council. 2005. *Consultation draft for The National Chronic Disease Strategy*. DOHA, Canberra.
- ²⁴ National Public Health Partnership. 2001 *Preventing chronic disease. Background paper. National Public Health Partnership, Melbourne*.
- ²⁵ Palliative Care Australia. 2005. *The Standards for Palliative Care Provision*. Palliative Care Australia. Canberra
- ²⁶ Australian Government Department of Health and Ageing. 2006. *National Chronic Disease Strategy*. Australian Government DOHA, Canberra.

- ²⁷ NSW Department of Health. 2005. *Draft NSW Chronic Care Program Phase Three: 2006 – 2009. NSW Chronic Disease Strategy*. NSW Department of Health, Sydney.
- ²⁸ Bellew,B, et.al. 2005. Chronic Disease – The Sleeping Giant of Health Expenditure. NSW Health Futures Planning Project. Pg 4. NSW Department of Health. Sydney
- ²⁹ Bellew,B, et.al. 2005. Chronic Disease – The Sleeping Giant of Health Expenditure. NSW Health Futures Planning Project. Pg 4. NSW Department of Health. Sydney
- ³⁰ Bellew,B, et.al. 2005. Chronic Disease – The Sleeping Giant of Health Expenditure. NSW Health Futures Planning Project. Pg 4. NSW Department of Health. Sydney
- ³¹ Garden,F, Moore,H, and Jorm,L. 2005. *The current and future status of the New South Wales population (Summary Report)*. NSW Department of Health. Sydney
- ³² Garden,F, Moore,H, and Jorm,L. 2005. *The current and future status of the New South Wales population (Summary Report)*. NSW Department of Health. Sydney
- ³³ Hunter New England Population Health. 2005.*Health in the Hunter New England*. Hunter New England Area Health Service. Available at:
http://www.hnehealth.nsw.gov.au/HHNE./bod/bod_dthcsa.htm. Accessed 20/2/06
- ³⁴ Hunter New England Population Health. 2005.*Health in the Hunter New England*. Hunter New England Area Health Service. Available at:
http://www.hnehealth.nsw.gov.au/HHNE./bod/bod_sepcause.htm. Accessed 20/2/06
- ³⁵ Hunter New England Population Health. 2005.*Health in the Hunter New England*. Hunter New England Area Health Service. Available at:
http://www.hnehealth.nsw.gov.au/HHNE./bod/bod_sepcause.htm. Accessed 20/2/06
- ³⁶ Hunter New England Population Health. 2005.*Health in the Hunter New England*. Hunter New England Area Health Service. Available at:
http://www.hnehealth.nsw.gov.au/HHNE./bod/bod_sepcause.htm. Accessed 20/2/06
- ³⁷ Australian Government Department of Health and Ageing. 2006. *National Chronic Disease Strategy*. Australian Government DOHA, Canberra.
- ³⁸ Lloyd,D. 2003. *Final Report on Meeting the Education, Training and Professional Development Needs of Community Health Staff for Chronic Disease Management*. Unpublished. Chronic Disease Management Program, Hunter Area Health Service. Newcastle.
- ³⁹ Australian Government Department of Health and Ageing. 2005. *National Service Improvement Framework for Asthma*. DOHA, Canberra.
- ⁴⁰ Australian Government Department of Health and Ageing. 2005. *National Service Improvement Framework for Diabetes*. DOHA, Canberra.
- ⁴¹ Australian Government Department of Health and Ageing. 2005. *National Service Improvement Framework for heart, stroke, vascular disease*. DOHA, Canberra.
- ⁴² Australian Government Department of Health and Ageing. 2005. *National Service Improvement Framework for cancer*, DOHA, Canberra.
- ⁴³ Australian Government Department of Health and Ageing. 2005. *National Service Improvement Framework for Osteoarthritis, Rheumatoid Arthritis and Osteoporosis*. DOHA, Canberra.
- ⁴⁴ Britt H, et al. 2005. General practice activity in Australia 2004 – 05. AIHW Cat. No, GEP 18, Canberra: Australian Institute of Health and Welfare (General Practice Series No. 18).
- ⁴⁵ World Health Organisation. 2005. *Preparing a workforce for the 21st century: the challenge of chronic conditions*. World Health Organisation, Non-communicable Diseases and Mental Health Cluster, Chronic Diseases and Health Promotion Department. Geneva.
- ⁴⁶ World Health Organisation. 2005. *Preparing a workforce for the 21st century: the challenge of chronic conditions*. World Health Organisation, Non-communicable Diseases and Mental Health Cluster, Chronic Diseases and Health Promotion Department. Geneva
- ⁴⁷ Australian Government Department of Health and Ageing. 2006. *National Chronic Disease Strategy*. Australian Government DOHA, Canberra.
- ⁴⁸ NSW Department of Health. 2005. *NSW Aboriginal Chronic Conditions Area Health Service Standards*. NSW Department of Health, Sydney.
- ⁴⁹ Population Health Division. *The health of the people of New South Wales - Report of the Chief Health Officer*. Sydney: NSW Department of Health. Available at:
http://www.health.nsw.gov.au/public-health/chorep/cob/cob_intro.htm. Accessed 2/2/06.
- ⁵⁰ Hunter New England Population Health. 2005
.Health in the Hunter New England. Hunter New England Area Health Service. Available at:
<http://www.hnehealth.nsw.gov.au/HHNE.htm>. Accessed 20/2/06

Chronic Disease Balanced Scorecard

5. STRATEGIC DIRECTIONS

- OUR VALUES**
- TEAMWORK
 - HONESTY
 - RESPECT
 - ETHICS
 - EXCELLENCE
 - CARING
 - COURAGE
 - COMMITMENT

VISION: Healthier communities: Excellence in healthcare
PURPOSE: Working with our communities to deliver quality health services

