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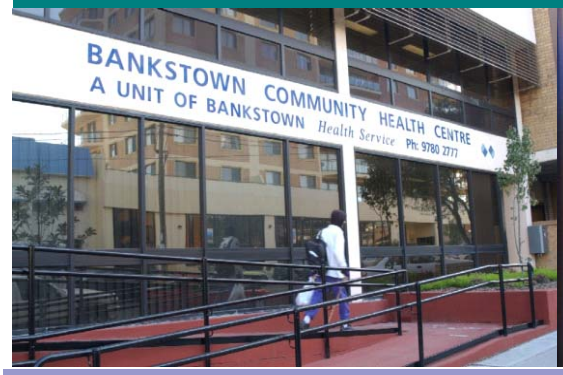
Sydney South West Area Health Service

Community Health Strategic Plan 2007—2012




SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

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Chief Executive's Message

Since its inception in January 2005 Sydney South West Area Health Service (SSWAHS) has faced the challenges of providing services equitably to a community characterised by geographic diversity in culture, language, population density, socioeconomic status, educational attainment, transport infrastructure and local health needs.

In addressing these challenges Community Health has integrated into an Area wide management structure and developed an Area wide strategic plan to provide "an integrated and coordinated primary and community health care system working in partnerships to promote health and well being of our community".

SSWAHS has an ongoing responsibility to provide modern accessible facilities from which community health is provided and is delivering on this through facility upgrades at Marrickville, Croydon and Canterbury and planning work for new facilities at Liverpool and Redfern.

In developing this Plan, Community Health has faced the difficult task of prioritising what can be provided. A Clinical Core Business Framework has been developed. This focuses on services the evidence tells us have the greatest potential impact on health outcomes. The Framework will need to vary over time as evidence changes and new models of care emerge, however, its very existence gives confidence that community health can move flexibly to meet emerging needs.

During its five-year timeframe, the strategic vision and operating statements guiding the Plan will shape services to best meet the significantly expanding population due to growth in the South West and urban consolidation in the Inner West. There is also the general trend of an ageing population, and all these needs will only accelerate over the longer horizon of coming decades.

Maintaining strong communities requires enduring partnerships between service providers and the community. This Plan provides the framework for further enhancing Community Health partnership arrangements with other SSWAHS clinical streams, Government agencies and primary care providers including general practice. Maintaining our strong relationship with Aboriginal Community Controlled Health Services is essential.

A widespread consultation process was undertaken with our communities in developing the Plan including input from Local Councils. The strategic directions identified are wholly consistent with the future directions for Health in NSW that were developed following extensive Statewide consultation. Indeed in focussing on early intervention, reducing health disadvantage, flexibility, strengthening partnerships, evidence based services and community participation, this Plan will take a leading role in shaping service development.

I would like to thank the Community Health staff, our internal and external partners in service provision, the general community and others who contributed to development of the SSWAHS Community Health Strategic Plan 2007-2012. It provides an excellent framework for the developments that will be necessary to meet the community health needs of a growing and ageing population in the South West of Sydney.

Mike Wallace
Chief Executive
Sydney South West Area Health Service

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EXECUTIVE SUMMARY

The first Community Health Strategic Plan for Sydney South West Area Health Service lays a clear foundation for the future development of Community Health in the Area. It has been developed as a result of a number of factors including the need to find new ways to respond to increasing community needs, the recently released strategic directions of NSW Health which prioritise community services and the recent Area Health Service amalgamations. The initiatives contained within will be a major contributor to achieving the vision of "Healthy People – Now and in the Future".

Community Health is integral in the provision of the comprehensive and responsive health care service provided by Sydney South West Area Health Service (SSWAHS).
Operationally managed as a facility, Community Health comprises many different services. These include a range of prevention, early intervention, assessment, treatment, health maintenance and continuing care services designed to improve or maintain the health and wellbeing of individuals and communities.

In SSWAHS, Community Health delivers services from 138 facilities, including Community Health Centres, community clinics, schools and outreach facilities. In 2005/06, Community Health staff provided approximately 685,000 non-admitted patient occasions of service (NAPOOS) to the local community, through the delivery of a range of education, assessment, diagnostic and treatment services. In addition to these individual services, staff conducted over 12,000 group programs with approximately 157,000 group participants and provided support to hospital inpatients, particularly in Ambulatory Care and Palliative Care. These services were provided by approximately 1,000 staff, across medical, nursing, allied health and administrative disciplines. By 2016, it is anticipated that Community Health may need to be providing over 1 million NAPOOS to the local community.

The delivery of community based health services is becoming a major focus for NSW, as these services have the capacity to facilitate early intervention and provide alternatives to hospital treatment. The development and expansion of such services is supported by the *NSW State Plan: A New Direction for NSW*, the *NSW State Health Plan Towards 2010: A New Direction for NSW* and the SSWAHS *Health Service Strategic Plan Towards 2010: A New Direction for Sydney South West*. Consistent with these directions, Community Health have identified a vision of being "an integrated and coordinated primary and community health care system working in partnerships to promote the health and wellbeing of our community".

Community Health has actively engaged a wide variety of stakeholders in the development of the Community Health Strategic Plan, including service consumers, the wider community, hospital and community health staff, local government, other government departments, non-government organisations and general practitioners. The issues raised by these stakeholders, along with extensive service and policy analysis, have informed the setting of objectives and the overall direction of the Plan.

Growth in demand for all Community Health services is anticipated across SSWAHS over the next five years and beyond. As a result, Community Health capacity will need to increase in a timely manner in order to be responsive to the increased need in the community. Much of the anticipated demand is directly related to population growth, although other significant factors include population ageing, increasing rates of chronic disease, a high rate of obesity, low breastfeeding and immunisation rates and changes to hospital models of care and technology which enable more people to be treated in the community setting.

To assist in ensuring that all Community Health services are effective in meeting population need and are evidence based, a Community Health Clinical Core Business Framework has been developed which briefly outlines priority clinical activities for each service type. The full

version of this Framework is provided as Appendix F. Development of the Clinical Core Business Framework has been a significant achievement for Community Health in defining across the whole Area, the most essential service elements. It is proposed that this framework will be reviewed annually in order to be responsive to changing circumstances.

Community Health envisages that significant service improvements can be made through systemic improvements such as improved use of technology, development and implementation of standardised policies and practices and other service development initiatives. These improvements can and will be made within existing resources. However, new resources will be required to expand the capacity of Community Health to provide additional services in response to increasing demand.

The following service types are essential to the delivery of a comprehensive and responsive community based service system to 2012 and beyond:

- Early Childhood Health Services
- Child Protection Services
- Community Development
- Multicultural Health
- Sexual Health
- Women's Health
- Sexual Assault
- HIV/AIDS Community Services
- Child, Adolescent and Family Health Services
- Community Counselling
- Community Nutrition Services
- Youth Health
- Community Health Nursing
- Palliative Care Nursing

The clinical services described above are supported by a Corporate Integration and Support Services structure, involving service integration, information management, information technology, service development, quality and clinical risk management, occupational health and safety and facilities and resources management. These support services have been identified as fundamental to the successful amalgamation of services into Area-wide structures, with consistent policies, programs and data collection methods.

The SSWAHS Community Health Strategic Plan has been developed to be consistent with key state and Area policy. Input from stakeholder groups has been essential to the development of the plan, with the issues raised by stakeholders forming the basis of both the Plans objectives and actions.

Implementation of the Plan involves some changes to models of care and to service delivery priorities within clinical services, along with improvements to the associated coordination and support services. Clinical governance and corporate governance are noted as being essential to the successful implementation of both the Plan and the Clinical Core Business Framework.

New resources will be required over time to expand the capacity of Community Health, both in terms of infrastructure and service capacity. Community Health is an active participant in Area wide service and asset planning, highlighting the need for ongoing provision of community based services to our existing and emerging communities. Consistent with this is also the need to constantly review the outcomes of our services to ensure the provision of high quality, effective services and best value for money. To this end, consideration will be given to disinvestment in particular services over time, if the evidence does not support their ongoing operation.

1. INTRODUCTION

Community Health refers to a range of community based prevention, early intervention, assessment, acute/post-acute treatment, health maintenance and continuing care services designed to improve or maintain the health and wellbeing of individuals and communities. These services are a significant and increasingly important aspect of the provision of a holistic population based health service.

Community Health services in Sydney South West Area Health Service (SSWAHS) form an integral part of the continuum of health treatment and care offered to the local community. The importance SSWAHS places on delivering community based health services is evidenced by the recent opening of the Marrickville and Croydon Community Health Centres and the planning work undertaken to develop new community health facilities in Redfern, Liverpool and Campbelltown.

The Community Health Strategic Plan provides:

- A vision for the development of Community Health in SSWAHS to 2012 and beyond;
- A description of the operating context for Community Health within SSWAHS, NSW Health and NSW;
- Objectives for the delivery of Community Health services in SSWAHS to 2012 and with a broader outlook to 2016;
- A Clinical Core Business Framework, outlining the key priorities for each Community Health service and plans for how these will be delivered;
- An action plan outlining how these objectives will be achieved.

Community Health in SSWAHS will offer a range of services within the newly created Directorates, as outlined below:

Child and Family Clinical Services	Diverse Clinical Services	Community Acute /Post Acute & Chronic Clinical Services	Corporate, Integration and Support Services	Finance & Operations Directorate
Section 6	**Section 7**	**Section 8**	**Section 9**	**Section 9**
Early Childhood Health Services Child Protection Child, Adolescent and Family Health Services	Community Development – The Hub Multicultural Health Sexual Health Women's Health Sexual Assault HIV/AIDS Community Services Community Counselling Community Nutrition Youth Health	Community Health Nursing Palliative Care Nursing	Service Integration Information Management Information Technology Service Development Quality and Clinical Risk Management Occupational Health and Safety Facilities and Resources Management Marketing of Community Health Workforce	

These, and other community based health services are provided across the whole of SSWAHS from 138 facilities, including Community Health Centres (CHCs), community clinics, schools and outreach facilities.

Community Health employs approximately 1,000 staff, across medical, nursing, allied health and administrative disciplines. In 2005/06, these staff provided approximately 685,000 non-admitted patient occasions of service (NAPOOS) to the local community, through the delivery of a range of education, assessment, diagnostic and treatment services. In addition to these individual services, staff ran over 12,000 group programs with approximately 157,000 group participants. Community Health staff also provide a small number of services to inpatients, particularly in relation to ambulatory and palliative care, in addition to the occasions of service reported above.

The vision, values and strategic directions of the health system, including Community Health, along with operating statements and objectives, are outlined in the following pages.

SEVEN STRATEGIC DIRECTIONS

1. Make Prevention Everybody's Business
2. Create Better Experiences for people using health services
3. Strengthen primary health and continuing care in the community
4. Build regional & other partnerships for health
5. Make smart choices about the costs & benefits of health services
6. Build a sustainable health workforce
7. Be ready for new risks & opportunities

NSW HEALTH VISION

Healthy People—Now and in the Future

SSWAHS VISION

For our communities:
Vibrant Communities who enjoy and value good health
and who work with us to improve health for everyone

For our staff:
An energetic & progressive team delivering innovative healthcare &
inspiring pride & confidence through a determined pursuit of excellence

SSWAHS VALUES

Justice, Integrity, Respect, Flexibility, Reflectiveness, Conviction

COMMUNITY HEALTH VISION

An integrated and coordinated
primary and community health care system
working in partnerships
to promote the health and wellbeing of our community

OPERATING STATEMENTS

- Prevention activities will address issues of inequity and disadvantage wherever possible
- Individuals and communities will be treated with respect
- Accessible, effective and coordinated services will be provided to meet each individual's needs
- There will be a stronger integrated network of primary and community based health services to support people's well being and quality of life in the community
- There will be partnerships with a range of other agencies and groups to ensure services meet the specific needs of local people and communities
- Interventions will be based on the best available evidence
- Services will be delivered by a skilled and committed workforce
- Services will be flexible and able to respond to a changing environment

1.1 Community Health Objectives 2007 - 2012

The objectives for Community Health over the five year period 2007 – 2012 have been developed consistent with the abovementioned vision, values and operating statements. They are presented according to the Seven Strategic Directions of the NSW Health System.

Strategic Direction 1
Make Prevention Everybody's Business

1.1 Reorient existing services to have an increasing focus on prevention, health promotion and education

1.2 Expand the range of preventative programs in line with emerging health and community needs

1.3 Work with a range of partners to reduce health disadvantage

Strategic Direction 2
Create Better Experiences for People Using Health Services

2.1 Develop and implement systems to monitor and manage demand in all services

2.2 Deliver services that are flexible and responsive to identified needs

2.3 Utilise collaborative processes involving consumer feedback and information from health care reporting systems to continuously improve the quality and safety of services

2.4 Enhance service integration across the continuum of care

2.5 Provide Community Health services in a range of safe, healthy and well maintained environments

Strategic Direction 3
Strengthen Primary Health and Continuing Care in the Community

3.1 Investigate opportunities to expand Community Health services across the Area

3.2 Strengthen the focus of Community Health services to provide early intervention

3.3 Deliver services consistent with the Community Health Clinical Core Business Framework

3.4 Enhance the profile of Community Health within Sydney South West and expand awareness of Community Health services

Strategic Direction 4
Build Regional and Other Partnerships for Health

4.1 Deliver services in collaboration with a range of partners

4.2 Develop systems to formalise and enhance relationships with partner organisations

4.3 Engage and involve stakeholders in the development of Community Health policies, plans and initiatives

Strategic Direction 5
Make Smart Choices about the Costs and Benefits of Health Services

5.1 Develop and implement integrated consistent data and information management systems and reporting processes

5.2 Provide evidence based services through the integration of best research evidence with clinical expertise and client values

5.3 Demonstrate that clients are better off as a result of the service delivered

5.4 Review and further develop sound financial management systems and procedures

Strategic Direction 6
Build a Sustainable Health Workforce

6.1 Support training and education opportunities to enable staff development and to ensure high quality care to clients

6.2 Create a positive work environment that values its workforce and treats staff fairly and with respect

6.3 Undertake workforce planning to match skills and resources to community needs

6.4 Apply the principles of risk management and Occupational Health and Safety to all structures, processes and procedures

Strategic Direction 7
Be Ready for New Risks and Opportunities

7.1 Implement the corporate planning framework through the integration of Community Health strategic and business/operating plans

7.2 Investigate opportunities to expand the research capacity of Community Health

2. BACKGROUND

2.1 Organisational Context and Governance

SSWAHS Community Health was established as a facility of SSWAHS in March 2006 and formally launched in August 2006. In the context of SSWAHS, Community Health is a grouping of community based services and/or facilities managed by the General Manager Community Health (GMCH). The GMCH reports to the SSWAHS Director of Clinical Operations (DCO). See copy of the SSWAHS organisational chart in Appendix A.

The Community Health structure is based around five Directorates, three of which are clinical (Child and Family Clinical Services, Diverse Clinical Services and Community Acute/Post Acute and Chronic Clinical Services). The Corporate Integration and Support Services Directorate and the Finance and Operations Directorate support each of the Clinical Directorates and ensure services are well integrated at a local level, in order to meet the needs of individuals and communities. A copy of the organisational chart for Community Health is also provided in Appendix A.

Community Health facilities is a term used to describe non-hospital facilities operated by the Area Health Service. The majority of these facilities in SSWAHS are used to house Community Health teams and deliver community based health services. They include Community Health Centres, Early Childhood Clinics and outreach vans. A description of these facilities is provided in Appendix B.

Whilst this plan focuses on those services that are managed by the General Manager Community Health, it should be noted that there are a range of other services provided in the community setting, or in Community Health facilities managed by other SSWAHS providers. These services include those provided by Aboriginal Health, Oral Health, Mental Health, Drug Health and Aged Care and Rehabilitation in particular. In terms of planning for future service infrastructure these and other community based services need to be considered.

2.2 Why do we need a Community Health Strategic Plan?

The population of SSWAHS is growing rapidly, and this growth is projected to continue as a result of the directions proposed in the NSW Government's Metropolitan Strategy. The Metropolitan Strategy plans for a significant proportion of Sydney's population growth to be based in the South West Growth Centre (centred mainly on the local government areas of Liverpool, Campbelltown and Camden). This growth is expected to occur over the next 10 to 20 years.

SSWAHS needs a Community Health Strategic Plan to guide the development and delivery of Community Health services over the next five years (2007 – 2012) and also to inform the development of new community based services to meet population demand over the next twenty plus years, particularly for new communities within the South West Growth Centre.

The impetus for developing the Plan comes from:

- the need to find new ways of delivering effective services to respond to the changing needs of the population, particularly in respect to population growth and ageing;
- the strategic direction of NSW Health, including a focus on prevention and strengthening primary health care in the community;
- the need to develop new community health services, particularly in the South West Growth Centre;
- the recent amalgamation of the former Central Sydney Area Health Service (CSAHS) and South Western Sydney Area Health Service (SWSAHS) to form SSWAHS, and the subsequent creation of a single Community Health Service structure across SSWAHS; and

- the near completion of the Central Sydney Resource Transition Program – a ten+ year program of capital redevelopment and a preliminary audit of Community Health assets undertaken in 2006

2.3 Scope of the Community Health Strategic Plan

The main focus of the Community Health Strategic Plan is on improving the way in which Community Health services are delivered to meet the changing needs and expectations of the community. Consideration is given to how Community Health services should develop in the longer term (to 2025), particularly in respect to meeting the need for community based services to cater for population growth across the Area, notably the South West Growth Centre.

The scope of the Community Health plan does not extend to:

- Undertaking a comprehensive review of each service;
- Developing of a comprehensive set of performance indicators for each Service;
- Resolving of all issues raised in the planning process;
- Undertaking detailed research to develop an evidence base;
- Addressing operational issues

With respect to the abovementioned issues, the Community Health Strategic Plan identifies specific needs and priorities to enable this work to occur in the future, and has established a framework for their development.

Various constraints have influenced the development of this first Community Health Strategic Plan for SSWAHS. They include:

- The absence of a recent Community Health Strategic Plan from either the former CSAHS or SWSAHS from which to build;
- Uncertainty regarding the management structure and personnel at the commencement of the planning process;
- Different team structures across the Area;
- Different Community Health responsibilities across the Area eg. in some localities aged day care is run by Community Health and in other areas is run by Aged Care;
- Not all services are provided consistently across the Area, some services have been developed in response to local community needs, external funding opportunities or the expertise of local staff;
- Data collection and reporting systems are not consistent or comparable across the Area;
- There are limited human and financial resources available to expand community health services

Significant effort has been made to minimise the impact of these constraints on the planning process. However, it should be recognised that this Plan will seek to address these constraints, thus enabling a more structured approach to be undertaken in future Community Health planning exercises.

2.4 The Planning Process

In mid-2006, a Community Health Strategic Planning Steering Committee (CHSPSC) was established to develop the SSWAHS Community Health Strategic Plan 2007 – 2012. A list of Steering Committee members is provided as Appendix C. To support the CHSPSC and to progress the planning process, a smaller Community Health Strategic Planning Management Team (CHSPMT) was also established. Members of the CHSPMT are shown in italics in Appendix C.

At the first meeting of the CHSPSC, a draft Communication and Consultation Plan was tabled and endorsed, subject to minor amendments. The Communication and Consultation plan outlined how key stakeholder groups were to be consulted. This is summarised as follows:

Community, Consumers, Non Government Organisations and other government departments – Community representatives (through the Consumer/Community Council and Consumer Networks), along with consumers of community based services were invited to participate in the Community Health planning forum held at Bankstown Sports Club on 19th September 2006. The forum provided an opportunity for stakeholders to raise issues with respect to the delivery of Community Health services and pose solutions to those issues.

Local Government – Each council regularly produces a Social Plan. The 15 Councils in SSWAHS completed their last Social Plans in approximately 2004, as a result of extensive community and stakeholder consultation. Each of these plans was reviewed and a short questionnaire was sent to local councils in mid 2006 to seek their views on a range of community health issues. Local government representatives also participated in the Community Health planning forum.

General Practitioners (GPs) – GPs are an essential partner in the delivery of primary and community care services across SSWAHS. As such, the CHSPSC included two GP representatives. To facilitate broader GP involvement, a short survey was sent to members of the Canterbury and Central Sydney Divisions of General Practice to ascertain their views on community health issues. For members of the remaining Divisions of General Practice, reference has been made to existing consultation and planning documents developed between the Divisions and the former SWSAHS. Divisions of General Practice were also invited to participate in the Community Health planning forum.

Facility General Managers – General Managers (GMs) of SSWAHS hospitals and other facilities were asked to complete a short survey during August 2006 to ascertain their views on community health.

Community Health Staff – Community Health staff were provided with various alternatives to provide formal and informal feedback into the development of the Plan. Team based questionnaires were distributed to all Community Health team leaders in August 2006 to facilitate formal team-based input. Subsequently, staff were also asked to provide feedback through informal groups of 4-5 staff if they felt they could make a unique contribution on a particular issue. Invitations to participate in the Community Health planning forum were sent to targeted staff, to ensure maintenance of service levels and even representation of service types.

Directors of Clinical Streams – Services provided by SSWAHS are generally categorised under clinical streams, for example Cancer, Oral Health and Mental Health. Staff from clinical streams refer clients to Community Health services and some community based services are also run directly by clinical streams, for example dental clinics, community aged care assessment and mental health outreach. To ascertain information about the way in which Community Health and other SSWAHS services work together, a short questionnaire was also distributed to Clinical Directors. Clinical Directors and/or their nominees were invited to participate in the Community Health planning forum.

The results of this extensive consultation process were analysed against criteria relating to relevance, strategic (as opposed to operational) nature and opportunity to address during the time period of the plan.

This information was then analysed, along with available demographic and epidemiological data, service activity data and available information on evidence based practice.

Version 1 of the draft Community Health Strategic Plan was distributed for comment to the Community Health Executive and the CHSPSC in early 2007, with comments incorporated into Version 2.

Version 2 of the Plan has been summarised and the summary document circulated directly to all participants in the planning process. The full copy of Version 2 has been made available to download from the SSWAHS website. Stakeholder comment on Version 2 is welcomed.

A listing of all the stakeholders involved in the development of the Community Health Strategic Plan is provided as Appendix D.

3. THE POLICY ENVIRONMENT

There are a range of policies and plans with which Community Health services must comply. The key state and SSWAHS (including former SWSAHS and CSAHS) policies and plans are described below. Given the breadth of services provided by Community Health it has not been possible to include detail on all the associated state policies which influence Community Health service delivery.

3.1 State Policy

A range of policies and plans at a State level inform the direction and delivery of Community Health and community based services in NSW. The key policy and planning documents are described below.

3.1.1 NSW State Plan

The NSW State Plan was launched in November 2006 (NSW Premiers Department, 2006). The Plan is focussed on outlining a clear direction for NSW and NSW Government services across five key areas of activity:

- Rights, respect and responsibility
- Delivering better services
- Fairness and opportunity
- Growing prosperity across NSW
- Environment for living

Within each of these areas, a range of goals are identified.

In relation to Health, the Plan focuses on improving prevention, early intervention and community based care, linked with avoiding hospital admissions. Specific priorities are also included focusing on Aboriginal health, mental health and child abuse/neglect.

3.1.2 A New Direction for NSW: State Health Plan Towards 2010

The NSW State Health Plan (NSW Department of Health, 2007) has been developed to be consistent with the NSW State Plan, described in Section 3.1.1 above and to meet the needs identified through the 2006 futures planning exercise conducted by NSW Health.

The NSW State Health Plan identifies the vision for NSW Health as being "Healthy People – Now and in the Future". Four key goals underpin the achievement of this vision, being:

- To keep people healthy;
- To provide the health care that people need;
- To deliver high quality services;
- To manage health services well

Seven strategic directions have been identified, as the basis for planning and service delivery across the NSW Health system. They are:

1. Make prevention everybody's business
2. Create better experiences for people using health services
3. Strengthen primary health and continuing care in the community
4. Build regional and other partnerships for health
5. Make smart choices about the costs and benefits of the health services
6. Build a sustainable health workforce
7. Be ready for new risks and opportunities

3.1.3 Two Ways Together: the NSW Aboriginal Affairs Plan 2003 -2012

Two Ways Together (NSW Premier's Department 2005) aims to "positively improve the lives of Aboriginal people in 7 priority areas". The first of these is health, along with education,

economic development, justice, families and young people, culture and heritage and housing and infrastructure. The philosophy of the plan is based on the interrelationships between these priority areas and the flow on effects of positive outcomes. Specific health issues being addressed through *Two Ways Together* include the health and wellbeing of Aboriginal mothers and children, otitis media and conductive hearing loss, injury, ill health and disease from substance misuse and physical health (for example cardiovascular disease and diabetes). Environmental health is also considered as it relates to the quality of living conditions.

3.1.4 Healthy People NSW

Healthy People NSW (NSW Department of Health 2007a) provides a vision for public health in NSW of "good health and wellbeing for all people in NSW" (NSW Department of Health 2007 a:9). The priorities for action to enable this vision to be achieved are: protect from threats to health; promote health and prevent disease, disability and injury and asses the health of populations.

Achieving the vision will require NSW to deliver sustained, effective and comprehensive programs to promote health and prevent infectious and chronic disease and injury; provide greater emphasis on creating environments that promote health and being able to respond and control threats to health.

3.1.5 NSW Health and Equity Statement: In All Fairness

The NSW Health and Equity Statement has been developed in recognition of the fact that not everyone shares the same level of health or resources to improve their health and that in working towards more equitable health it is important to respond to people with differing needs in different ways (NSW Department of Health, 2004).

The key priorities for action include strong beginnings (or investing in the early years of life); increased participation, a stronger primary health care system; regional planning and inter-sectoral action; organisational development and resources (NSW Department of Health 2004).

3.1.6 Integrated Primary and Community Health Policy 2007 - 2012

The Integrated Primary and Community Health (IPaCH) policy was released in late 2006. The policy has been developed with extensive input from GPs, the Community Health sector and non-government organisations (NGOs). The policy identifies that IPaCH provides an opportunity to reorient the health system in NSW to be more responsive to consumer needs. Priorities for action are grouped into six areas: integrated service planning, integrated service delivery, improved models of care, stronger partnerships, improved workforce capability and enhanced information management and research.

3.1.7 Families NSW

Families NSW, formerly Families First, is a NSW Government initiative with five government agencies responsible for implementation – NSW Health, Department of Community Services (DoCS), Department of Ageing, Disability and Home Care (DADHC), Department of Education (DET) and the Department of Housing. Families NSW operates throughout Sydney South West and includes partnerships with non government and community agencies. Families NSW is a prevention and early intervention strategy for children antenatally through to eight years of age and focuses on the promotion of health. Research shows that supporting families during this time will have a lasting influence on children in later life. Families NSW works on a strong evidence base, utilising service models that research indicates provide good outcomes for children.

3.1.8 Better Futures

"The Better Futures Strategy is designed to increase the effectiveness of services for vulnerable young people aged 9-18 years across NSW. The Strategy enables the NSW

Government to build on our increasing understanding of risks and protective factors for young people, complement existing services and programs, and encourage innovation and advancements in practice at the local level" (www.familiesfirst.nsw.gov.au). At this stage the Better Futures strategy is being redeveloped by the Communities Division of DoCS and has not been developed in SSW.

3.1.9 Aboriginal Child, Youth and Family Strategy

"The Aboriginal Child, Youth and Family Strategy (ACYFS) forms part of the Government's efforts to improve outcomes for Aboriginal children, young people and their families and communities. ACFYS focuses on better coordination and targeting of existing government and non-government resources, ensuring mainstream services are meeting the needs of Aboriginal people and testing new ways of supporting these communities" (www.familiesfirst.nsw.gov.au). The ACFYS is currently being developed in SSW.

3.1.10 NSW Youth Action Plan

The NSW Youth Action Plan highlights key actions that the NSW Government wishes to achieve in order to ensure that young people (aged 12 to 24) in NSW have opportunities for rewarding and positive lives. Actions are focused on the five key areas of Belonging to Family and Community, Learning and Earning, Feeling Good and Staying Healthy, Engaging in Culture, Sport and Recreation and finally, Feeling and Being Safe.

In relation to health, the NSW Youth Action Plan has a particular focus on addressing issues associated with mental health; drugs, tobacco and alcohol; sexual health; nutrition, weight and exercise and pregnancy and parenthood (www.youth.nsw.gov.au).

3.1.11 NSW Framework for the Integrated Support and Management of Older People in the NSW Health Care System (The Framework)

Developed by NSW Health to assist Area Health Services to "re-engineer the system to better manage the needs of older people" (NSW Department of Health 2004a), the Framework provides guidance to Area Health Services on the key components in providing integrated care.

The Framework has identified 5 pressure points on the existing system, being the management of older people in emergency departments, discharge planning and post-acute care, management of cognitively impaired older people, increasing demand for community based assessments and services and coordination of care.

3.1.12 The NSW Chronic Care Program

The NSW Chronic Care Program is currently in its second phase. It aims to improve the quality of care and the quality / quantity of life for people with chronic and complex conditions and their families/ carers and to reduce crisis situations and unplanned / avoidable admissions to hospitals.

The program has developed recommendations and standards to strengthen the involvement of GPs in the provision of chronic care services (NSW Health, 2005a) and to support AHS's to develop appropriate Aboriginal services (NSW Health, 2005).

Resulting from this program is a toolkit called, 'Improving Care for People with Chronic Disease (NSW Department of Health 2005b), which should be used to guide clinical care.

Given the high rates of chronic disease in the Aboriginal community, specific standards, known as the Aboriginal Chronic Conditions Area Health Service Standards, have been developed. The standards relate to coordination in the prevention and management of chronic disease, targeted health promotion initiatives across the life-course and disease

continuum, effective systems for diagnosis and care and enhancing the Aboriginal health workforce (NSW Department of Health 2005c).

3.1.13 Strategic Framework to Advance the Health of Women

This Strategic Framework provides four key strategic directions to guide the implementation of strategies that will improve and maintain the health of women in NSW. These key strategic directions are: incorporate a gendered approach to health; work in collaboration with others to address the social determinants of health; advance research on women's health experience and morbidity; and apply a health outcomes approach (NSW Health 2000).

The Strategic Framework affirms the priorities of the National Women's Health Policy (NWHP). Both the NWHP and the programs linked to it recognise the impact of social determinants on health by adopting a social model of health. They endorse a strong equity focus and prioritise policy initiatives for women with greatest need.

3.1.14 NSW Police, NSW Health and Office of the Director of Public Prosecutions Guidelines for Responding to Adult Victims of Sexual Assault

These guidelines, released in August 2006, have been developed by NSW Police, the NSW Department of Health and the Office of the Director of Public Prosecutions. The guidelines clearly articulate the roles of each agency in responding to the short and long term needs of adult victims of sexual assault. Issues pertaining to SSWAHS include access to medical and counselling services, policies and procedures for the collection and management of evidence and for working with other agencies.

3.1.15 NSW Child Protection Service Plan 2004 - 2007

The NSW Child Protection Service Plan 2004 – 2007 (NSW Department of Health 2004b) aims to provide a framework in which all Area Health Services can concentrate efforts relating to the early identification and prevention of child abuse and neglect and the provision of timely, responsive and culturally appropriate services. The Plan promotes a responsive, consistent and coordinated response across agencies and organisations.

3.1.16 Policy and Procedures for Identifying and Responding to Domestic Violence

This policy (NSW Health 2003) outlines the characteristics and consequences of domestic violence and identifies the role of NSW Health generally and Area Health Services specifically, in recognising and responding to domestic violence.

The policy introduces a new preventative strategy involving universal routine screening for domestic violence in services where significant numbers of women have been found to be at risk. The aims are twofold: to reduce the incidence of domestic violence through primary and secondary prevention approaches; and to minimise the trauma that people living with domestic violence experience, through tertiary prevention approaches, ongoing treatment and follow-up counselling.

In 2006, NSW Health amended Section 3 of the policy, Intervention with victims of domestic violence. The child protection focus of this section has been strengthened by requiring health staff to also ask patients additional questions to determine, initially, whether they have children, and if so to find out where they are and whether the patient is worried about their safety.

3.1.17 Draft NSW Hepatitis C Strategy 2006 - 2009

The Draft NSW Hepatitis C Strategy 2006 – 2009 (NSW Department of Health, 2006a) provides a state-wide strategic framework for the prevention and management of Hepatitis C. The Strategy focuses on minimising transmission, improving the health status of people

with Hepatitis C and minimising the negative impacts of the disease. Priority populations for action include people who inject drugs, Aboriginal people and people from culturally and linguistically diverse backgrounds.

3.1.18 NSW HIV/AIDS Strategy 2006 - 2009

This strategy aims to identify key priorities in the prevention and treatment of HIV/AIDS in NSW and provide an overarching framework for responding to these priorities. Issues associated with research and workforce development are also considered. The strategy identifies specific targets to address these priorities, including targets in relation to reducing incidence, improving diagnosis, improving ongoing care and treatment and reducing mortality (NSW Department of Health, 2006b).

3.1.19 NSW Sexually Transmissible Infections Strategy 2006 – 2009

The goals of this strategy are to reduce the transmission of sexually transmissible infections (STIs) and to reduce morbidity associated with STIs. Priority populations for the strategy are Aboriginal people, gay and other homosexually active men, young people, sex workers, people with HIV/AIDS, people who inject drugs and heterosexuals with recent partner change. Priority issues relate to health promotion, partnerships, prioritising access to public sexual health services, promoting testing and contact tracing, workforce development, research and surveillance (NSW Department of Health, 2006c).

3.1.20 NSW Immunisation Strategy 2003 – 2006

The NSW Immunisation Strategy 2003 – 2006 (NSW Department of Health, 2003a:11) aims to "sustain and increase immunisation coverage at all stages of life, for all vaccines listed for use currently and in the future, in the Australian Standard Vaccination Schedule". The strategy identifies that this aim can be achieved through both population health measures and the provision of additional clinical services, using an evidence based approach. Further, particular attention is focussed on the needs of groups who are sub-optimally immunised.

3.1.21 Management Policy to Reduce Fall Injury Among Older People 2003 – 2007 (Falls Prevention Policy)

The overall aim of the Falls Prevention Policy is to "actively reduce the burden of falls injury across the community" (NSW Department of Health 2003b, p4). The policy has three core components, being: generating a low risk population, preventing injury in people from high risk groups and improving the effectiveness of health and other systems, including data collection.

3.2 SSWAHS Policies and Plans

SSWAHS, including the former CSAHS and SWSAHS have in the recent past undertaken extensive analysis and consultation exercises to develop plans and policies. The priorities identified and direction set in these plans will be used to inform the Community Health Strategic Plan as appropriate. Key documents are described below.

3.2.1 A New Direction for Sydney South West - Health Service Strategic Plan Towards 2010:

The SSWAHS Strategic Plan 2006 – 2010 is the first corporate plan for Sydney South West Area Health Service. The Plan is the premier planning document for the Area, setting the overall direction for the development and delivery of all services and systems within SSWAHS. The Plan is consistent with the NSW State Plan and the NSW State Health Plan. Consistent with the vision outlined by NSW Health, the SSWAHS vision is twofold and described below:

The SSWAHS vision for our communities is "vibrant communities who enjoy and value good health and who work with us to improve health for everyone". For our organisation and staff,

the SSWAHS vision is “an energetic and progressive team delivering innovative health care and inspiring pride and confidence through a determined pursuit of excellence”.

The values underpinning the work of SSWAHS are justice, integrity, respect, flexibility, reflectiveness and conviction.

SSWAHS has identified numerous corporate objectives which support the vision.

3.2.2 SSWAHS Draft Healthcare Services Plan 2006 - 2016

The draft Healthcare Services Plan 2006 – 2016 has been developed through extensive consultation since the establishment of SSWAHS in January 2005. The plan outlines an approach for management of increased demand in SSWAHS over the next ten years based on the establishment of clinical networks. Community Health is identified as being an integral component of these networks with respect to providing prevention and early intervention services, hospital avoidance and post-acute services, as well as care for people with long term illness and/or disability.

Service enhancement focus areas identified for Community Health to 2016 include:

- Development of a Community Health Strategic Plan 2006-07
- Moving towards universal Sustained Home Visiting across SSWAHS;
- Further expansion of Health Promoting Schools and other school outreach programs;
- Expansion of Community Health Nursing services to meet the needs of ageing communities;
- Expanding community development activities;
- Clarifying the role of community health in post-acute care service provision;
- Establishing additional community health services/facilities in areas with new housing development and significant population growth;
- Exploring options for co-location of community health service provision with other community facilities integrating Primary Health and Community Care Centres;
- Working in partnership with other agencies to deliver “whole of government” responses to community needs; and
- Improving the linkage and interaction of community health services with general practice.