Focus Area: Patients, Carers and Communities
 To achieve our vision, the key outcomes we must deliver are:

- ❖ Patients, carers and communities are enabled to participate in disease prevention and management
- ❖ Reduced health disadvantage and improved equity of access to services, particularly for Aboriginal People

Focus Area: External Partners
 To deliver the required community outcomes, we need to excel in:

- ❖ Engaging and supporting GPs and other external partners in improving the prevention and management of chronic disease

Focus Area: Internal Networking and Processes
 To deliver the required community outcomes, we need to excel in:

- ❖ Person-centred care and quality health service experience
- ❖ Effective integration across clinical networks
- ❖ Evidence based healthcare safely delivered
- ❖ Disease prevention and health promotion

Focus Area: Resource Accountability
 To deliver the required community outcomes, we need to excel in:

- ❖ Resources and assets are managed effectively to minimise health disadvantage and maximise health benefit

Focus Area: Our People, Culture and Capability
 (Employees and Contracted)
 To achieve the desired community outcomes and sustain our ability to change and improve, we need to excel in:

- ❖ Skilling staff in the prevention and management of chronic disease
- ❖ Effective consultation and communication
- ❖ Demonstrating effective leadership and innovation in chronic disease management
- ❖ Evidence based strategic workforce planning

6. STRATEGIC ACTION PLAN

Chronic Disease Balanced Scorecard

ABBREVIATIONS:

Ab.Hlth	Aboriginal Health
ACDP	Area Chronic Disease Programs
ACP	Advance Care Planning
AET	Area Executive Team
AGMs	Hospital Group General Managers
CD	Chronic Disease
CGMs	Cluster General Managers (Primary and Community Networks)
ClinLds	Clinical Leaders
CNCs	Clinical Nurse Consultants
Comm. Unit	Communications Unit
Comm. Officer	Communication Officer – Chronic Disease Account
Dir Clin Redes	Director Clinical Redesign
Dir Clin Re-Des Unit	Director Clinical Re-design Unit
Dir Pal Care	Director Palliative Care Services
Dir PI Unit	Planning Unit
Dir Workforce Plan/Devmt	Director Workforce Planning and Development
Dir. Int	Director of Integration and Partnerships
DOCFAX	Doctor faxing application
EDRS	Electronic Discharge and Referral System
GMs	Hospital and Cluster General Managers
IT	Information Technology
Man Org Cap and Learn Unit	Manager Organisational Capability and Learning Unit
CN Project Manager	Clinical Network Project Manager
MHLOs	Migrant Health Liaison Officers
Pal Care	Palliative Care Service
Proj Man. Pop Health	Project Manager Population Health
Ser Mans	Service Managers
Tele-Hth Proj Off	Tele-Health Project Officer
Trans Coord	Transitional Coordinator
Wrkfce Unit	Workforce Unit

Responsibility:

It is acknowledged that many strategies listed in this plan require collaboration between service units to achieve successful implementation. The unit/position listed for each strategy is responsible for leading implementation of the strategy and ensuring reporting requirements are met.

Chronic Disease Balanced Scorecard

FOCUS AREA:	Patients, carers and communities						
OBJECTIVE:	To achieve our vision, a key outcome we must deliver is: Patients, carers and communities are enabled to participate in disease prevention and management						Risk Rating Current Target B D
DESTINATION STATEMENT:	<i>Prevalence of preventable chronic disease is reduced and patients are skilled in healthy behaviours</i>						
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H
Percent smoking 16 years and over	Decrease by 10%	Annual	<ul style="list-style-type: none"> Facilitate development and promotion of a network of community based physical activity options for a broad range of groups including adolescents, aged, aboriginal people Introduce “wellness” programs for people identified as having significant chronic disease risk factors (including criteria for referral, management plans, health coaching skills). Build on existing infrastructure where available and appropriate. Stage 1: Scope model of care Stage 2: Pilot /implement model of care 	Proj Man. Pop Health	2007	3	H
Percent alcohol risk 16 years and over	Decrease by 10%	Annual		ACDP CGMs	2007 2008	3 3	H M
Percent overweight or obese 16 years and over	Decrease by 10%	Annual	<ul style="list-style-type: none"> Identify existing self management support options and establish a community based network of self management programs/training Make supportive environments available, including smoke free health service and work with key organisations to establish physical activity infrastructure 	ACDP	2006/ 2008	3	L – M
Percent adequate physical activity 16 years and over	Decrease by 10%	Annual		Proj Man. Pop Health CGMs AGMs	2006/ 2010	2/3	H

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required
 ★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Chronic Disease Balanced Scorecard