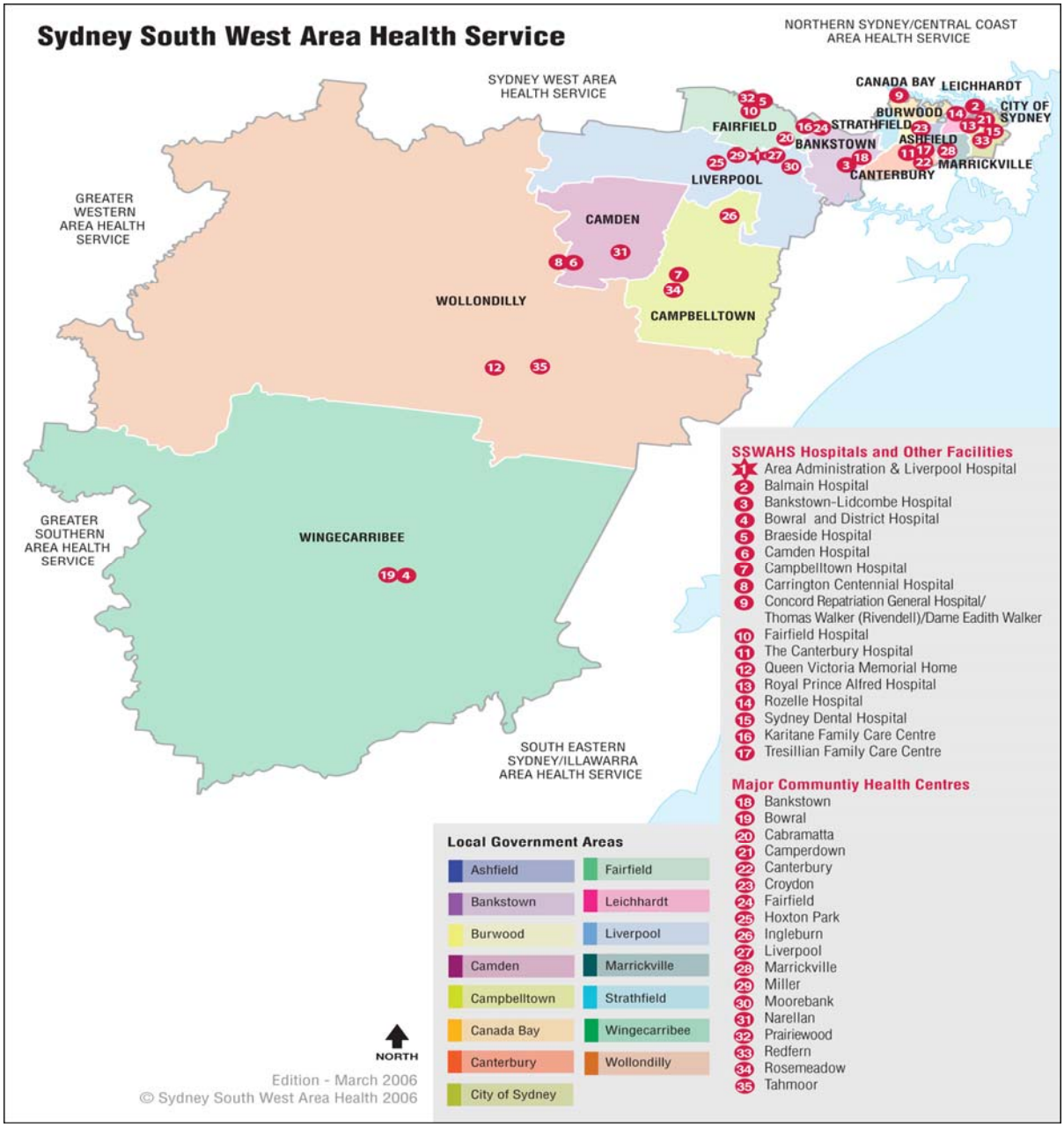
3.2.3 SSWAHS Community Participation Framework

The SSWAHS Community Participation Framework (SSWAHS, 2006) provides a structure in which SSWAHS can work with consumers, carers and the broader community to improve health service delivery. The framework is based around enabling consumers, carers and the community to become actively involved in the planning, delivery and evaluation of health services; ensuring the community are well informed and that there is transparency and accountability in decision making.

4. SSWAHS PROFILE - GEOGRAPHY, DEMOGRAPHY AND HEALTH CHARACTERISTICS

The Sydney South West (SSW) region comprises the 15 Local Government Areas (LGAs) of City of Sydney (part), Leichhardt, Marrickville, Canterbury, Canada Bay, Ashfield, Burwood, Strathfield (referred to herein as the inner west) and, Bankstown, Fairfield, Liverpool, Campbelltown, Camden, Wollondilly and Wingecarribee (referred to herein as the south west). Combined, these LGAs make up a total geographic area of 6,380km². Settlements vary from scattered rural townships in the south, through to the densely populated inner city. A map of SSW is shown below in Figure 4.1.

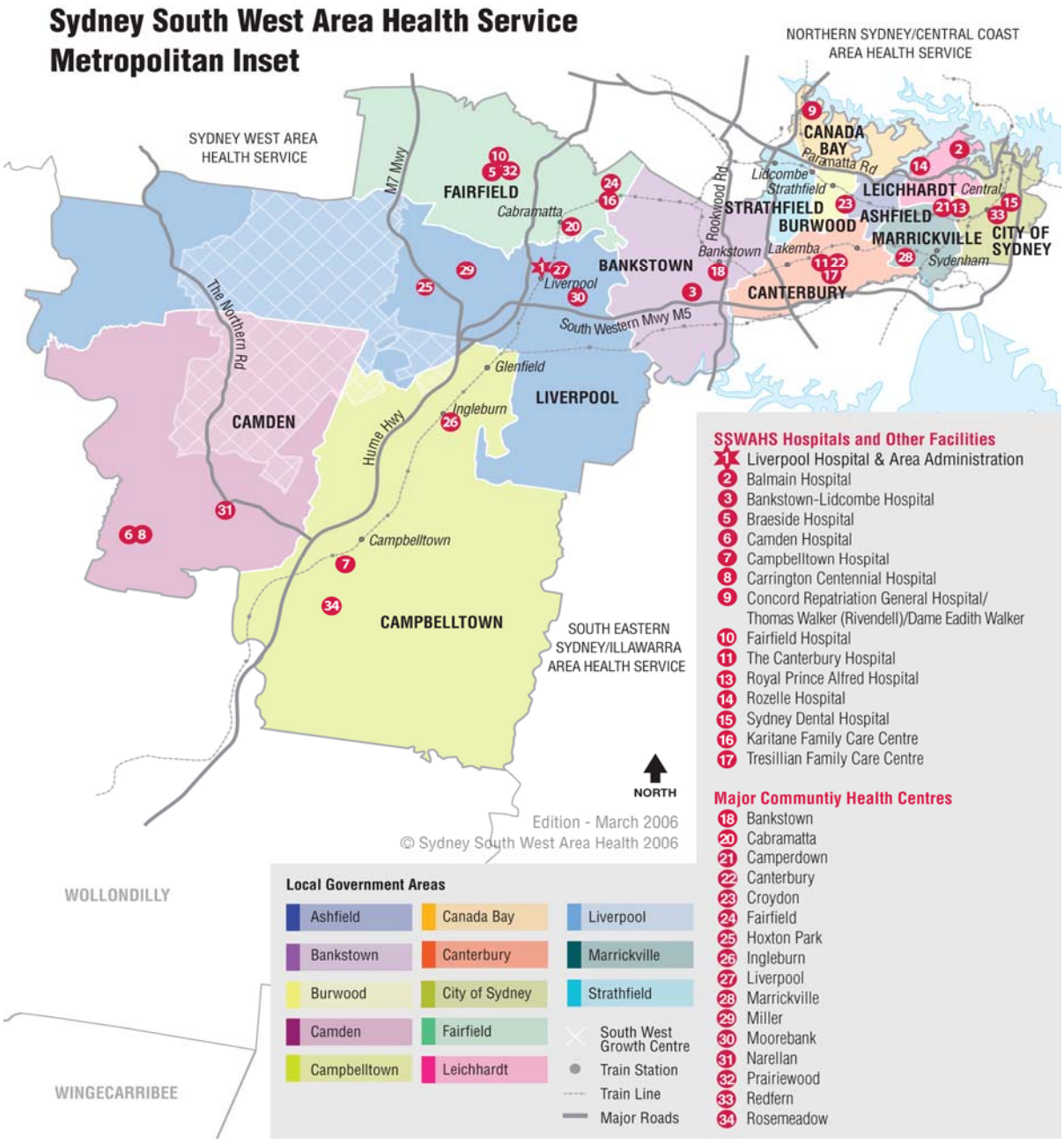
Figure 4.1 The Sydney South West Region



4.1 Population Size and Growth

In 2006, the population of SSW was estimated at 1.35 million (20% of the total population of NSW). This is projected to increase to 1.52 million in 2016, due to the planned release of land in the South West Growth Centre (see Figure 4.2) and urban consolidation in the Inner West. The majority of the impact of the South West Growth Centre will be experienced past 2016.

Figure 4.2 SSWAHS Facilities and the South West Growth Centre



The majority of the population growth will occur in the south west (notably the LGAs comprising the South West Growth Centre – Liverpool, Camden and Campbelltown). Almost 120,000 new residents are expected in the south west in the next 10 years, compared to nearly 48,000 in the inner west. Liverpool LGA will receive the majority of this growth with an additional 58,000 residents between 2004 and 2016, followed by Camden with 28,400 and Campbelltown with 24,970 additional residents in the same period. Further detail on population growth between 2001 and 2016 by LGA is provided in Figure 1 of Appendix E.

Further detailed demographic information can be obtained from *A Health Profile of Sydney South West: A Status Report describing the population, their health and the services provided for Sydney South West Area Health Service* (SSWAHS, 2005), available to download at http://www.cs.nsw.gov.au/agm/DemProfile.pdf

4.2 Population Structure

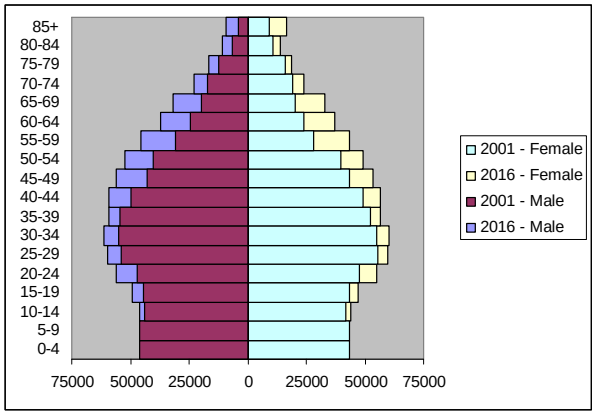
In 2001, the age structure of SSWAHS reflected a combination of the generally older inner west and younger south west areas. LGAs with the highest proportion of younger people (0-14) are in Camden, Campbelltown and Liverpool. LGAs with the highest proportion of older people (85+) are in Ashfield, Burwood and Strathfield.

In terms of the projected population growth, the most substantial growth is occurring in the older age groups. The population of people aged 65 and over is projected to increase by 45% in the 15 years from 2001 to 2016, and the population aged 85 and over, who are substantial users of health services, is projected to almost double over the same period.

Table 2 in Appendix E shows the projected change in the population age structure of SSWAHS between 2001 and 2016.

The following figure (Figure 4.3) shows the way the structure (age and gender) of the population will change between 2001 and 2016. Most noticeable is the ageing of the population and the longevity of women as compared to men.

Figure 4.3 SSWAHS Age and Gender Structure 2001 and 2016



Source: DIPNR Population Projections 2004

4.3 Population Diversity

In SSW in 2001, 13,772 people identified as being Aboriginal or Torres Strait Islander (herein referred to as Aboriginal). This is 10% of the Aboriginal population of NSW. LGAs with the highest number of people identifying as Aboriginal at the 2001 census were Campbelltown, Liverpool and City of Sydney (part).

Sydney South West is the most culturally diverse Area Health Service in NSW, with 39% of people speaking a language other than English at home, compared with 19% in NSW. Most notable is that in the Fairfield and Canterbury LGAs, over 60% of people do not speak English at home. See Table 3 in Appendix E for further details.

Of the people within SSW who speak a language other than English at home, 117,160 (24%) rate themselves as speaking English either not well or not at all. The greatest number of people who speak a language other than English, speak Vietnamese, Cantonese, Arabic and Mandarin.

The south west of SSWAHS has historically been a preferred area of settlement for both migrants and refugees arriving in NSW (Community Relations Commission for a Multicultural NSW, 2006). According to the Department of Immigration Multicultural and Indigenous Affairs (DIMIA) between January 1999 and October 2004, over 50,000 new arrivals settled in SSW. Of these, approximately 19% (over 9,000) were humanitarian arrivals, or refugees. Table 4 in Appendix E describes the pattern of new arrivals in SSW by entry status. Refugees have a range of health issues, including presence of vaccine preventable diseases, poor oral health, poor nutrition, delayed development, sexual health issues, experiences of trauma or torture, poor mental health, potential for alcohol and drug dependence and difficulties in understanding and accessing the complex health system in NSW and Australia (Community Relations Commission for a Multicultural NSW, 2006).

4.4 Socioeconomic Status

Population density is significantly higher in inner city LGAs (Leichhardt, South Sydney, Ashfield) compared to middle ring LGAs (Strathfield, Bankstown, Fairfield) and urban fringe areas (Camden, Wingecarribee, Wollondilly). Fairfield, Campbelltown, Bankstown and Wollondilly have the highest proportion of population who were living in the same LGA five years ago. The City of Sydney (formerly Sydney and South Sydney), Leichhardt, Ashfield, Marrickville and Camden have experienced the highest rates of population turnover. The highest proportions in rented accommodation are in City of Sydney (part), Leichhardt and Marrickville.

The LGAs with the highest proportion of the population being Centrelink customers are Fairfield, Bankstown, Canterbury, Marrickville and Ashfield. Mean taxable income is lowest in Fairfield, Canterbury, Campbelltown and Liverpool. (See Table 5 in Appendix E).

From census data, the ABS has developed an index of relative socio-economic disadvantage which brings together a range of socio-economic indicators such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations into a single index figure reflecting overall socio-economic disadvantage. The index is known as the Socio-Economic Index for Areas (SEIFA). The lower the value the more disadvantaged an area is compared to other areas. The most disadvantaged Sydney metropolitan postcodes are located within SSWAHS. These relate to the suburbs of Waterloo, Punchbowl, Yennora, Cabramatta, Prairiewood, Miller, Macquarie Fields, Minto, Claymore and Airds. Table 6 in Appendix E shows each of the SSW LGAs according to their SEIFA value.

On the basis of this index, the LGAs in SSWAHS with socio-economic disadvantage greater than the State median, in order of ranking, are Fairfield, Canterbury, Campbelltown, Liverpool, Bankstown and Marrickville. Fairfield has the second highest level of disadvantage of all NSW LGAs.

4.5 Family Household Structure

SSWAHS contains significant variations between LGAs in the characteristics of family households. The average household size across SSWAHS is 2.7, ranging from 1.9 for the City of Sydney to 3.2 in Fairfield. Detailed data is presented in Table 7 in Appendix E.

4.6 Other Population Groups

Certain population groups are known to have unique health needs. These groups include people who are homeless, people working in the sex industry and people on release from prison. It has not been possible to find local information to quantify the numbers of people in these groups who reside in SSWAHS. However, it is known that people in these groups have unique health needs which may not necessarily be catered for through mainstream health services.

4.7 Sexual Assault

Data on the number of reported sexual assaults in NSW is recorded by the Bureau of Crime Statistics and Research (BOCSAR) each year. Figure 2 in Appendix E shows the number of sexual assaults recorded in SSW by LGA in 2004/05 and 2005/06. The data shows that although over 700 sexual assaults were reported each year, there was a reduction in the overall number of assaults reported during the period. The City of Sydney and Campbelltown LGAs both had the highest reported rates of sexual assaults. Across SSWAHS, the rate of sexual assault was 5.518 per 10,000 people, slightly less than that for NSW as a whole, at 5.664 per 10,000 people.

4.8 Child Abuse and Neglect

The Department of Community Services (DoCS) records cases of suspected and actual child abuse and neglect. According to the DoCS Annual Statistical Report 2004/05, in that 12 month period there were 35,084 reports to the DoCS Helpline which were considered sufficiently serious for follow up in the Metro Central and Metro South West DoCs regions. This was a 16% increase on the previous year. It should be noted that the Metro Central region of DoCS covers LGAs which are not a part of SSWAHS.

4.9 Domestic Violence

Similarly to sexual assault incidents described above, BOCSAR also collects data on reported incidents of domestic violence (DV) related assault. The data in Figure 3 in Appendix E shows that reports of DV have increased in Sydney South West in the period 2004/05 to 2005/06, with over 5,500 incidents reported in the latter year. Campbelltown had the highest number of reported DV related assaults in 2005/06 followed by the City of Sydney. Again, this data does not capture the number of DV related assaults occurring which are not reported to the police.

4.10 Maternal and Infant Health

In 2004, SSWAHS had the highest number of births of any Area Health Service in NSW (by maternal area of residence). The total number of births in 2004 was 18,720 a slight decrease on the previous two years (NSW Department of Health 2005d).

The average age of mothers has been increasing over time, with the predominant age group being 30-34 (33.7% in 2004). With increasing maternal age come a range of co-morbidities including hypertension and gestational diabetes. Approximately 3% of births in SSW (593) in 2004 were to teenage mothers (NSW Department of Health, 2005d).

The NSW Department of Health (2005d) notes that the majority of women (around 83%) do present for an antenatal check before 20 weeks gestation. In addition to this are the women who participate in antenatal shared care with their GP. However, within SSWAHS, between 2002 and 2004, only around 72% of women from the Campbelltown and Bankstown LGAs presented for antenatal care in this period (NSW Department of Health 2006d).

With respect to birth-weight, 2,500 grams or more is considered to be optimal for both short and long term health. In 2004, 6.7% of all resident births in SSWAHS were below this target (NSW Department of Health 2005d). Reasons for low birthweight include smoking and drug and/or alcohol use during pregnancy.

In 2004, 90% of SSW women did not smoke during pregnancy (NSW Department of Health 2005d). However, the 2006 Chief Health Officers Report (NSW Department of Health 2006d) or download from www.health.nsw.gov.au/public-health/chorep) noted that between 2002 and 2004, almost 25% of pregnant women in the Campbelltown LGA smoked.

4.11 Communicable Diseases and Immunisation

Communicable diseases is a term used to encompass Sexually Transmitted Infections (STIs), blood borne viruses (BBV) and other diseases which are easily transferred between people eg. influenza. Some of these diseases are notifiable to NSW Health.
Between 2003 and 2005, crude notification rates for Hepatitis B, Hepatitis C, gonorrhoea and syphilis were higher for SSW than for NSW.

According to NSW Health, data from the Australian Childhood Immunisation Register indicates that childhood immunisation rates in SSWAHS at 31 December 2005 were below the average for NSW. Specifically, the percentage of children fully immunised by 15 months was 89% in SSW compared to 91% in NSW.

4.12 Mortality

During 1998 – 2002 there were 3,897 deaths for males and 3,479 deaths for females in SSW. The age standardised death rate for both males and females is higher than that for NSW.

For males, the age standardised death rates are significantly higher than the NSW average in the inner west LGAs of Leichhardt, South Sydney (now City of Sydney), Ashfield, Marrickville and Burwood. This phenomenon occurs to a lesser extent in Campbelltown, Camden and Liverpool. For females, the age standardised death rates are higher than the NSW average (by order of magnitude) in Ashfield, Campbelltown, Camden, Liverpool, Leichhardt, South Sydney, Marrickville, Fairfield and Wollondilly.

The major causes of death in SSWAHS (and NSW) are circulatory diseases, cancers, injury/poisoning and respiratory diseases. In 2000 - 2002 these diseases accounted for 80% of all deaths.

4.13 Selected Health Conditions

Information on selected health conditions has been sourced from the NSW Health Survey 2002 and 2003 of people aged over 16 years and from the Chief Health Officer's Report 2006 (NSW Department of Health 2006d). Key points are summarised as follows:

- Crude cancer incidence rates in the period 1998 – 2002 were lower in SSWAHS than in NSW as a whole (NSW Cancer Registry). In males the most common form of cancer was prostate cancer, with breast cancer the most common in females;
- Asthma rates for men were approximately 9% and women 11%
- Diabetes/high blood sugar affected 8% of men and 7% of women;
- High blood pressure affected 25% of men and 22% of women;
- High blood cholesterol affected 27% of men and 30% of women;
- Overweight/obesity was an issue for 52% of males and 37% of females.

4.14 Health Risk Factors

Information obtained from the NSW Chief Health Officers Report 2006 (NSW Department of Health 2006d) indicates the following health risk factors amongst the SSWAHS population aged 16+:

- Smoking – the male smoking rate was 22.8% and the female smoking rate 16.1%;
- Alcohol risk drinking – the risk drinking behaviour rate for males was 32% compared to 21.5% for females

4.15 Health Protection Factors

Information obtained from the Chief Health Officers Report 2006 (NSW Department of Health 2006d) and from the NSW Healthy Survey 2002 and 2003, indicates the following health protection factors amongst the SSWAHS population aged 16+:

- Adequate physical activity was performed by 58.4% of males and 43.7% of females;
- Adequate fruit intake was consumed by 49.2% of the population;

- Adequate vegetable intake was consumed by 6.4% of the population;
- Breast cancer screening rates were 46% in women aged 50-69 in the period July 2002 – June 2004;
- Biennial cervical cancer screening rates were 57% for women aged 20 – 69 in the period January 2001 to December 2002

4.16 Levels of Private Health Insurance

It is estimated that SSWAHS has lower levels of private health insurance (PHI) than the NSW average, at 48.4% and 52.9% respectively (see Table 8 in Appendix E). There is a notable difference in the levels of PHI coverage depending on where in the Area a person resides.

4.17 General Practitioners

General Practitioners (GPs) play an essential role in providing primary health care services to the SSW community. GPs work in a range of settings in the SSWAHS region from solo practices to group practices. These are predominantly private practices and include both those owned by GPs as well as larger corporate practices.

The majority of these GPs are members of a local Division of General Practice. The area covered by SSWAHS includes seven Divisions of General Practice. These are Central Sydney, Canterbury, Bankstown, Fairfield, Liverpool, Macarthur and Southern Highlands Divisions.

There are 1,210 GPs who are members of one of these local Divisions of General Practice, however the total number of GPs in the AHS is greater. Table 9 in Appendix E summarises the numbers of GPs (members and non-members) in each Divisional area. Non-members' numbers are an approximation as they are difficult to accurately estimate due to the constant movement of the GP workforce. It also needs to be borne in mind that a small percentage of Division members may not actively practice in the area.

Area populations have been provided to give an idea of what size population the GPs are servicing however an accurate GP:population ratio cannot be determined from GP numbers alone. These GPs work a range of hours from 10 to 60+ hours per week. Therefore the full-time equivalent (FTE) workforce is actually less than the numbers shown. Table 9 in Appendix E also shows a FTE GP:population ratio estimate.

4.18 Non-Government Organisations

SSWAHS administers NSW Health funding to 85 non-government organisation (NGO) services in 2006/07, at a total of $22.2 million. Some of these services are state-wide, with a head office based in Sydney South West. Major areas of service delivery include Women's Health (clinical services, health promotion, counselling, domestic violence and sexual assault services); Drug and Alcohol; HIV/AIDS; Aged and Disabled; Carers and organisations working with people with a specific illness. There are also many other NGOs not funded through NSW Health, providing a range of health, welfare and community services. Strong NGO networks in SSWAHS provide an excellent opportunity for Community Health to strengthen mutually advantageous partnerships, particularly with Women's Health, HIV/AIDS and illness specific NGO's.

5. COMMUNITY HEALTH SERVICES AND ACTIVITY - NOW AND IN THE FUTURE

Community Health comprises a diverse group of services provided in a variety of locations throughout SSWAHS. As a result of historical differences and local variation, there is a range of service models used across the Area, along with other key operational differences. The Community Health Strategic Plan provides a clear service framework to achieve the vision for Community Health.

Principles in the Delivery of Community Health Services

Community Health services will:

- Respond to identified and emerging need in the community
- Be evidence based (or have systems in place to ensure evaluation)
- Be delivered in accordance with current best practice
- Demonstrate that clients are better off as a result of receiving the service
- Deliver value for money
- Be delivered equitably across the Area, with a mixture of core services and targeted services in areas of unique need

The following sections (6 – 9) describe:

- the current structure and model of care for each service (as at May 2007)
- service activity for 2005/06 (where available)
- current and emerging issues
- core business and the future model of care
- projected future activity

As outlined below, each section corresponds to a newly created Directorate within Community Health, for ease of reference (see also Appendix A).

Section 6	**Child and Family Clinical Services**	o Early Childhood Health Services o Child Protection o Child, Adolescent and Family Health Services
Section 7	**Diverse Clinical Services**	o Community Development – The Hub o Multicultural Health o Sexual Health o Women's Health o Sexual Assault o HIV/AIDS Community Services o Community Counselling o Community Nutrition o Youth Health
Section 8	**Community Acute/Post Acute and Chronic Clinical Services**	o Community Health Nursing o Palliative Care Nursing
Section 9	**Corporate, Integration and Support Services** **and** **Finance and Operations Directorate**	o Service Integration o Information Management o Information Technology o Service Development o Quality and Clinical Risk Management o Occupational Health and Safety o Facilities and Resources Management o Marketing of Community Health o Workforce

5.1 Community Health Clinical Core Business Framework

The Community Health Clinical Core Business Framework outlines the clinical services provided and delivered by Community Health. It identifies and prioritises the clinical core business of each service group. It does not include the other essential aspects of Community Health staff work such as community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies.

The purpose of this framework is to guide clinicians and managers in the provision of clinical services, following consideration of client need, available resources and efficacy of desired outcomes.

Priorities (along with the descriptions of current and emerging issues, in Sections 6-9) have been identified as a result of analysis of:

- An understanding of current policy direction;
- Information gathered through the consultation process;
- Demographic and service activity data;
- The available evidence base and service outcome information

It is this analysis which informs both the Clinical Core Business Framework and the Action Plan.

Priority One

High priority services that:

- are mandated by policy or legislation;
- have the greatest potential impact on health outcomes; and
- should be available across the Area Health Service.

Priority Two

Services that have:

- a moderate potential impact on health outcomes;
- may not be available across the Area Health Service; and
- are provided following consideration of available resources and clinical need.

Priority Three:

Services that:

- have a limited potential impact on health outcomes;
- may not be available across the Area Health Service; and
- are provided following consideration of available resources and clinical need.

A copy of the full Community Health Clinical Core Business Framework is provided as Appendix F.

5.2 Activity and Performance Data

Within Sections 6-9, activity data is presented for the 2005/06 financial year. For ease of reference, data has been grouped according to service type and location. In this Plan, data for the inner west refers to the LGAs of City of Sydney (part), Leichhardt, Marrickville, Ashfield, Burwood, Canada Bay, Strathfield and Canterbury. Data for Macarthur refers to the LGAs of Campbelltown, Camden and Wollondilly. All other data is presented at an LGA level.

There are a number of significant issues relating to Community Health data at both a state and Area level. These include:

- different data management and information technology systems;
- different data definitions;
- different standard reporting requirements eg. client registrations;
- different service structures and models of care, resulting in data which cannot be compared across locations.

As such, the quality of data used in this document is variable and not always reliable.

Significant work is underway to address these issues at a local level (discussed further in the Action Plan). This local work is closely linked to the Community Health and Outpatient Care Information Project, which will deliver a standardised, state-wide data set that contains a record for each health service provided to clients in community health and outpatient care settings.

In terms of planning for a future model of care, there is a need for reliable performance and outcome data. There is currently a paucity of such data in the NSW and SSWAHS Community Health setting. This will in part be addressed by the Community Health and Outpatient Care Information Project and other local initiatives aimed at strengthening the Area's capacity to evaluate clinical practice and outcomes.

6. CHILD AND FAMILY CLINICAL SERVICES

Child and Family clinical services are delivered within the context of the Families NSW philosophy, which recognises that supporting families and children in the early years of life will have a lasting health and social impact. Services are grouped as follows:

- Early Childhood Health Services (Section 6.1)
- Child Protection Service (Section 6.2)
- Child, Adolescent and Family Health Services (Section 6.3)

Health promotion and education is provided by all services and specific programs are offered across the Area in Community Health Centres (CHCs), council buildings, schools and other locations as appropriate.

The following sections describe the current situation and future plans for each service type.

6.1 Early Childhood Health Services

Early Childhood (ECH) Services are provided for children aged 0-5 and their families.

ECH Services are staffed by a range of health professionals, including qualified Child and Family Health Nurses (CFHN), midwives, lactation consultants, social workers, nurse audiometrists and other support staff.

Service delivery and clinical practice for CFHN's is centred on the wellness model of care, the core principles of which are embodied in health promotion, early intervention, prevention, screening and surveillance strategies. Primary health care principles of access and equity underpin the provision of services. For allied health and medical services, ECH services are linked to Child, Adolescent and Family Health Services.

ECH services comprise a range of activities, each of which is briefly described below.

- Universal home visiting (UHV) is offered to all families within two, at most four, weeks of the birth of a baby. The visit includes a routine psycho-social assessment, the provision of health education and referral to appropriate support services. In the inner west, domestic violence (DV) and post natal depression screening are offered through this service. Referrals are received direct from hospital maternity units, although the referral mechanism varies across the Area. A central intake system operates in the south west;
- Sustained home visiting (SHV) is not widely available in SSWAHS at present. Where possible, SHV is provided for families with complex health and social issues, including families with drug and alcohol issues, mental health issues, maternal disability, parenting difficulties and to young parents and Aboriginal families. Specific externally funded services are offered in some areas, including Aboriginal specific services in the south west and the Miller Early Childhood Sustained Home Visiting (MECSH) project which is a pilot project visiting vulnerable families in the postcode area 2160, ceasing 2007. In addition, a new Area wide SHV service for Aboriginal teenage parents is being rolled out and has already commenced in the Inner West;
- Breastfeeding clinics and support groups have also been established across the Area to promote breastfeeding and assist mothers managing lactation and associated issues;
- Developmental monitoring of babies is offered at early childhood clinics across the Area;
- Young Parenting Services are offered across the Area in conjunction with a variety of clinical streams e.g. Youth Health, Child & Family, Maternity & Drug Health.
- Opportunistic immunisation to 'at risk' groups across the Area, with specific clinics currently located at Redfern and Hoxton Park;
- Social work services providing assessment and intervention to assist in adjustment to parenting, post natal emotional distress (including depression and anxiety), domestic violence, managing child developmental stages (such as separation anxiety, tantrums,

toileting and sleep problems), family and relationship issues (such as conflict or variation of parenting styles), effects of separation/divorce on the child, grief and loss, and other social issues.

Activity data for Early Childhood Health services in 2005/06 is provided in Table 6.1 below. Please note, this data has limited reliability (see Section 5.2).

Table 6.1 Early Childhood Health Activity 2005/06

Service	Individual OOS	New client registrations	Group Sessions	Total Participants in Group Sessions	Average Group Size
Bankstown	27,365	Not available	190	915	**5**
Fairfield	19,386	Not available	82	534	**7**
Liverpool	15,998	Not available	48	285	**6**
Macarthur	34,742	Not available	558	7,109	**13**
Bowral	7,868	Not available	13	101	**8**
Inner West	65,999	8,482	1,231	12,727	**29**
TOTAL	168,346	-	2,272	22,925	10

Source: 2005/06 DOHRS and PIRS Reporting

6.1.1 Current and Emerging Issues

- **Parenting support** – there is significant demand for the delivery of parenting support services to be provided both in the home and in centre based, group models;
- **Low breastfeeding rates** – SSWAHS has low breastfeeding rates. Strategies to improve breastfeeding rates are required;
- **Domestic violence** – domestic violence places young children at risk of harm. Adequate DV screening and follow-up support is required through ECH services;
- **Post natal depression** – post natal depression services are limited and it can be difficult to access mother/baby beds, thus resulting in higher demand for community based services;
- **Equipment** – additional/more modern equipment is required to assist in the delivery of clinical and support services, including education;
- **Interpreters** – in some language groups and at particular times, there is unmet demand for interpreter services;
- **Social isolation** – many parents are socially isolated, particularly people from different cultural and linguistic backgrounds. Services to alleviate isolation and promote community based support are required;
- **Prevention** – comprehensive early childhood services can assist in the prevention of health and social problems for children and families. Adequate capacity is required to enable this comprehensive support;
- **Partnerships -** there is a need for ECH services to work closely with other government departments, local government, health services and non-government organisations, particularly to support vulnerable families;
- **Workforce –** there is a limited supply of qualified practitioners, despite a large ECH population in the Area. There is a need to make the field of ECH nursing attractive to staff;
- **Information technology –** there is a need for improved data and communication systems;
- **Physical resources –** there is a need for larger and more appropriate group rooms to enable the effective delivery of group sessions. Rooms and facilities should have appropriate access for twin prams. Any new Early Childhood services/centres should be colocated with other health and/or community services, with sites determined based on the best possible access for communities.

6.1.2 Core Business and Future Model of Care

Early Childhood Health services will be provided and delivered to the community in line with the Community Health Clinical Core Business framework (see Appendix F). Clinical priorities have been identified through an analysis of need and an understanding of the

effectiveness of intervention outcome. The highest clinical priority services in Early Childhood Services are outlined below, with priority two and three services outlined in Appendix F.

Child and Family Health Nursing

A number of risk factors are considered across several domains in determining service activities/intervention: the child, the parent-infant relationship, and maternal, partner, family, environment and life events. These risk factors are categorised as per the draft NSW Health *Supporting Families Early* (Health Home Visiting Guidelines). They are as follows:

Level 1 response: No specific vulnerabilities factors detected

Level 2 response: Vulnerability factors that may impact on the ability to parent – young (under 19 years), unsupported parent; single, unsupported parent; multiple birth; complicated and/or premature birth; child or parent with disability/chronic illness; adjustment to parenting issues; anxiety, depression; history of mental health problem; grief or loss associated with the death of a child or other significant family member; relationship issues; financial stress; housing issues; isolation (geographic, lack of support); refugee status, recent migrant

Level 3 response: Complex risk factors that may impact on the ability to parent – current mental health symptoms; current substance abuse; parent with developmental disability; current or history of domestic violence; current or history of child protection issues

Child and Family Health Nursing

Priority One:

Universal home visiting (including a bio-psychosocial assessment - pregnancy history, family medical history, family social history, screening for domestic violence, Edinburgh Depression Scale, 1- 4 week infant health record assessment, infant-parent interaction)

- Parent groups (for example, new parent groups, early bird groups, introduction to solids groups, sleep and settling groups, transition to toddler groups)
- Parent support clinics focussing on feeding, settling, parent support, education and health promotion
- Targeted follow up of Level 2 families, including 6 to 8 week/6 to 8 month and 18 month bio-psychosocial assessment
- Involvement in the case management of Level 3 families, for example, participation in protective planning meetings with DoCS
- Opportunistic immunisation
- Sustained home visiting to specific target groups

Early Childhood Social Work

Priority One

- Clients for whom a response is mandated according to legislation and policy (for example, high risk behaviour/self-harm, domestic violence, child protection issues)
- Parenting and other group programs where, evidence indicates, early intervention will have the greatest potential impact on health outcomes (for example, Toddler Terrific or Terrible, parent-infant interaction groups)
- Referrals where post-natal distress or adjustment to parenting issues are identified. Assessment and counselling sessions conducted in accordance with the home visiting model

There will sometimes be exceptions to the implementation of the Clinical Core Business Framework. In these circumstances clinicians will be guided by management as to appropriate service provision, following consideration of client need, available resources and efficacy of desired outcome/s.

In addition to these clinical priorities all services will include community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities

will be in accordance with the Community Health Strategic Plan 2007 - 2012, and reviewed and reported on during annual planning activities.

Sustained home visiting, a significant initiative of the Families NSW program, has been proven to be most effective when provided to teenage mothers and mothers who experience poverty, social isolation and disadvantage. Ideally, people requiring SHV would be identified through a psychosocial assessment at the first antenatal visit. However, it is recognised that this group has a low level of presentation for antenatal care, and as such, an additional opportunity to identify appropriate clients is also provided through the universal home visiting program. In order of priority, this service should be expanded to all teenage mothers, all mothers aged under 25 who experience poverty, social isolation and/or disadvantage on the birth of their first child and finally to all mothers under the age of 25. The future model of care for early childhood services in SSWAHS focuses on the delivery of a comprehensively available SHV service.