FOCUS AREA:	Patients, carers and communities						
OBJECTIVE:	To achieve our vision, a key outcome we must deliver is: Reduced health disadvantage and improved equity of access to services, particularly for Aboriginal People						Risk rating Current Target A D
DESTINATION STATEMENT:	<i>Risk factors for chronic disease are reduced and the well-being of those with chronic disease is improved</i>						
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H
Percent Aboriginal people referred to chronic disease rehabilitation services	Increase by 20%	Annual	<ul style="list-style-type: none"> Develop guidelines/audit tool for maximising cultural appropriateness of existing services, eg: rehabilitation for Aboriginal 	Sector Mgers – Dir Ab.Hlth ACDP	2007	2	
Percent CALD people referred to chronic disease rehabilitation services	Increase by 20%	Annual	<ul style="list-style-type: none"> Develop guidelines/audit tool for maximising cultural appropriateness of existing services, eg: rehabilitation for CALD communities 	MHLOs ACDP	2007	2	
Percent Aboriginal people attending chronic disease rehabilitation services following referral	Increase by 20%	Annual	<ul style="list-style-type: none"> Develop, implement and evaluate 2 (urban and rural) pilot programs for disease prevention and management for Aboriginal communities 	ACDP, Ab. Hlth	2008/ 2010	3	H
Percent CALD people attending chronic disease rehabilitation services following referral	Increase by 20%	Annual	<ul style="list-style-type: none"> Develop disease prevention and management programs for rural communities 	ACDP, Proj Man. Pop Health CGM's	2007/ 2009	3	M
			<ul style="list-style-type: none"> Develop, implement and evaluate 2 (rural and urban) pilot programs for whole of government approach to risk factor and disease management for socio disadvantaged group 	ACDP Dir. Int CGMs	2007/ 2009	3	M
			<ul style="list-style-type: none"> Implement NSW Aboriginal Chronic Conditions Area Health Service Standards 	Dir Ab Hth	2006/ 2008	2-3	
Percent young people successfully transitioned from paediatric to adult services * * State-wide data system currently being developed – reporting of this measure will not occur until system implemented	80%	Annual	<ul style="list-style-type: none"> Implement and evaluate clinical team and individual young people's transition plans for adolescents transitioning to adult services 	Trans Coord	2006/ 2008	2	
			<ul style="list-style-type: none"> Identify an adolescent transition liaison/contact person for relevant adult services eg: respiratory, cardiac, endocrinology 	Trans Coord	2007	2-3	M
			<ul style="list-style-type: none"> Undertake training/education for staff on specific needs of adolescents transitioning to adult service care 	Trans Coord	2006/ 2008	1	
			<ul style="list-style-type: none"> Establish systems for flagging and referral of disengaged high risk adolescents that require reconnection with adult health services 	Trans Coord	2008	2	

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required

★ **Priority Key:** Strategic Initiatives/Actions that require "Enhancement Funding" (3) are to be prioritised as either Low, Medium or High, based on their contribution to achieving the objective

Chronic Disease Balanced Scorecard

FOCUS AREA:	External Partners							
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: Engaging and supporting GPs and other external partners in improving the prevention and management of chronic disease						Risk rating Current Target K N	
DESTINATION STATEMENT:	<i>Our partnerships deliver benefits to Hunter New England people through shared goals, programs and clearly agreed responsibilities</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H	
GP satisfaction score	85%	Annual	<ul style="list-style-type: none"> Advocate for implementation of DOCFAX to northern sector with AGMs and IT Advocate for development of EDRS to comply with chronic disease standards with AGM's and IT 	ACDP	2006/7	1		
Percentage of shared project recommendations implemented	90%	Annual	<ul style="list-style-type: none"> Design, conduct and evaluate integrated service development programs including: <ul style="list-style-type: none"> - Advanced care planning (HUDGP/NEDGP) – in progress - Diabetes (Barwon/NEDGP) – in progress - Muscular skeletal - Neuro degenerative - Adolescent transition Investigate and establish a partnership with NGO/s to deliver community self management training programs eg: Living Well With Chronic Disease (Stanford University), Flinders University Self Management Program Explore opportunities to establish partnerships with other government and non-government organisations, community based services and education/research facilities to improve the management of people with chronic diseases. 	ACDP Dir. Int	2006	3	M M M	
				ACDP Dir. Int	2006 2008 2008 2007			2
				ACDP/ Man Org Cap and Learn Unit	2006/10			1

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required
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Chronic Disease Balanced Scorecard

FOCUS AREA:	Internal Networking and processes	
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: Person-centred care and quality health service experience	Risk rating Current Target J L
DESTINATION STATEMENT:	<i>People who come in contact with us experience consistently safe, effective and appropriate services that are focused on the needs of those who receive our care</i>	

Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H
Overall consumer satisfaction score	70%	Annual	<ul style="list-style-type: none"> All projects and target services eg: rehabilitation, wellness programs, self management programs to have an evaluation framework that measures focus on person/carer 	ACDP	2006/2007	2	
			<ul style="list-style-type: none"> Develop an evaluation framework for care plans that measures (including adolescent transition plans) <ul style="list-style-type: none"> Patient/carer involvement in plan development Achievement of patient/carer identified outcomes/goals 	ACDP Trans Coord	2006/2007	2	
			<ul style="list-style-type: none"> Establish a network of staff across HNE Health qualified to deliver train the trainer programs in Flinders University model of self management 	ACDP	2006/2007	3	H
			<ul style="list-style-type: none"> Undertake 4 patient journey redesign projects, focusing on muscular skeletal, neuro-degenerative, adult multiple co-morbidities and adolescent transition*. To include: <ul style="list-style-type: none"> service standards for discharge planning, follow-up and monitoring of at risk patients, including those with chronic disease risk factors include audit process for compliance with standards <p>* Priority target area to maximise NSW Health funding support until Oct 07</p>	Dir Clin Re-Des Unit ACDP	2007/2010	3	M
			<ul style="list-style-type: none"> Develop, implement and evaluate a care coordination/case management model with a focus on adults with multiple co-morbidities and adolescent transition. <ul style="list-style-type: none"> Stage 1: Scope model of care Stage 2: Pilot/implement model of care 	ACDP Trans Coord	2006/2007 2008/2010	3	M

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required
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Chronic Disease Balanced Scorecard

FOCUS AREA:	Internal networking and processes						
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: Effective integration across clinical networks						Risk rating Current Target D H
DESTINATION STATEMENT:	<i>Clinical and support staff have structures and processes to work together to deliver coordinated, consistent healthcare</i>						
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	Funding 1,2,3	★ Priority L, M, H
Readmissions within 28 days with specific chronic diseases	Decrease by 10%	6 monthly	<ul style="list-style-type: none"> Ensure the principles and elements of effective chronic disease management are incorporated in the service plans and functionality of CNs. Develop “inpatient re-admission risk identification” criteria/tool 	Dir PIUnit/ CN Project Manager/ACDP	2006/08	1	
Potentially avoidable hospital separations (per100, 000) for ambulatory care sensitive conditions	Decrease by 3%	6 monthly		ACDP AGMs	2007	1	
Percent patients with 3 or more unplanned admissions per annum	Decrease by 15%	6 monthly	<ul style="list-style-type: none"> Develop and trial evidence based post discharge support services for select populations, including patients with heart failure and those with multiple co morbidities Identify opportunities to trial and evaluate tele-health monitoring system for at risk patients in a rural and urban setting (physical isolation) Establish and evaluate interdisciplinary team models for high risk patient groups and to support specialist, generalist and primary care staff - incorporating case review, care planning, problem solving and professional development Support trial and evaluation of the Electronic Health Record for people with chronic disease Participate in NSW Health initiatives to improve and integrate IT systems (CHIME, iPIMS), to meet chronic disease needs Establish recall systems for chronic disease focused services, including standards and guidelines for long term follow up Develop a marketing strategy for “My Health Record”, incorporating consumers/carers, general community, internal and external service providers 	ACDP CNC’s	2007/ 2010	3	M
				ACDP TeleHealth Proj Off	2006/ 2007	3	M
				Dir AI Hth ACDP	2007/ 2010	3	L
				ACDP/ Man IT	2006	1	Pilot
				ACDP		1	
				ACDP	2007/ 2009	2 - 3	L
	Comm. Officer ACDP	2006	2				

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Chronic Disease Balanced Scorecard

FOCUS AREA:	Internal networking and processes						
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: Evidence-based healthcare, safely delivered						Risk rating Current Target D L
DESTINATION STATEMENT:	<i>We ensure our care is based on best practice and minimises harm</i>						
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H
Percent patients receiving care in accordance with national and state standards	70%	Annual	<ul style="list-style-type: none"> Undertake a change program (eg: Maggie or collaborative methodology) to implement National Service Improvement Frameworks and NSW Health Clinical Service Frameworks Undertake a change program (eg: Maggie or collaborative methodology) to implement Palliative Care Australian Standards for non-cancer patients Participate in NSW Health initiatives to establish systems for the collection and reporting of data to demonstrate compliance with national and state clinical standards and to provide feedback to HNE service providers on compliance 	Clin Red Unit ACDP Dir Clin Red Unit ACDP Clin Dir Pal Care ACDP	2007/2008 2007/2008 2006/2007	2-3 3 1	 H
Disease specific clinical outcomes • Physical function	*	2009	<ul style="list-style-type: none"> Develop an evidence based demonstration model/pilot for integrated cardiac, respiratory and diabetes rehabilitation in Newcastle, Armidale and Great Lakes 	ACDP Dir Clin Re-Des Unit Clin leaders/ CNC's	2007/2009	3	M
Disease specific clinical outcomes • Quality of life	*	2009					
Percent patients, over 70 years, with a substitute decision maker/enduring guardian identified **	40%	Annual	<ul style="list-style-type: none"> Establish a systematic program for the implementation of advanced care planning principles across HNE 	ACDP, Advanced Care Planning Team	2006/2008	2-3	H

* Outcome in comparison to functional and quality outcomes of specialised rehabilitation programs i.e.: outcomes for generic programs should be = to or > than those of specialist programs.

** Data collection system to be established

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required

★ **Priority Key:** Strategic Initiatives/Actions that require "Enhancement Funding" (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Chronic Disease Balanced Scorecard

FOCUS AREA:	Internal networking and processes						
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: Disease prevention and health promotion across all service areas						Risk Rating Current Target B L
DESTINATION STATEMENT:	<i>We embrace all opportunities to prevent disease and promote healthy lifestyle choices</i>						
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H
Percent patients with at risk behaviour provided with risk reduction	85%	Annual	• Provide staff training program on assessment of smoking and dependence status, smoking cessation support including referral to QUIT, NRT advice	ACDP, CNCs Project Man Pop Hlth	2006/ 2007	3	H
			• Implement risk identification and stratification strategy/tool incorporating health behaviour assessment at key contact points	ACDP, Clinical Leaders/CNCs	2008	2 - 3	M
			• Participate in a clinical redesign project for inclusion of prevention activities in usual care	Projects Manager Pop Hlth ACDP	2007/ 2009	1 - 2	

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required
 ★ **Priority Key:** Strategic Initiatives/Actions that require "Enhancement Funding" (3) are to be prioritised as either Low, Medium or High, based on their contribution to achieving the objective