6.1.3 Projected Future Activity

The number of births to residents of SSWAHS in 2004 was 18,720. By 2011, this is expected to increase to 18,964 and by 2016 to 19,221 (aiM 2006). An increasing number of births is projected for residents within parts of the South West, with projected decline in more established areas. However, these trends will be monitored. Revised projections are due to be released in late 2007 and these will be reviewed against current available projections.

In order to provide the abovementioned priority one services, growth will be required across Early Childhood Health. The potential changes in demographics will need to be monitored over time to determine service provision.

If services were to deliver priority two and three services as outlined in the Clinical Core Business Framework, additional growth would be required. For example, if a comprehensive SHV service was offered in SSWAHS, it would involve approximately 105,000 additional occasions of service per annum. This has been calculated on the basis of 15% of families requiring an SHV service, with each family receiving approximately 35 visits over two and a half years.

6.2 Child Protection Service

Child Protection services across the Area were reviewed in 2006 to create the SSWAHS Child Protection Service (CPS). The Area wide structure will be implemented in 2007. Whilst the CPS is based in Community Health its' work crosses all facets of the Health Service and incorporates planning and program development, direct service provision, consultation, and training. The CPS also manages statutory requirements outlined in the Children and Young Persons (Care and Protection) Act 1998. Referrals to the CPS are only accepted from the Department of Community Services (DoCS).
There are several components of child protection services in Community Health.

- **Leadership and strategic planning, program and policy development in regard to child protection** – in relation to all health services (hospital and community based) which come into contact with children, young people and families within the child protection framework. There is also a funded position to enhance access to services for Aboriginal families and communities
- **Child Protection Counselling Service** – only accepts referrals for children 0 –18 years and their parents/carers for whom physical abuse, emotional abuse and/or neglect has been confirmed by DoCS. The service is part of a statewide network of services funded by NSW Health to provide a tertiary level, therapeutic intervention service (including therapy/counselling and casework). The service is primarily a home visiting service providing intervention for 3 – 18 months in duration. Staff are located in Bankstown, Fairfield, Liverpool, Ingleburn, Narellan, Tahmoor, Rosemeadow and Croydon CHCs.

All referrals to the counselling service must come directly from DoCS with priority given to:

- a previous non-accidental child death in the family
- the previous assumption of care of the child or siblings
- Serious physical or psychological injury of the child
- A child under 5 years who has been physically or emotionally abused or neglected
- Multiple risk of harm reports regarding a child
- Polysubstance abuse by the parents or caregiver
- A parent or child with a disability

- **Child Protection Assessment Service** - based at Liverpool and Canterbury Hospitals. This service provides 24 hour access to crisis medical and counselling services and general medical assessments for children who have been physically abused or neglected. The medical service is coordinated by the child protection Staff Specialist Paediatrician whose role includes the planning development, management and monitoring of medical services, along with some clinical care. An after hours on-call Social Work service is also available at Liverpool Hospital in the event of crisis child presentations in South West Sydney.
- **Consultation** – on all matters related to child protection is available to all SSWAHS and DoCS staff. This service is provided as needed, and encompasses a variety of services from telephone advice to clinical consultations, case review meetings and assistance in mediation.
- **Child Protection training** – child protection training is mandatory for all staff and is delivered at different levels depending on the level of contact the staff member will have with children or young people. Child protection trainers are responsible for the development, organisation, delivery and evaluation of child protection training to SSWAHS staff. Specialist training is also available.
- **Statutory Requirements** – significant resources are invested by all staff in ensuring all statutory requirements are met. This includes reporting to DoCS, managing data, and court preparation.

Activity data for Child Protection counselling services in 2005/06 is provided in Table 6.1 below. Medical assessments in child protection are recorded differently across the Area, and as such are not able to be represented in this table (see Section 5.2).

Table 6.2 Child Protection Service Activity 2005/06

Service	Adult Face to Face Sessions	Adult Phone Sessions	Child Face to Face Sessions	Child Phone Sessions
Inner West	871	647	812	**6**
South West	598	542	304	**1**
TOTAL	**1,469**	**1,189**	**1,116**	**7**

Source: NSW Health PANOC Services Report 2005/06

6.2.1 Current and Emerging Issues

- **Standardisation of practice across SSWAHS** – there is a need to establish an Area Child Protection Coordination Group to facilitate the standardisation of policies and practice across the Area and to enable the sharing of information, development and use of consistent data systems and quality management;
- **Prevention –** CPS services need to link with other early childhood services to develop prevention based initiatives;
- **Screening –** opportunities to develop and implement appropriate screening tools;
- **Early intervention –** existing services should be refocused to ensure awareness and reporting of possible issues;

- **Service integration –** an integrated response is required to the needs of vulnerable children within and across program areas;
- **Education and training –** AHS staff should all receive mandatory training on child protection, suitable to their role within the AHS;
- **Responsiveness** – services must be responsive in terms of access time and appropriateness in order to minimise the impacts of child abuse/neglect;
- **Referral pathways** – there is a need to strengthen the referral pathways between DoCS and CPS across the AHS;
- **Legislative requirements –** are subject to change. Accountability requirements with respect to documentation require considerable non-clinical time. Policies should be developed to ensure legislative compliance eg. policy of photographing children's injuries;
- **Specialist services –** are required to treat some children, particularly those under ten exhibiting sexualised behaviours

6.2.2 Core Business and Future Model of Care

Child Protection services will be provided and delivered to the community in line with the Community Health Clinical Core Business framework (see Appendix F). Clinical priorities have been identified through an analysis of need and an understanding of the effectiveness of intervention outcome. The highest priority clinical services in Child Protection are outlined below, with priority two and three services outlined in Appendix F.

There will sometimes be exceptions to the implementation of the core business framework. In these circumstances clinicians will be guided by management as to appropriate service provision, following consideration of client need, available resources and efficacy of desired outcome/s.

In addition to these clinical priorities all services will include community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007 - 2012, and reviewed and reported on during annual planning activities.

Priority One:

- Provision of consultation to health services regarding clinical management of clients, and child protection roles and responsibilities as per policy directives;
- Provision of mandatory child protection training for all relevant staff;
- Provision of consultation to the Department of Community Services (DoCS) regarding SSWAHS child protection policies, and therapeutic/treatment issues for child protection cases;
- Casework, counselling, groupwork and therapeutic intervention services for children/young people and their parents/carers for whom physical abuse, emotional abuse, domestic violence and/or neglect has been confirmed by DoCS. Primarily an outreach service providing weekly intervention for 3-18 months, focussing on increasing safety and reducing the risk for children in the family context, or ameliorating the effects of past abuse on a child. All referrals must come directly from DoCS with priority given to: a previous non-accidental child death in the family, the previous assumption of care of the child or siblings, serious physical or psychological injury of the child, a child under five years who has been physically or emotionally abused or neglected, multiple risk of harm reports regarding a child, poly-substance abuse by the parents or caregiver, or a parent or child with a disability;
- Support the provision of the 24 hour medical and crisis counselling services for children who present to SSWAHS hospitals with physical abuse and/or neglect. Provide a direct forensic medical response for children/young people presenting to Liverpool Hospital, including child sexual assault assessment in conjunction with the Sexual Assault Service, as required.

6.2.3 Projected Future Activity

SSWAHS will continue to have a role in the delivery of Child Protection services, in collaboration with DoCS and relevant NGOs. According to the *DoCS Child Protection*

Quarterly Report September 2004 – March 2006 (NSW Department of Community Services 2006a), the number of reports in NSW increased by almost 50% in that period. The majority of these reports were referred for further assessment. After the police, Health service staff were the main reporters of suspected child abuse and neglect in NSW.

Additional demand is likely to be observed in child protection services, as a result of population growth and greater community and staff awareness in relation to child protection reporting.

6.3 Child, Adolescent and Family Health Services

Child, Adolescent and Family Health (CAFH) services are provided for children aged 0 –18 years and their families. Clinical services provided include centre based, home, school or preschool assessments and interventions. A range of intervention models are offered including individual, group, consultation, collaboration, and parent training. Clinical services are supported by a range of non-clinical services such as health promotion and partnership development.

CAFH services are staffed by a range of professionals including allied health, nursing and medical staff. Each of these is described briefly below.

Allied Health Services

- **Occupational Therapy** services provide assessment and intervention for children who have difficulty with their occupational performance in play, fine motor, self care, school readiness and sensory motor skills. This includes children with, or at risk of, a developmental delay, a learning difficulty, mild autistic spectrum disorder, mild intellectual or physical disability;
- **Orthoptics** services provide primary and secondary orthoptic screening of children, which includes assessment of vision, ocular movements and strabismus;
- **Physiotherapy** services provide assessment and intervention for babies and children with difficulties or delay in the development or coordination of movement skills, including case management of children with recognised needs in the mild range of physical disability;
- **Psychology** services for children and young persons at school include assessment, individual and group psychological therapy for problems associated with everyday psychological functioning and the diagnosis and treatment of mental illness (by clinical psychologists);
- **Social Work** services provide psychosocial screening, assessment, therapeutic interventions, liaison and advocacy, counselling and group programs for children, adolescents and families presenting with cognitive, emotional, behavioural and social problems. Social workers work within a family context where possible;
- **Speech Pathology** services provide assessment and intervention for children with communication impairment and their families. This includes children with difficulties in receptive language, expressive language, speech articulation, voice, fluency, mild feeding difficulties, mild Autistic Spectrum Disorder and mild developmental delay or disability. A range of centre, preschool, home and school based intervention models are offered including individual, group, consultation, collaboration, home/school programs and parent/teacher training.

Nursing services

- Health promotion with schools in line with health priorities and evidence based programs;
- Health surveillance and case management of school age students on referral by either self, parents or teachers. This may include vision, hearing and or speech screening and address any other concerns that may affect the students' learning and wellbeing;
- Audiometry nursing service;
- Parenting;

- Transition to school programs;
- School based adolescent health services.

Medical Services

Community Paediatrics provides population and community based non-acute services for children, adolescents and their families. Availability of the following services varies across the Area:

- Community and outpatient based paediatric medical diagnostic and assessment and treatment services for children, and young people referred with cognitive, physical, emotional, behavioural and social problems;
- Assessment of children and young people with suspected neglect, physical, and/or sexual abuse;
- Clinical supervision of ambulatory paediatric services for children and young people with chronic and complex conditions;
- Developmental assessments;
- Assessment and management of children with ADHD;
- Medical services to Youth Health.

Child, Adolescent and Family Health activity data, incorporating allied health, nursing and medical services, is provided in Table 6.3. Please note, this data has limited reliability (see Section 5.2).

Table 6.3 Child, Adolescent and Family Health Activity 2005/06

Service	Individual OOS	Client registrations	Group Sessions	Total Participants in Group Sessions	Average Group Size
Bankstown	5,267	Not available	422	2,561	6
Fairfield	3,143	Not available	24	263	11
Liverpool *	3,437	Not available	297	2,871	10
Macarthur	3,614		484	7,474	15
Wingecarribee	1,884	Not available	9	62	7
Inner West	57,366	9,581	3,062	25,757	8
TOTAL	**74,711**	**-**	**4,298**	**38,988**	**9**

Source: 2005/06 DOHRS and PIRS Reporting; Clinical Activity Reporting Drs Woolfenden and Blackmore 2005/06; Liverpool Speech Pathology Activity 2005/06

6.3.1 Current and Emerging Issues

- **Service access**- there are waiting lists to access various services across the Area. However, the government Medicare-funded initiative Better Access to Mental Health Care is likely to assist in addressing this issue. The high costs associated with private health services, and the limited availability of private health providers in SSWAHS exacerbate this issue;
- **Service flexibility** - Some families experience difficulty in accessing services during standard business hours. Other families experience difficulty in accessing services at centralised locations. Service flexibility in relation to delivery settings and opening hours will assist in achieving greater flexibility/accessibility;
- **Assessment** – a significant number of clients, while initially presenting to one service, on assessment require multidisciplinary assessment and intervention;
- **Cultural and Linguistic Diversity -** the multicultural nature of many communities requires the provision of services with detailed understanding of cultural issues and the capacity to support families to understand and access health and community service systems. Interpreter services can be difficult to access;
- **Prevention** – CAFH services should focus on the delivery of prevention initiatives in partnership with other stakeholders to improve the health and wellbeing of families and children;
- **Early intervention** - A range of early intervention services and supports are essential to address the needs of young children and families in a timely manner. These include self management, assistance for parents to manage their children's difficult behaviours and support for families who have special needs;

- **Disability services** – the service system for children with a disability and their families is fragmented. Improved coordination is required between SSWAHS services and with other service providers;
- **Complex clients** – many clients have complex needs and relationships with a number of Community Health services, as well as with other health providers including Mental Health and Drug Health. Coordination and case management is required to ensure the appropriate support of these clients. Complex clients often have ongoing social and academic difficulties that require multidisciplinary intervention to achieve their full potential;
- **Provider continuity** – parents and children value continuity in their health care provider, as much of the service delivery revolves around developing trusting relationships;
- **Differences in practice across SSWAHS** – due to the current service structure, there are significant differences in practice across the Area which need to be addressed to ensure equity;
- **Quality and effectiveness** – there is a need for ongoing evaluation systems to monitor service quality and effectiveness.

6.3.2 Core Business and Future Model of Care

Child, Adolescent and Family Health services will be provided and delivered to the community in line with the Community Health Clinical Core Business Framework (see Appendix F). Clinical priorities have been identified through an analysis of need and an understanding of the effectiveness of intervention outcome. The highest priority clinical services in Child, Adolescent and Family Services are outlined below, with priority two and three services outlined in Appendix F.

Priority One – Paediatric Occupational Therapy

- Clients for whom a response is mandated according to legislation and policy (for example, child protection issues), urgent assessment for funding purposes, children in refuges;
- Children with a mild physical or intellectual disability for whom no or untimely Occupational Therapy intervention on our part will result in significant adverse outcomes (for example, children with mild cerebral palsy, splinting);
- Children aged 0-5 years for whom, evidence indicates, early intervention will have the greatest potential impact on health outcomes (for example, children with developmental delay in play, fine motor, self care, school readiness and sensory motor skills).

Priority One – Speech Pathology

- Clients for whom a response is mandated according to legislation and policy (for example, child protection issues), urgent assessment for funding purposes;
- Children for whom no or untimely Speech Pathology intervention on our part will result in significant adverse outcomes (for example, recent cochlear implant clients requiring intensive follow up);
- Children aged 0-5 years for whom, evidence indicates, early intervention will have the greatest potential impact on health outcomes (for example, children with specific language and speech impairment, stuttering and voice intervention).

Priority One - Physiotherapy

- Clients for whom a response is mandated according to legislation and policy (for example, child protection issues), urgent assessments for funding purposes;
- Children for whom no or untimely Physiotherapy intervention on our part will result in significant adverse outcomes (for example, children with talipes, cerebral palsy, torticollis, connective tissues disorders);
- Children aged 0-5 years for whom, evidence indicates, early intervention will have the greatest potential impact on health outcomes (for example, children with delay/difficulties in development or coordination of movement skills).

Priority One – Social Work

- Clients for whom a response is mandated according to legislation and policy (for example, high risk behaviours/self-harm, domestic violence, child protection issues);

- Comprehensive psychosocial screening and assessment at the point of referral/intake to determine the counselling response, or advice about alternative agencies;
- A presenting mental, behavioural or emotional problem (e.g. risk of harm to self or others) that is of such concern as to require an urgent response;
- Provision of evidence-based intervention to children, young people and families, assessed or screened at intake, as requiring a counselling response or other intervention (for example, current evidence indicates effective management is dependent upon early intervention);
- Group programs where, evidence indicates, early intervention will have the greatest potential impact on health outcomes.

Priority One – Psychology and Clinical Psychology

- Clients for whom a response is mandated according to legislation and policy (for example, high risk behaviours/self-harm, domestic violence, child protection issues);
- A presenting mental or emotional problem (e.g. risk of harm to self or others) that is of such concern as to require an urgent response;
- Comprehensive screening/assessment to determine the most clinically appropriate response, including referral to external agencies;
- Provision of evidence-based individual and group therapy for children, young people and families.

Priority One – Orthoptics

- Primary screening: children seen at Early Childhood Health Clinics, home, child-care centres, pre-schools and schools. Identified problems referred to appropriate agencies, for example, public hospital eye clinic, private ophthalmologists or optometrists.

Priority One - Nursing

- Health surveillance and case management: teacher/parent referrals (centre-based and school-based);
- Parenting and other group programs where, evidence indicates, early intervention will have the greatest potential impact on health outcomes (for example, Triple P, TIPS, Toddler Terrific or Terrible - in conjunction with Child and Family Health Teams, Schools as Community Centres).

Priority One – Medical

- Children and families for whom a response is mandated according to legislation and policy (for example, child protection issues)
- Community and outpatient based paediatric medical diagnostic assessment and treatment services
- Developmental assessments
- Assessment of children with suspected autism spectrum disorders (ASD)
- Assessment and management of children with behavioural problems, for example ADHD
- Assessment of management of medical problems of “at risk” youth in Youth Health Services

In addition to these clinical priorities all services will include community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007 - 2012, and reviewed and reported on during annual planning activities.

6.3.3 Projected Future Activity

Demand for child, adolescent and family services in allied health, nursing and medical disciplines will continue to increase in line with population growth, although service demand may be concentrated in particular areas, subject to local demographics. Service demand is related to the provision of comprehensive early intervention based assessment and treatment services, particularly to children with physical and cognitive disabilities or other complex needs, and their families. Rates of disability are expected to remain at least stable in the future.

The School Health Nursing service will be reviewed in 2007, with a view to developing a consistent model of care and service priorities across the Area.

7. DIVERSE CLINICAL SERVICES

Diverse Clinical services include a wide range of specialised services designed to meet the unique needs of particular target groups. They include:

- Community Development – The Hub (Section 7.1)
- Multicultural Health (Section 7.2)
- Sexual Health Services(Section 7.3)
- Women's Health Services (Section 7.4)
- Sexual Assault Services (Section 7.5)
- HIV/AIDS Community Services (Section 7.6)
- Counselling Services (Section 7.7)
- Nutrition Services (Section 7.8)
- Youth Health Services (Section 7.9)

The following sections describe the current situation and future plans for each service type.

7.1 Community Development – The Hub

Community Development as a designated service type is delivered by 'The Hub' at Miller, in the Liverpool LGA. This is a specific service, which is complemented by the extensive community development work undertaken as part of the core business of many other Community Health services.

The Hub was established in 2000 as part of the Wellbeing in the Valley initiative funded by NSW Health from 1999-2002. It was initiated in response to significant community unrest, crime and fear in the Miller area and involved a partnership between the Community, Liverpool Health Service, Liverpool City Council, the Department of Housing, Police, NGOs and other community based organisations.

The Hub functions as a community information and referral resource centre and facilitates access to health and social welfare services for Miller residents through a co-located services model (i.e. both government and non-government agencies are on-site at different times). Both staff and volunteers facilitate the provision of these services. The Hub is based on a social determinants of health framework and has a strong focus on community participation and employment activities. It has a dynamic volunteer support base and provides a setting and infrastructure for community groups and resident action.

Usage statistics from the period 2005/2006 show that The Hub was accessed 20,337 times: 5,780 telephone enquiries (28%) and 14,577 visits (72%). On average, there were 241 telephone calls and 606 visits a month. Visits comprised information and referral, attendance at meetings, participation in groups and activities, appointments with service providers, and use of facilities (such as internet, fax etc).

7.1.1 Current and Emerging Issues

- **Meeting community need**– Household surveys of Miller residents conducted by the Centre for Health Equity Training Research and Evaluation (CHETRE, 2006) show demonstrated improvements in community perceptions of health, safety, crime and the urban environment from 1999 to 2005. At the same time, new migrant and refugee communities are moving into the Miller area. A new needs analysis is required to develop a service and health approach for the Miller community;
- **Community capacity and participation** – the Hub has been successful in engaging residents in planned activities and programs. There is now a need to promote community leadership in solving local problems and in developing a healthy community for the future;

- **Partnerships and programs** – partnerships have been central to the delivery of community development programs and comprehensive primary health care services to the Miller community. It is likely that new partnerships and programs will need to be developed to reflect changing community need;
- **Access and equity** – there is a need to ensure that community participation in Hub activities and programs reflects population needs rather than being designed for those most capable of accessing the service;
- **Evidence and effectiveness** – community development has a growing evidence-base. There is a need to contribute to this evidence-base through continued evaluation and reporting of the Hub model and through research activities with other organisations;
- **Community development network** – there is a need to strengthen the capacity of community development work across SSWAHS through development of a community development network;
- **Training and education** – on the Hub model is provided to community groups, TAFE and university students. There is a need to strengthen and expand training to other organisations and SSWAHS staff.

7.1.2 Core Business and Future Model of Care

The Hub does not provide any direct clinical services and as such, core business has not been defined through the Clinical Core Business Framework.

The core business and future model of care for The Hub will incorporate:
- Community development and capacity building activities based on identified community need;
- A central information and referral centre for the Miller community;
- Meeting spaces for resident groups;
- Development and maintenance of partnerships to provide health and other outreach services from the Hub.

The success of these services will be measured through improvements to the health and wellbeing of Miller residents.

Models of care for any future Community Development services will be determined in conjunction with the local community and other stakeholders.

7.1.3 Projected Future Activity

SSWAHS has some of the highest levels of community disadvantage in NSW. Miller is one of the most disadvantaged communities in the Liverpool LGA with high levels of unemployment, low levels of education and identified health need. Community Development services will continue to be of relevance to the Miller community and other disadvantaged communities, in the future.

Future Community Development initiatives, such as The Hub, may be required as a result of social conditions and/or government policy. These services will be developed as required.

7.2 Multicultural Health

A review of Multicultural and Migrant Health Services was commenced in 2006 with the intent of developing an Area wide Multicultural Health service.

Currently, across SSWAHS, Multicultural Health staff are involved in a range of activities including direct service provision, planning, health promotion, program development and training. In undertaking these roles, Multicultural Health staff work with bilingual/multicultural workers in other clinical streams to develop and deliver specific services.

Direct service provision relates to services provided to both individuals and groups. Historically, some activity has occurred in the inpatient setting, although this work is predominantly

undertaken in community settings. Direct service provision to groups includes physical activity, delivering tobacco control programs and the like. Bilingual Early Parenting Educators play a significant role in the delivery of services such as antenatal and parenting support.

Multicultural health also undertakes a range of non-clinical functions including the facilitation of local compliance with legislation and policy (such as Ethnic Affairs Priorities Statement), provides advice and assistance on improving access for CALD communities to health services and conducts specific health promotion, research and evaluation projects. In addition, Multicultural Health provides cultural awareness training programs for all staff.

Activity data for Multicultural Health services in 2005/06 is provided in Table 7.1 below. Please note, this data has limited reliability (see Section 5.2).

Table 7.1 2005/06 Multicultural Health Activity

Service	Individual OOS	No. of registrations	Group Sessions	Total Participants in Group Sessions	Average Group Size
Bankstown	2,081	Not available	190	7,074	37
Fairfield	56	Not available	258	5,945	23
Liverpool	154	Not available	194	3,052	16
Macarthur	Not available – delivery of group services				
Inner West	2,163	33	860	15,161	18
TOTAL	**4,454**	**-**	**1,502**	**31,232**	**21**

Source: 2005/06 DOHRS and PIRS reporting

7.2.1 Current and Emerging Issues

- **New communities** – across SSWAHS a number of new migrant/refugee communities are emerging. These new communities are predominantly African, with people coming from the Sudan, Sierra Leone, Ethiopia, Ghana, Nigeria, Somalia and Eritrea. People from the Asian nations of Burma and Bangladesh, as well as Pacific Islanders, are also settling in SSWAHS. Many people from these countries have poor health and have experienced trauma/torture;
- **Partnerships** – there is a need to strengthen partnerships within and between health services and local communities, NGOs, schools and other government departments to respond to the health needs of people from CALD backgrounds at both an Area and local level;
- **Interpreters** – in some language groups and at particular times, there is unmet demand for interpreter services;
- **Translated material –** there is limited access to simple, translated health information;
- **Differences in practice across SSWAHS** – due to the current service structure, there are sometimes significant differences in practice across the Area which need to be addressed to ensure equity;
- **Cultural competency and awareness** – good practice in working with people from CALD backgrounds is fundamental to the provision of all services, not just those provided by multicultural health;
- **Workforce** – there is a need for both generalist and language specific workers. However, the workforce should remain flexible to respond to the needs of emerging communities, language groups and health issues;
- **Quality and effectiveness** – there is a need for ongoing evaluation systems to monitor service quality and effectiveness;
- **Prevention and health promotion** – services need to have a focus on prevention and health promotion, including the delivery of basic health education information;
- **Service information** – information about service availability and access needs to be circulated more widely, for example through ethnic media;
- **Service flexibility and access** – transport is often a barrier to access, services need to have flexible delivery models to improve access.

7.2.2 Core Business and Future Model of Care

The main focus of Multicultural Health services is to deliver non-clinical services including community development, health education and promotion, consultation and the development of partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007 - 2012, and reviewed and reported on during annual planning activities.

In Multicultural Health, only the Bilingual Early Parenting Educators (BEPEs) deliver clinical services. Clinical Multicultural Health services will be provided and delivered to the community in line with the Community Health Clinical Core Business framework (see Appendix F). Clinical priorities have been identified through an analysis of need and an understanding of the effectiveness of intervention outcome. The highest priority clinical services in Multicultural Health are outlined below.

Priority One

- Sustained home visiting: provide assistance to the family as it engages with health and other services, and maintain ongoing support and continuity of care to prevent premature disengagement;
- Antenatal and parenting information and support;
- Develop and monitor care plans for individual clients in collaboration with relevant services;
- Participate in multidisciplinary case management meetings

There will sometimes be exceptions to the implementation of the Clinical Core Business Framework. In these circumstances clinicians will be guided by management as to appropriate service provision, following consideration of client need, available resources and efficacy of desired outcome/s.

7.2.3 Projected Future Activity

SSWAHS is expected to continue to be a favoured settlement area for migrants. As such, Multicultural Health services will continue to be in demand.

Flexibility in the service is required to ensure that the service is able to appropriately cater for the language and cultural groups most in need of services. This will be subject to ongoing monitoring and analysis of demographic data.

There is a need to expand the capacity and capability of Multicultural Health services to work with and support emerging communities, including people from a refugee background.

7.3 Sexual Health Services

At present, two distinct Sexual Health services are provided in SSW. Whilst they share many similarities, there are also substantial differences in the focus of each service. As a result of these differences, a review of Sexual Health services was undertaken in late 2006. The recommendations from the Sexual Health Service review have been considered and most will be implemented.

The NSW Sexually Transmissible Infections (STI) Strategy 2006-2009 and the NSW HIV Strategy 2006-2009 inform the provision of sexual health services in SSWAHS. The priority populations for both strategies are gay and other homosexually active men, people living with HIV/AIDS, Aboriginal people, sex workers, injecting drug users and young heterosexuals. Emphasis is also given to supporting General Practitioners (GPs) around sexual health care.

Bigge Park Centre Sexual Health service located at Liverpool provides services to inpatients and outpatients across the South West, regarding aspects of sexual health, HIV medicine, clinical immunology and infectious hepatitis (A, B and C). In addition, the unit provides medical care for all occupational exposures to blood borne viruses (BBV) and is a prescriber of HIV medications.

Clinics are also provided at Reiby Juvenile Justice Centre, Bowral and Goulburn Correctional Centres and Campbelltown CHC. Referrals to the service are accepted from local doctors and specialists or self referral. In addition linked services such as Youth Services, Drug and Alcohol Services, Women's Health Services, Justice Health and NGOs may refer patients. Currently, inpatients enter the service either via the emergency department, transfer from outpatient clinic or referral from another medical unit within the Area.

The Inner West Sexual Health Service is located at RPAH, with the clinical and sexual health promotion services situated in separate premises.

In addition, the service runs outreach clinics at Marrickville Community Health Centre and 'The Sanctuary' (Newtown). The clinical service provides outpatient Sexually Transmitted Infection (STI) screening and management, HIV medicine, and infectious hepatitis clinical care. Also provided are several specialised clinics, including a men's clinic, Aboriginal Women's clinic, Chinese and Vietnamese language clinics, a sex worker clinic, and a clinic for clients of drug rehabilitation services.

The service also operates as a secondary needle and syringe program outlet, providing safe injecting equipment, information, referral, resources and safe disposal of used equipment.

Each sexual health service has a Health Promotion Team. The programs delivered by these teams are an essential part of the NSW population based response to current STI, HIV and Hepatitis C epidemiology and include professional education and training, resource and policy development, community awareness campaigns, and outreach education. Programs are provided in partnership with relevant services such as sexual health clinical services, drug and alcohol services, youth services and NGOs. Specific health promotion project portfolios include Aboriginal women, Aboriginal men, gay and other homosexually active men, past and current injecting drug users, people living with Hepatitis C, and sex workers.

Activity data for Sexual Health services in 2005/06 is provided in Table 7.2 below. Please note, this data has limited reliability (see Section 5.2).

Table 7.2 Sexual Health Activity 2005/06

Service	Individual OOS	New client registrations	Group Sessions	Total Participants in Group Sessions	Average Group Size
South West	13,893	993	17	338	20
Inner West	17,610	1,973	560	14,666	26
TOTAL	**31,503**	**2,966**	**577**	**15,004**	**26**

Source: SSWAHS Sexual Assault Services 2005/06
Note: Bigge Park activity includes specific HIV service data, Inner West activity includes non-clinical groups

7.3.1 Current and Emerging Issues

- **Increasing rates of STIs** – including Gonorrhoea, Chlamydia and Hepatitis C;
- **Priority populations** – Aboriginal people, gay and other homosexually active men; people living with HIV/AIDS; sex workers and injecting drug users are key populations to focus on in sexual health promotion and service delivery;
- **Prevention and health promotion** – are essential roles of Sexual Health services through community development and education programs and population health initiatives;
- **Screening** – screening enables early identification and treatment of STIs, HIV and Hepatitis C;
- **Cultural diversity** – different cultural views relating to sexual health require highly trained staff and culturally specific services to ensure appropriate delivery;
- **Outreach** – outreach services are effective in working with particular target groups including Aboriginal people and in the gay community;
- **Evidence based practice** – there is a need to expand the evidence base in some areas of care and to undertake rigorous evaluation;

- **Partnerships**– delivering GP education regarding sexual health, STIs, HIV and Hepatitis C with the Australasian Society for HIV Medicine and the Divisions of General Practice will result in an increased capacity in the community to access detection and treatment services;
- **Tertiary support** – sexual health services provided by SSWAHS should act as a tertiary support service to a range of primary services offered through General Practice, Aboriginal Medical Services, other Community Health services and NGOs.

7.3.2 Core Business and Future Model of Care

Sexual Health services will be provided and delivered to the community in line with the Community Health Clinical Core Business Framework (see Appendix F). Clinical priorities have been identified through an analysis of need and an understanding of the effectiveness of intervention outcome. The highest priority clinical services in Sexual Health are outlined below, with priority two and three services outlined in Appendix F.

Priority One:
(Clients seen on the same day if possible)
- Clients who may have been exposed to HIV who require assessment for HIV post-exposure prophylaxis;
- At risk young people requesting emergency contraception;
- New/recent HIV diagnoses;
- HIV clients who are unwell;
- Clients with anogenital symptoms which may indicate an STI;
- Aboriginal people;
- Needle stick and Body Fluid Exposure;
- Clients presenting to Needle Syringe Program (NSP).

There will sometimes be exceptions to the implementation of the core business framework. In these circumstances clinicians will be guided by management as to appropriate service provision, following consideration of client need, available resources and efficacy of desired outcome/s.

In addition to these clinical priorities all services will include community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007 - 2012, and reviewed and reported on during annual planning activities.

7.3.3 Projected Future Activity

Given the increasing rates of some STI's there will be an increased demand for sexual health services in SSWAHS. Sexual Health is actively undertaking GP education to improve the detection and treatment of these infections by primary care providers.

However, the demand for SSWAHS Sexual Health services will remain, particularly in relation to the aforementioned priority populations.

Ongoing planning processes for HIV/AIDS funded services and more specifically the Sexual Health service, will entail a more detailed trend and service analysis, combined with activity projections.

7.4 Women's Health Services

Women's Health services across SSWAHS have recently been amalgamated into a single Area wide service. Work is currently underway to restructure these services, which have historically been provided through slightly different models of care.

The role of Women's Health as a service has been to build on existing intersectoral partnerships to improve women's health status, focussing on health issues which can be actioned by other services. Women's Health undertakes a range of policy, program, health promotion and community development work, as well as offering direct clinical services through women's health clinics.

Of the non-clinical services provided by Women's Health, much of the focus is on coordinating, facilitating and managing the implementation of women's health policy and programs to respond to women's health needs, and establishing collaborative partnerships (in particular through the Women's Health Forum) to improve women's health status. In addition, significant investment has been made in a range of community development projects, including the Villawood Icebreaker Project, which has been effective in engaging a range of government and non-government organisations to work collaboratively to support the Villawood community and has achieved statistically significant improvement in mental health outcomes for women. Also of note is the Bilingual Community Educator (BCE) Program specifically targeting women from new and emerging migrant/refugee communities to improve their access to information and skills relating to health as well as education and employment opportunities.

The clinical role of the Women's Health service centres on the provision of Well Women's Clinics, targeting women who experience social disadvantage or who do not access mainstream health services. The Clinics are conducted by the Women's Health Nurses (WHN's) on an ongoing basis, in partnership with key stakeholders. These services include Pap test screening, pelvic examinations, breast examinations, counselling and education/information programs for women about contraception, menopause, sexually transmissible infections, gynaecological health and related matters. To access these clinics clients must be over the age of 14 and live within SSWAHS. Referrals are accepted from a wide range of sources, including self-referrals, with clients not requiring a Medicare card to access Women's Health Clinics. Across SSWAHS, specific clinics are conducted on needs basis as a stand-alone service, or in conjunction with local general practitioners. Regular clinics are also held at Campsie and Ashfield.

Women's Health services provided by SSWAHS complement a wide range of services available through NGOs.

Activity data for Women's Health services in 2005/06 is provided in Table 7.3 below. Please note, this data has limited reliability (see Section 5.2).

Table 7.3 2005/06 Activity Women's Health Clinical Services

Service	Individual OOS	Client Registrations	Group Sessions	Total Participants in Group Sessions	Average Group Size
Bankstown (covers Liverpool and Fairfield)	138	Not available	40	578	14
Macarthur	260	Not available	9	171	19
Wingecarribee	373	Not available	23	142	6
Inner West	265	126	6	102	17
TOTAL	**1,036**	**-**	**78**	**993**	**13**

Source: DOHRS and PIRS Reporting 2005/06

7.4.1 Current and Emerging Issues

- **Domestic violence** - Limited availability of services to respond to the needs of women experiencing domestic violence, abuse and/or trauma;
- **Prevention** - Need to strengthen participation in community development and prevention activities. Screening rates need to be increased including breast and cervical cancer screening and STIs;
- **Partnerships** - Need to strengthen current partnerships with other government and non-government agencies and to participate in joint planning and development initiatives to improve the service system;

- **Counselling services -** Need for additional counselling services, including in languages other than English;
- **Service access** - Need for "one stop shop" facilities where women can access multiple services/resources. These services should be supported by outreach services to access women in appropriate locations;
- **Refugees -** Women who are refugees have unique health issues and needs. Refugee groups are changing, with each group having unique prior experiences and needs.

7.4.2 Core Business and Future Model of Care

Clinical Women's Health services will be provided and delivered to the community in line with the Community Health Clinical Core Business Framework (see Appendix F). Clinical priorities have been identified through an analysis of need and an understanding of the effectiveness of intervention outcome. The highest priority clinical services in Women's Health are outlined below, with priority two services outlined in Appendix F.

Priority One:
- Cervical screening;
- Pelvic examinations;
- Breast examinations;
- Postnatal checks;
- Advice/information about contraception, menopause, sexually transmitted infections, gynaecological health and wider health and wellbeing issues

There will sometimes be exceptions to the implementation of the core business framework. In these circumstances clinicians will be guided by management as to appropriate service provision, following consideration of client need, available resources and efficacy of desired outcome/s.

A significant proportion of the Women's Health service involves non-clinical work including community development, health education and promotion, policy development, consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007 - 2012, and reviewed and reported on during annual planning activities.

7.4.3 Projected Future Activity

As the population of SSWAHS grows, demand for Women's Health clinical services, delivered by WHNs, will continue to increase.

WHNs target socially and economically disadvantaged women and those with the poorest health outcomes. Specialised services may need to be developed to ensure the health needs of particular groups are met, for example women from refugee backgrounds.

Women's health will continue to deliver non-clinical services in partnership with other SSWAHS and non-government services.

7.5 Sexual Assault Services

Sexual Assault services across SSWAHS were reviewed in 2006 to create an Area wide model. As a result of the review, management of sexual assault medical services has been transferred to the acute setting, with sexual assault counselling services continuing to be managed by Community Health. Significant work is required to ensure cooperative systems are established and maintained to minimise disruption to clients as a result of these arrangements, particularly in relation to crisis care.

Sexual Assault teams are currently based at RPAH, Liverpool, Bankstown, Macarthur and Bowral. The Eastern and Central Sexual Assault Service (ECSAS) provides services to adults and young people. Children under 14 years are treated at either Westmead or Sydney

Children's Hospitals. ECSAS also provides services to adults and young people over the age of 14 years to clients living in the northern section of the South Eastern Sydney Illawarra Area Health Service (SESIAHS). ECSAS is located in KGV Camperdown with regular outreach being provided at the Royal Hospital for Women at Randwick and Canterbury CHC. The remaining teams provide services to people of all ages.

Referrals to the service come from a wide range of sources including self referrals, family and friends, ambulance, police, other health services and other government departments. The main client groups seen are children (south west only), recent rape victims, non-offending parent/partners and friends and adult survivors of childhood sexual assault.

Counselling services are focussed on assessment and crisis support, information, ongoing counselling, court preparation and support and group work programs.

Follow-up counselling is conducted in a range of facilities including RPAH, The Royal Hospital for Women Randwick, Canterbury Community Health Centre, Liverpool and Bankstown Hospitals, Ingleburn and Narellan CHCs. At the Eastern and Central Sexual Assault Service, an initial counselling contract of six to eight sessions is offered with further sessions being available after a review of progress. In the South-West, no limit has been applied.

Sexual Assault Services are also involved in consultation, training, education and research activities, as well as working in collaboration with government and non-government agencies in respect to case review, provision of court reports, protection, planning, consultation, and education and training to both staff and the community.

Activity data for Sexual Assault services in 2005/06 is provided in Table 7.4 below. Please note, this data has limited reliability (see Section 5.2).

Table 7.4 2005/06 Sexual Assault Service Activity

Service	Individual OOS	Client Registrations	Group Sessions	Total Participants in Group Sessions	Average Group Size
Bankstown	2,338	Not available	5	22	4
Liverpool	8,329	Not available	188	419	2
Macarthur	4,086	260	14	302	22
Wingecarribee	781	Not available	0	0	0
Inner West	10,156	399	14	85	6
TOTAL	**25,690**	**-**	**292**	**828**	**3**

Source: 2005/06 PIRS and DOHRS reports; Macarthur Sexual Assault Service
Note: figures include medical services

7.5.1 Current and Emerging Issues

- **Incidence of sexual assaults** – whilst the incidence of reported sexual assaults may have fallen (see Figure 2 in Appendix E), many sexual assaults are not reported to the police;
- **Crisis support** – there is a need to ensure timely crisis intervention for both forensic medical and counselling services following an assault;
- **Ongoing support** – there is a need to provide follow up counselling to people who have experienced sexual assault;
- **Service access** – sexual assault services are provided throughout the Area. Outreach services are essential, particularly in new communities, to provide appropriate support;
- **Services to at risk groups** – recent research has indicated that sexual assault services to Aboriginal communities should be strengthened to address the high rates of reported abuse;
- **Prevention and community development** – staff report limited capacity to work with partners on developing and implementing these initiatives;
- **Training and education** – staff report having limited capacity to provide training and education to clinical staff;

- **Data comparability** – inconsistencies in the way sexual assault activity data is collected and reported across the Area has been identified, making projecting future requirements problematic.

7.5.2 Core Business and Future Model of Care

Sexual Assault services will be provided and delivered to the community in line with the Community Health Clinical Core Business framework (see Appendix F). Clinical priorities have been identified through an analysis of need and an understanding of the effectiveness of intervention outcome. The highest priority clinical services in Sexual Assault services are outlined below, with priority two and three services outlined in Appendix F.

Priority One:

- 24 hour crisis counselling and medical response to adults, young people and children who have experienced a recent sexual assault
- Ongoing counselling to adults, young people and children who have experienced sexual assault and their (non-offending) family/significant others. In accordance with NSW Health policy directives, for those services which see both adults and children, priority for client allocation will be given in descending order to the provision of services for new clients and non-offending family members from the following categories:
  a. Children, where the sexual assault has occurred within the past seven days and adults who have been sexually assaulted in the last seven days (this also includes their non-offending parents and siblings)
  b. Any disclosure of sexual assault by a child or young person under the age of 16 (this also includes their non-offending parents and siblings)
  c. Any disclosure of sexual assault by a young person aged 16-18
  d. Adult victims sexually assaulted in the last year
  e. Any sexual assault victims requiring court preparation and support or cases where the assault is the subject of some investigation and does not fit into category one to four
  f. Adults who have been sexually assaulted as adults more than one year ago
  g. Adults who have been sexually assaulted as a child
- Follow-up medical services
- Group work services for victims and non-offending family and friends

There will sometimes be exceptions to the implementation of the core business framework. In these circumstances clinicians will be guided by management as to appropriate service provision, following consideration of client need, available resources and efficacy of desired outcome/s.

In addition to these clinical priorities all services will include community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007 - 2012, and reviewed and reported on during annual planning activities.

7.5.3 Projected Future Activity

To project future clinical activity, it has been assumed that the current rate of reported sexual assaults of 5.518 per 10,000 population (see Section 4.7) continues in SSWAHS over the next 5-10 years. This assumption factors in that not all sexual assaults are reported and that SSWAHS will make a contribution to reducing the overall rate of sexual assault in the area through prevention initiatives.

The data presented in Table 7.5 below indicates that between 2006 and 2011 there is projected to be a 6% increase in demand for sexual assault services, with a further 6% increase between 2011 and 2016. Further work is required on data reporting systems to determine how this translates to occasions of service.

Table 7.5 Projected Sexual Assault Activity to 2011 and 2016 in SSWAHS

	2005/06	2011 (est)	% change 2005/06 - 2011	2016 (est)	% change 2011 - 2016	% change 2005/06 - 2016
Number of Sexual Assaults	745	789	6%	837	6%	12%

Additional activity will continue in relation to community development and prevention initiatives, which are not captured using existing data systems.

7.6 HIV/AIDS Community Services

The majority of community HIV/AIDS services in SSWAHS are situated in the inner west, consistent with the distribution of people living with and at risk of HIV/AIDS (82% of SSWAHS HIV notifications 2001-2005 are inner west residents). The main HIV Immunology service in the south west involves case management, counselling, education and support groups provided through the Bigge Park Centre at Liverpool (see Section 7.3)

The Community HIV Service incorporates three community based programs - 'Positive Central' (Redfern CHC), the Sanctuary (Newtown) and Positive Heterosexuals (Camperdown/Statewide). The Positive Central staff and Sanctuary program provide a comprehensive range of allied health services for clients who are HIV positive, predominately within the inner west of SSWAHS. This includes peer education, health promotion and individual and group intervention.

The Positive Central team includes Occupational Therapists, Social Workers, Physiotherapists and a Dietician. Self referrals, interagency referrals and ambulatory hospital transfers to the community are allocated at a weekly intake meeting. Multi-disciplinary or joint assessments are completed for all referrals, with case coordination provided by the appropriate health professional.

The Sanctuary offers individuals with HIV, their partners or primary carer, health maintenance programs - including Health Education and support, Complimentary Therapy (massage) Service, Peripheral Neuropathy Clinic (research), Multi-disciplinary/allied health clinics and Primary Care service development, and a diverse range of treatment, support and living skills groups.

The Heterosexual HIV/AIDS Service or Pozhets are the lead agency statewide, providing services for heterosexual men and women living with HIV/AIDS, their families and carers. Services include peer education and support groups/workshops, activities specifically for women, men and families, a 1800 telephone support line, interactive website, Weekend Retreat and Annual Workshop. A program of HIV worker training, peer education and support, interagency partnerships, resource development and outreach programs is also provided.

Activity data for HIV/AIDS Community services in 2005/06 is provided in Table 7.6 below. Please note, this data has limited reliability (see Section 5.2).

Table 7.6 HIV/AIDS Community Service Activity 2005/06

Service	Individual OOS	Client Registrations	Group Sessions	Total Participants in Group Sessions	Average Group Size
HIV/AIDS Community Services	10,679	65	277	1,585	6

Source: DOHRS Reports 2005/06
Note: Bigge Park activity is recorded with Sexual Health activity in Table 7.2

7.6.1 Current and Emerging Issues

- **Prevention and Health Promotion –** HIV notification rates increased slightly between 2000 and 2005 in SSWAHS residents, in line with state trends. There is a need to focus on prevention and health promotion to address this trend;
- **Social isolation –** people with HIV/AIDS often experience social isolation which can lead to further health problems. Many people experience discrimination and social stigmatisation;
- **Cultural diversity** – specific programs and a trained workforce are required to support clients and their families from culturally and linguistically diverse backgrounds (more than 50% of all people diagnosed with HIV in the south west were born overseas, with the comparable figure for the inner west being just under one third);
- **Ageing community** – the population of people living with HIV/AIDS is ageing. People are requiring additional support associated with their age/frailty, delivered in an appropriate environment and culture;
- **Complex clients** – many people with HIV/AIDS have associated health issues including mental health problems and drug and alcohol problems. Coordinated and comprehensive models of care are required to support these clients;
- **Specialist services** – specialist HIV/AIDS services play a role in the delivery of tailored care and support, which complements that available through generic services;
- **Service equity** – access to services should be available across the Area, recognising the distribution of people with HIV/AIDS and the need for specialist services;
- **Self management** – can improve the health and well-being of people living with HIV/AIDS;
- **Service integration** – particularly between hospital and home should be improved to ensure clear communication of instructions and care plans;
- **Counselling and support** – is required for people living with HIV/AIDS and their families;
- **Partnerships** – working with NGOs can assist HIV/AIDS community services to better meet the needs of people with specific issues.

7.6.2 Core Business and Future Model of Care

SSWAHS is currently developing a Strategic Framework for HIV/AIDS program funded services, with estimated completion during the 2007 calendar year. This Framework aims to ensure that available funding is distributed equitably to meet the existing and emerging needs among priority populations, consistent with Commonwealth/State policy directions, reflecting community expectations, according to best practice models and within a monitoring framework supported by service agreements, performance indicators and targets.

Within the existing HIV/AIDS Community Services, services will be provided and delivered to the community in line with the Community Health Clinical Core Business Framework (see Appendix F). Clinical priorities have been identified through an analysis of need and an understanding of the effectiveness of intervention outcome. The highest priority clinical services in HIV/AIDS Community Services are outlined below, with priority two and three services outlined in the Appendix.

***Priority One* - Positive Central**

- *Social Work* - Assessment, goal identification and care planning, counselling, advocacy, service coordination (complex needs), housing assessments and support;
- *Occupational Therapy* – Assessment, care planning, motivation and goal setting, home modifications, meaningful activity problem solving, cognitive/memory assessment, fatigue/energy conservation advice, personal and domestic care assessments;
- *Physiotherapy* - Assessment, care planning, exercise programs, physical rehabilitation, peripheral neuropathy clinic, mobility and respiratory assessments, pain relief management, hydrotherapy group, services to residents of The Bridge (AIDS Dementia Residential Unit);
- *Dietetics* - Assessment, care planning, nutritional assessment, supplement service, lipodystrophy monitoring, budget shopping;
- *Multidisciplinary Group Work* – focus areas include mental health, ageing, communication, social isolation, grief, physical and emotional health
- *The Sanctuary* - Complimentary therapy (massage) service, peripheral neuropathy clinic.

The Sanctuary (Area-wide service)

- Complementary therapy (massage) service, peripheral neuropathy clinic

There will sometimes be exceptions to the implementation of the core business framework. In these circumstances clinicians will be guided by management as to appropriate service provision, following consideration of client need, available resources and efficacy of desired outcome/s.

In addition to these clinical priorities all services will include community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007 - 2012, and reviewed and reported on during annual planning activities.

7.6.3 Projected Future Activity

The slight increases in HIV diagnoses experienced over recent years and lengthening survival rates with improvements in HIV pharmacotherapy indicate that there will remain an ongoing need for HIV specific services provided within a Community Health context. The complex and specific service needs of people living with HIV/AIDS will continue to require discrete service provision differentiated from mainstream Community Health service provision.

7.7 Counselling Services

The Community Health Counselling service will be reviewed in 2007, with a view to developing a consistent care model across the Area. At present, a discrete counselling service operates in the South West providing child and adult counselling. However, in the inner west counselling is provided through Child, Adolescent and Family teams. Only limited adult counselling services are available in the inner west. Across the Area, a significant amount of counselling is also provided through NGOs.

The Community Health Counselling service employs Psychologists, Clinical Psychologists, Social Workers and Health Education Officers. Counselling services are provided for people who require counselling support for issues which are able to be managed outside of Mental Health services. The service provides both group and individual/family counselling, as well as undertaking health promotion and community development initiatives in partnership with other clinical services and organisations.

Children up to 12 years and their families are referred to Community Counselling services with problems such as adjustment (to school, parental separation etc), self-esteem, interpersonal communication, sexualised behaviour and depression or anxiety. These services will report through to the clinical directorate of Child and Family Clinical Services, as the part of

Community Health responsible for setting direction and defining clinical core business for all presentations relating to children and their families.

In the south west, youth and adult referrals to counselling services are predominantly for issue such as anxiety and depression, stress, grief and loss, domestic violence or interpersonal difficulties. There is limited capacity to respond to demand for this type of counselling in the inner west.

Activity data for Community Counselling services in 2005/06 is provided in Table 7.7 below. Please note, this data has limited reliability (see Section 5.2).

Table 7.7 2005/06 Community Counselling Activity

Service	Referrals	Individual OOS	Group Sessions	Number of Participants in Group Sessions	Average Group Size
Bankstown	375	577	11	81	7
Liverpool	325	2,490	22	187	9
Fairfield	412	7,188	24	450	19
Macarthur	502	1,495	31	181	6
TOTAL	**1,614**	**11,750**	**88**	**899**	**10**

Source: PIRS Reporting 2005/06

7.7.1 Current and Emerging Issues

- **Service access** – waiting lists exist to access Community Counselling services across the Area. In the inner west there is limited access to adult counselling services;
- **Partnerships** – working with non-government organisations can assist counselling services to meet the needs of people with specific issues;
- **Outcome measurement** – evaluation tools are required to demonstrate the effectiveness and benefits of counselling services;

7.7.2 Core Business and Future Model of Care

The Core Business and Future Model of Care for Community Counselling Services will be determined through a service review to be undertaken in 2007. A preliminary analysis has been developed to inform this review.

It is proposed that Community Counselling Services, will be provided and delivered to the community in line with the Community Health Clinical Core Business Framework (see Appendix F), subject to review. Clinical priorities have been identified through an analysis of need and an understanding of the effectiveness of intervention outcome. The highest priority clinical services in Community Counselling Services are outlined below, with priority two and three services outlined in the Appendix.

Priority One

- Adults for whom a response is mandated according to legislation and policy (for example, high risk behaviours/self-harm, domestic violence, victims of crime, child protection issues)
- Comprehensive psychosocial screening and assessment at the point of referral/intake to determine the counselling response, or advice about alternative agencies
- Provision of evidence-based intervention to adults, assessed or screened at intake, as requiring a counselling response or other intervention (for example, current evidence indicates effective management is dependent upon early intervention)
- Group programs where, evidence indicates, early intervention will have the greatest potential impact on health outcomes

There will sometimes be exceptions to the implementation of the core business framework. In these circumstances clinicians will be guided by management as to appropriate service provision, following consideration of client need, available resources and efficacy of desired outcome/s.

In addition to these clinical priorities all services will include community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007 - 2012, and reviewed and reported on during annual planning activities.

7.7.3 Projected Future Activity

Community Health will maintain a role in the provision of Community Counselling services. However, it is not possible to determine the projected future activity until the service review is complete.

7.8 Community Nutrition Services

Community nutrition services are provided by Community Health, Allied Health, General, Geriatric and Rehabilitation Medicine (GGRM), Population Health and hospitals, with differing program availability and models of care across the Area. Community Health, Allied Health and Population Health work collaboratively to develop and implement nutrition programs.

Community Nutrition services are primarily delivered using a population-based approach in partnership with key stakeholders, and include health promotion work and public health nutrition projects. Target population groups include early childhood (0-5 years), school-aged children, and people accessing HACC funded services.

In addition to the population-based work, some individual dietetic intervention is provided to early childhood and people eligible to receive HACC funded services. The variation in funding, and program commencement dates, results in variation in clinical activity, as reflected in Table 7.8 below (see also Section 5.2).

Table 7.8 Community Nutrition Activity 2005/06

Service	Individual OOS	Client registrations	Group Sessions	Number of Participants in Group Sessions	Average Group Size
Bankstown	0	Not available	37	684	18
Bowral	397	Not available	12	122	10
Inner West	260	192	87	1,085	12
TOTAL	**657**	**-**	**136**	**1,891**	**14**

Source: 2005/06 DOHRS Reporting

7.8.1 Current and Emerging Issues

- **Food security** – many people in SSWAHS experience food insecurity, particularly as a result of low incomes;
- **Levels of malnutrition** – a high proportion of older people living in the community experience malnutrition or are at risk of malnutrition;
- **Population ageing** – as the population ages, there will be an increased demand for community nutrition services and community based meals services funded through the HACC program;
- **Obesity** – there is a high level of obesity in SSWAHS. Programs and services, combined with population health initiatives, may assist in decreasing the level of obesity in the Area;
- **Breastfeeding** – some areas of SSWAHS have particularly low breastfeeding rates. Breastfeeding promotes good nutrition in early life and should be promoted and encouraged;
- **Service equity** – community nutrition services should be available equitably across the Area;
- **Clinical and corporate governance** – for community nutrition services differs across the Area.

7.8.2 Core Business and Future Model of Care

Community Nutrition Services will be provided and delivered to the community in line with the Community Health Clinical Core Business Framework (see Appendix F). Clinical priorities have been identified through an analysis of need and an understanding of the effectiveness of intervention outcome. The highest priority clinical services in Community Nutrition services are outlined below, with priority two services outlined in Appendix F.

Priority One
- Paediatric nutrition and dietetic service for children aged zero to five and their parents;
- Nutrition and dietetic service for clients eligible for HACC funded services.

There will sometimes be exceptions to the implementation of the core business framework. In these circumstances clinicians will be guided by management as to appropriate service provision, following consideration of client need, available resources and efficacy of desired outcome/s.

In addition to these clinical priorities all services will include community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007 - 2012, and reviewed and reported on during annual planning activities.

7.8.3 Projected Future Activity

Given the current and emerging issues outlined above, there is an increasing demand for community based nutrition services, offering an early intervention approach. This will primarily focus on children up to age five and on frail, older people. However, the SSWAHS Obesity Prevention and Management Plan (currently in development) may identify additional service needs particularly for older children and adults.

Future activity in Community Nutrition will in part be determined through a review of governance structures, which will assist in facilitating equity of service provision across the Area. Active linkages with other clinical services, within and outside of Community Health, along with Population Health will need to be maintained.

7.9 Youth Health Services

There are currently five specific youth health services in SSWAHS. They are 'The Corner' at Bankstown, Fairfield Liverpool Youth Health Team (FLYHT) at Carramar, Traxside at Campbelltown, Youthblock Health at Camperdown and a multicultural service at Canterbury. Services are provided to people between the ages of 12 and 24, focussing on providing support and assistance to young people who are homeless or at risk, including those who are isolated and unsupported, new arrivals including refugees and young Aboriginal people.

Referrals to youth health services are accepted from a broad range of service providers including youth services, refuges, welfare agencies, DoCS, the Department of Juvenile Justice (DJJ), other Area Health Service facilities and services, schools and alternative school programs, as well as parents/guardians and self-referral by clients. Services are provided for voluntary clients only, although some clients have been recommended by the courts to see a counsellor.

SSWAHS youth health services have been designed around priority areas such as drug and alcohol use, tobacco use, nutrition, physical activity, mental health, sexual health and injury.

A holistic, multidisciplinary service model of care is provided, enabling programs and services to be tailored to individual client needs. Clients are able to access a range of developmentally appropriate services, including health promotion, prevention, early intervention, counselling, nursing and medical services, including specialist services such as

psychiatry and dental. In addition, services run a variety of community development programs in music, visual arts and IT.

Whilst services are provided in the Youth Health Centres, some services are provided on an outreach basis in conjunction with other stakeholders such as schools, and generalist youth centres.

In interpreting the data provided in Table 7.9 below, it should be noted that a significant proportion of the service delivery undertaken by youth health services is associated with "drop in" support. Drop in clients are not registered with the service and are not recorded in client registration statistics. See also Section 5.2.

Table 7.9 Youth Health Service Activity 2005/06

Service	Individual OOS	Client registrations	Group Sessions	Number of Participants in Group Sessions	Average Group Size
The Corner (Bankstown)	459	Not available	228	5,899	26
FLYHT (Fairfield/ Liverpool Youth Health)	807	Not available	314	6,795	22
Traxside (Macarthur)	980	Not available	22	882	40
Youthblock Health and Canterbury (Inner West)	5,048	436	360	6,949	19
TOTAL	**7,294**	**-**	**924**	**20,525**	**22**

Source: 2005/06 DOHRS reporting

7.9.1 Current and Emerging Issues

- **Access** - Locational, cultural and physical barriers can limit access to youth health services. Additionally, current referral, intake and appointment systems can be a barrier to access. There is a need to expand outreach services, including improving linkages with youth services, youth groups and schools;
- **Premises** – the physical location of youth health services and the design of buildings impact on the success of centralised youth health services. Premises should be located in areas with high numbers of young people, particularly at risk young people, be easily accessible by public transport and have an appropriate youth friendly environment;
- **Health behaviours** - Increasing rates of risk behaviour including alcohol and drug use, injury and unprotected sex;
- **Health literacy** - Poor health literacy and capacity for advocacy amongst young people;
- **Technology** – opportunities exist to use technology eg. SMS to engage young people;
- **Health promotion and education** - Health promotion and education initiatives for young people need to be improved and evaluated for effectiveness;
- **Service integration** - Further integration of youth health with other health services, other government and non-government organisations and GPs is required to provide holistic care;
- **Cultural awareness** - Workers need to understand the social and cultural backgrounds of clients/ potential clients;
- **Research on Outcomes** – different models of care are employed across the Area in the delivery of services. Further research is required to determine whether group or individual programs are more effective, in order to inform future service planning;
- **Workforce** – vacancies in the youth health workforce limit the capacity of the service to provide the full range of services required.

7.9.2 Core Business and Future Model of Care

Youth Health Services will be provided and delivered to the community in line with the Community Health Clinical Core Business Framework (see Appendix F). Clinical priorities have been identified through an analysis of need and an understanding of the effectiveness of intervention outcome. The highest priority clinical services in Youth Health services are outlined below, with priority two services outlined in the Appendix.

Priority One

- Young people at risk of harm for whom a response is mandated according to legislation and policy (for example, high risk behaviours/self-harm, domestic violence, child protection issues);
- Comprehensive assessment at the point of referral/intake to determine the most clinically appropriate response, including referral to external agencies;
- Evidence - based intervention to young people, assessed or screened at intake, as requiring a counselling response or other intervention;
- Group programs where, evidence indicates, early intervention will have the greatest potential impact on health outcomes (for example, anxiety/stress management groups, fighting depression programs, parent support groups);
- Nursing and/or medical clinics to "at risk" young people via appointment and drop in services, prioritising young people who require medical advice, cervical screening, advice/information about contraception, sexually transmissible infections, assistance with prescriptions, and wider health and wellbeing issues;
- Secondary Needle and Syringe Program (NSP) services and the provision of opportunistic brief intervention.

There will sometimes be exceptions to the implementation of the core business framework. In these circumstances clinicians will be guided by management as to appropriate service provision, following consideration of client need, available resources and efficacy of desired outcome/s.

In addition to these clinical priorities all services will include community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007 - 2012, and reviewed and reported on during annual planning activities.

7.9.3 Projected Future Activity

Youth Health services will continue to focus on the health needs of at risk young people. Youth Health is an area in which the NSW Government has identified the need to improve outcomes, particularly in relation to mental health, drugs, tobacco and alcohol, sexual health; nutrition; weight and exercise and pregnancy and parenthood. To make significant gains in this area will require further investment in Youth Health services, and other clinical services targeting young people. Flexibility in the design and delivery of youth health services for the future is required to take into account changing demographic patterns and the unique needs of this group.

8. COMMUNITY ACUTE – POST ACUTE AND CHRONIC CLINICAL SERVICES

The Community Health Clinical Directorate known as Community Acute – Post Acute and Chronic Clinical Services comprises a wide range of primary health care, nursing, post acute and chronic care services designed to meet the unique needs of particular target groups. They include:

- Community Health Nursing (Section 8.1)
- Palliative Care Nursing (Section 8.2)

The following sections describe the current situation and future plans for each service type.

8.1 Community Health Nursing

Community Health Nursing (CHN) is provided to people of all ages across SSWAHS. Currently, the availability of services and models of care vary slightly across the area, although all operate within a primary health care philosophy. Services are provided in different environments according to client needs, including the home, workplace, or health care centre. The majority of referrals to CHN are from general practitioners (GPs), hospital wards, emergency departments (EDs) and direct from clients/families.

Registered Nurses (RNs) and in the south west, Enrolled Nurses (ENs) provide services such as:

- Community acute care - substituting ie. avoiding hospital admission or reducing length of stay through the provision of a range of interventions in partnership with GPs, local hospitals and Ambulatory Care units;
- Wound management - treatment of people with acute and chronic wounds, including the provision of specialist wound clinics in some areas;
- Continence and catheter management;
- Post-surgical and post-hospital care including management of drainage devices;
- Respiratory care, including asthma management;
- Chronic disease self-management - incorporating the development of a self-management plan in collaboration with the client and the GP and facilitation of self-management groups;
- School health services including screening and delivery of the Health Promoting Schools (HPS) program in some areas;
- Palliative care;
- In some localities, support to staff and residents of residential aged care facilities (RACF) to prevent unnecessary admission and post-acute support where possible.

To support the provision of this range of services and ensure clinical quality, access is available to community based Clinical Nurse Consultants (CNCs) in a range of specialties including Continence, Oncology/Palliative Care, Primary Health Care, Paediatrics, Community Acute Care, Women's Health, HIV/AIDS, Wound Care/Infection Control and Spinal Injuries. The availability of CNC's in each of these specialities is variable across locations. Additional support is also available from hospital based CNC's in specialties such as Cardiology, Diabetes and Infection Control. Again the availability of these services is variable across the Area.

Services operate seven days a week, between 0730 and 2230hrs, although the exact hours of operation for each service are variable across the Area.

CHNs are funded through a mix of NSW Health and HACC program funding. As such, the level of funding available across the Area varies, depending on local needs identified through the HACC planning process and the availability of other nursing providers. The majority of CHN services are provided to people aged over 65, although the demographics of populations served may vary across the Area.

Based on the activity data presented in Table 8.1 below, at present CHN's provides 1.8 individual OOS, per person aged over 65, per annum. Group activity is variable depending on the location.

Activity data for Community Health Nursing services in 2005/06 is provided in Table 8.1 below. Please note, this data has limited reliability (see Section 5.2).

Table 8.1 CHN Activity 2005/06

Service	Individual OOS	Inpatient OOS	Group Sessions[1]	Number of Participants in Groups	Average group size
Bankstown	32,690	14	52	521	10
Fairfield	45,896	862	87	917	11
Liverpool	48,603		239	2,420	10
Macarthur	34,246		0	0	0
Wingecarribee	15,919	507	47	728	15
Inner West	89,573		46	294	6
TOTAL	**266,927**	**1,383**	**471**	**4,880**	**10**

Source: 2005/06 DOHRS reporting
Notes: excludes some Palliative Care Activity; includes some school based activity and ambulatory care activity

8.1.1 Current and Emerging Issues

- **Ageing population** - Clients are becoming increasingly complex and frail, with this trend expected to continue as the population ages. Further, older people are expressing a desire to remain living independently for as long as possible, thus requiring CHN services at home rather than receiving nursing care through a residential facility;
- **Chronic Disease** – the prevalence of chronic disease in the community will place increasing demands on CHN services;
- **Multiple Funding Sources** – CHN funding comes from multiple funding sources including NSW Health and the Home and Community Care (HACC) program. There are differing systems and requirements associated with each funding source and associated issues in relation to funding being sufficient to meet award increases without reducing service delivery;
- **Prevention and health promotion** – there is a need to deliver services which focus on prevention and health promotion
- **Workforce** – services are currently provided by both RNs and ENs, though the staffing profile varies between localities. Reasonable workloads need to be identified and implemented equitably across the Area;
- **Service Access and Flexibility –** need to link CHN with other services such as aged day care to improve service flexibility and responsiveness and to improve service efficiency;
- **Avoidable Hospital Admissions –** CHNs can prevent hospital admissions through early identification and treatment of illness. This support is required for people living at home and also in residential care facilities;
- **Palliative care –** people requiring palliative care are increasingly expressing a desire to die at home, resulting in increased demand for community based services;
- **Community Acute/Post Acute Care** - CHN services provide post acute care and support in combination with outpatient and ambulatory care services. As length of stay continues to decline in the inpatient setting, CHN services will increasingly be required to provide care to patients with higher acuity needs in the community;
- **Client discharge and referral –** many CHN clients will require ongoing care and may also require additional community support services. CHNs need to be aware of the services available locally to support clients and be supported to discharge or refer clients to the most appropriate services. The lack of availability of some community care services limits the capacity of CHNs to discharge clients;

[1] Group services are generally those provided using a group model eg. school screening, immunisation. However, individual OOS are still provided.

- **Goods and equipment** – the costs of consumables for use by CHNs is increasing. New and more sophisticated equipment is also becoming available which enables higher quality care and promotes efficiency, however the use of such equipment has cost implications;
- **Delivery of school based services** – is undertaken through different service models and governance structures across the Area. There is a need to ensure service equity in the delivery of school based health care;
- **Interpreters** – in some language groups and at particular times, there is unmet demand for interpreter services.
- **Motor vehicles, information technology and communication systems** – CHNs are a highly mobile workforce with a heavy reliance on fleet vehicles and remote communication systems. Service efficiencies can be gained through investment in information technology to enhance communication and through ensuring the availability of a suitable and sufficient fleet, including vehicles capable of transporting equipment;
- **Equity** – Different funding and structures across the Area have resulted in disparate service availability. In some cases, external funding has enabled the establishment of specialist positions in particular localities and not in others.

8.1.2 Core Business and Future Model of Care

CHN services will be provided and delivered to the community in line with the Community Health Clinical Core Business Framework (see Appendix F). Clinical priorities have been identified through an analysis of need and an understanding of the effectiveness of intervention outcome. The highest priority clinical services in CHN are outlined below, with priority two and three services outlined in Appendix F.

Priority One:
(Client seen within 24 hours)
- Intravenous medication and management of central lines;
- Risk of infection/complications, for example wounds, injections, with priority given to: significant carer stress; frail aged; isolated; minimal social support; no General Practitioner; significant functional/mobility/developmental impairment; chronic wound that has been clinically assessed as at risk; risk of hospitalisation (for example, respiratory, wound, exacerbation of chronic condition);
- Clients who are unable to self care/manage or do not have access to an alternative provider;
- Palliative Care/Oncology: Deteriorating condition, symptom management

There will sometimes be exceptions to the implementation of the core business framework. In these circumstances clinicians will be guided by management as to appropriate service provision, following consideration of client need, available resources and efficacy of desired outcome/s.

In addition to these clinical priorities all services will include community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007 - 2012, and reviewed and reported on during annual planning activities.
Participation in the planning for and development of alternative models of care will be undertaken to ensure that Community Health Nursing services are able to meet the increase in demand expected as a result of the ageing population. This includes greater involvement in shared care programs, *HealthOne* initiatives with General Practice and targeted programs for chronic and aged care.

8.1.3 Future Activity Projections

As the population grows, additional CHN services will be required to maintain the current level of service provision. Further, with the majority of CHN resources utilised on older people and/or people with chronic diseases, additional capacity will be required to meet

demand. The activity projections presented in Table 8.2 below are based on the current activity rate of 1.8 individual OOS per person over 65, projected to 2011 and 2016. The projections suggest that by 2016, CHNs will need to provide at least an additional 87,000 individual OOS per year. This is likely an under-projection as demand will increase exponentially through population ageing and chronic disease demands. However, this will need to be reviewed as models of care in hospitals and other settings develop.

Table 8.2 Projected CHN Activity to 2011 and 2016 in SSWAHS

	2005/06	2011	2016
Individual OOS	266,927	300,916	354,313

CHN funding may be sourced through the HACC program, although it is not possible to determine whether SSWAHS will be the funding recipient for any growth in HACC nursing services. A determination on the level of future activity through CHN will be subject to HACC funding availability, the role of community based nursing services provided through other streams and the development of new services eg. HealthOne (Integrated Primary and Community Care) and post acute care services.

Greater efficiencies in CHN may be gained through additional Community Health Centre based nursing clinics and through improved technology to expedite administrative processes.

8.2 Palliative Care Nursing

Specialist community Palliative Care Nursing services are provided Area wide as a consultative service to primary providers of Palliative Care ie: Community Health Nurses and GP's, as well as providing consultative services to hospitals, Residential Aged Care Facilities and other facilities. These specialist services operate from local CHCs and use different governance models.

In the south west the specialist team in some sites also contributes to the provision of the palliative care after hours/weekend services along with Community Health Nurses.

Table 8.3 2005/06 Palliative Care Nursing Activity

Service	Individual OOS	Inpatient OOS	Group Sessions	Number of Participants in Group Sessions	Average group size
Bankstown	8,825	713	25	522	21
Liverpool	4,042	0	0	0	0
Fairfield	7,516	114	42	421	10
Macarthur	1,814	70	0	0	0
Bowral	1,733	188	6	86	14
TOTAL	**23,930**	**783**	**73**	**1,029**	**45**

Source: 2005/06 PIRS Reports
Note: Palliative Care activity in the Inner West is reported through CHN (See Table 8.1)

8.2.1 Current and Emerging Issues

- **Ageing population** - clients are becoming increasingly complex and frail, often with limited alternative care options. This trend is expected to continue as the population ages. Further, older people are expressing a desire to remain living independently for as long as possible, thus requiring CHN services at home rather than receiving nursing care through a residential facility;
- **Place of death** – an increasing number of palliative care clients are choosing to die at home, or remain at home for as long as possible before death, resulting in an increased demand for community based palliative care nursing services;
- **Increasing incidence of cancer** – people with cancer make up the majority of palliative care work. The incidence of cancer is expected to increase over the next five years;
- **Avoidable Hospital Admissions –** community based palliative care can prevent or minimise potentially avoidable hospital admissions through earlier referral and the

management of symptoms. This support is required for people living at home and also in residential care facilities;
- **Goods and equipment** – the costs of consumables for use by nursing staff is increasing. New and more sophisticated equipment is also becoming available which enables higher quality care and promotes efficiency, however the use of such equipment has cost implications;
- **Interpreters** – in some language groups and at particular times, there is unmet demand for interpreter services;
- **Motor vehicles, Information technology and communication systems** – palliative care nurses are a highly mobile workforce with a heavy reliance on fleet vehicles and remote communication systems. Service efficiencies can be gained through investment in information technology to enhance communication and through ensuring the availability of a suitable and sufficient fleet, including vehicles capable of transporting equipment;
- **Clinical and corporate governance** – developing consistency in clinical and corporate governance structures across the Area will ensure an equitable and efficient service system.

8.2.2 Core Business and Future Model of Care

Palliative Care specialist services will be provided and delivered to the community in line with the Community Health Clinical Core Business Framework (see Appendix F). Clinical priorities have been identified through an analysis of need and an understanding of the effectiveness of intervention outcome. The highest priority clinical services in Palliative Care are outlined below.

Priority One:
- Clinical assessment to determine client need. For example, liaison with other health professionals (occupational therapist for aids and equipment, GP, social worker); suitability to link to inpatient palliative care services, the 1300 telephone support and advice line, and other appropriate support services (respite care, provision of personal care services);
- Management of pain and other distressing symptoms;
- End of life care. For example, maintaining clients at home if that is their choice;
- Education and support to clients, families/significant others and care providers;
- Bereavement follow up and support to families/significant others and care providers.

There will sometimes be exceptions to the implementation of the core business framework. In these circumstances clinicians will be guided by management as to appropriate service provision, following consideration of client need, available resources and efficacy of desired outcome/s.