Chronic Disease Balanced Scorecard

FOCUS AREA:	Resource Accountability						
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: Resources and assets are managed effectively to minimise health disadvantage and maximise health benefit						Risk Rating Current B Target H
DESTINATION STATEMENT:	<i>Resources are allocated to meet identified health needs according to agreed priorities and population needs</i>						
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H
Funding secured for development and evaluation of new models	Increase by 25%	Annual	<ul style="list-style-type: none"> Establish core chronic disease code set for monitoring of utilisation expenditure (scope) Audit resource utilisation (using common data collection/measures), to identify gaps/surpluses across the whole area Include 'unplanned' demand and administration costs in any estimation of resource utilisation Identify ongoing funding/resource opportunities (eg Aboriginal funding, State, National, AHS or NGOs for community activities) Develop a system for establishing and monitoring burden of chronic disease, and opportunities for prevention and appropriate staffing establishment Identify and plan IT software resource requirements for prevention, service delivery, clinical management and data collection, including video and teleconference hardware/ongoing costs, in consultation with Information Technology Service Identify and incorporate IT needs in budget preparation for all new models of care and projects 	ACDP ACDP ACDP ACDP Pop Health ACDP ACDP, Pop Hth Tele-Hth Proj Off ACDP/ Man IT	2006/2010 2006/2010 2006/2010 2006/2010 2006/2010 2007 2007	2 2 1 1 2-3 2 2	

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required
 ★ **Priority Key:** Strategic Initiatives/Actions that require "Enhancement Funding" (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Chronic Disease Balanced Scorecard

FOCUS AREA:	Our people, culture and capability							
OBJECTIVE:	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in: Effective consultation and communication						Risk Rating Current Target D K	
DESTINATION STATEMENT:	<i>We have structures and communication systems that effectively involve staff, patients, carers and communities in decision-making and ensure that knowledge is shared</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	Funding 1,2,3	Priority L, M, H	
Consumer satisfaction: Information provided about prevention/risk factor reduction disease management and service	85%	Annual	• Develop fact sheets, postcards and consumer guides/ checklists in multiple mediums for patients, carers and community members	ACDP Comm. Officer	2006/2008	2		
			• Develop a website to access to information for special needs groups eg: transition to adult services for young people and their families.	Comm. Officer Trans Coord	2006/2008	2		
			• Develop a communication strategy to support focus on chronic disease management	Comm. Officer ACDP	2006/2008	2		
			• Consumer representation/ strategy to be included for all steering committees/project teams	Comm. Officer ACDP	2006/2008	2		
Staff satisfaction: Access to information on clinical issues and service developments	85%	Annual	• Establish a HNE chronic disease clinical alliance (professional group)	ACDP ClinLds CNCs	2006/2010	2		
			• Conduct chronic disease clinical alliance forums	ACDP ClinLds CNCs	2006/2010	3		M
			• Develop and maintain a chronic disease intranet site	ACDP ClinLds CNCs	2006/2010	2		
			• Establish a systematic process for dissemination of AHS, state and national clinical guidelines, plans and reports	ACDP ClinLds CNCs	2006/2010	2		M
			• Establish list serves for special interest groups	ACDP ClinLds CNCs	2006/2010	2		

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required
 ★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Chronic Disease Balanced Scorecard

FOCUS AREA:	Our people, culture and capability
OBJECTIVE:	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in: Demonstrating effective leadership and innovation in chronic disease management
	Risk Rating Current Target N N
DESTINATION STATEMENT:	<i>Managers and clinical leaders recognize and address the changing service needs of people with chronic disease and staff</i>

Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L, M, H
Percent strategic initiatives implemented to timeframe	80%	Annual	<ul style="list-style-type: none"> • Include responsibilities for chronic disease strategies, services, including prevention and care in job descriptions for managers and clinical leaders and service organisational charts • Provide funding for staff to participate in AHS, state and national level chronic disease planning and development groups • Support inclusion of chronic disease management issues in relevant leadership programs • Implement a performance management framework and systems to support staff working with people with chronic disease 	ACDP CGMs/AGMs	2007	2	
Number of chronic disease and workforce initiatives submitted for recognition (awards/publications)	3	Annual		ACDP, CGMs/AGMs	2006/ 2010	2	M
				Man Org Cap and Learn Unit ACDP Dir Workforce Plan and Devmt CGMs/AGMs	2006/ 2010 2007	2 1	

◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required
 ★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

Chronic Disease Balanced Scorecard

FOCUS AREA:	Our people, culture and capability							
OBJECTIVE:	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in: Evidence based strategic workforce planning						Risk Rating Current Target C H	
DESTINATION STATEMENT:	<i>Our workforce is available and equipped to meet the needs of people with chronic disease and their carers</i>							
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding 1,2,3	* Priority L, M, H	
Staff satisfaction (managers) - Assessment of management confidence in undertaking workforce planning	85%	Annual	<ul style="list-style-type: none"> Develop and trial a best practice workforce model that addresses: <ul style="list-style-type: none"> - generalist and specialist staffing establishment needs based on population and disease and risk factor prevalence - new health provider roles/positions eg: health coaches/facilitators, preventative care, case managers and support workers, - integration between specialist streams such as Mental Health and Aged Care 	Dir Workforce Plan/ Devmt ACDP CGMs/ACMs	2007/2010	3	H	
			<ul style="list-style-type: none"> Map workforce profile to clinical service provision in chronic disease 	Dir Workforce Plan/ Devmt ACDP CGMs/ACMs	2007	2		
			<ul style="list-style-type: none"> Develop and provide access to reliable workforce information management systems 	Dir Workforce Plan/ Devmt ACDP CGMs/ACMs	2007/2008	2		
			<ul style="list-style-type: none"> Engage the chronic disease workforce and stakeholders in workforce planning 	Dir Workforce Plan/ Devmt ACDP CGMs/ACMs	2007	1		
			<ul style="list-style-type: none"> Explore the scope of workforce design and redesign within the context of chronic disease management 	Dir Workforce Plan/ Devmt ACDP CGMs/ACMs	2007/2008	2		

7. APPENDICES

Appendix 1 - Stakeholder Consultation List

Core Planning Group:

Scott McLachlan, Director Operations – Primary and Community Networks (Executive Sponsor)