In addition to these clinical priorities all services will include community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007 - 2012, and reviewed and reported on during annual planning activities.

8.2.3 Projected Future Activity

Demand for Palliative Care services is expected to increase in line with population growth, population ageing, increasing cancer rates and greater choice in relation to place of death. These additional factors will result in demand for Palliative Care services growing at a faster rate than general population growth.

9. CORPORATE, INTEGRATION AND SUPPORT SERVICES AND FINANCE AND OPERATIONS

Corporate Integration and Support Services and Finance and Operations are new Directorates within Community Health. The two directorates comprise a wide range of support and ancillary services which serve to strengthen the capacity of clinical services to deliver efficient and effective care. These Directorates have strong relationships to Corporate Services provided by the broader SSWAHS, including Information Management and Technology, Strategic Workforce Development, Human Resources and the like. Relevant functions of the units are described below:

- Service Integration (Section 9.1)
- Information Management (Section 9.2)
- Information Technology (Section 9.3)
- Service Development (Section 9.4)
- Quality and Clinical Risk Management (Section 9.5)
- Occupational Health and Safety (Section 9.6)
- Facilities and Resources Management (Section 9.7)
- Marketing of Community Health Services (Section 9.8)
- Workforce (Section 9.9)

The following sections describe the current situation and future plans for each functional area.

9.1 Service Integration

Three Service Integration Manager positions have been established within Community Health, primarily to:

- Ensure the delivery of coordinated services for the public at the point of entry and throughout the client journey;
- Form and maintain strong partnerships with other internal and external health services (including local hospitals and clinical streams), community organisations, NGOs, Local Councils and other government departments
- Coordinate administrative support to clinical staff at a local level including information management, occupational health and safety, cleaning, waste management, infection control, fleet management, centre maintenance, pest control and security to the clinical teams.

The Service Integration Managers will support clinical staff in undertaking non-clinical roles relating to community development, health promotion and partnership programs.

9.2 Information Management

The Information Management Unit (IMU) will be responsible for the planning, coordination and development of an information management structure for all services within Community Health.

Key responsibilities of the IMU include:

- Development and management of systems and processes to support clinical practice, service planning, research, quality improvement, evaluation and reporting requirements;
- Collection, analysis and reporting of information and relevant service statistics;
- Development of an information culture in Community Health services;
- Identification of information needs in collaboration with services and facilitation of access to relevant data and information;
- Implementation of continuous improvement systems and processes, in collaboration with quality improvement processes;
- Participation in change management through actively working with staff and other services to promote, plan, implement, manage and evaluate change processes particularly those involving information technology and management initiatives;
- Management of medical records and development of standardised policies and procedures to meet government legislation.

9.2.1 Current and Emerging Issues

- **Client Health Records** - Policies and procedures for culling of Client Health Records (CHR) are to be standardised across Community Health Centres. The improved management of client files will result in the need for appropriate primary, secondary and tertiary storage space for these records.
- **Central Intake** – creation of a central intake process will require not only changes in clinical systems but will require a central "call-centre" space.

9.3 Information Technology

The Information Technology (IT) Unit provides support across Community Health and Population Health for all aspects of information technology management, including hardware and software applications purchasing and maintenance, system backups, intranet/internet and cabling/networking.

9.3.1 Current and Emerging Issues

- **Equipment** – the availability and age of equipment varies markedly across the area. There is no ongoing maintenance program, or equipment replacement program to support regular equipment upgrades;
- **Software** – there is variable access to software across the Area, with different sites operating different programs;
- **Asset management –** there is a need to strategically plan for and manage the IT assets within Community Health;
- **Communication** – in order to achieve the stated objectives of the Community Health Strategic Plan improved communication within and between sites is essential;
- **IT Support and Helpdesk** – there is a need to evaluate the support received from the IT helpdesk in order to plan improvements to services.

9.4 Service Development

The Service Development Unit (SDU) is directly responsible for facilitating and coordinating activities that will improve delivery of client services. A major focus of this Unit is on care provided to clients. The SDU also oversees the facilitation and coordination of performance contracts, strategic directions and service policies within Community Health.

The SDU works with Clinicians and Managers in Community Health to:

- Develop services that improve clinical practices and are client focussed;
- Establish competencies for professional groups within Community Health services;
- Develop clinical governance processes and strategies;
- Improve clinical leadership;
- Establish indicators for performance and clinical services.

9.4.1 Current and Emerging Issues

- **Evidence based practice** – evidence based practice should inform the delivery of all clinical services. There is a need to foster an environment of evidence based practice and to up-skill staff in this area;
- **Performance indicators –** are required to measure and monitor performance.

9.5 Quality and Clinical Risk Management

The Quality and Clinical Risk Management Unit (QCRMU) provides:

- Specialist advice in relation to quality improvement, safety initiatives and accreditation reporting processes for Community Health;
- Leadership in the development, implementation, management and coordination of quality improvement initiatives across Community Health in accordance with the strategic direction of Community Health and a focus on outcomes;
- Leadership in the development and implementation of systems to support continuous quality improvement and risk management across Community Health;
- Assistance with change management;
- Liaison between the Area Clinical Governance Unit and Community Health.

The QCRMU will also facilitate the Accreditation processes for Community Health. Accreditation will be sought through membership of the Australian Council of Healthcare Standards (ACHS) using EQuiP 4.

9.5.1 Current and Emerging Issues

- **Clinical Indicators** – there is a need to finalise the development of indicators to measure clinical management and care outcomes, with a view to facilitating benchmarking opportunities for all clinical services within Community Health;
- **Clinical Risk** – an integrated risk management system is required to coordinate effective monitoring, review and evaluation of clinical risks and incidents across Community Health;
- **Complaints** – improved systems to manage and action complaints are required;
- **Consumer participation** – is essential to the implementation of sound quality and clinical risk management systems;
- **Accreditation –** Community Health is required to be accredited through the ACHS standards known as the EQuiP 4. This is a complex task given the recent amalgamation of services, different service and operational structures and a new EQuiP format.

9.6 Occupational Health and Safety

The health and well-being of staff is critical to the provision of a quality service to clients and in retaining highly skilled staff.

The Community Health Occupational Health and Safety Unit is responsible for developing and supporting the effective management of Occupational Health and Safety (OH&S) in Community Health and promoting a safety culture. This includes establishing and maintaining an Area Community Health structure to support implementation and ongoing management of a comprehensive OH&S risk management system in Community Health.

SSWAHS is committed to providing staff and clients with a safe environment in which to work and/or receive care. A recent audit of all Community Health facilities was undertaken to assess OH&S risks, so that appropriate strategies are put into place to eliminate or minimise the risks. The tools that are used for monitoring and reporting, including the IIMS (Incident Information Management System), the OH&S Numerical Profile and the Safety Audit.

9.6.1 Current and Emerging Issues

- **Ergonomics –** there is a need for all staff to undertake ergonomic assessments of their workplaces to ensure OH&S risks are managed;
- **OH&S Risk Management –** the diversity of Community Health service delivery sites poses challenges for coordinated OH&S risk management, particularly in relation to manual handling and the undertaking of risk assessments. Consistent policies and procedures are required across the Area, supported by ongoing education and training;
- **Hazardous substances –** need to be maintained in accordance with relevant policy;
- **Consultation –** improved consultation structures for OH&S policy development and risk identification and management are required across Community Health;
- **Data collection and management** – ongoing analysis of data collected through IIMS is required to identify trends and assist in developing appropriate management strategies;
- **Evaluation** – there is a need to evaluate the effectiveness of OH&S solutions.

9.7 Facilities and Resources Management

Community Health manages well over 100 facilities across the Area. Some of these facilities are owned by SSWAHS, whilst others are leased from private or public organisations. SSWAHS also utilises space in privately owned premises for the delivery of outreach services. A listing of all the Community Health facilities currently managed by SSWAHS is provided as Appendix B.

9.7.1 Current and Emerging Issues

- **Awareness of Community Health Centres –** Some CHCs may be difficult to locate and identify. Signage to and at CHCs should be improved to promote access and usage;
- **Maintenance –** improved systems to monitor and action maintenance issues at CHCs are required to ensure safety and comfort. Improved management of cleaning services is also required;
- **Storage –** there is insufficient storage space in many CHCs. However, there is a need for all CHCs to review their storage requirements and to appropriately dispose of, or archive, any outdated, disused or damaged equipment and documents;
- **Disabled access –** an audit of all CHCs is required to ensure disability standards are being met;
- **Nature of facilities –** it is important to have a range of facilities available to suit local needs, this includes smaller facilities for the provision of outreach services, complemented by larger CHCs offering multidisciplinary services in a "one stop shop" environment;
- **Demountables -** a number of issues have been identified with the use of demountables, including poor utilisation, isolation, security, safety, inappropriate entry, maintenance, access, alarms, locks, signage, air-conditioning units, configuration and client file storage;
- **Colocation with other agencies/organisations –** opportunities should be sought to colocate with other government and non-government agencies providing complementary services and/or services to the same target group. Opportunities to colocate with private for-profit providers should also be investigated;
- **Internal environments –** the internal environments of CHCs should be culturally appropriate and inviting. Information on service availability, alternative services, emergency contacts and complaints should be easily available. In some CHCs improvements to air conditioning are also required;
- **Point of contact –** CHCs should offer reception services appropriate to the size and nature of the facility;
- **Transport and parking –** CHCs should be located on public transport routes and provide safe access to public transport. Parking, including disabled parking, should also be available on site;
- **Security –** Security systems should be available to ensure staff and clients receive care in a secure environment. This includes provision of public needle/syringe disposal facilities, emergency duress alarms, keypad entry to clinical areas and after-hours security back-ups. Outreach clinics should be assessed for safety and security, with appropriate measures put in place prior to use. There is variable availability and use of security services across the Area.

9.8 Marketing of Community Health Services

Community Health has been a key aspect of health service delivery across the Area for some decades. However, the profile of Community Health both within the Area Health Service and the local community is lacking. Community Health needs to promote its capacity as a set of niche services which support all aspects of the public health and welfare sectors, through a community centred focus on prevention, early intervention, community based acute/post acute care and chronic disease self-management.

9.8.1 Current and Emerging Issues

- **Website** – the Community Health website needs to be developed to provide a consolidated site for information about Community Health facilities and services;
- **Aboriginal people** – Aboriginal people report a need to have information on Community Health services available through appropriate media including the Koori Mail and Koori Radio. Specific links with Aboriginal Health services should also be made and maintained,
- **Cultural diversity** – many people from diverse cultural backgrounds are not familiar with the Community Health system and services. Specific attention should be paid to

promoting the availability of services within existing and new communities through language specific media, cultural organisations and welfare groups;
- **Accessibility of information** – written material should be in plain English and universal symbols should be used where appropriate. Information should be made available in community languages, or at a minimum should direct people to appropriate translating/interpreting services;
- **Interagency participation –** relevant Community Health staff should participate in appropriate interagencies in order to develop and maintain links with other local operators and to promote the availability of services.

9.9 Workforce

For SSWAHS, our workforce is an investment. An investment in the care of our community; an investment in the future sustainability of the care we need to provide to our community; and an investment in the individual and their career with us. Thus, the theme of the SSWAHS Workforce Strategic Plan is "Investment in our Workforce".

The workforce goal is for SSWAHS to be the Area Health Service in which people want to work. In achieving this goal, there are four key tasks:
- Secure, retain, develop, manage and support our workforce;
- Be a good place to work;
- Offer opportunities to build a career with us; and
- Ensure our workforce numbers and skills, and their tasks, location and mix, are sufficient to meet our service needs.

Community Health has a current workforce of approximately 1,000 people employed as 850 FTE.

The workforce is based across the Area in a variety of locations and in a variety of single discipline and multidisciplinary teams. Some teams have a local management structure, whilst others are managed remotely. The head office (Executive Management Unit) for Community Health is currently located at Camperdown, although the Executive Management team are based across the Area. Consideration is being given to relocation of the Executive Management Unit to Liverpool in the future.

9.9.1 Current and Emerging Issues

- **Leadership -** the establishment of an Area-wide Community Health service has resulted in the need to develop a leadership structure and leadership team for Community Health;
- **Staff Numbers and Reasonable Workloads -** there has been an overall reduction in the number of staff in Community Health over recent years. There is a need to review the staffing profile for all services to determine the best configuration for each service/team, in the context of the agreed model of care;
- **Workforce Planning -** Workforce planning is currently occurring through the Strategic Workforce Development division of SSWAHS. This work is informed by the draft Area Healthcare Services Plan. The Community Health Strategic Plan will also inform this Area wide process. Initiatives undertaken at an Area level should be supported by specific initiatives within Community Health;
- **Recruitment -** SSWAHS has recently introduced an electronic recruitment system to streamline the recruitment process. Community Health staff should work with the SSWAHS Recruitment unit to ensure all necessary training in the use of the system is provided to Community Health staff;
- **Staff Retention -** With the limited pool of skilled and qualified staff available, it is important to retain the existing, quality staff in Community Health. To do this, particular attention needs to be paid to the circumstances in which staff are working, including their work/life balance, work environment, the availability of resources required to perform their roles (including support staff, IT infrastructure, motor vehicles and clinical

equipment), work satisfaction, having good internal communication systems, valuing and support of staff and opportunities for career development.

- **Professional Development (Training and Education) –** Staff and other stakeholders identified the need for professional development in areas such as cultural awareness, information technology, data management, research and the development of an evidence base for service delivery, integrating research into practice, current and emerging health needs of local communities and community development. The need for improved training in supervision and performance management for team leaders/managers, has also been raised. These training needs will be discussed with the SSWAHS Centre for Education and Workforce Development and a program of training opportunities for Community Health staff established;
- **Equity across the Area -** Given the differing structures of Community Health across the Area prior to amalgamation, there is disparity in both the distribution and grading of positions across the Area. Some situations exist in which people are paid at different levels to perform the same functions depending on when and where they were recruited. In other cases, significant organisational change has resulted in changing work demands which are not reflected in the current grading. A service review process is being undertaken at present to reflect equity and parity of positions across the Area.
- **Generalist versus Specialist Roles -** Consistent with the direction being developed by NSW Health for primary and community health services, is the need to develop a tiered approach to the provision of Community Health services. This approach supports the development of both generalist and specialist staff. This was also raised in staff consultations, which noted the need to develop specialist roles (such as Clinical Nurse Consultants) within services to provide clinical expertise and support to generalist and/or less experienced staff. It is expected that through the development of this model, greater efficiencies will be gained in the delivery of services at the level most appropriate to the needs of the client.
- **Student Placements -** Community Health provides placement for a large number of students each year (approximately 300 per annum). High quality placements and supervision during this phase may encourage students to seek careers in community health. Staff supervising student placements require support to continue to perform their core functions whilst providing a structured, learning environment and a quality service to clients;
- **Relationships with Universities –** opportunities to improve relationships with universities should be explored, including the creation of joint appointments and the expansion of research interests.

10. FUTURE COMMUNITY BASED HEALTH SERVICES

There are currently 138 community based service outlets in SSWAHS (see Appendix B), most of which are managed by Community Health. The outlets range from large scale, multidisciplinary Community Health Centres, such as those at Croydon, Marrickville, Bankstown and Bowral, to single service centres such as early childhood health centres. Having this range of outlet types distributed across the Area, enables the provision of the best possible access for clients and the most cost effective delivery of services. However, many Community Health and community based services have outgrown the outlets from which they are provided, particularly as new models of care, such as multidisciplinary clinics and increased community based care for older people, alter the way in which health services are delivered.

With the anticipated growth in demand for all Community Health services, and emerging areas of new demand, for example men's health, Community Health capacity will need to expand over the next five years and beyond. Much of the demand is directly related to population growth, although other significant factors include population ageing, increasing rates of chronic disease, a high rate of obesity, low breastfeeding and immunisation rates and changes to hospital models of care and technology which enable more people to be treated in the community setting. Consistent with this is also the need to constantly review the outcomes of our services to ensure the provision of high quality, effective services and best value for money. To this end, consideration will be given to disinvestment in particular services over time, if the evidence does not support their ongoing operation.

Improvements to community based health facilities across the Area are a priority for SSWAHS. This is evidenced by the recent opening of modern, purpose built facilities at Croydon and Marrickville, which provide a convenient location from which clients can receive a range of services. Planning is currently being undertaken to open new Community Health facilities in Redfern, Liverpool and Campbelltown, again for the convenience of residents.

As the population of SSWAHS continues to grow, and particularly as new populations establish in the South West Growth Centre (projected to be around 300,000 people over the next 20 – 25 years), the demand for additional, locally based services will intensify. SSWAHS is an active participant in planning for the land releases within the South West Growth Centre. Planning for these communities includes recognition of the likely health needs of the community, based on current trends and projections. Initial planning is underway for the first release precincts of Oran Park and Turner Road.

Future community based health facilities provided in SSWAHS will likely include a mix of services managed either by Community Health, or by Clinical Streams such as Mental Health, Oral Health, Aged Care and Drug Health. Preliminary clinical service planning for these streams in 2005 and 2006 has identified demand for new clinical services in the South West Growth Centre, for example oral health clinics and community aged care assessment and treatment services.

Planning work currently being undertaken in relation to Maternity Services, Obesity Prevention and Management, HIV/AIDS services, Aboriginal Health and as proposed for Child and Youth, may also result in identification of additional needs for community based services. Further work is required to quantify demand for services, as information becomes available about the likely demographic mix within the South West Growth Centre. Opportunities to co-locate health services with other community services, government agencies and service providers will be explored at this time. This will include consideration of opportunities to work more closely with other primary health care providers, such as general practitioners, through integrated primary and community health care services, such as those being developed through *HealthOneNSW*.

11. IMPLEMENTATION, MONITORING AND EVALUATION

Development and implementation of the Community Health Strategic Plan has been identified as a priority for SSWAHS through the Area Strategic Plan.

The SSWAHS Community Health Strategic Plan is intended to guide the delivery and development of Community Health Services in the period 2007 – 2012. However, the Plan is a living document and will be subject to change as circumstances change.

The Action Plan presented in the following section outlines in detail how Community Health intends to achieve its objectives over the next five years. The Action Plan is presented according to the Seven Strategic Directions of NSW Health, to enable effective mapping of actions and achievements against the SSWAHS Health Service Strategic Plan, the NSW State Health Plan and the NSW State Plan. Links to the key priority areas within the NSW Integrated Primary and Community Health Policy have also been identified.

To assist in understanding the Action Plan, the following key is provided.

GMCH	General Manager Community Health
AGM CAPACCS	Assistant General Manager Community Acute/Post Acute and Chronic Clinical Services
AGM C&FCS	Assistant General Manager Child and Family Clinical Services
AGM CISS	Assistant General Manager Corporate Integration and Support Services
AGM F&O	Assistant General Manager Finance and Operations
CEWD	Centre for Education and Workforce Development
CH Executive	Community Health Executive
Clinical AGM's	Community Health Assistant General Managers in Child and Family Clinical Services, Diverse Clinical Services and Community Acute/Post Acute and Chronic Clinical Services
TBD	To be determined (through a planning or investigative process)

Implementation of the Plan will be monitored through six monthly progress reporting on activity and performance indicators, as noted in the Action Plan. Progress on the implementation of the Plan will also be a standing item on the Community Health Executive Agenda to ensure ongoing monitoring and issue identification as required. Achievements and risks will be highlighted to the SSWAHS Executive through the Director of Clinical Operations.

The Plan will be comprehensively reviewed after five years and its success evaluated, prior to the development of a further Community Health Strategic Plan for the Area.

Sydney South West Area Health Service – Community Health Strategic Plan 2007- 2012

Action Plan

STRATEGIC DIRECTION 1 – MAKE PREVENTION EVERYBODY'S BUSINESS					
Objective 1.1 **Reorient existing services to have an increasing focus on prevention, health promotion and education**				**Link to SSWAHS Corporate Plan Objective:** *1a*	***Link to NSW Health IPaCH Policy Priority Area:*** *3*
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
1.1.1 Audit existing services to determine current range of activities and percentage (%) of time spent undertaking and related to, health screening, prevention, health promotion and education	Audit of % time allocated to prevention completed and deficits in range of services noted	Clinical AGMs	Population Health	Within existing	June 2008
	% of time allocated to HP tasks for all services determined	Clinical AGMs	Population Health		June 2008
1.1.2 Develop a set of minimum standards and targets for prevention, health promotion and education within existing roles	Standards established	Clinical AGMs	Population Health	Within existing	September 2008
1.1.3 Targets for prevention, health promotion and education established within each service	Targets set against baseline measures. Reviewed annually	Clinical AGMs	Population Health	Within existing	September 2008
1.1.4 Implement screening consistent with the Community Health Clinical Core Business Framework	Establish Targets • DV (100% of all eligible women) • Edinburgh scale (all women who have given birth) • STI's • Pap Smears (%) • Hearing (SWISH 100% of all newborns)	Clinical AGMs		Within existing	Ongoing
	Report performance against agreed targets	Clinical AGMs			Annually

Objective 1.2 **Expand the range of preventative programs in line with emerging health and community needs**				***Link to SSWAHS Corporate Plan Objective:*** 1c	***Link to NSW Health IPaCH Policy Priority Area:*** 3
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
1.2.1 Review existing preventative services in the context of Fit for Futures	Recommendations from the review implemented	Clinical AGMs		Within existing	December 2008
1.2.2 Develop and formalise relationships with Population Health and other Clinical Directorates to develop programs in response to emerging community needs e.g. falls prevention	Partnership Agreement formalised (includes who will be providing the services)	GMCH / Relevant Clinical Directors / Director Population Health		Within existing	December 2008
	Programs are established and evaluated	GM / Relevant Clinical Directors, Director Population Health			Ongoing
1.2.3 Develop and formalise relationships with other Government and Non-Government organisations to implement community development programs in response to emerging community needs	Partnership Agreement formalised (includes who will be providing the services)	GM / Managers of Government and Non-Government Organisations	Government and Non Government Organisations, Councils	Within existing	December 2008
	Programs are established and evaluated	GM / Managers of Government and Non-Government Organisations	Government and Non Government Organisations, Councils		Ongoing

Objective 1.3 **Work with a range of partners to reduce health disadvantage**				***Link to SSWAHS Corporate Plan Objective:*** 1b	***Link to NSW Health IPaCH Policy Priority Area:*** 4
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
1.3.1 Establish priorities within each service of those groups most at risk	Priorities established	Clinical AGM's	Population Health, Councils, Other Government and Non Government Organisations	Within existing	December 2007
1.3.2 Develop appropriate resources, programs and partnerships to meet the needs of priority populations within each service	Resources developed; programs and partnerships established and evaluated	Clinical AGM's	Population Health, Councils, Other Government and Non Government Organisations	Within existing – grant funding opportunities will be explored	Ongoing from December 2007
1.3.3 Participate in the development of the SSWAHS Aboriginal Health Plan	CH staff involved in Aboriginal Health Plan	GMCH		Within existing	December 2008
	% of CH actions in Aboriginal Health Plan completed in required timeframe	GMCH		TBD	Ongoing
1.3.4 Participate in the development of the SSWAHS Disability Plan	CH staff involved in Disability Plan	GMCH		Within existing	December 2008
	% of CH actions in Disability Plan completed in required timeframe	GMCH		TBD	Ongoing
1.3.5 Participate in the development of the SSWAHS Maternity Services Plan	CH staff involved in Maternity Services Plan	Assistant General Manager – Child and Family Clinical Services		Within existing	December 2008
	% of CH actions in Maternity Services Plan completed in required timeframe	Assistant General Manager – Child and Family Clinical Services		TBD	Ongoing
1.3.6 Participate in the development of the SSWAHS HIV/AIDS and Sexual Health Plan	CH staff involved in HIV/AIDS and Sexual Health Plan	Assistant General Manager Diverse Clinical Services		Within existing	December 2008
	% of CH actions in HIV/AIDS and Sexual Health Plan completed in required timeframe	Assistant General Manager Diverse Clinical Services		TBD	Ongoing

Objective 1.3 **Work with a range of partners to reduce health disadvantage**				***Link to SSWAHS Corporate Plan Objective:*** 1b	***Link to NSW Health IPaCH Policy Priority Area:*** 4
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
1.3.7 Participate in the development of the SSWAHS Obesity Prevention and Management Plan	CH staff involved in Obesity Prevention and Management Plan	Assistant General Manager Diverse Clinical Services		Within existing	December 2008
	% of CH actions in Obesity Prevention and Management Plan completed in required timeframe	Assistant General Manager Diverse Clinical Services		TBD	Ongoing

STRATEGIC DIRECTION 2 – CREATE BETTER EXPERIENCES FOR PEOPLE USING HEALTH SERVICES					
Objective 2.1 **Develop and implement systems to monitor and manage demand in all services**				***Link to SSWAHS Corporate Plan Objective:*** 2b	***Link to NSW Health IPaCH Policy Priority Area:*** 6
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
2.1.1 Formalise and implement the Clinical Core Business Framework for Community Health	Clinical Core Business Framework endorsed by each Clinical Directorate and implemented	GMCH and CH Executive		Within existing	April 2007
2.1.2 Establish service delivery priorities within each service – entry criteria / service criteria	Priorities established with agreed criteria	Clinical AGM's		Within existing	June 2007
2.1.3 Develop clinical indicators to measure internal services against agreed baseline	All services have an agreed baseline measure(s)	Clinical AGM's		Within existing	June 2007
	Clinical Indicators are reported on quarterly	Clinical AGM's			Ongoing
2.1.4 Develop and implement a Community Health Demand Management Policy and associated plans for each service which include: • Staffing profile • Waiting list • Entry and exit policy	Policy Developed and published	Clinical AGM's		Within existing	December 2007
	Indicator report to Executive monthly	Clinical AGM's			Ongoing
	100% of services have development and implemented Demand Management Plans	Clinical AGM's			June 2008

Objective 2.2 **Deliver services that are flexible and responsive to identified needs**				***Link to SSWAHS Corporate Plan Objective:*** 2b	***Link to NSW Health IPaCH Policy Priority Area:*** 2
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
2.2.1 Investigate opportunities to develop innovative service delivery strategies that include • Outreach options • Tele-health • Population specific services • Home based services • Flexible hours • Flexible service boundaries • Multidisciplinary clinics	Options paper developed and models costed	Clinical AGM's		Within existing	December 2008
	Business cases developed for new models	Clinical AGM's		Additional resources may be required – subject to business case	Ongoing from December 2008
2.2.2 Review intake systems for each service and/or discipline including investigation of future options eg: • Centralised intake systems • Triaging systems • Clinical v administrative intake officers	Review completed and distributed appropriately	Clinical AGM's	AGM CISS	Within existing	September 2008
	Recommendations implemented	Clinical AGM's	AGM CISS	Additional resources may be required	December 2009
2.2.3 Review hours of operation for each service	Consistent hours of operation defined for each service	Clinical AGM's		Within existing	June 2007
	Business cases developed if recommendations to expand hours where necessary	Clinical AGM's		Additional resources may be required – subject to business case	Ongoing
2.2.4 Review current child minding arrangements in Community Health	Develop a policy on the provision of child minding	General Manager		Within existing	June 2009
	Consumer feedback on the availability of child minding	AGM Corporate Integration and Support Services		Within existing	Ongoing

Objective 2.3 **Utilise collaborative processes involving consumer feedback and information from health care reporting systems to continuously improve the quality and safety of services**				***Link to SSWAHS Corporate Plan Objective:*** 2a	***Link to NSW Health IPaCH Policy Priority Area:*** 1
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
2.3.1 Develop a strategy to improve the participation of consumers and community in the review and ongoing development of Community Health services in conjunction with community and consumer representatives	Consumer and Community Participation Strategy developed and implemented	AGM CISS	Clinical Directors, Community Participation Manager, consumer and community representatives	Within existing	December 2008
	Increase in level of community and consumer participation in Community Health	Clinical AGM's	Community Participation Manager, consumer and community representatives	Within existing	Annually
2.3.2 Develop strategies to actively seek and utilise client feedback on quality and safety, including through complaints and comments and a regular client feedback survey	Strategies developed and implemented	Clinical AGM's; AGM CISS	SSWAHS Clinical Governance Unit; Community Participation Manager, consumer and community representatives	Within existing	December 2008
	Consumer complaints/comments mechanism developed, utilised and evaluated	Clinical AGM's; AGM CISS	SSWAHS Clinical Governance Unit; Community Participation Manager, consumer and community representatives	Within existing	December 2008
	Survey results analysed and recommendations actioned	AGM CISS	SSWAHS Clinical Governance Unit		December 2009 and ongoing
2.3.3 Develop and implement a Quality and Safety Framework to support the Clinical Core Business Framework for Community Health.	Quality and Safety Framework developed and implemented	GMCH	SSWAHS Clinical Governance Unit	Within existing	December 2007
2.3.4 Develop a Quality and Safety Plan linked to the Community Health Strategic Plan and EQuIP4	Quality and Safety Plan developed and implemented	Clinical AGM's; AGM CISS	SSWAHS Clinical Governance Unit, Australian Council of Healthcare Services	Within existing	December 2008
	% of Quality and Safety Plan actions implemented in agreed timeframe	Clinical AGM's; AGM CISS	SSWAHS Clinical Governance Unit, Australian Council of Healthcare Services	TBD	Annually
2.3.5 Develop and implement a system for evaluating and monitoring regulatory and legislative compliance	Regulatory and legislative compliance is demonstrated through audit and assessment results	GMCH	Area Corporate Services, SSWAHS Clinical Governance Unit, Internal Audit, NSW Health	Within existing	December 2007
2.3.6 Participate in the EQuIP 4 process	Accreditation obtained	GMCH	SSWAHS Clinical Governance Unit	Within existing	December 2010

Objective 2.4 **Enhance service integration across the continuum of care**				***Link to SSWAHS Corporate Plan Objective:*** 2c	***Link to NSW Health IPaCH Policy Priority Area:*** 2
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
2.4.1 Establish Service Integration Manager positions to work across SSWAHS Community Health and with hospitals, clinical streams and other internal and external partners to improve client outcomes	Positions appointed	AGM CISS	Hospital General Managers, Area Clinical Stream Directors, External partners	Within existing	June 2007
2.4.2 Establish capacity and mechanisms across Community Health to ensure multidisciplinary service delivery occurs	Evidence of multidisciplinary practices	Clinical AGM's	AGM Corporate Integration and Support Services	Within existing	June 2008
2.4.3 Review referral pathways within Community Health between services in SSWAHS and with key external partners	Review complete	Clinical AGM's	AGM Corporate Integration and Support Services; Divisions of General Practice	Within existing	December 2007
	Recommendations actioned	Clinical AGM's		TBD	Ongoing
2.4.4 Review referral pathways between Community Health and services in SSWAHS and with key external partners	Review complete	Clinical AGM's	AGM CISS	Within existing	April 2009
	Recommendations actioned	Clinical AGM's		TBD	Ongoing
2.4.5 Establish Information Management Unit to oversee the integration of client management systems and streamlining communication	Unit established	AGM CISS	ISD	Within existing	September 2007
	Flagging system for at risk clients operational	AGM CISS	Clinical AGM's, ISD	Within existing	June 2009
2.4.6 Actively participate in the development and piloting of innovative models of service delivery, for example Integrated Primary Care Model – Health One	Models developed and piloted	GMCH	Divisions of General Practice, Area Clinical Directors, Population Health, Planning and Performance	NSW Health – HealthOne funding	June 2008
2.4.7 Identify opportunities to improve communication between Community Health and General Practitioners for ongoing management of clients	Options developed and recommendations identified and implemented	GMCH	Divisions of General Practice	Within existing	December 2009

Objective 2.4 **Enhance service integration across the continuum of care**				***Link to SSWAHS Corporate Plan Objective:*** 2c	***Link to NSW Health IPaCH Policy Priority Area:*** 2
2.4.8 Participate in processes to determine the appropriate governance structure for Centre Based/Aged Day Care services across SSWAHS	Community Health issues incorporated into governance review processes	GMCH	Aged Care/GGRM, SSWAHS Executive, Aboriginal Health	Within existing	April 2007

Objective 2.5 **Provide Community Health services in a range of safe, healthy and well maintained environments**				***Link to SSWAHS Corporate Plan Objective:*** 2b	***Link to NSW Health IPaCH Policy Priority Area:*** 2
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
2.5.1 Physical Resources workplan is monitored, reviewed and resourced to upgrade and maintain community health facilities	Building Equipment and Works Committee minutes evidence of outcomes of work	AGM CISS	SSWAHS Director Capital Works, Councils	TBD	Ongoing
2.5.2 Participate in the development of an asset management strategy for SSWAHS	Plan for CH documented	AGM CISS	SSWAHS Director Capital Works	Within existing	Ongoing
2.5.3 Implementation of prioritised facility audit 2006 recommendations	% of actions completed in recommended timeframe	AGM CISS	SSWAHS Director Capital Works, Councils	Resources required	Jun 2012
2.5.4 Audit of existing Community Health facilities to assess • Parking • Disabled access • Cultural appropriateness of décor and design • Signage (including external and street directional signage) • Primary and secondary storage capacity	Develop Action Plan and implement and review outcomes	AGM CISS	SSWAHS Director Capital Works, Councils	Within existing	Ongoing
2.5.5 Develop a Service Level Agreement template and Service Level Agreements to address issues such as maintenance, renovations and occupational health and safety with other services utilising Community Health managed facilities	Service Level Agreements utilised for 100% of non-Community Health services based within Community Health facilities	AGM CISS	Councils	Within existing	September 2008

STRATEGIC DIRECTION 3 – STRENGTHEN PRIMARY HEALTH AND CONTINUING CARE IN THE COMMUNITY					
Objective 3.1 **Investigate opportunities to expand Community Health services across the Area**				***Link to SSWAHS Corporate Plan Objective:*** 3a	***Link to NSW Health IPaCH Policy Priority Area:*** 1
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
3.1.1 For any proposed service enhancement or expansion, submit business cases to the SSWAHS Executive for additional funding based on available data and evidence	Business cases submitted	GMCH		Within existing	Ongoing
3.1.2 Apply for additional external funding to expand CHN services	HACC funding for CHN	AGM CAPAC	GGRM	Within existing	Annually
	Service outputs for CHN	AGM CAPAC	GGRM	External funding	Annually
3.1.3 Apply for additional external funding to expand Allied Health services	Additional funding allocation	Clinical AGMs	Allied Health	Within existing	Annually
	Service outputs for Allied Health	Clinical AGMs	Allied Health	External funding	Annually
3.1.4 Work with Health Services Planning and Population Health to develop proposals for new services in the South West Growth Centre	New services available	GMCH	Health Services Planning; Population Health	Within existing	Ongoing
3.1.5 Undertake a mapping exercise to determine the availability of men's health services in SSWAHS	Mapping exercise undertaken	Clinical AGMs	Other relevant Clinical Services, Non Government Organisations	Within existing	December 2008
3.1.6 Develop a men's health network across SSWAHS in collaboration with key stakeholders	Men's Health network established	GMCH	Other relevant Clinical Services, Non Government Organisations	TBD	June 2009
3.1.7 Investigate opportunities to develop men's health services in SSWAHS	Options paper documented	Men's Health Network	Other relevant Clinical Services, Non Government Organisations	TBD	June 2010
3.1.8 Investigate opportunities to expand adult counselling services consistent with the Clinical Core Business Framework	Opportunities explored by development of a position paper	Clinical AGMs		TBD	December 2007

Objective 3.2 **Strengthen the focus of Community Health services to provide early intervention**				***Link to SSWAHS Corporate Plan Objective:*** 3b	***Link to NSW Health IPaCH Policy Priority Area:*** 3
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
3.2.1 Investigate opportunities to increase sustained home visiting services, including the establishment of a SHV service for Aboriginal teenage parents	Business cases submitted	AGM C&FCS and AGM CAPACCS	Aboriginal Health; relevant Area clinical services	Within existing	June 2008
	Aboriginal teenage mothers SHV service established	AGM C&FCS	Aboriginal Health	Within existing	June 2007
3.2.2 Audit services to determine current % of time spent undertaking early intervention and develop a set of minimum standards and targets for early intervention within existing roles	Audit of % time allocated to early intervention	Clinical AGM's		Within existing	June 2008
	Standards established	Clinical AGM's			September 2008
3.2.3 Develop and implement strategies to reduce avoidable hospital admissions amongst users of Community Health services for example. • Chronic disease self management • New models of care	Reduction in potentially avoidable hospital admissions for: • Vaccine preventable conditions including measles, pertussis and influenza, community acquired pneumonia • Acute conditions including dental conditions, ENT and kidney infections, cellulitis, urinary tract infections • Chronic conditions including angina, diabetes complications and COPD, bronchitis and asthma	Clinical AGM's	Hospital General Managers; Manager Performance and Redesign, Clinical Directors, Director Population Health, Divisions of General Practice	TBD	Ongoing

Objective 3.3 **Deliver services consistent with the Community Health Clinical Core Business Framework**				***Link to SSWAHS Corporate Plan Objective:*** nil	***Link to NSW Health IPaCH Policy Priority Area:*** 1
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
3.3.1 Finalise and implement Community Health Clinical Core Business Framework and review annually	Community Health Clinical Core Business Framework finalised and implemented and reviewed annually	General Manager		Within existing	June 2008 and annually
	Staff aware of and demonstrate understanding of Community Health Clinical Core Business Framework	Clinical AGMs			December 2007

Objective 3.4 **Enhance the profile of Community Health within Sydney South West and expand awareness of Community Health services**				***Link to SSWAHS Corporate Plan Objective:*** **3a**	***Link to NSW Health IPaCH Policy Priority Area:*** 1
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
3.4.1 Develop and implement Community Health Marketing/Communications plan to improve the image of and communication about Community Health and Community Health services. Plan to address communication with various target groups.	Marketing/Communications plan completed	AGM CISS	Public Affairs and Marketing	Within existing	June 2008
	% of actions completed in agreed timeframe	AGM CISS		TBD	Ongoing
3.4.2 Establish Community Health internet and intranet sites	Site established	AGM CISS	ISD	Within existing	December 2007
	Number of hits	AGM CISS	ISD		Ongoing
3.4.3 Develop and distribute printed material regarding Community Health facilities and services which is culturally appropriate and available in community languages	Printed material available	AGM CISS	Public Affairs and Marketing	Within existing	Ongoing
3.4.4 Promote Community Health services in Aboriginal, ethnic and mainstream media	Number of articles per year	AGM CISS	Public Affairs and Marketing	Within existing	Annually

STRATEGIC DIRECTION 4 – BUILD REGIONAL AND OTHER PARTNERSHIPS FOR HEALTH					
Objective 4.1 **Deliver services in collaboration with a range of partners**				***Link to SSWAHS Corporate Plan Objective:*** 4b	***Link to NSW Health IPaCH Policy Priority Area:*** 2
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
4.1.1 Investigate opportunities to colocate services with relevant partners	Options paper developed	GMCH and Clinical AGM's	Area Director Corporate Services; Area Director Population Health, Planning and Performance; Councils; NGOs; Divisions of General Practice	Within existing	December 2009
4.1.2 Develop a colocation policy to guide negotiations for example, shared costs, space, OH&S, linked to Service Level Agreements	Policy developed and implemented	AGM CISS	Area Director Corporate Services	Within existing	December 2009
4.1.3 Develop partnerships to deliver services which address the health needs of particular target groups, including: • Aboriginal and Torres Strait Islander people • People from culturally and linguistically diverse communities • People from emerging communities, particularly refugees • Young people • Women • Older people • People with a disability • Children • People with chronic disease • People who are socially and/or geographically isolated • People with mental health issues • People with drug and alcohol issues • People with multiple comorbidities/dual diagnosis	Evidence of partnerships established	GMCH and Clinical AGM's	Director Population Health, Aboriginal Health, NSW Refugee Health, Drug Health, Mental Health, Councils, NGO's, Divisions of General Practice	Within existing	Ongoing
	Appropriate indicators developed	GMCH and Clinical AGM's	Director Population Health, Aboriginal Health, NSW Refugee Health, Drug Health, Mental Health, Councils, NGO's, Divisions of General Practice		December 2012

Objective 4.2 **Develop systems to formalise and enhance relationships with partner organisations**				***Link to SSWAHS Corporate Plan Objective:*** 4a	***Link to NSW Health IPaCH Policy Priority Area:*** 4
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
4.2.1 Develop and utilise a Partnership Agreement / Service Level Agreement template.	100% of service delivery partnerships are documented in template	AGM CISS	As identified	Within existing	April 2010
4.2.2 Review partnership arrangements for each service, including: • Existing partners • Current partnership agreements • Evaluation of success/outcomes • Potential for partner/partnership expansion	100% of existing partnerships reviewed and opportunities for expansion identified	Clinical AGMs	As identified	Within existing	April 2010

Objective 4.3 **Engage and involve stakeholders in the development of Community Health policies, plans and initiatives**				***Link to SSWAHS Corporate Plan Objective:*** 4b	***Link to NSW Health IPaCH Policy Priority Area:*** 1
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
4.3.1 Investigate opportunities to improve community participation in Community Health	Options paper developed	AGM CISS	SSWAHS Manager Community Participation, Councils, Non Government Organisations, Community Organisations	Within existing	December 2007
4.3.2 Establish Consumer and Community Participation Representatives on CH Area wide committees in accordance with the Community Participation Framework	Community representatives on all CH Area committees	AGM CISS	SSWAHS Manager Community Participation, Councils, Non Government Organisations, Community Organisations	Within existing	December 2007 and ongoing
4.3.3 Involve stakeholders in the development of local programs and initiatives	Evidence of stakeholder involvement	Clinical AGM's	SSWAHS Manager Community Participation, Councils, Non Government Organisations, Community Organisations	Within existing	Ongoing

STRATEGIC DIRECTION 5 – MAKE SMART CHOICES ABOUT THE COSTS AND BENEFITS OF HEALTH AND HEALTH SUPPORT SERVICES					
Objective 5.1 **Develop and implement integrated consistent data and information management systems and reporting processes**				***Link to SSWAHS Corporate Plan Objective:*** 5b	***Link to NSW Health IPaCH Policy Priority Area:*** 6
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
5.1.1 Develop and implement an Information Technology strategy which addresses infrastructure provision and maintenance and communication systems and resources	Strategy developed	AGM CISS	ISD	Within existing	December 2007
	% of actions from strategy completed within the agreed timeframe	AGM CISS	ISD	TBD	Ongoing
5.1.2 Identify and collect useful data that supports clinical practice	All clinical teams have identified relevant data to support core business	AGM CISS	ISD	Business case to be developed	December 2008
5.1.3 Develop and implement a clinical activity reporting system that is standardised across Community Health	Clinical activity reporting system developed	AGM CISS	Director, Clinical Governance	Within existing	June 2008
	Policy guidelines developed	AGM CISS		Within existing	June 2008
5.1.4 Roll-out CERNER products across the whole of Community Health	CERNER installed on all Community Health computers	AGM CISS	ISD	TBD	December 2012
	% of staff trained in the use of CERNER	AGM CISS	ISD	TBD	December 2012
5.1.5 Develop a SSWAHS Community Health Intranet site to facilitate staff access to current policy, program information, databases, forms etc.	Intranet site developed	AGM CISS	ISD	Within existing	June 2009
	Utilisation of intranet site	AGM CISS	ISD		Ongoing
5.1.6 Implementation of Risk Management Technologies (RMT) Chem alert database for chemical management in community health facilities	80% of staff trained to search for Material Safety Data Sheets (MSDS) by December 2008 and 95% by December 2009	AGM CISS		May require e-learning module from RMT – nominal charge across all NSW Health	As per performance indicators
	100% of chemicals in CH with a risk assessment completed by December 2009	AGM CISS			

Objective 5.2 **Provide evidence based services through the integration of best research evidence with clinical expertise and client values**				***Link to SSWAHS Corporate Plan Objective:*** 5b	***Link to NSW Health IPaCH Policy Priority Area:*** 3
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
5.2.1 Work with Centre for Education and Workforce Development (CEWD) to deliver training on how to implement evidence based practice	Training program developed	AGM CISS	CEWD, Clinical AGM's	TBD	June 2009
	Annual number of staff successfully completing training	AGM CISS	CEWD, Clinical AGM's		Annually
5.2.2 Encourage staff to participate in professional evidence based practice groups	Number of staff participating annually	Clinical AGM's	AGM CISS	Within existing	December 2007 and ongoing
5.2.3 Develop and implement a clinical supervision system and policy	% of people receiving clinical supervision as per policy	AGM CISS, Clinical AGM's	Director Clinical Governance	Within existing	September 2007 and ongoing

Objective 5.3 **Demonstrate that clients are better off as a result of the service delivered**				***Link to SSWAHS Corporate Plan Objective:*** 5b	***Link to NSW Health IPaCH Policy Priority Area:*** 3
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
5.3.1 Develop, collect and report on clinical indicators for every Community Health clinical service. Consideration to be given to the development of both qualitative and quantitative indicators.	Sets of clinical indicators developed	AGM CISS, Clinical AGM's	Clinical Directors; Divisions of General Practice	Within existing	December 2007
	6 monthly reports complete	Clinical AGM's			Bi-annually – Jun and December
5.3.2 Review existing outcome and evaluation measures, for example, through the formation of peer review teams	Review complete and recommendations developed	GMCH	Clinical Directors, Divisions of General Practice	Within existing	December 2009

Objective 5.4 **Review and further develop sound financial management systems and procedures**				***Link to SSWAHS Corporate Plan Objective:*** 5a	***Link to NSW Health IPaCH Policy Priority Area:*** 6
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
5.4.1 Financial planning reflects the priorities and direction of the Community Health Strategic Plan	Changes to directions/priorities are costed and systems established for internal adjustments of budget allocations	AGM Finance and Operations		Within existing	Annually
5.4.2 Develop a standard template for Business Cases	Template developed	AGM Finance and Operations		Within existing	June 2008
	Staff utilise and demonstrate awareness of template	AGM Finance and Operations			September 2008
5.4.3 Acquit to funding bodies as per Funding Agreements	100% of acquittals submitted on time	AGM Finance and Operations		Within existing	Ongoing

STRATEGIC DIRECTION 6 – BUILD A SUSTAINABLE HEALTH WORKFORCE					
Objective 6.1 **Support training and education opportunities to enable staff development and to ensure high quality care to clients**				***Link to SSWAHS Corporate Plan Objective:*** 6b	***Link to NSW Health IPaCH Policy Priority Area:*** 5
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
6.1.1 Liaise with the Centre for Education and Workforce Development (CEWD) to link Service Managers into the Leadership Development Program	Number of Service Managers who have completed the Leadership Development Program	GMCH	CEWD, AGMs	Within existing	Ongoing
6.1.2 Investigate opportunities for staff to improve their cultural awareness for example, through training or mentoring and recommend a preferred option(s)	Preferred option implemented	GMCH	CEWD Aboriginal Health	Within existing	June 2007
6.1.3 Support staff to undertake further relevant qualifications through internally and externally provided courses as per the SSWAHS Learning and Development Policy	Number of staff completing qualifications each year	GMCH	CEWD	Within existing	Ongoing

Objective 6.1 **Support training and education opportunities to enable staff development and to ensure high quality care to clients**				***Link to SSWAHS Corporate Plan Objective:*** 6b	***Link to NSW Health IPaCH Policy Priority Area:*** 5
6.1.4 Develop and implement a system to monitor and manage attendance at Corporate Orientation and other mandatory training	System developed and implemented	AGM CISS		Within existing	September 2007
	% of staff completing 100% of mandatory training within 3 months of commencement	AGM CISS			Ongoing
6.1.5 Annually evaluate and update the Community Health Orientation Program consistent with the SSWAHS Corporate Orientation Program	Community Health orientation program evaluated and recommendations implemented	AGM CISS	Director Strategic Workforce Development	Within existing	Ongoing
6.1.6 Utilise the SSWAHS framework for the delivery of clinical and locality based orientation for field based staff	% of staff completing clinical and locality based orientation within 1 month of commencement	AGM CISS		Within existing	Ongoing
6.1.7 Seek opportunities to influence the direction and contents of programs offered by the CEWD	% of courses nominated by Community Health delivered	GMCH		Within existing	December 2011
6.1.8 Continue to deliver Child Protection (CP) training for all SSWAHS staff	% of staff completed mandatory CP Training	AGM C&FCS	CEWD	Within existing	Ongoing
6.1.9 Train key Community Health staff as Manual Handling Train the Trainers – to promote good manual handling practices, reduce injuries and workers compensation costs.					
6.1.10 Identify the opportunities to increase the number of people with post graduate qualifications relevant to community based practice	The % of staff with post graduate qualifications	GMCH	CEWD	Within existing	December 2011
6.1.11 Train Community Health staff to undertake service and program evaluation	Number of staff completing training	GMCH	CEWD	Within existing	June 2010
6.1.12 Review the gaps in availability of Manual Handling trainers across SSWAHS CH facilities and implement a competency based Manual Handling training program for CH staff	% of identified Manual Handling Trainers trained	AGM CISS		Within existing	June 2008

Objective 6.2 **Create a positive work environment that values its workforce and treats staff fairly and with respect**				***Link to SSWAHS Corporate Plan Objective:*** 6a	***Link to NSW Health IPaCH Policy Priority Area:*** 5
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
6.2.1 Review equity and parity of staffing, positions and grading across Community Health services and implement recommendations of review	Equity and parity of staffing, positions and gradings across Community Health services	GMCH	AGMs	TBD	December 2007
6.2.2 Develop and implement a consistent performance management framework across Community Health Services	% of staff receiving annual performance appraisal	GMCH		Within existing	September 2008
6.2.3 Survey staff on job satisfaction, training and development needs, career aspirations	Survey undertaken and report produced highlighting recommendations for action	GMCH		Within existing	December 2008
6.2.4 Conduct exit interviews with all staff, noting reasons for resignation	% of staff receiving exit interview	Clinical AGM's		Within existing	Ongoing

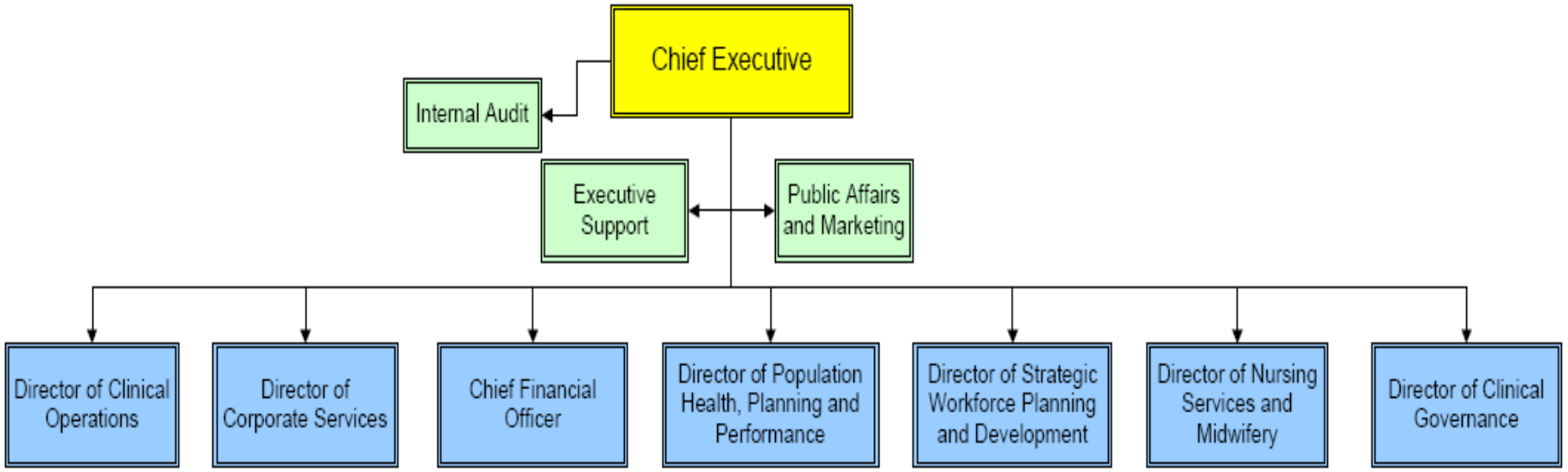
Objective 6.3 **Undertake workforce planning to match skills and resources to community needs**				***Link to SSWAHS Corporate Plan Objective:*** 6b	***Link to NSW Health IPaCH Policy Priority Area:*** 5
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
6.3.1 Work with the Director Strategic Workforce Development and the Directors of Population Health and Allied Health to accurately compile the baseline information for the development of monthly workforce profiles	Monthly workforce profiles adjusted to reflect current Community Health workforce	AGM F&O	SSWAHS Director Strategic Workforce Development, SSWAHS Director Population Health, SSWAHS Director Allied Health	Within existing	June 2008
6.3.2 Develop and implement Community Health workforce plan addressing issues such as succession planning, recruitment and retention	Community Health workforce plan developed	GMCH	SSWAHS Director Strategic Workforce Development, SSWAHS Director Population Health, SSWAHS Director Allied Health	Within existing	June 2010
	% of actions completed in agreed timeframe	GMCH			Ongoing
6.3.3 Explore, support and expand the role of volunteers in Community Health	Review complete and recommendations implemented	GMCH	SSWAHS Manager Community Participation, Director Strategic Workforce Development	Within existing	June 2009
6.3.3 Up-skill staff to be able to deliver services in line with the Clinical Core Business Framework	Performance management outcomes	Clinical AGM's		Within existing	Ongoing

Objective 6.4 **Apply the principles of risk management and occupational health and safety to all structures, processes and procedures**				***Link to SSWAHS Corporate Plan Objective:*** 2a	***Link to NSW Health IPaCH Policy Priority Area:*** 2
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
6.4.1 Develop a Risk Management Plan to meet annual workplace health and safety targets specified in SSWAHS Performance Agreement, and Working Together Public Sector OHS and Injury Management Strategy 2005 -2008	Risk management plan revised	AGM CISS		Within existing	December 2007
	Annual targets achieved	AGM CISS		TBD	Annually
6.4.2 Review and revise policies and procedures in consultation with staff to ensure risk management principles underpin all activities	100 % policies reviewed and revised	AGM CISS		Within existing	December 2012
6.4.3 Develop practical strategies to promote identification, assessment and control of hazards and integration into all practices in consultation with staff	10% reduction in staff workplace injuries	AGM CISS		Within existing	June 2008
6.4.4 Include quantifiable risk management objectives in all business plans.	% business plans which include risk management objectives.	AGM CISS		Within existing	April 2009
	Improve Numeric Profile score by 10%.	AGM CISS			April 2009 and ongoing
6.4.5 Establish a comprehensive risk register and progressively assess and control risks according to priority	Central and local risk register available	AGM CISS		Within existing	December 2007
	80% of identified risks assessed and controlled	AGM CISS			Ongoing
6.4.6 Continue to improve OHS performance in the Numerical Profile (NP) and Security Improvement TOOL (SIT) audits	Maintain Numerical Profile score with new audit tool and 10% improvement in SIT audit score	AGM CISS; Clinical AGMs		Within existing	Bi-annually (NP) and Annually (SIT)

STRATEGIC DIRECTION 7 – BE READY FOR NEW RISKS AND OPPORTUNITIES					
Objective 7.1 **Implement the corporate planning framework through the integration of Community Health strategic and business/operating plans**				***Link to SSWAHS Corporate Plan Objective:*** 7b	***Link to NSW Health IPaCH Policy Priority Area:*** 1
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
7.1.1 Formally monitor the SSWAHS Community Health Strategic Plan to assess progress on implementation	% of performance indicators completed within agreed timeframe	GMCH		Within existing	6 monthly from Jun 2007
7.1.2 Every Community Health service develops a business/operating plan linked to the Community Health Strategic Plan	100% of business/operating plans linked to Community Health Strategic Plan	Clinical AGM's		Within existing	June 2008

SSWAHS Community Health Strategic Plan Objective: **Investigate opportunities to expand the research capacity of Community Health**				**Link to SSWAHS Corporate Plan Objective:** 7b	**Link to NSW Health IPaCH Policy Priority Area: 6**
Action	**Performance Indicator**	**Responsibility**	**Partners**	**Resources**	**Timeframe**
7.2.1 Undertake a research audit addressing research capabilities, publications, grants and current projects by Community Health staff	Audit completed	GMCH		Within existing	December 2008
7.2.2 Develop a grants calendar identifying potential grant funding sources, requirements and frequency	Grants calendar developed	GMCH		Within existing	April 2009
7.2.3 Identify research priorities as a result of known expertise/interest and available grants	Listing of research priorities developed	GMCH		Within existing	April 2009
7.2.4 Apply for grant funding consistent with research priorities	Annual amount of research grant funding received	Clinical AGM's		Within existing	April 2009 and ongoing
	% of grant applications successful	Clinical AGM's		Within existing	April 2009 and ongoing
7.2.5 Investigate opportunities to collaborate with tertiary institutions on Community Health research	Number of collaborative projects	GMCH	Divisions of General Practice; Tertiary Institutions	Within existing	December 2012 and ongoing

APPENDIX A SSWAHS and COMMUNITY HEALTH ORGANISATIONAL CHARTS



SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

Community Health Organisational Chart 2007

LEGEND

---- Dotted lines depict professional leadership lines from other directorates to DNS

GENERAL MANAGER

Assistant General Manager DIVERSE CLINICAL SERVICES

- The Hub - Community Development
- Multicultural Health Services
- Sexual Health Services
- Women's Health Services
- Sexual Assault Services
- HIV / AIDS Community Services
- Community Counselling Service
- Nutrition Services
- Youth Health Service

Assistant General Manager CHILD & FAMILY CLINICAL SERVICES

- Early Childhood Services
- Families First
- Child Protection
- Child, Adolescent & Family Services

DIRECTOR NURSING SERVICES - CH & Assistant General Manager COMMUNITY ACUTE – POST ACUTE & CHRONIC CLINICAL SERVICES (CAPACCS)

- Community Health Nursing
- Community Palliative Care Nursing Services

Assistant General Manager CORPORATE, INTEGRATION & SUPPORT SERVICES

- Services Integration Managers
  - < Fairfield & Liverpool
  - < Bankstown & Central
  - < Macarthur& Wingecarribee
- Information Management Unit
- Information Technology Unit
- Service Development Unit
- Quality & Clinical Risk Management Unit
- Occupational Health & Safety Unit
- Physical Resources Unit

Assistant General Manager FINANCE & OPERATIONS

- Finance & Operations Managers

Wednesday, 20 June 2007

APPENDIX B COMMUNITY BASED HEALTH FACILITES IN SSWAHS (AS AT JANUARY 2007)

Note: Not all facilities are managed by Community Health

LGA	Facility	Tenure/ Plans	Services Provided	Usage (weeks, days and hours)
City of Sydney (part)	Redfern CHC	Planned through RTP. Start date not confirmed. SSWAHS own land and building	Community Nursing Service	Mon - Fri 8.30 - 5.00pm
			Community HIV/AIDS Service	
			Migrant Health Team	Tues 8.30 - 12.00md Outreach
			Mental Health Service	
	Camperdown CHC - KGV L5 and 6	SSWAHS owned - RTP Refurbishment completed November 2004	Child, Adolescent and Family Health	Mon - Fri 8.30 - 5.00pm
			Paediatric OT and Physio	
			Child Audiology Clinic	Tues, Thurs 8.30 - 4.00pm - >3yr olds Wed 8.30 - 4.00pm - 1/month <3yr olds
			Early Childhood Health Service	Mon - Fri 8.30 - 5.00pm
			Aboriginal ECH Service	
			Sexual Assault Service	
			Community Nutrition	
			Mental Health	
			Adolescent Mental Health	
			Aboriginal Mental Health	
			Adolescent Medical Service	
	RPAH Building 12 - Ground Floor and Level 1	SSWAHS owned	Multicultural HIV/AIDS and Hep C	Mon - Fri 8.30 - 5.00pm
			Positive Heterosexual Service (Pozhets)	
			HIV Program Coordination	
			Sexual Health Service - Health Promotion Team	
	KGV 9th floor	SSWAHS owned	Community Health/Population Health Administration	Mon - Fri 8.30 - 5.00pm
	Youthblock Health	Leased premises	Youth Health Service	Mon - Fri 9.00 - 5.30pm
	Redfern ECHC	Council owned	Early Childhood Health Service + supported playgroup	Tues, Thurs 8.30 - 5.00pm
	Glebe ECHC	Council owned	Early Childhood Health Service	Mon - Thurs 8.30 - 5.00pm
	Ultimo ECHC	Council owned (use of shared room)	Early Childhood Health Service + Chinese speaking parents group	Mon 8.30 - 12.30pm

LGA	Facility	Tenure/ Plans	Services Provided	Usage (weeks, days and hours)
Marrickville	Marrickville CHC	SSWAHS owned	Child, Adolescent and Family Health	Mon - Fri 8.30 - 5.00pm
			Paediatric OT and Physio	
			Early Childhood Health Services	
			Migrant Health Team	
			Community Nursing Service	
			Sexual Health	
			Oral Health Clinic	
			Mental Health Service	
			Living Skills	
	Sexual Health Clinic	SSWAHS owned	Sexual Health Services	Mon - Fri 8.30 - 5.00pm
	Dulwich Hill ECHC	Council owned	Early Childhood Health Services	Mon - Fri 8.30 - 5.00pm
	The Sanctuary	Leased premises	Community HIV/Aids Services	Mon - Fri 8.30 - 5.00pm
			Sexual Health Service	
Leichhardt	Leichhardt ECHC	Council owned	Early Childhood Health Services	Mon - Fri 8.30 - 5.00pm
	Balmain ECHC	Council owned	Early Childhood Health Services	Mon - Fri 8.30 - 5.00pm
Strathfield	Homebush ECHC	Council owned	Early Childhood Health Services	Mon, Tues, Wed 8.30 - 5.00pm
Canada Bay	Concord Hospital B19	SSWAHS owned	Community Nursing Service	Mon, Tues, Wed 8.30 - 5.00pm
	Five Dock ECHC	Council owned	Early Childhood Health Services	Mon - Fri 8.30 - 5.00pm
			Child Audiology Clinic no longer from this centre	
	Concord ECHC	Council owned	Early Childhood Health Services	Mon - Fri 8.30 - 5.00pm
	Drummoyne ECHC	Leased by Council	Early Childhood Health Services	Tues, Wed, Thurs 8.30 - 5.00pm
Ashfield	Ashfield ECHC	Council owned	Early Childhood Health Services	Mon - Fri 8.30 - 5.00pm, 2nd Wed 9.30 - 3.30pm
			Women's Health Clinic	
	Summer Hill ECHC	Council owned	Early Childhood Health Services	Wed 8.30 - 5.00pm
Burwood	Croydon	SSWAHS owned	Child, Adolescent and Family Health	Mon - Fri 8.30 - 5.00pm
			Paediatric OT and Physio	
			Community Nursing Service	
			Early Childhood Health Services	
			Drug Health	
			Mental Health	
			Living Skills	
			Oral Health Clinic	
			Child Protection – policy and planning, training and management	
			Podiatry	

LGA	Facility	Tenure/ Plans	Services Provided	Usage (weeks, days and hours)
Canterbury	Canterbury CHC	SSWAHS owned	Child, Adolescent and Family Health	Mon - Fri 8.30 - 5.00pm
			Youth Health	
			Paediatric OT and Physio	
			Child Audiology Clinic	
			Community Nursing Service	
			Migrant Health Team	
			Drug Health	
			Mental Health	
	Belmore Youth Health Service	Council owned	Multicultural Youth Health Service	Mon - Fri 8.30 - 5.00pm
	Lakemba ECHC	Council owned	Early Childhood Health Services	Mon - Fri 8.30 - 5.00pm
			Young Parents Service	
	Campsie ECHC	Council owned	Early Childhood Health Services	Mon - Fri 8.30 - 5.00pm 1st Sat 9.00 - 1.00pm
	Campsie	AMES Building - No Rental charged	Women's Health Clinic	Once per week 9.00 - 4.00pm
	Belmore ECHC	Council owned	Early Childhood Health Services	Mon, Tues, Wed 8.30 - 5.00pm
	Earlwood ECHC	Council owned	Early Childhood Health Services	Tues, Thurs, Fri 8.30 - 5.00pm
	Roselands ECHC	Leased by Council	Early Childhood Health Services	Mon - Fri 8.30 - 5.00pm 1st Sat 9.00 - 1.00pm
Bankstown	Bankstown CHC - Raymond St	SSWAHS owned	Child and Family Counselling	Mon - Fri 8.30 - 5.00pm
			Adult counselling	after hours by arrangement
			Child Development Assessment	Mon - Fri 9.00 - 4.30pm
			Speech pathology	Mon - Fri 8.30 - 5.00pm
			Paediatric Occupational therapy	
			Physiotherapy	Mon - Fri 8.30 - 5.00pm
			Multicultural Health	Mon - Fri 8.30 - 5.00pm
			Sexual Assault	
			Women's Health	Mon - Fri 8.30 - 5.00pm
			Drug Health	Mon - Fri 8.30 - 5.00pm
			Mental Health	
			Health promotion	
			Aboriginal Health	
			Community Nutrition	
			Family Care	
			Stuttering Unit	

LGA	Facility	Tenure/ Plans	Services Provided	Usage (weeks, days and hours)
Bankstown	Bankstown North P/S	Demountable owned by SSWAHS. Land owned by DET	Child oral health clinic	Mon - Fri 8.30 - 5.00pm
	Chester Hill ECHC	Council owned	Early Childhood Clinic	Mon - Fri 8.30 - 5.00pm
	Georges Hall ECHC	Council owned	Early Childhood Clinic	Mon - Fri 8.30 - 5.00pm
	Greenacre ECHC	Council owned	Early Childhood Clinic	Mon - Fri 8.30 - 5.00pm
	Padstow ECHC	Council owned	Early Childhood Clinic	Mon - Fri 8.30 - 5.00pm
	Panania ECHC	Council owned	Early Childhood Clinic	Mon - Fri 8.30 - 5.00pm
	Yagoona ECHC	Council owned	Early Childhood Clinic	Mon - Fri 8.30 - 5.00pm
	Villawood East P/S	SSWAHS demountable on DET land	Early Childhood Clinic	Mon - Fri 8.30 - 5.00pm
	Greenfield Pde, Bankstown	leased premises	Community health nursing	Mon - Fri 8.30 - 5.00pm
			Home nursing	7 days/week 8.30 - 5.00pm
			School screening	Outreach to schools
			Ambulatory care CHN component	7 days/week 8.00 -10.30pm
			Early Childhood	Mon - Fri 8.30 - 5.00pm
			Palliative care	7 days/week 8.30 -5.00pm
	The Corner	SSWAHS owned	Youth Health Service	Mon - Fri 8.30 - 5.00pm
	Yagoona CHC	SSWAHS building DET owned land	Oral Health clinic	Mon - Fri 8.30 - 5.00pm
Liverpool	Hoxton Park CHC	SSWAHS owned.	Ethnic Day Care	Mon - Fri 8.30 - 5.00pm
			Aboriginal Day Care	
			Community Health Nursing	Mon - Fri 8.30 - 5.00pm.
			Immunisation clinic	3rd Wed of month 5.00 - 7.00pm
			Early Childhood Nurses	Mon 8.3.0 - 5.00pm Wed Fri 9.30 - 12.00md
			Palliative Care Nurses	Mon - Fri 8.30 - 5.00pm
			Continence Nurses	
			Oral Health clinic	Closed during 2007
			Green Valley Domestic Violence Service	Mon - Fri 8.30 - 5.00pm
			Paediatric Ambulatory Service	
			Community Counselling Team	
			Hearing Clinic	
			Sexual Assault Counselling	
			Miller Early Childhood Sustained Home visiting project	

LGA	Facility	Tenure/ Plans	Services Provided	Usage (weeks, days and hours)
Liverpool	Miller CHC	Council owned - no rent	Aboriginal Child and Family	2nd Tues of month 9.30 - 12.00md
			Aboriginal Vascular Health Program	Mon - Fri 8.30 - 5.00pm
		Sydney Mission	Aboriginal Child and Family	Wed 9.30 -12.00md
	The Hub	Based at Miller opposite Miller CHC. Established in 2000 building bought through Premiers Dept. funding of $350,000. SSWAHS owned. No rent charged to other occupying agencies.	Base for co located service model of health and well being services both Govt and non Govt Community Development style of service provision working within local communities. Base for Aboriginal Mens Group	Mon - Fri 8.30 - 5.00pm
	Miller Coffee Shop	SSWAHS owned	Miller Coffee Shop - Mental Health shop front. Youth training.	Mon - Fri 8.30 - 5.00pm
	Liverpool CHC George Street Clinic	Building Leased.	Early Childhood Nursing. Drug and Alcohol clinic (BRANCHES) opposite B wing	Mon 8.30 - 5.00pm, Thurs Clinic 9.00 - 12.00md, Fri 9.00 - 1.00pm Sat 9.00 -12.00md
			Immunisation clinic	1st Tues monthly 10.00 - 12.30pm.
	Park House, Liverpool	SSWAHS owned	Sexual Health Service	Mon - Fri 8.30 - 5.00pm
	Health Services Building, Liverpool	SSWAHS owned	Sexual Assault Service	Mon - Fri 8.30 - 5.00pm
			Community Counselling Service	
			Dietetics	
			Occupational Therapy	
			Physiotherapy	
			Speech Therapy	
			PADP	
			Respiratory medicine - chest clinic	
			Aged Care	
			Oral Health clinic	
	B Wing	Liverpool Hospital - relocating due to Liverpool Stage 2 redevelopment	Community Paediatrics	Mon - Fri 8.30 - 5.00pm
			Nutrition, CPFS	
	Liverpool ED - assessment room	Liverpool Hospital	Sexual Assault Service	Mon - Sun 7.30 - 9.00pm for CHN Mon - Fri 8.30 - 5.00pm other teams

LGA	Facility	Tenure/ Plans	Services Provided	Usage (weeks, days and hours)
Liverpool	Hugh Jardine	Liverpool Hospital	Area Oral Health Services	Mon - Fri 8.30 - 5.00pm
			Community Paediatrics	
			Families First	
			Multicultural Health	
	Carboni St	SSWAHS owned - temporary relocation due to Liverpool Stage 2	Child protection services	
	Moorebank CHC	Owned by Council. Occupancy via ongoing lease, with Council responsible for all repairs and maintenance.	Drug Court services	Thurs 9.00 - 12.00md
			Early Childhood Clinic	
	Bringelly P/S	Occupy School Building - Nil rent. Cleaning costs	School Clinic	No set days. Screening only
	Wattle Grove P/S	Occupy School Building - Nil rent. Cleaning costs	School Clinic	No set days. Screening only
	Hinchinbrook P/S	Occupy School Building - Nil rent. Cleaning costs	School Clinic	No set days. Screening only
	Holsworthy P/S	Demountable owned by LHS. Cleaning costs	School Clinic	No set days. Screening only
	Greenway Park P/S	Occupy School Building - no rent but cleaning costs	School Clinic	No set days. Screening only
	Hammondville P/S	Demountable owned by Health - no rent but cleaning costs	School Clinic	No set days. Screening only
	Cartwright Dental Clinic	Occupy School Building - $2,500 per annum	Oral Health clinic	No set days. Screening only
	Lurnea Adult Day Care	Council- rent	Aged care service	Mon - Fri 8.30 - 5.00pm
	Mission Australia Miller	Occupy NGO Bldg - nil rent but service costs eg electricity.	Paediatric ambulatory care (LPACS)	Tues 9.30 - 1.30pm

LGA	Facility	Tenure/ Plans	Services Provided	Usage (weeks, days and hours)
Fairfield	Fairfield CHC/ FLYHT Building	SSWAHS owned	Early Childhood and Parenting Service	Mon - Fri 8.30 - 5.00pm
			Youth Health	
			Speech pathology	
			Community Counselling team	
			Mainstream Aged Care Day Care	
			Multicultural Aged Care Day Care	
	Cabramatta CHC	Land owned by DET. Building owned by SSWAHS.	Community Nursing including Palliative Care	Mon - Fri 8.30 - 5.00pm
			Multicultural Health Service	
			Speech Pathology	
			Nurse Audiometrist	
			Community Counselling	
	Prairiewood CHC	SSWAHS owned	Community Health Nursing including Palliative Care, Community Acute Care	Mon - Sun 7.30 - 9.00pm for CHN Mon - Fri 8.30 - 5.00pm other teams
			Chronic and Complex respiratory liaison nurse	
			Speech pathology	
			Community Counselling	
			Early Childhood	
	William Stimson P/S, Wetherill Park	SSWAHS Demountable - nil rent	Disability Unit	Mon - Sun 7.30 - 9.00pm for CHN Mon - Fri 8.30 – 5.00pm other teams
	William Stimson P/S, Wetherill Park	Occupy School Bldg - nil rent	School Clinic	Screening Plus 1 hr per day CHN
	Smithfield West P/S	FHS Demountable	School Clinic	Screening Plus 1 hr per day CHN
	Smithfield P/S	Occupy School Bldg - nil rent	School Clinic	Tues 9.00 - 1.00pm. Screening Plus 1 hr per day CHN ECHC
	Prairievale P/S	Occupy School Bldg - nil rent	School Clinic	Screening Plus 1 hr per day CHN
	Bossley Park P/S	Occupy School Bldg - nil rent	School Clinic	Fri 9.00 - 1.00pm. Screening Plus 1 hr per day CHN ECHC
	King Park P/S	Occupy School Bldg - nil rent	School Clinic	
	Governor Phillip King P/S	FHS Demountable	School Clinic	Screening Plus 1 hr per day CHN