Viki Brummell, Project Manager, Chronic Disease and Aged Care

Carolyn Bailey, Coordinator, Chronic Disease Strategies, Population Health and Planning

Louise Saville, Nursing Coordinator, Taree Community Health

Anne MacKenzie, Planning Officer, Population Health, Planning and Performance

Alison Chisholm (to December 05), Communication Officer, Hunter New England Health

Jennifer Jennings, Balanced Scorecard Project Officer, Hunter New England Health

HNE Chronic Disease Strategy Group (Plan Reference Group):

Derene Anderson, General Manager, Greater Newcastle Cluster

Delys Brady, Director Integration and Partnerships, Population Health Planning and Performance

Kim Browne, Director Population Health, Planning and Performance

Viki Brummell, Project Manager, Chronic Disease and Aged Care

Sue Carter, Director Strategic and Clinical Service Planning

Deborah Church, Project Manager, Hunter Population Health

Tamaryn Curry, Communications Officer, Hunter New England Health

Candice Dahlstrom, Aboriginal Cardiovascular Project Officer, Northern Hunter New England Health

Barbara Durrant, Operations Manager, Newcastle Mater Misericordiae Hospital

Peter Fletcher, Director Division of Cardiology, John Hunter Hospital

Paul Gorrick, General Manager, Peel Cluster

Rebecca Harris, Transition Coordinator for Young People, Greater Newcastle Cluster

Michael Hensley, Director Respiratory and Sleep Medicine, Hunter New England Health

Wendy Hordern, Manager, Upper Hunter Community Health

Grantly Hunt, Manager, Casemix Group, Population Health Planning and Performance

Helen Jackson, Director, Nutrition and Dietary Services

Julia Lowe, Area Director, Hunter Area Diabetes Service

Tony Martin, Area Director, Aboriginal Health

Helen Milne, Director, Innovation of Clinical Service Model Development

David Rhodes, Director, Allied Health

John Ward, Clinical Director, Aged Care Services, Greater Newcastle Cluster

Jennie West, Director, Clinical Services and Nursing

Michael Pollock, Director, Rehabilitation Medicine

Stakeholders Group:

The following groups were consulted during the development of the Plan.

Greater Newcastle Health Forum

Lower Mid North Coast Health Forum

Peel Cluster Health Forum

Hunter Urban Division of General Practice

Hunter Rural Division of General Practice

Barwon Division of General Practice

New England Division of General Practice

North Western Slopes Division of General Practice

Armidale Community Health Service

Belmont Hosp Physiotherapy

Belmont Hosp CARE Cardiopulmonary Rehab

Belmont Hosp - Medical Floor

Bingara Hospital

Cardiopulmonary rehabilitation CARE

Dungog Hospital

Emmaville - Vegetable Creek Health Service

Glen Innes Cardiac Rehabilitation (Hospital and Community Health)

Glen Innes Pulmonary Rehabilitation/Asthma Education Hospital/Community Health

Area Diabetes Service (Hunter)

JHH Cardiac Rehabilitation

Nephrology Community Dialysis CN Practitioner

Community Stroke Team - HRS Building

JHH Ward G2 Neurology

JHH Respiratory Medicine Pulmonary Rehabilitation

JHH Respiratory Medicine Asthma Management

JHH Respiratory Med Adult Cystic Fibrosis Service

Aboriginal Health and Risk Assessment Program

Maitland Dungog Community Health

Moree District Health Service

Narrabri Community Health Service

Quirindi Cardiac Rehabilitation/Diabetes - Upper Hunter Cluster

Rankin Park Centre - JHH Campus

Royal Newcastle Hospital – Rheumatology Department

RNH Youth Health - Chronic illness/Condition

Scott Memorial Hospital, Scone
Tamworth Rural Referral Hospital Area Renal Service
Tamworth Rural Referral Hospital Emergency Dept (ASET)
Tamworth Hospital Cardiac Rehabilitation
Tamworth Hospital - Dietetics Department
Tamworth Hospital Medical Ward
Tamworth Hospital New England Brain Injury Rehabilitation
Nioka Palliative Care
Tamworth Hospital - Physiotherapy Department
Rotary Respite Service Tamworth Hospital
Tamworth Hospital Social Work
Tamworth Hospital Ward 8
Taree Aboriginal Health
Taree Community Health
Upper Hunter Community Health
Warialda Community Hospital
Warialda Community Nursing
Wee Waa Narrabri Health Service
Wee Waa Community Health cardiac rehabilitation/asthma education
Regional Health Service, Upper Hunter Cluster
Cessnock Community Health
Singleton Community Health Diabetes Education
Singleton Community Health Asthma Education
Singleton Hospital
Upper Hunter Rural Rehabilitation
Tamworth Hospital Rehabilitation Unit
Wee Waa Community Health
Tenterfield Community Health
Manning Hospital Pulmonary Rehabilitation
Newcastle Mater Misericordiae Hospital

Appendix 2 - Aboriginal Health Impact Statement and Checklist

Title of Policy, Program or Strategy

Please complete: HNE Chronic Disease Strategic Plan

Have all items of the checklist been reviewed and answered?

Yes

If not, give reasons:

Will this policy, program or strategy significantly affect the health* of Aboriginal people? (the checklist may assist you to answer this question)

Yes

If so, how:

The planning for services is inclusive of Aboriginal Community needs and cultural sensitivity is mentioned throughout the plan

Is this policy, program or strategy likely to lead to a change in the nature or level of resources or health services available for Aboriginal Health?

Yes

If so, specify:

The plan identifies the need to make mainstream Chronic Disease services appropriate for Aboriginal Communities. There is also recognition that if mainstream services are not effective then the option to develop Aboriginal specific services needs to be explored.