LGA	Facility	Tenure/ Plans	Services Provided	Usage (weeks, days and hours)
Fairfield	Edensor Park P/S	Occupy School Bldg - nil rent	School Clinic	Thurs 9.00 -1.00pm. Screening Plus 1 hr per day CHN ECHC
	Horsley Park P/S	FHS Demountable	School Clinic	Screening Plus 1 hr per day CHN
	Bonnyrigg P/S	Occupy School Bldg - nil rent	School Clinic	
	Bonnyrigg Heights P/S	Occupy School Bldg - nil rent	School Clinic	Thurs 9.00 -1.00pm. Screening Plus 1 hr per day CHN ECHC
	Old Guildford P/S	Occupy School Bldg - nil rent	School Clinic	Screening Plus 1 hr per day CHN
	Villawood North School Clinic	Occupy School Bldg - nil rent	School Clinic	Screening Plus 1 hr per day CHN
	Lansvale P/S	Occupy School Bldg - nil rent	School Clinic	Screening Plus 1 hr per day CHN
	Fairfield Heights P/S	Occupy School Bldg - nil rent	School Clinic	Screening Plus 1 hr per day CHN
	Fairfield P/S	Occupy School Bldg - nil rent	School Clinic	Screening Plus 1 hr per day CHN
	Canley Vale P/S	Occupy School Bldg - nil rent	School Clinic	Screening Plus 1 hr per day CHN
	Cabramatta West P/S	SSWAHS Demountable and school building	School Clinic	Screening Plus 1 hr per day CHN
	Harrington St P/S	Occupy School Bldg - nil rent	School Clinic	Screening Plus 1 hr per day CHN
	Mt Pritchard P/S	Occupy School Bldg - nil rent	School Clinic	Screening Plus 1 hr per day CHN
	Mt Pritchard East P/S	Occupy School Bldg - nil rent	School Clinic	Screening Plus 1 hr per day CHN
	St Johns Park P/S	Occupy School Bldg - nil rent	School Clinic	Wed 9.00 - 1.00pm. Screening Plus 1 hr per day CHN
	Lansvale East P/S	FHS Demountable	School Clinic	Screening Plus 1 hr per day CHN
	Fairvale P/S	Occupy School Bldg - nil rent	School Clinic	Screening Plus 1 hr per day CHN
	Fairfield West P/S	Occupy School Bldg - nil rent	School Clinic	Wed 9.00 - 4.00pm. Screening Plus 1 hr per day CHN ECHC
	Carramar P/S	Occupy School Bldg - nil rent	School Clinic	Screening Plus 1 hr per day CHN
	Canley Heights P/S	Occupy School Bldg - nil rent	School Clinic	Screening Plus 1 hr per day CHN
	Fairfield ECHC	FCC - nil rent	Early Childhood Clinic	Mon, Tues, Thurs 8.30 - 5.00pm
	Fairfield Heights Early Childhood Centre	FCC - nil rent	Early Childhood Clinic	Wed, Fri 9.30 -12.00md Tues, Thurs 9.00 - 3.30pm
	Cabramatta ECHC	FCC - nil rent	Early Childhood Clinic	Mon, Tues, Thurs, Fri 8.30 - 5.00pm Wed 8.30 -12..30pm
	Mt Pritchard ECHC	FCC - nil rent	Early Childhood Clinic	Tues 9.00 - 4.00pm, Wed 9.30 - 12.30pm

LGA	Facility	Tenure/ Plans	Services Provided	Usage (weeks, days and hours)
Fairfield	Canley Heights ECHC	FCC - nil rent	Early Childhood Clinic	Tues 9.30 - 4.00pm, Wed 9.30 - 1.00pm
	Aimees Place	SSWAHS owned	Aged Care / Dementia Cottage	Mon - Fri 8.30 - 5.00pm
	Corella Lodge		Drug Health Services	Inpatient Unit at Fairfield Hospital
	Cabramatta Drug HS	Anthony House - SWSAHS owned	Drug Health Services	Don't think it is being used at present
Camden	Narellan CHC	SSWAHS owned	Speech Pathology	Mon - Fri 8.30 - 5.00pm
			Child and family nursing team	
			Women's health clinics	
			Health promotion	
			Child Protection Family Service	
			Early Childhood Clinic	
			Hearing Clinic	
			Oral Health clinic	
			Community Counselling	
	Camden Central P/S	SSWAHS Demountable - nil rent	School Clinic	Tue, Sat 9.00 - 2.00pm
			Early Childhood Clinic	
	The Oaks P/S	Occupy School Grounds - SSWAHS Demountable	School Clinic	Wed 9.00 - 12.00md
Campbell town	Campbelltown CHC	Private rental – pending redevelopment of a long term CHC	Speech Pathology	Mon - Fri 8.30 - 5.00pm
			Sexual Assault Services	
			Community Counselling	
			Multicultural Health	
	Campbelltown CH Centre	Leased premises	Sexual Health Services	Mon - Fri 8.30 - 5.00pm
			Speech Pathology clinics	
	11/261Queen		Drug and Alcohol treatment services	
	Ingleburn CHC	SSWAHS owned	Speech pathology	Mon - Fri 8.30 - 5.00pm
			Women's health nursing	
			Community Counselling	
			Aboriginal Health	
			Multicultural Health	
			Child Protection Family Service	
			Oral Health clinic	

LGA	Facility	Tenure/ Plans	Services Provided	Usage (weeks, days and hours)
Campbell town	Rosemeadow CHC	SSWAHS owned	Speech pathology	Mon - Fri 8.30 - 5.00pm
			Community health nurses	
			Drug health	
			Sexual Assault - counselling and medical	
			Community counselling	
			Diabetes	
			Oral health	
	Rosemeadow CHC	SSWAHS owned	Podiatry	Mon - Fri 8.30 - 5.00pm
			Child Development Service	
			Aged Care - Respite and Day Care	
			Palliative Care	
	Broughton House	SSWAHS owned	Aged Care	Mon - Fri 8.30 - 5.00pm
	Browne Street Mental Health	SSWAHS owned	Mental health	Mon - Fri 8.30 - 5.00pm
	Aged Care Service	Occupy Dept of Housing Bldg - nil rent	Aged Care	Mon - Fri 8.30 - 5.00pm
	Briar Road P/S	occupy School Grounds - SSWAHS Demountable	School Clinic	Thurs 9.00 - 12.00md
	Claymore P/S	Occupy School Bldgs - nil rent	School Clinic	Wed 9.00 - 12.00md
	Campbellfields P/S	Occupy School building - nil rent	Early Childhood Clinic	1st, 3rd and 5th Thurs of month 9.00 - 12.00md
	Macarthur Square Clinic	3 rooms within Macarthur Square	Early Childhood Clinic	Mon - Fri 8.30 - 5.00pm Thurs 2.00 - 7.00pm, Sat 9.00 - 12.00md
	Ingleburn ECHC	Occupy Council Building - rent	Early Childhood Clinic	Tues - Fri 9.00 - 12.00md Thurs 4.00 - 8.00pm
			Hearing Clinic	Tues, Thurs 9.00 - 3.00pm
	Macquarie Fields ECHC	Occupy Council Building - rent	Early Childhood Clinic	Tues - Thurs 9.00 -12.00md
	Mawson Park ECHC	Occupy Council Building - rent	Early Childhood Clinic	Tues - Thurs 9.00 -12.00md
	Mount Annan P/S	Occupy School Building - nil rent	Early Childhood Clinic	Wed 9.00 -12.00md
	Robert Townsend P/S	Occupy School Building - nil rent	Early Childhood Clinic	Thurs 9.00 -12.00md
	St Andrews P/S	Occupy School Building - nil rent	Early Childhood Clinic	Tues 9.00 -12.00md

LGA	Facility	Tenure/ Plans	Services Provided	Usage (weeks, days and hours)
Campbell town	The Grange	Occupy School Building - nil rent	Early Childhood Clinic	2nd and 4th Thurs 9.00 -12.00md
	Child and Adolescent Mental Health	Private rental	Mental health	2nd and 4th Thurs 9.00 -12.00md
	Traxside Youth Health	SSWAHS owned	Youth Health	Mon - Fri 8.30 - 5.00pm
Wingecarribee	Bowral CHC	Conjoint development with Wingecarribee Council (Council land). SSWAHS owned - 99 year lease	Community Health Nurses	Mon - Sun 8.00 - 8.30pm
			Palliative Care	
			Community Counselling	Mon - Fri 8.30 -5.00pm
			Women's Health	
			Nutrition	According to need
			Sexual Assault	Mon - Fri 8.30 - 5.00pm
			Oral Health clinic	
			Drug Health	
	Bowral CHC	Conjoint development with Wingecarribee Council (Council land). SSWAHS owned - 99 year lease	Aged Care	Mon - Fri 8.30 -5.00pm
			Youth Mental Health Service	
			Mental Health	
	Bundanoon ECHC	Rented privately - $1,200 per annum	Early Childhood Clinic	Tues 9.30 - 3.00pm
	Moss Vale ECHC	CWA	Early Childhood Clinic	Tues and alternate Thurs 9.30 - 3.00pm
	Mittagong ECHC	CWA	Early Childhood Clinic	Thurs 9.30 - 3.00pm
	Hilltop ECHC	Occupy School Premises - SSWAHS Demountable - nil rent	Early Childhood and School Clinic	Mon 9.30 - 3.00pm
	New Berrima ECHC	Rented from Wingecarribee Council $250/annum	Early Childhood and Womens Health	2nd Wed 9.30 - 3.00pm
	Robertson ECHC	Rented privately - $360/annum	Early Childhood Clinic	1st and 3rd Wed 9.30 - 3.00pm

LGA	Facility	Tenure/ Plans	Services Provided	Usage (weeks, days and hours)
Wollondilly	Tahmoor / Wollondilly CHC	SSWAHS owned.	Speech pathology	Mon - Fri 8.30 - 5.00pm
			Women's health clinics	
			Early Childhood Clinic	
			Hearing Clinic	
			Oral Health clinic	
			Community Counselling	
	Warragamba Neighbourhood Centre	Occupy Council Building - nil rent. Shared with other services	Early Childhood Clinic	Fri 9.00 - 12.00md
	Picton P/S	Occupy School Grounds - SSWAHS Demountable	School Clinic	Tues, Wed 9.00 - 12.00md
	Bargo P/S	Occupy School Grounds - SSWAHS Demountable	School Clinic	Thurs 9.00 -12.00md
	Thirlmere P/S	Occupy School Bldgs - nil rent	School Clinic	Mon 9.00 -12.00md
	Coopers Cottage		Drug and Alcohol treatment Services	

APPENDIX C SSWAHS COMMUNITY HEALTH STRATEGIC PLAN STEERING COMMITTEE MEMBERSHIP LIST

A/Prof Peter Sainsbury Director of Population Health and General Manager Community Health (Chair July 2006 – September 2006), SSWAHS
Ms Dianna Kenrick, Assistant General Manager Community Health – Transition and Planning, SSWAHS (Chair September 2006 – February 2007)
Ms Sharyn O'Grady, A/General Manager, Community Health (September 2006 -)
Ms Alison Derrett, Assistant General Manager – Diverse Clinical Services, Community Health
Mr Mitchell Garbler, Business Manager, Community Health
Ms Jane Bowen-Jones, Clinical Quality and Risk Manager, Community Health
Ms Ivanka Komusanak, A/Director Community Health (Central)
Ms Dianna Jagers, Manager Information Management Unit, Community Health
Ms Kate Partington, A/Locality Director (Wingecarribee), Community Health
Ms Trish Clark, A/Locality Director (Liverpool), Community Health
Ms Deb McNamara, A/Locality Director (Bankstown), Community Health
Ms Penny Waldon, A/Locality Director (Macarthur), Community Health
Mr Malcolm Stokes, Nurse Unit Manager, Fairfield Community Health Nursing Team
Dr Katherine Moore, Director Allied Health
Ms Julie-Ann O'Keeffe, Senior Service Manager, General, Geriatric and Rehabilitation Medicine
Ms Lyn Bearlin, Manager, NGO Program, SSWAHS
Dr Teresa Anderson, General Manager, Liverpool Hospital (Director Clinical Operations, SSWAHS – December 2006 -)
Ms Jennie Burrows, Community Representative, Consumer/Community Council
Mr Jim Colvin, Community Representative, Community Networks
Dr Aline Smith, General Practitioner, Central Sydney Division of General Practice
Dr Susan Harnett, General Practitioner, Bankstown Division of General Practice
Ms Paula Caffrey, Service Development Officer, Community Health
Ms Louise Chapman, Project Officer, Community Health – Area Services
Ms Lou-Anne Blunden, Director Health Services Planning, SSWAHS
Ms Leah D'Souza, Senior Planner, SSWAHS

APPENDIX D PEOPLE CONSULTED IN THE DEVELOPMENT OF THE PLAN

- **COMMUNITY HEALTH STRATEGIC PLANNING FORUM and CONSULTATIVE DISCUSSIONS**

1. Meraris Acosta - Student
2. Jamal Ajami - Cancer Council NSW
3. Zarifah Akhbar – Fairfield Migrant Resource Centre
4. Karen Aldin – Bankstown Women's Health Centre
5. Mary Allan – Indigenous Coordination Centre
6. Ruben Allas – Strathfield City Council
7. Dr Garth Alperstein – Community Paediatrician, Community Health, SSWAHS
8. Carol Amorim – Inner Western Sydney BEP
9. Sophia Anderson – Learning Links
10. Evette Andreou – Fairfield CHC, SSWAHS
11. Marina Antonas – Burwood City Council
12. Veck Apostolovski – Reconnect Inner City
13. Joseph Banno – Leichhardt City Council
14. John Barr – Marrickville City Council
15. Karen Beale – Burwood Police
16. Lyn Bearlin, Manager, NGO Program, SSWAHS
17. Emma Beh – Traxside Youth Health Service
18. Geoff Berry – Community Representative
19. Nina Berry – Community Representative
20. Sarah Bishop – JPET (Wesley Uniting Unemployment)
21. Sheila Biswas – Bankstown Primary Health Nursing, SSWAHS
22. Robert Bosi – Drug Health, SSWAHS
23. Joanne Boyce – Randall, Occupational Therapy Advisor, Community Health SSWAHS
24. Beatrice Brown – Community Representative
25. Jennie Burrows – Community Representative
26. Allison Bush – Aboriginal Midwife, SSWAHS
27. Peter Butler – Community Representative
28. Daniel Byrne – JPET (Innerskill)
29. Margaret Challenger – Community Representative
30. Kay Churchill – Social Work Advisor, Community Health, SSWAHS
31. Paul Colwell – TAFE Counselling and Careers
32. Craig Cooper – HIV/AIDS Programs, SSWAHS
33. Mayet Costello – Centacare - CSA
34. Siew Lian Crossley – Fairfield CHC, SSWAHS
35. Marcia Cunningham – Rosemount Youth and Family Services
36. Corey Czok – Aboriginal Health, SSWAHS
37. Natasha Davies – Community Representative
38. Julie Deane – Campbelltown City Council
39. Helen Dirkis – Health Promotion, SSWAHS
40. Sam Donni – Glebe/Leichhardt PCYC
41. Vanessa D'Souza – NSW Association for Adolescent Health
42. Joella Dwyer – Community Representative
43. John Eastwood – Community Paediatrics, SSWAHS
44. B-Ann Echevarria – NSW Refugee Health Service
45. Julianne Elliott – Marrickville Legal Centre
46. Wendi Etherington – Lakemba School as Community Centre
47. Sarah Ferguson – Burwood City Council
48. Therese Findlay – Centre for Education and Research on Ageing
49. Carmel Flavell – Community Links – Wollondilly
50. Lyn Frankovich – Marrickville Council

51. David Freeman – Traxside Youth Health Service
52. Leslie Fuller – Aboriginal Men's Health, SSWAHS
53. Wendy Geddes – Acting Assistant General Manager, Community Health
54. Caroline George – Community HIV Services, SSWAHS
55. Stuart Gibb – Leichhardt City Council
56. Caroline Glass-Pattison – Marrickville City Council
57. Anita Hanna – Liverpool City Council
58. Janette Hannaford – Carer Support, SSWAHS
59. Colleen Rosowicz – Carer Support, SSWAHS
60. John Hanrahan – Just for Older Men (Chesterfield)
61. Janeane Harlum – Area Nurse Coordinator, Palliative Care, WZ
62. Allan Harvey – Indigenous Coordination Centre
63. Le Hoang – National Carers Counselling Program
64. Sandra Hoot – Mental Health, SSWAHS
65. Narelle Horwitz – JPET (MTC Work Solutions)
66. Stella Hristias – Woodville Community Services Inc.
67. Kim Huynh – Bankstown Women's Health Centre
68. Graeme James – Lifeline Sydney and Uniting Church in Australia
69. Liz James – Wesley Dalmar Youth Outreach
70. Maria Jesus-Velasco – Centre Based Day Care, SSWAHS
71. Mary Kang – Carer Support, SSWAHS
72. Brendon Kelaher – Aboriginal Health, SSWAHS
73. Mary Kemp – TAFE NSW
74. Judy King – Volunteer Worker, The Hub, SSWAHS
75. Michael King – Centacare Ageing and Disability Services
76. Brigid Kirby – Community Representative
77. Voula Kougelos – The Corner Youth Health
78. Allison Kyriakis – Burwood City Council
79. Denis Laris – Wesley Dalmar Youth Outreach
80. Matt Laxton - Canterbury Community Health
81. Rosemary LePage – DoCS Metro Central
82. Tracey Liondas - Miller Community School and Early Intervention
83. George Long - Aboriginal Health, SSWAHS
84. Andrew Longhurst - Northcott Disability Services
85. Jan Malley - Bankstown Women's Wellness Centre
86. Kim McCausland - WILMA Women's Health Centre
87. Sue McClelland - Bankstown Women's Health Centre
88. Romelda McInenery – Burwood PCYC
89. Ann McKenzie - Macarthur Child and Family Health Team, SSWAHS
90. Michael Moore - Central Sydney Division of General Practice
91. John Moulds – Psychology Advisor, Community Health, SSWAHS
92. Elfa Moraitakis - Cancer Council NSW
93. Rebecca Moran - Burwood City Council
94. Reen Mumbulla - NSW Department of Education and Training
95. Scott Muttdon - Student
96. Eileen Neal - Volunteer Worker, The Hub, SSWAHS
97. Hanadi Nemra - Multicultural Health, SSWAHS
98. Hanh Nguyen - Woodville Community Services Inc.
99. Sylvia O'Brien - Community Links – Wollondilly
100. Anne Partridge - Tresillian
101. Esta Paschalidis-Chilas - Canterbury-Bankstown Migrant Resource Centre
102. Wayne Phillips – Fairfield Paediatric Outreach Service, SSWAHS
103. Marcia Pitt – Reconnect Inner City
104. Vita Pittavino – Community Representative
105. Kerry Plumer – Acting Assistant General Manager, Community Health
106. Megan Potter – Rosemeadow CHC, SSWAHS

107. John Powers – Oral Health, SSWAHS
108. Liz Poynting – Ingleburn CHC, SSWAHS
109. David Price – Community Representative
110. Gabrielle Rennard – Ashfield City Council
111. Joe Rosa – Department of Housing
112. Vanessa Rose – The Hub, SSWAHS
113. Karen Rushbrour – Community Representative
114. Bernice Sarpong – Family Planning NSW
115. Lidija Sestakova – Multicultural Health Service Bankstown, SSWAHS
116. Dorothy Shipley – Aboriginal Health, SSWAHS
117. Sue Sid – Volunteer Worker, The Hub, SSWAHS
118. Deborah Silva – CHD Partners
119. Fiona Sinnathamby – Traxside Youth Health Service, SSWAHS
120. Kylie Smith - Campbelltown City Council
121. Gail Smith – Aboriginal Health, SSWAHS
122. Eric Snowball – Canterbury CHC, SSWAHS
123. Eithne Stack – Marrickville CHC, SSWAHS
124. Gai Stackpool – Health Promotion, SSWAHS
125. Garry Starr – Bankstown City Council
126. Anthony Stralow – Youthblock Health Services, SSWAHS
127. Tina Taylor – Campbelltown City Council
128. Sian Thomas – Centacare - CSA
129. Margaret Thompson - Community Representative
130. Janice Tolley – Fairfield Aged Day Care Service, SSWAHS
131. Angela Van Dyke – Fairfield City Council
132. Patti Veliz – City of Canada Bay Council
133. Kate Wade – Physiotherapy Advisor, Community Health, SSWAHS
134. Kelly Walker – Traxside Youth Health Service, SSWAHS
135. Rebecca Whitford – Youth Solutions
136. Bradley Whitwell – Early Intervention, SSWAHS
137. Colin Williams – Bankstown Elders Group
138. Alice Wood – Health Promotion, SSWAHS
139. Sue Woolfenden – Community and Ambulatory Paediatrics, SSWAHS
140. Nicholas Zwar – General Practice Unit, SSWAHS
141. SSWAHS Disability Committee Members

- **SSWAHS CLINICAL DIRECTORS & COMMUNITY HEALTH STAFF**

- **SSWAHS CLINICAL DIVISIONS OF GENERAL PRACTICE**

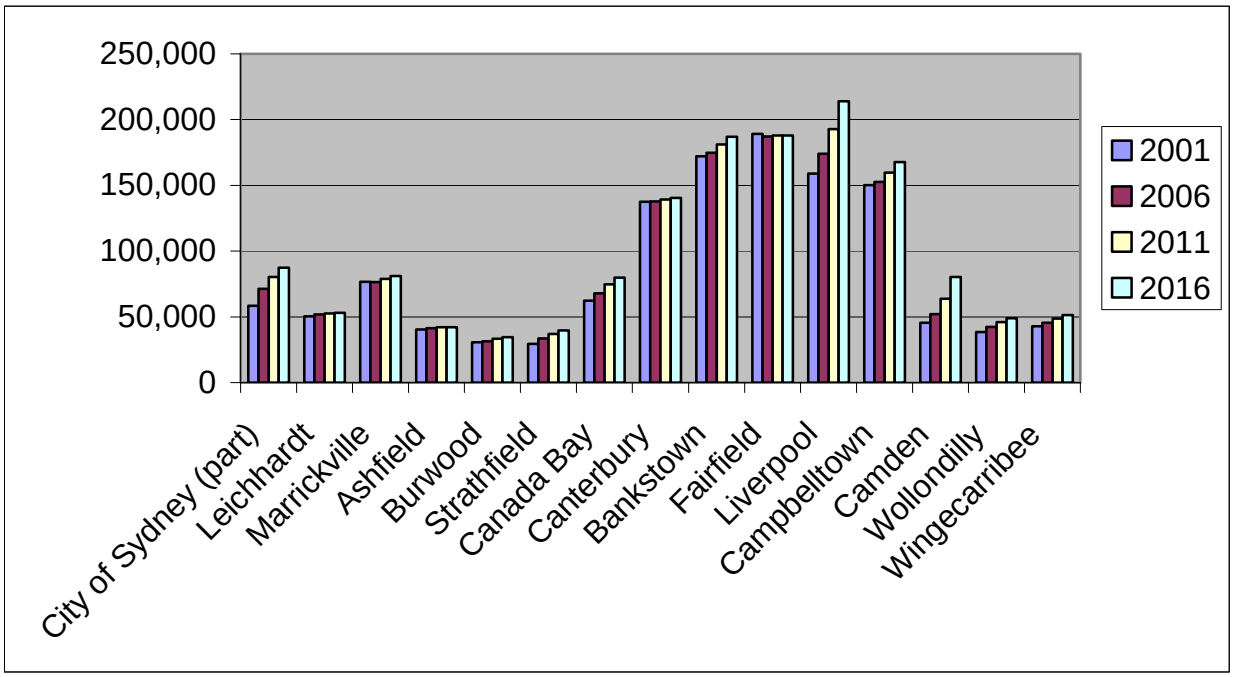
  Members of Central Sydney and Canterbury Divisions of General Practice. Previous information collected from the Bankstown, Liverpool, Macarthur and Southern Highlands Divisions of General Practice was also utilised.

- **LOCAL GOVERNMENT**

Ashfield City Council
Bankstown City Council
Burwood City Council
Camden City Council
Campbelltown City Council
Canada Bay Council
Canterbury City Council
City of Sydney City Council
Fairfield City Council
Leichhardt City Council
Liverpool City Council
Marrickville City Council
Strathfield City Council
Wingecarribee Shire Council
Wollondilly Shire Council

APPENDIX E DETAILED DATA ON DEMOGRAPHY AND HEALTH CHARACTERISTICS OF SSWAHS RESIDENTS

Figure 1 Population Growth 2001-2016



Source: NSW SLA Population Projections, 2005 Release. NSW Department of Planning, 2007

Table 1 Population Change in SSW 2001 - 2016

LGA	2001	2006	2011	2016
City of Sydney (part)	58,503	71,306	80,446	87,348
Leichhardt	50,456	51,799	52,512	53,179
Marrickville	76,743	76,425	78,794	81,151
Ashfield	40,521	41,430	42,036	42,068
Burwood	30,580	31,477	33,294	34,673
Strathfield	29,433	33,567	36,921	39,701
Canada Bay	62,322	67,973	74,846	79,760
Canterbury	137,492	137,808	139,231	140,480
Bankstown	171,994	174,884	181,004	187,055
Fairfield	189,034	187,153	187,892	187,841
Liverpool	159046	174038	192,862	213,915
Campbelltown	150,154	152,600	159,762	167,679
Camden	45,454	52,084	63,663	80,420
Wollondilly	38,424	42,242	46,050	48,847
Wingecarribee	42,740	45,598	48,609	51,341
SSWAHS	**1,282,896**	**1,340,384**	**1,417,922**	**1,495,458**
NSW	**6,578,980**	**6,872,530**	**7,164,950**	**7,454,050**

Source: NSW SLA Population Projections, 2005 Release. NSW Department of Planning, 2007

Table 2 Change in Population Age Structure 2001 - 2016

Age Group	2001	2006	2011	2016	Total change 2001- 2016	% change 2001-2016
0-4	89,787	87,091	86,316	88,601	-1,187	-1.32%
5-9	89,703	87,264	86,958	87,300	-2,403	-2.68%
10-14	85,458	89,340	89,130	89,648	4,191	4.90%
15-19	87,812	90,917	95,825	96,620	8,808	10.03%
20-24	94,415	100,016	105,362	111,309	16,894	17.89%
25-29	109,907	104,859	112,037	119,126	9,219	8.39%
30-34	109,929	114,864	113,278	121,285	11,356	10.33%
35-39	106,854	109,961	116,224	116,268	9,414	8.81%
40-44	98,879	105,271	109,808	116,240	17,361	17.56%
45-49	86,668	97,345	104,192	109,058	22,390	25.83%
50-54	80,006	84,041	94,610	101,330	21,325	26.65%
55-59	59,057	75,008	79,449	89,328	30,272	51.26%
60-64	48,459	54,910	69,742	74,125	25,666	52.96%
65-69	40,378	44,152	50,782	64,423	24,045	59.55%
70-74	36,408	35,883	40,088	46,678	10,270	28.21%
75-79	28,662	30,696	30,902	35,153	6,491	22.65%
80-84	17,257	21,901	24,102	24,924	7,666	44.42%
85+	13,494	16,452	21,302	25,664	12,169	90.18%
Total	**1,283,132**	**1,349,973**	**1,430,105**	**1,517,077**	**233,946**	**18.23%**

Source: DIPNR Population Projections 2004

Table 3 Indicators of Population Diversity, SSWAHS 2001

LGA	2001 Population	Aboriginal Identified	% Speaking LOTE at home	Main Languages Spoken
City of Sydney (part)	58,511	1,195	25	Greek, Cantonese
Leichhardt	50,450	631	16	Italian, Greek
Marrickville	76,770	983	39	Greek, Vietnamese, Arabic
Ashfield	40,540	205	44	Italian, Mandarin
Burwood	30,590	113	52	Cantonese, Italian
Strathfield	29,450	93	54	Cantonese, Korean
Canada Bay	62,350	228	30	Italian, Greek
Canterbury	137,520	664	62	Arabic, Greek
Bankstown	172,030	1,303	46	Arabic, Vietnamese
Fairfield	189,020	1,118	66	Vietnamese, Cantonese
Liverpool	159,070	2,038	44	Arabic, Italian, Vietamese
Campbelltown	150,160	3,602	19	Arabic, Spanish, Tagalog
Camden	45,450	525	8	Italian
Wollondilly	38,460	577	5	Italian, Arabic
Wingecarribee	42,760	497	4	Italian, German
SSWAHS	**1,283,132**	**13,772**	**39**	
NSW	**6,578,980**	**134,888**	**19**	

Source: 2001 ABS Census

Table 4 Migration to SSW by Visa Type 01/01/99 to 31/10/04

LGA	Visa Type				
	Family	Skilled	Humanitarian	Other	Total
Fairfield	5,579	887	4,231	2	10,699
Canterbury	5,064	2,982	923	0	8,969
Liverpool	3,092	1,890	3,180	11	8,173
Bankstown	3,506	1,316	466	1	5,289
Marrickville	1,896	1,175	165	2	3,238
Strathfield	1,073	1,848	168	0	3,089
Ashfield	1,194	1,688	93	2	2,977
Campbelltown	1,505	1,261	171	1	2,938
Burwood	872	1,266	55	3	2,196
Leichhardt	1,003	865	22	7	1,897
Canada Bay	810	805	28	0	1,643
Camden	149	209	18	0	376
Wingecarribee	146	69	0	0	215
Wollondilly	0	0	0	0	0
Total SSWAHS	25,889	16,261	9,520	29	51,699

Source: DIMIA Settlement Database 2005, Note: excludes City of Sydney

Table 5 Socioeconomic Indicators

LGA	Popn. Density Persons / km^2	% Living in same LGA 5 years ago	% in rented dwelling	Public housing tenant households [1]	Centrelink Income Support Customers [2]	Centrelink Customers as % 2004 popn.	Mean Taxable Income $
Sydney (part) *	4,586.8	14.7	50.4	399 (est.)	1,571 (est)	11.2	51,435
South Sydney (part)	5,068.2	39.4	52.9	2,980	9,209 (est)	21.5	47,740
Leichhardt	5,007.9	51.5	44.2	2,385	10,755	16.2	55,107
Marrickville	4,630.4	57.1	40.5	828	17,779	23.0	39,212
Ashfield	4,871.0	56.2	38.0	193	8,784	21.2	41,065
Burwood	4,296.2	59.0	33.3	350	6,321	19.9	40,948
Strathfield	2,124.4	60.1	31.1	541	5,122	16.3	43,280
Canada Bay	3,206.1	62.4	26.9	763	10,180	15.4	49,947
Canterbury	4,074.6	67.6	34.4	3,213	35,023	25.3	34,239
Bankstown	2,256.7	74.1	26.4	6,431	45,121	25.5	35,688
Fairfield	1858.0	78.5	28.8	4,665	55,129	29.1	33,185
Liverpool	535.3	61.2	30.2	4,867	35,188	21.0	35,592
Campbelltown	482.5	75.9	30.3	6,998	30,720	20.1	35,581
Camden	237.8	58.5	17.8	358	6,009	11.8	39,282
Wollondilly	15.2	70.2	13.7	142	6,605	16.1	37,884
Wingecarribee	16.2	69.7	19.7	382	8,754	19.5	40,582
SSWAHS	**214.7**	**N/A**	**33.2**	**35,495**	**292,270**	**21.9**	**39,610**
NSW	**8.3**	**69.4**	**27.5**	**125,401**	**1,474,412**	**21.8**	**41,623**

1 Includes households receiving rental subsidy and those not.
2 Includes age pension, disability support pension, Newstart allowance, parenting payment single, youth allowance, austudy, carer payment, double orphan pension, exceptional circumstances, mobility allowance, Newstart mature age allowance, parenting payment partnered, partner allowance, sickness allowance, special benefit, widow allowance, wife pension and widow class B. People receiving more than one payment type are only counted once using the main payment type.
* combined to form City of Sydney (part)
Source: NSW Regional Profile 2004, ABS.