Statement

The health needs and interests of Aboriginal people have been considered, and where relevant, incorporated and appropriately addressed in the development of this health policy, program or strategy.

Head of Unit Name:

Scott McLachlan

Unit Name:

Executive Sponsor, Director of Primary and Community Networks, Hunter New England Health.

*For Aboriginal people, health is defined as not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community.

Development of the Policy, Program or Strategy

- 1. Has there been appropriate representation of Aboriginal stakeholders in the development of the policy, program or strategy?**

Yes

- 2. Have Aboriginal stakeholders been involved from the early stages of policy, program or strategy development?**

Yes

Please provide a brief description

Membership on the Chronic Disease Strategies Implementation Group, opportunity to comment via Stakeholder Survey, Service Profile and draft Plan documents

- 3. Have consultation/negotiation processes occurred with Aboriginal stakeholders:**

Yes

- 4. Have these processes been effective?**

Yes

Explain

Good response to Survey, Service Profile and requests for comments on draft documents.

Existing relationships between Aboriginal Health and Chronic Care have supported effective communication.

- 5. Have links been made with relevant existing mainstream and/or Aboriginal-specific policies, programs and/or strategies?**

Yes

Explain

NSW Aboriginal Chronic Conditions Area Health Standards

Vascular Program (Northern) – Risk Assessments and Family Tree Program

- 6. Has the policy, program or strategy been endorsed by the NSW Aboriginal Health Partnership/Local Aboriginal Health Partnership where required?**

N/A

Contents of the Policy, Program or Strategy

- 1. Does the policy, program or strategy clearly identify the effects it will have on Aboriginal health outcomes and health services?**

Yes

Comments

The plan contains measures specifically identifying Aboriginal Health outcomes to reduce health disadvantage. The strategies listed will be beneficial for Aboriginal Communities.

- 2. Have these effects been adequately addressed in the policy, program or strategy?**

Yes

Explain

As above

- 3. Are the identified effects on Aboriginal health outcomes and health services sufficiently different for Aboriginal people (compared to the general population) to warrant the development of a separate policy, program or strategy?**

Yes

Explain

We acknowledge there is a higher burden of Chronic Conditions for the Aboriginal population. The NSW Aboriginal Chronic Conditions Area Health Service Standards are being implemented across the Area and have been included in this plan.

Implementation and Evaluation of the Policy, Program or Strategy

- 4. Will implementation of the policy, program or strategy be supported by an adequate allocation of resources specifically for its Aboriginal health aspects?**

Yes

Describe

Partnership approaches to service delivery are mentioned throughout the plan.

- 5. Will the policy, program or strategy be implemented in partnership with Aboriginal stakeholders?**

Yes

Briefly describe the intended implementation process

Aboriginal Health representation on committees e.g. HNE Chronic Disease Strategies Implementation Group, Expert Working Groups in Northern for Cardiovascular Disease, Respiratory, Diabetes, Palliative Care, and a partnership approach to service delivery with Aboriginal Community Controlled Health Services and internally with Aboriginal Health staff.

Joint education e.g. Cultural Respect, and specific clinical training

6. Does an evaluation plan exist for this policy, program or strategy?

N/A

7. Has it been developed in conjunction with Aboriginal stakeholders?

N/A

Briefly describe Aboriginal stakeholder involvement in the evaluation plan

Regular reporting against the identified measures in the plan is to occur

Appendix 3 - Draft Corporate Risk Matrix Enhanced with Community, Reputation, Partnership, Equipment and Produce Descriptors

CORPORATE CONSEQUENCE

Serious	Major	Moderate	Minor	Minimum
<p>Patients with Death unrelated to the natural course of the illness of the illness and differing from the immediate expected outcome of the patient management or:</p> <p>Suspected suicide Suspected homicide National Sentinel Events -Procedures involving the wrong patient or body part -Suspected suicide in hospital -Retained instruments -Unintended material requiring surgical removal -Medication error involving patient death -Intravascular gas embolism -Haemolytic blood transfusion -Maternal death associated with labour and delivery -Infant discharged to the wrong family</p>	<p>Patients suffering a major permanent loss of function (sensory, motor, physiologic or psychologic) unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following:</p> <ul style="list-style-type: none"> • Suffering significant disfigurement as a result of the incident • Patient at significant risk due to being absent against medical advice • Threatened or actual physical or verbal assault of patient requiring external or police intervention 	<p>Patients with Permanent reduction in bodily functioning (sensory, motor, physiologic, or psychologic) unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following:</p> <ul style="list-style-type: none"> • Increased length of stay as a result of the incident • Surgical intervention required as a result of the incident 	<p>Patients requiring Increased level of care including:</p> <ul style="list-style-type: none"> • Review and evaluation • Additional investigations • Referral to another clinician 	<p>Patients with No injury or increased level of care or length of stay</p>
<p>Community: Childhood vaccination coverage of target groups fall below levels where epidemics can occur. Inadequate planning and preparation for the Avian Influenza Pandemic. Failure to reduce the risk of Chlamydia transmission in the community. Failure to reduce the gap in health and well being between Aboriginal and Non-Aboriginal people.</p>	<p>Community: Failure to reduce childhood obesity rates. Inadequate compliance with Smoke Free Environment Act and Tobacco Regulations in terms of Public Health Act. Failure to use Population Health information in agency decision making . Breakdown in organisational capacity to identify, assess and respond to Aboriginal Health priorities.</p>	<p>Community: Failure to influence main stream managers to take responsibility for integrated service delivery to the Aboriginal Population which results in core business issues not being incorporated into appropriate operational committees and expert working groups.</p>	<p>Community: Heightened Community Concern, Cluster Manager review leading to service improvement.</p>	<p>Community: Community inconvenience not related to safety, quality or clinical outcomes</p>
<p>Reputation and Partnerships: Loss of Reputation or Image. External Investigation or Ministerial Inquiry</p>	<p>Reputation and Partnerships: Public Outrage, Media Outcry. NSW Health Inquiry. Failure to meet health service standards and loss of accreditation.</p>	<p>Reputation and Partnerships: Loss of Consumer Confidence. CE Internal audit or review. Regulatory Breach or High Priority Improvement Notice.</p>	<p>Reputation and Partnerships: Heightened Consumer Concern, Review or assessment that identifies system deficits that need /rectification.</p>	<p>Community and Partnerships: Consumer annoyance or not related to safety, quality or clinical outcomes</p>
<p>Staff: Death of staff member related to work incident, or suicide, or hospitalisation of 3 or more staff</p>	<p>Staff: Permanent injury to staff member, hospitalisation of 2 staff, or lost time or restricted duty or illness for 2 or more staff or pending or actual WorkCover prosecution, or threatened or actual physical or verbal assault of staff requiring external or police intervention</p>	<p>Staff: Medical expenses, lost time or restricted duties or injury / illness for 1 or more staff</p>	<p>Staff: First aid treatment only with no lost time or restricted duties</p>	<p>Staff: No injury or review required</p>
<p>Visitors: Death of visitor or hospitalisation of 3 or more visitors</p>	<p>Visitors: Hospitalisation of up to 2 visitors related to the incident / injury or pending or actual WorkCover prosecution</p>	<p>Visitors: medical expenses incurred or treatment up to 2 visitors not requiring hospitalisation</p>	<p>Visitors: Evaluation and treatment with no expenses</p>	<p>Visitors: No treatment required or refused treatment</p>
<p>Services, Equipment and Products: Complete loss of service or output. Unserviceable equipment or products that could lead to patient death. Loss of essential services.</p>	<p>Services, Equipment and Products: Prolonged reduction in full scope of service provision. Unserviceable or poorly design equipment or products that could lead to patient injury.</p>	<p>Services, Equipment and Products: Interrupted reduction in service provision. Unserviceable equipment or products that could lead to inappropriate therapy, misdiagnosis, surgical intervention or increased length of stay.</p>	<p>Services, Equipment and Products: Minor disruption in service provision. Unserviceable equipment or products that could lead to additional patient investigations, compromised sterility, incomplete or unclear instructions</p>	<p>Services, Equipment and Products: No loss of service. Unserviceable equipment or products that pose no risk to patients, staff, visitors or the health service.</p>
<p>Financial: loss of or damage to assets or investments with replacement value Greater than \$1M</p>	<p>Financial damage to assets or loss of investments with replacement value \$100 – \$1M</p>	<p>Financial: damage to assets or loss of investments with replacement value \$10K – \$100K</p>	<p>Financial damage to assets or loss of investments with replacement value \$5-Less than \$10K</p>	<p>Financial: damage to assets or loss of investments with replacement value No cost.</p>
<p>Environmental and Disaster Management: Toxic release off-site with detrimental effect. Fire requiring evacuation</p>	<p>Environmental and Disaster Management: Off-site release with no detrimental effects or fire that grows larger than an incipient stage</p>	<p>Environmental and Disaster Management: Off-site release contained with outside assistance or fire incipient stage or less</p>	<p>Environmental and Disaster Management: Off-site release contained without outside assistance</p>	<p>Environmental and Disaster Management: Nuisance releases</p>

Probability	Definition
Frequent	Is expected to occur again either immediately or within a short period of time (likely to occur most weeks or months)
Likely	Will probably occur in most circumstances (several times a year)
Possible	Possibly will recur – might occur at some time (may happen every 1 to 2 years)
Unlikely	Possibly will recur – could occur at some time in 2 to 5 years
Rare	Unlikely to recur – may occur only in exceptional circumstances (may happen every 5 to 30 years)

LIKELIHOOD TABLE

RISK ESCALATOR/ACTION REQUIRED	
Extreme Risk	Escalate risk to Chief Executive SAC1 immediate action required – Reportable Incident Brief (RIB) for all SAC 1 incidents must be forwarded to the DoH within 24 hours. A Privileged Root Cause Analysis (RCA) investigation must be undertaken for all Clinical SAC 1 incidents with a report being submitted to the DoH.
High Risk	Escalate risk to Director SAC2 need to notify senior management. Detailed investigation required. Ongoing monitoring of trended aggregated incident data may also identify and prioritise issues requiring a practice improvement project.
Medium Risk	Escalate risk to Service or Hospital Manager SAC3 management responsibility must be specified – Aggregate data then undertake a practice improvement project. Exception – all financial losses must be reported to senior management
Low Risk	Escalate risk to immediate supervisor SAC4 manage by routine procedures – Aggregate data then undertake a practice improvement project
NB: RIB reports are completed for SAC 2, 3 or 4 incidents if there is the potential for media interest or they require direct notification under legislative reporting or policy directives.	

ACTION REQUIRED TABLE

CORPORATE RISK MATRIX					
<i>Determine the consequences before the likelihood of an event occurring</i>					
CONSEQUENCE \ LIKELIHOOD	Serious	Major	Moderate	Minor	Minimum
Frequent	A	B	J	P	S
Likely	C	D	K	Q	T
Possible	E	H	L	R	U
Unlikely	F	I	N	V	X
Rare	G	M	O	W	Y