Table 6 Index of Relative Socio-Economic Disadvantage

LGA	SEIFA Value
Ashfield	1026.72
Bankstown	954.05
Burwood	1003.52
Camden	1040.92
Campbelltown	940.61
Canada Bay	1072.90
Canterbury	923.04
Fairfield	849.22
Leichhardt	1076.91
Liverpool	948.93
Marrickville	999.55
Strathfield	1027.95
Sydney	1052.29
Wingecarribee	1028.43
Wollondilly	1022.85

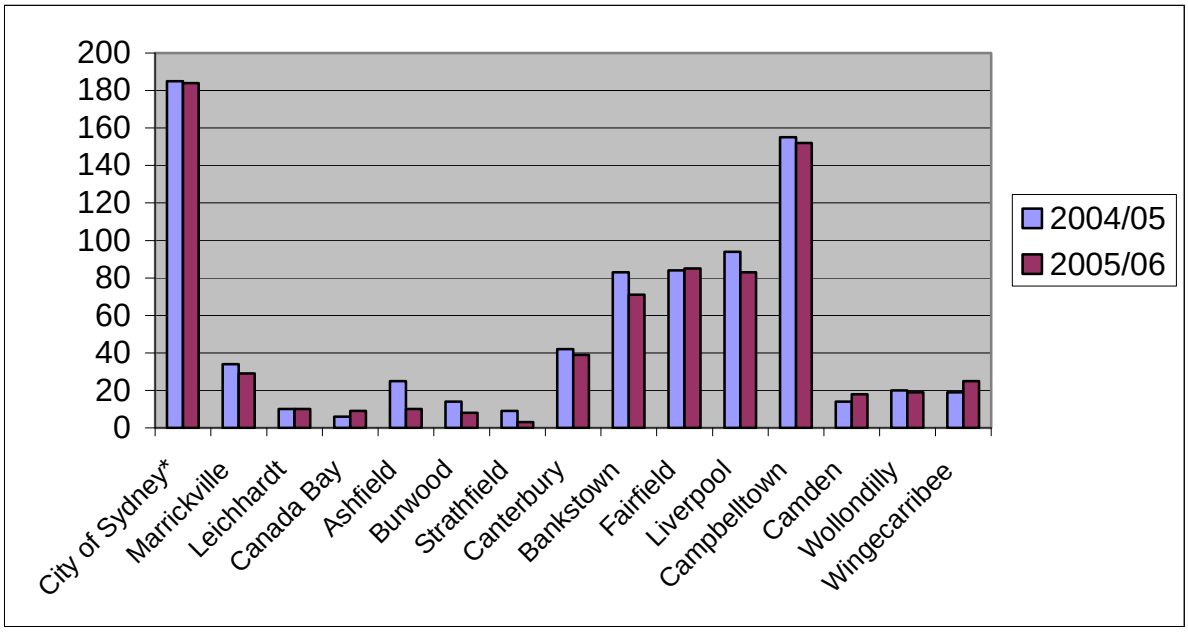
Source: ABS SEIFA 2001

Table 7 Family Household Structure

LGA	No. of Households	% of Households				Average Household Size
		Single Family	Multiple Family	Lone Person	Group	
Sydney (part)	4,506 (est)	48	0.4	36	15	2
South Sydney (part)	17,377 (est)	42	0.5	45	13	1.8
Leichhardt	25,835	56	0.5	33	10	2.1
Marrickville	27,940	58	1.6	30	10	2.3
Ashfield	14,436	63	1.5	29	7	2.4
Burwood	9,931	68	2.2	24	7	2.7
Strathfield	9,035	73	2.4	21	4	2.9
Canada Bay	22,198	69	1.4	24	5	2.5
Canterbury	43,455	72	2.5	22	3	2.8
Bankstown	53,397	76	2.6	20	2	2.9
Fairfield	53,341	79	4.2	14	2	3.2
Liverpool	46,807	80	2.7	15	2	3.1
Campbelltown	45,195	80	1.8	15	2	3
Camden	13,985	83	1.3	14	2	3
Wollondilly	11,796	82	1.6	15	2	3
Wingecarribee	14,546	74	1	23	2	2.5
SSWAHS	**413,780**	**70**	**2.1**	**23**	**5**	**2.7**
NSW	**2,232,828**	**72**	**1.3**	**23**	**4**	**2.6**

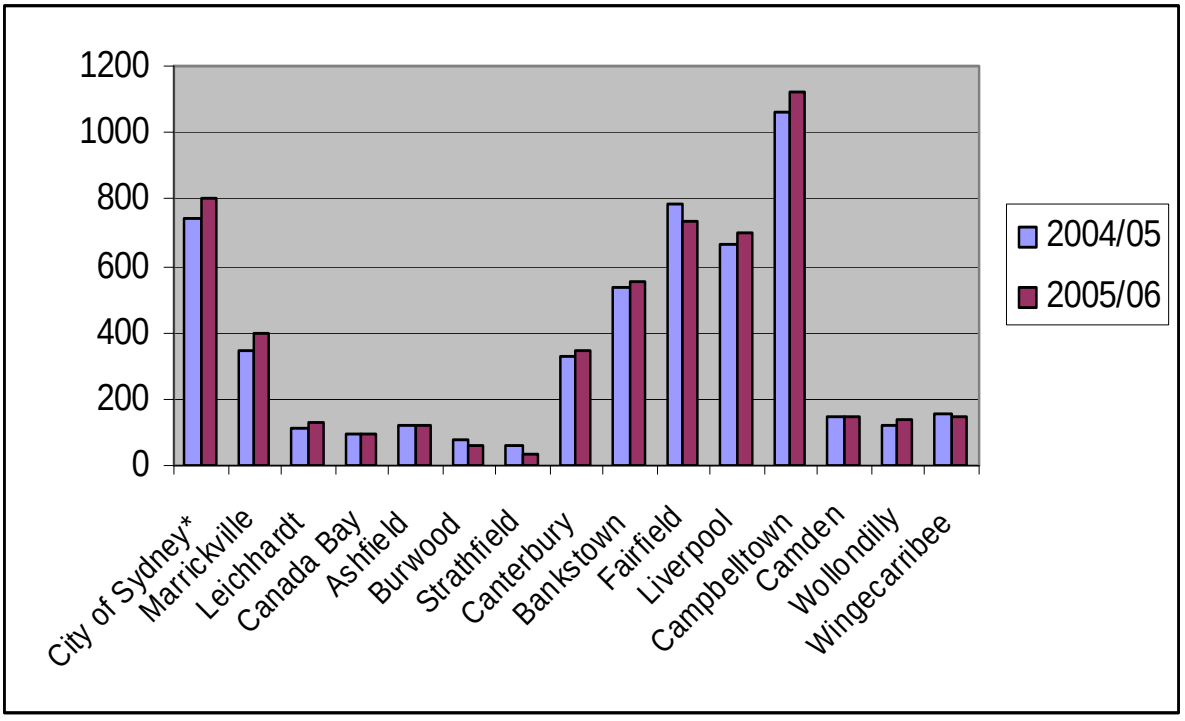
Source: 2001 Census

Figure 2 Recorded Sexual Assaults in SSW 2004/05 and 2005/06



Source: BOCSAR 2006

Figure 3 Domestic Violence Reported Incidents in SSW 2004/05 and 2005/06



Source: BOCSAR 2006

Table 8 Private health insurance in SSWAHS and NSW 2003 (16 years +)

Private health insurance coverage						
	Yes	%	No	Did not answer	Don't know	Total
Estimate based on population						
EZ	223,395	54.5	179,761	1,607	5,208	409,972
WZ	265,755	44.2	326,435	3,430	5,376	600,996
SSWAHS	489,150	48.4	506,196	5,037	10,584	1,010,968
NSW	2,732,118	52.9	2,361,814	8,600	59,945	5,162,477
Health Insurance rate based on survey respondents						
EZ	408	56.0	310	2	8	728
WZ	321	45.4	379	2	5	707
SSWAHS	729	50.8	689	4	13	1,435
NSW	6,320	48.6	6,583	15	90	13,008

Source: NSW Continuous Health Survey Dataset 2003, HOIST, NSW Health Department (Accessed on 25 July 2005)

Table 9 GPs in SSWAHS 2005

Division	Members[1]	Non-members[1]	Total	Population estimates 2004 ABS	FTE GP: population ratio 2003[5]	Approx. No. of GPs that speak a language other than English[2,3,4]
Bankstown	175	21	196	175,428	1:1,107	102
Canterbury	154	49	203	135,048	1:1,185	102
Central Sydney	350	210	560	366,347	1:1,119	350
Fairfield	190	28	218	187,683	1:1,187	143
Liverpool	115	41	156	167,880	1:1,602	66
Macarthur	176	34	210	200,263	1:1,584	83
Southern	50	2	52	45,000[6]	1:1,525[1]	5
Total GPs SSWAHS	**1,210**	**385**	**1,595**	**1,277,649**	**N/A**	**851**

1. The seven Divisions of General Practice in SSWAHS (September 2005)
2. Database (GPs in Western zone 2004) GP Unit, SSWAHS
3. Eastern zone GP database SSWAHS intranet
4. Medical Directory of Australia 2005
5. Annual Survey of Divisions – Primary Health Care Research and Information Service www.phcris.org.au/resources/divisions
6. Wingecarribee Shire Council

APPENDIX F COMMUNITY HEALTH CLINICAL CORE BUSINESS FRAMEWORK

Sydney South West Area Health Service
Community Health - Clinical Core Business Framework 2007 - 2008

Introduction

The Community Health Clinical Core Business Framework outlines the clinical services provided and delivered by Community Health. It identifies and prioritises the clinical core business of each service group. It does not include the other essential aspects of Community Health staff work such as community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies.

The purpose of this framework is to guide clinicians and managers in the provision of clinical services, following consideration of client need, available resources and efficacy of desired outcomes.

Priorities have been identified by each clinical service through an analysis of need and effectiveness of intervention outcome, with the following categories assigned:

Priority One - High priority services that are mandated by policy or legislation; have the greatest potential impact on health outcomes; and should be available across the Area Health Service.

Priority Two - Services that have a moderate potential impact on health outcomes; may not be available across the area; and are provided following consideration of available resources and clinical need.

Priority Three - Services that have a limited potential impact on health outcomes; may not be available across the area; and are provided following consideration of available resources and clinical need.

An asterisk (*) denotes services or activities that are considered on a case-by-case basis, in discussion with the relevant manager of the Clinical Directorate.

Child and Family Clinical Services – Clinical Core Business
Outlines the clinical services and priorities of each health discipline within Child and Family Clinical Services

Child and Family Health Nurses (0-5 years)

A number of risk factors are considered across several domains in determining service activities/intervention: the child, the parent-infant relationship, and maternal, partner, family, environment and life events. These risk factors are categorised as per the draft NSW Health *Supporting Families Early* (Health Home Visiting Guidelines). They are as follows:

Level 1 response: No specific vulnerabilities factors detected

Level 2 response: Vulnerability factors that may impact on the ability to parent – young (under 19 years), unsupported parent; single, unsupported parent; multiple birth; complicated and/or premature birth; child or parent with disability/chronic illness; adjustment to parenting issues; anxiety, depression; history of mental health problem; grief or loss associated with the death of a child or other significant family member; relationship issues; financial stress; housing issues; isolation (geographic, lack of support); refugee status, recent migrant

Level 3 response: Complex risk factors that may impact on the ability to parent – current mental health symptoms; current substance abuse; parent with developmental disability; current or history of domestic violence; current or history of child protection issues

Priority One:

- Universal home visiting (including a bio-psychosocial assessment - for example, pregnancy history, family medical history, family social history, screening for domestic violence, Edinburgh Depression Scale, 1-4 week infant health record assessment, infant-parent interaction)
- Parent groups (for example, new parent groups, early bird groups, introduction to solids groups, sleep and settling groups, transition to toddler groups)
- Parent support clinics focussing on ongoing feeding, settling, parent support, education and health promotion
- Targeted follow up of Level 2 families, including 6 to 8 week/6 to 8 month and 18 month bio-psychosocial assessment
- Involvement in the case management of Level 3 families - for example, participation in protective planning meetings with DoCS
- Opportunistic immunisation
- Sustained home visiting for specific target groups

Priority Two:

- 6 to 8 week, 6 to 8 month, and 18 month, bio-psychosocial assessment for Level 1 families

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012 and reviewed and reported on during annual planning activities.

Child Health Nurses/Community Health Nurses (4-18 years)

Services provided include health screening of near school age children up to adolescent students. Assessment includes vision, hearing, speech and language and any other problem that may affect the child's learning in school. Health education and promotion is offered to schools and community groups.

Priority One:

- Health surveillance and case management: teacher/parent referrals (centre-based and school-based)
- Parenting and other group programs where, evidence indicates, early intervention will have the greatest potential impact on health outcomes (for example, Triple P, TIPS, Toddler Terrific or Terrible - in conjunction with Child and Family Health Teams, Schools as Community Centres)

Priority Two:

- Transition to school surveillance (one-off, and referred to appropriate services if issues identified)
- Health training to school communities for specific health issues (staff, parents and students)
- Audiometry nursing services (self referral)
- School based adolescent health service

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Paediatric Occupational Therapy (0 – 18 years)

Services provided include assessment and intervention for children who have difficulty with their occupational performance in play, fine motor, self care, school readiness and sensory motor skills. This includes children with, or at risk of, a learning difficulty, mild autistic spectrum disorder, mild intellectual or physical disability.

Priority One:

- Clients for whom a response is mandated according to legislation and policy (for example, child protection issues), urgent assessment for funding purposes, children in refuges
- Children with a mild physical or intellectual disability for whom no or untimely Occupational Therapy intervention on our part will result in significant adverse outcomes (for example, children with mild cerebral palsy, splinting)
- Children aged 0-5 years for whom, evidence indicates, early intervention will have the greatest potential impact on health outcomes (for example, children with developmental delay in play, fine motor, self care, school readiness and sensory motor skills)

Priority Two:

- Children aged 5-12 years for whom, evidence indicates, intervention will have a moderate impact on health outcomes (for example, children with developmental delay in play, fine motor, self care and sensory motor skills)
- Chronic impairments that require review and management at crucial points in development (for example, mild cerebral palsy, mild autism, mild developmental delay and learning difficulties)

Priority Three:

- Children for whom evidence indicates treatment may have a limited outcome (for example, children whose improvements have plateaued or potential outcome is limited) *
- Children for whom evidence indicates spontaneous recovery is likely and there are no significant long-term impacts on the social emotional or academic outcomes (for example, children in high school with mild difficulties) *

Services which are not clinical core business

- Children with moderate to severe intellectual or physical disabilities
- Children with moderate to severe autism

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Speech Pathology (0 – 18 years)

Services provided include assessment and intervention for children with communication impairment and their families. This includes children with difficulties in receptive language, expressive language, speech articulation, voice, fluency, mild feeding difficulties, mild Autistic Spectrum Disorder and mild developmental delay or disability. A range of centre, preschool, home and school based intervention models are offered including individual, group, consultation, collaboration, home/school programs and parent/teacher training.

Priority One:

- Clients for whom a response is mandated according to legislation and policy (for example, child protection issues), urgent assessment for funding purposes
- Children for whom no or untimely Speech Pathology intervention on our part will result in significant adverse outcomes (for example, recent cochlear implant clients requiring intensive follow up)
- Children aged 0-5 years for whom, evidence indicates, early intervention will have the greatest potential impact on health outcomes (for example, children with specific language and speech impairment, stuttering and voice intervention)

Priority Two:

- Children aged 5-12 years for whom, evidence indicates, intervention will have a moderate impact on health outcomes (for example, children with specific language and speech impairment)
- Chronic impairments that require review and management at crucial points in development (for example, children with Specific Language Impairment at transition to school and high school, and children with specific language and speech impairment over 8 years of age)

Priority Three:

- Children for whom, evidence indicates spontaneous recovery is likely and there are no significant long-term impacts on the social emotional or academic outcomes (for example, children with mild articulation and phonological impairments) *

Services which are not clinical core business:

- Children with global developmental delay (moderate to profound range)
- Children needing specialist services (that is, tube feeds, complex feeding issues, modified barium swallows, cleft palate clinic etc)
- Children with specific reading and literacy difficulties, without language impairment
- Children with moderate to severe Autistic Spectrum Disorder

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Physiotherapy (0 - 18 years)
Services provided include centre, preschool, home or school based assessment and intervention for children aged 0-18 years with difficulties in the development or coordination of movement skills, including case management for children with recognised special needs in the mild range of disability
Priority One: ▪ Clients for whom a response is mandated according to legislation and policy (for example, child protection issues), urgent assessments for funding purposes ▪ Children for whom no or untimely Physiotherapy intervention on our part will result in significant adverse outcomes (for example, children with talipes, cerebral palsy, torticollis, connective tissues disorders) ▪ Children aged 0-5 years for whom, evidence indicates, early intervention will have the greatest potential impact on health outcomes (for example, children with delay/difficulties in development or coordination of movement skills)
Priority Two: ▪ Children aged 5-8 years for whom, evidence indicates, intervention will have a moderate impact on health outcomes (for example, children with difficulties in development or coordination of movement) ▪ Children with chronic impairments that require review and management at crucial points in development (for example, mild cerebral palsy)
Priority Three: ▪ Children for whom, evidence indicates spontaneous recovery is likely and there are no significant long-term impacts on the social emotional or academic outcomes (for example, children requiring assessment for lower limb posture concerns) *

Services which are not clinical core business:

- Babies and children with respiratory conditions
- Children for post-fracture rehabilitation
- Children aged 10 years+ with orthopaedic conditions

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Social Work (0 - 18 years)

Early Childhood Social Work (0-5 years)

Services provided include assessment, counselling and advocacy for families with children 0 to 5 years. Assessment and counselling is primarily conducted in the home. The focus of intervention is the parent/child relationship. Early Childhood Social Work referrals include: adjustment to parenting; post natal emotional distress (including depression and anxiety); managing child developmental stages (such as separation anxiety, tantrums, toileting and sleep problems); family and relationship issues (such as conflict or variation of parenting styles); and effects of separation/divorce on the child. The following issues may also influence a referral to Early Childhood Social Work: domestic violence; grief and loss; social issues and isolation, in terms of the impact these issues have on parent resources and family stability.

Priority One:

- Clients for whom a response is mandated according to legislation and policy (for example, high risk behaviours/self-harm, domestic violence, child protection issues);
- Parenting and other group programs where, evidence indicates, early intervention will have the greatest potential impact on health outcomes (for example, Toddler Terrific or Terrible, parent-infant interaction groups);
- Referrals where post-natal distress or adjustment to parenting issues are identified. Assessment and counselling sessions conducted in accordance with the home visiting model

Priority Two:

- Parents for whom no or untimely Social Work intervention by Community Health may result in adverse outcomes for the infant/child (for example, parental distress)

Child and Family Social Work (0-18 years)

Services provided include psychosocial screening, assessment, therapeutic interventions, liaison and advocacy, counselling and group programs for children, adolescents and families presenting with cognitive, emotional, behavioural and social problems. Interventions are provided within a family context where possible.

Child, adolescent and family referrals include: adjustment difficulties; anxiety; ADHD; behavioural problems; grief and loss; interpersonal difficulties; issues associated with domestic violence (including work with the non-offending parent); parenting strategies for child behaviour; sadness and depression; school refusal; social skills; self harm/suicidal ideation; trauma; and children whose parents have a mental illness

Priority One:

- Clients for whom a response is mandated according to legislation and policy (for example, high risk behaviours/self-harm, domestic violence, child protection issues)
- Comprehensive psychosocial screening and assessment at the point of referral/intake to determine the counselling response, or advice about alternative agencies;
- A presenting mental, behavioural or emotional problem (e.g. risk of harm to self or others) that is of such concern as to require an urgent response
- Provision of evidence-based intervention to children, young people and families, assessed or screened at intake, as requiring a counselling response or other intervention
- Provision of evidence based individual and group therapy for children, young people and families

Services which are not clinical core business:

- Long term intensive psychotherapy
- Marital/couple counselling
- Children's problems that are primarily school focused
- Requests to write court reports in the absence of intervention
- Monitoring of children at risk
- Case management only
- Children with a moderate to severe level of cognitive disability/adaptive functioning, and children with a moderate to severe level of physical disability
- Out of centre crisis response
- Out of hours crisis response

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Psychology and Clinical Psychology (0 - 18 years)
Psychology services accept referrals for assistance/help/support with: ADHD, adjustment disorders; anxiety (including fears and phobias, generalised anxiety, obsessive compulsive disorder, panic attacks, separation anxiety, social anxiety); autistic spectrum concerns; behaviour problems; children whose parents have a mental illness; eating concerns, encopresis; enuresis; grief and loss; interpersonal difficulties; issues associated with domestic violence (including work with the non-offending parent); sadness and depression; school refusal; self esteem; self harm/suicidal risk; sleep problems; social skills; stress and trauma.
Priority One: ▪ Clients for whom a response is mandated according to legislation and policy (for example, high risk behaviours/self-harm, domestic violence, child protection issues). ▪ A presenting mental or emotional problem (e.g. risk of harm to self or others) that is of such concern as to require an urgent response ▪ Comprehensive screening/assessment to determine the most clinically appropriate response, including referral to external agencies ▪ Provision of evidence-based individual and group therapy for children, young people and families
Priority Two: ▪ Psychometric testing to support applications for funding for early intervention (for example, prior to commencement of school for children with special needs), when it is reasonable to expect that this service would not be otherwise available
Priority Three: ▪ Individual intervention when accessible and appropriate evidence-based group intervention is declined by the family * ▪ Psychometric testing to assist colleagues in other professions in their service provision*

Services which are not clinical core business:

- Long term intensive psychotherapy
- Interventions with, and management of, children, adolescents and families requiring intensive long term involvement
- Assessment or intervention during/pending court proceedings
- Intervention with children who have a moderate to profound intellectual disability
- Marital/couple counselling
- Psychometric testing, except as provided above
- Management of school behaviour (in the absence of other concerns)
- Assessment where second opinion regarding a mental health diagnosis is the sole request for intervention
- Interventions where alternative specialist service is accessible

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Orthoptics (0 – 18 years)

Primary and secondary orthoptic screening of children, which includes assessment of vision, ocular motility and strabismus

Referrals accepted from: Early Childhood Health Services, School Nurses, Community Health staff, Community Health Medical Officers, General Practitioners, school counsellors and teachers

Priority One:

- Primary screening: referral children seen at Early Childhood Health Clinics, home, child-care centres, pre-schools and schools. Identified problems referred to appropriate agencies, for example, public hospital eye clinic, private ophthalmologists or optometrists

Priority Two:

- Secondary screening: referral children seen at Community Health Centres and schools. Identified problems referred to appropriate agencies, for example, public hospital eye clinic, private ophthalmologists or optometrists

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Community Health Medical Officers (0 – 18 years)

Community Paediatrics provides population and community based non-acute services for children, adolescents and their families with cognitive, physical, emotional, behavioural and social problems.

Priority One:

- Children and families for whom a response is mandated according to legislation and policy (for example, child protection issues)
- Community and outpatient based paediatric medical diagnostic assessment and treatment services
- Developmental assessments
- Assessment of children with suspected autism spectrum disorders (ASD)
- Assessment and management of children with behavioural problems, for example ADHD
- Assessment and management of medical problems of "at risk" youth in Youth Health Services

Services which are not clinical core business:

- Medical consultation to health workers for common childhood conditions

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Child Protection

Child Protection Services are provided in accordance with NSW policy directives and the statutory responsibilities outlined in the Children and Young Person's (Care and Protection) Act 1998

Priority One:

- Provision of consultation to health services regarding clinical management of clients, and child protection roles/responsibilities as per policy directives
- Provision of mandatory child protection training for all relevant staff
- Provision of consultation to Department of Community Services (DoCS) regarding SSWAHS child protection policies, and therapeutic/treatment issues for child protection cases
- Casework, counselling, groupwork and therapeutic intervention services for children/young people and their parents/carers for whom physical abuse, emotional abuse, domestic violence and/or neglect has been confirmed by DoCS. Primarily an outreach service providing weekly intervention for 3-18 months, focussing on increasing safety and reducing the risk for children in the family context, or ameliorating the effects of past abuse on a child. All referrals must come directly from DoCS with priority given to: a previous non-accidental child death in the family, the previous assumption of care of the child or siblings, serious physical or psychological injury of the child, a child under 5 years who has been physically or emotionally abused or neglected, multiple risk of harm reports regarding a child, poly-substance abuse by the parents or caregiver, or a parent or child with a disability
- Support the provision of the 24 hour medical and crisis counselling services for children who present to SSWAHS hospitals with physical abuse and/or neglect. Provide a direct forensic medical response for children/young people presenting at Liverpool Hospital, including child sexual assault assessment in conjunction with the Sexual Assault Service, as required

Priority Two:

- Provision of specialist child protection training for relevant staff
- Targeted clinical services provided by the child protection paediatrician, including: clinical and forensic training in child protection to medical and nursing staff in emergency and paediatric departments; advanced training for community paediatric registrars

Priority Three:

- Provision of specific clinical assessment and follow up services for children identified as at risk of abuse and neglect.

Services which are not clinical core business:

- Group work
- Audio visual services (for example, clinical photography for forensic purposes)
- Children's court assessments and reports
- Young people who are alleged sex offenders
- Perpetrator programs

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Diverse Clinical Services
Outlines the clinical services and priorities of each service located in the Diverse Clinical Service stream

HIV/AIDS Community Services

- **Positive Central – Multidisciplinary Allied Health**
- **The Sanctuary – Health Maintenance Program**
- **Pozhet – Heterosexual HIV Support/Education**

Priority One:

Positive Central

- Social Work: Assessment; goal identification and care planning; counselling; advocacy; service coordination (complex needs); housing assessment and support
- Occupational Therapy: Assessment; care planning; motivation and goal setting, home modifications, meaningful activity problem solving, cognitive/memory assessment, fatigue/energy conservation advice, personal and domestic care assessments
- Physiotherapy: Assessment, care planning, exercise programs, physical rehabilitation, peripheral neuropathy clinic, mobility and respiratory assessments, pain relief management, hydrotherapy group, services to residents of The Bridge (AIDS Dementia Residential Unit)
- Dietetics: Assessment, care planning, nutritional assessment, supplement service, lipodystrophy monitoring, budget shopping
- Multidisciplinary group work: Focus areas include mental health, aging, communication, social isolation, grief, physical and emotional health

The Sanctuary (Area-wide service)

- Complementary therapy (massage) service, peripheral neuropathy clinic

Priority Two:

- Social Work: Ensuring access to appropriate medical care (for example, attending specialist appointments, follow up to auxiliary services, advocacy with medical services)

Services which are not clinical core business:

- Case management of ADAHPTS (AIDS Dementia and HIV Psychiatry Team) clients
- Case management of supported housing clients
- Transport of clients to appointments
- Clinical support services to heterosexual people with HIV and Hepatitis C co-infection, and their families

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Community Nutrition Services

The community nutrition service receives referrals from health services, such as community health nursing, early childhood health, GPs , allied health and other government and non-government agencies.

Priority One:

Paediatric nutrition and dietetic service for children aged 0 – 5 and their parents
Nutrition and dietetic service for clients eligible for HACC funded services

Services which are not clinical core business:

- Nutrition and dietetic service for school aged children and their carers
- Eating disorders
- Overweight and obese school aged children and adolescents
- Allergies

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Sexual Assault Services

Sexual Assault Services provide services for children, young people and adults who have experienced sexual assault and their families/significant others. Sexual Assault Services offer a specialist response through the following activities: 24 hour crisis intervention, specialist medical assessment and treatment including collection of forensic material, documentation of injury, post exposure prophylaxis for potential sexually transmitted diseases, post coital contraception, ongoing counselling, court preparation and support, and the provision of reports when needed for victims of sexual assault.

Priority One:

- 24 hour crisis counselling and medical response to adults, young people and children who have experienced a recent sexual assault
- Ongoing counselling to adults, young people and children who have experienced sexual assault and their (non –offending) family/significant others. In accordance with NSW Health policy directives, for those services which see both adults and children, priority for client allocation will be given in descending order to the provision of services for new clients and non-offending family members from the following categories:
  1. Children, where the sexual assault has occurred within the past seven days and adults who have been sexually assaulted in the last seven days (this also includes their non-offending parents and siblings)
  2. Any disclosure of sexual assault by a child or young person under the age of 16 (this also includes their non-offending parents and siblings)
  3. Any disclosure of sexual assault by a young person aged 16 - 18
  4. Adult victims sexually assaulted in the last year
  5. Any sexual assault victims requiring court preparation and support or cases where the assault is the subject of some investigation and does not fit into category one to four
  6. Adults who have been sexually assaulted as adults more than one year ago
  7. Adults who have been sexually assaulted as a child
- Follow-up medical services
- Group work services for victims and non-offending family and friends

Services which are not clinical core business:

- Work with offenders

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Women's Health

Well Women's Clinics are conducted by women's health nurses and provide women with health checks and the opportunity to access health information on a wide range of women's health issues. The clinics target women who experience social disadvantage or who do not access mainstream health services.

The clinics are free, and conducted on an on-going basis in partnership with key stakeholders (for example, community based health services, GPs, non-government agencies and other facilities within SSWAHS).

Priority One:

Cervical screening, pelvic examinations, breast examinations, postnatal checks, and advice/information about contraception, menopause, sexually transmissible infections, gynaecological health and wider health and wellbeing issues

Priority Two:

Targeted clinics on a needs, stand alone basis (for example, clinics for populations of women where, evidence indicates, by the nature and extent of their social, economic and/or health disadvantage, tend to have poorer health outcomes than other women. These groups include: Aboriginal and Torres Strait Islander women, women of non-English speaking background, women of low socioeconomic status, refugee women and young women)*

Services which are not clinical core business:

- Skin spot checks
- Blood Borne Virus (BBV) screening
- Pregnancy blood test
- Provision of medication
- Terminations
- Provision of contraception (for example, Implanon)

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Multicultural Health Services

Bilingual Early Parenting Educators

The role of the Bilingual Early Parenting Educators (BEPEs) is to improve the health of families with children 0-2 years from culturally and diverse communities through an early intervention program.

Priority One:

- Sustained home visiting: provide assistance to the family as it engages with health and other services, and maintain ongoing support and continuity of care to prevent premature disengagement
- Antenatal and parenting information and support
- Develop and monitor care plans for individual clients in collaboration with relevant services
- Participate in multidisciplinary case management meetings

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Youth Health Services

Services provided include assessment, therapeutic interventions, counselling, medical, nursing and group programs for young people identified as "at risk" and their families/carers.

Referrals include: issues associated with homelessness or risk of homelessness, disengagement or risk of disengagement from school/family/home, unemployed youth, mental health issues (including suicidal ideation, self harm, depression and anxiety), sexuality issues, parenting, sexual health issues, disability issues, resettlement issues (including refugees), co-morbidity issues, trauma, grief and loss and behaviour issues.

Priority One:

- Young people at risk of harm for whom a response is mandated according to legislation and policy (for example, high risk behaviours/self-harm, domestic violence, child protection issues)
- Comprehensive assessment at the point of referral/intake to determine the most clinically appropriate response, including referral to external agencies
- Evidence-based intervention to young people, assessed or screened at intake, as requiring a counselling response or other intervention
- Group programs where, evidence indicates, early intervention will have the greatest potential impact on health outcomes (for example, anxiety/stress management groups, fighting depression programs, parent support groups)
- Nursing and/or medical clinics to "at risk" young people via appointment and drop in services, including medical advice, cervical screening, advice/information about contraception, sexually transmissible infections, assistance with prescriptions, and wider health and wellbeing issues
- Secondary Needle and Syringe Program (NSP) services and the provision of opportunistic brief interventions

Priority Two:

- Targeted programs for specific population groups where, evidence indicates, intervention will have a moderate impact on health outcomes, but are conducted to increase access and engagement including Youth Week activities, World Aids Day, Health week, and school holiday programs

Services which are not clinical core business:

- Couples counseling (parents)
- Requests to write court reports in the absence of intervention
- School screening
- Direct treatment to an individual for the perpetration of violence

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Sexual Health Services

Sexual Health services provide diagnosis, treatment and counselling for sexual health problems, usually related to the acquisition of a sexually transmitted infection or blood borne virus.

Priority One: *(Clients seen on the same day if possible)*

- Clients who may have been exposed to HIV who require assessment for HIV post-exposure prophylaxis
- At risk young people requesting emergency contraception
- New/recent HIV diagnoses
- HIV clients who are unwell
- Clients with anogenital symptoms which may indicate a sexually transmitted infection
- Aboriginal people
- Needle stick and Body Fluid Exposure
- Clients presenting to Needle Syringe Program (NSP)

Priority Two: *Clients seen within 1 week at most)*

- Clinical services are provided / targeted to the following groups in accordance with the NSW Health STI and HIV/AIDS Strategies: HIV infected individuals, homosexual men, injecting drug users, commercial sex workers, at risk or disadvantaged young people
- GP referrals

Priority Three: *(Clients seen within 2 weeks at most)*

- Additional target groups for clinical services in SSWAHS include: at risk Chinese speaking clients (specific weekly clinic with interpreter), at risk Vietnamese speaking clients (specific weekly clinic with interpreter), at risk Thai speaking clients (specific weekly clinic with interpreter), pregnant women at risk of HIV/STIs

Services which are not clinical core business:

People requesting an appointment or presenting to the service are assessed by an experienced Sexual Health Registered Nurse. If the person is not included in the priority areas listed above, they are referred to local GPs who will provide a sexual health service

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Community Counselling

A review of Community Counselling Services will be undertaken in 2007 to determine future models of care (including clinical core business)

The counselling service consists of Psychologists, Clinical Psychologists and Social Workers.

Referrals for adult clients include: adjustment disorders, anxiety disorders, depressive disorders, interpersonal difficulties/poor self esteem/social skills, domestic violence, grief and loss, stress, suicidal ideation (low-moderate), trauma/victims of crime

Priority One:

- Adults for whom a response is mandated according to legislation and policy (for example, high risk behaviours/self-harm, domestic violence, victims of crime, child protection issues)
- Comprehensive psychosocial screening and assessment at the point of referral/intake to determine the counselling response, or advice about alternative agencies
- Provision of evidence-based intervention to adults, assessed or screened at intake, as requiring a counselling response or other intervention (for example, current evidence indicates effective management is dependent upon early intervention)
- Group programs where, evidence indicates, early intervention will have the greatest potential impact on health outcomes

Priority Two:

- Group programs where, evidence indicates, intervention will have a moderate impact on health outcomes

Services which are not clinical core business:

- Direct treatment to an individual for the perpetration of violence
- Couple counselling and family mediation requests
- Report writing and letters of support in the absence of intervention

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Community Acute / Post Acute and Chronic Clinical Services– Clinical Core Business
Outlines the clinical services and priorities of each health discipline within Community Acute / Post Acute and Chronic Clinical Services

Community Health Nursing
Services provided are based on the philosophy of Primary Health Care, which promotes self-management and prevention aimed at reducing avoidable hospital admissions. Services range from acute/post acute care to palliative care and are provided to clients of all ages. Community Health Nursing operates from a case management framework whereby all clients are holistically assessed; vulnerabilities identified and prioritisation applied according to need; and, where appropriate, referrals made to other services. All clients are triaged through intake assessment and followed up by a telephone assessment, conducted by the case manager within 24 hours of referral. A more comprehensive assessment is conducted during the initial face-to-face contact and continues throughout the care period as does education, support, and referral to appropriate services. Community Health Nursing Services are funded from a variety of sources including HACC, State (Area Health Services) and other Australian Government funding sources. Funding bodies place particular requirements on services in relation to the funding provided which include meeting specific standards, providing services to particular population groups and specific reporting mechanisms.
Priority One: (Client seen within 24 hours) ▪ IV medication and management of central lines; ▪ Risk of infection/complications, for example, wounds, injections, with priority given to: significant carer stress; frail aged; isolated; minimal social support; no General Practitioner; significant functional/mobility/developmental impairment; chronic wound that has been clinically assessed as at risk; risk of hospitalisation (for example, respiratory, wound, exacerbation of chronic condition) ▪ Client unable to self care/manage or does not have access to an alternative provider; ▪ Palliative Care/Oncology: Deteriorating condition, symptom management
Priority Two: (Client seen within 3 days) ▪ Client has limited social support/carer coping but concerned ▪ Not at immediate risk of hospitalisation ▪ Management of chronic condition: not at risk of immediate complications ▪ Able to self manage in immediate short term
Priority Three: *Over 3 days* ▪ Intervention not required within 3 days ▪ Support and education for ongoing treatment. For example, catheters, diabetes management (short term only) ▪ Requires intervention but client has high level of social support and/or self care ▪ Chronic disease - self management education- long term hospital avoidance ▪ Oral medication management – where alternative services cannot be provided and is specifically in relation to HACC funded nursing services

Services which are not clinical core business:

- Monitoring of vital signs and blood levels in isolation to any other nursing care needs and/or where a specific medical treatment plan is not directing the outcome of care
- Invasive treatments such as enemas that have not been fully investigated to ensure the safety of clients
- Long term personal care
- Routine transport
- Delivery of large equipment

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

Palliative Care

The specialist Palliative Care service promotes the World Health Organisation (WHO) approach to palliative care through the prevention and relief of suffering via early identification, assessment and treatment of pain and other problems, with the aim of improving the quality of life of clients and their families dealing with issues associated with life threatening illness. Palliative care nurses provide a consultative service to other health professionals, using a multidisciplinary approach.

Priority One:

- Clinical assessment to determine client need. For example, liaison with other health professionals (occupational therapist for aids and equipment, GP, social worker); suitability to link to inpatient palliative care services, the 1300 telephone support and advice line, and other appropriate support services (respite care, provision of personal care services)
- Management of pain and other distressing symptoms
- End of life care. For example, maintaining clients at home if that is their choice
- Education and support to clients, families/significant others and care providers
- Bereavement follow up and support to families/significant others and care providers

Services which are not clinical core business:

- 24 hour home visitation
- Ongoing palliative care education to all aged care facilities on an individual basis
- Longer term bereavement support

In addition to clinical priorities, related activities include: community development, health education and promotion, intake, and consultation and partnerships with General Practitioners, other health services and external agencies. Participation in these activities will be in accordance with the Community Health Strategic Plan 2007-2012, and reviewed and reported on during annual planning activities.

LIST OF ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACHS	Australian Council of Healthcare Standards
ACYFS	Aboriginal Child, Youth and Family Strategy
ADHD	Attention Deficit Hyperactivity Disorder
AGM	Assistant General Manager
AGM	Assistant General Manager Community Acute/Post Acute and Chronic
CAPACCS	Clinical Services
AGM C&FCS	Assistant General Manager Child & Family Clinical Services
AGM CISS	Assistant General Manager Corporate Integration and Support Services
AIDS	Acquired Immune Deficiency Syndrome
ASD	Autism Spectrum Disorders
BBV	Blood Borne Virus
BCE	Bilingual Community Educator
BEPE	Bilingual Early Parenting Educator
BOCSAR	Bureau of Crime Statistics and Research
CAFH	Child, Adolescent and Family Health
CFHN	Child and Family Health Nurse
CH	Community Health
CHC	Community Health Centre
CHN	Community Health Nurse
CHR	Client Health Records
CHSPMT	Community Health Strategic Plan Management Team
CHSPSC	Community Health Strategic Plan Steering Committee
CNC	Clinical Nurse Consultant
COPD	Chronic Obstructive Pulmonary Disease
CSAHS	Central Sydney Area Health Service
DCO	Director Clinical Operations
DET	Department of Education and Training (NSW)
DIMIA	Department of Immigration, Multicultural and Indigenous Affairs (Australian Government)
DJJ	Department of Juvenile Justice (NSW)
DOCS	Department of Community Services (NSW)
DV	Domestic Violence
ECH	Early Childhood Health
ECHC	Early Childhood Health Centre
ED	Emergency Department
EQuIP	Evaluation Quality Improvement Program
FTE	Full Time Equivalent
GM	General Manager
GMCH	General Manager Community Health
GP	General Practitioner
GVDV	Green Valley Domestic Violence program

HACC	Home and Community Care
HEO	Health Education Officer
HIV	Human Immunodeficiency Virus
HPS	Health Promoting Schools
IIMS	Incident Information Management System
IMU	Information Management Unit
IT	Information Technology
IPaCH	Integrated Primary and Community Health
KGV	King George V
LGA	Local Government Area
MECSH	Miller Early Childhood Sustained Home Visiting
MMR	Mumps Measles Rubella
NAPOOS	Non-Admitted Patient Occasions of Service
NGO	Non Government Organisation
NPG	Network Program Group
NSP	Needle Syringe Program
NWHP	National Women's Health Policy
OT	Occupational Therapy
PHI	Private Health Insurance
P/S	Public School
QCRMU	Quality and Clinical Risk Management Unit
RACF	Residential Aged Care Facility
RPAH	Royal Prince Alfred Hospital
RTP	Resource Transition Program
SDU	Service Development Unit
SEIFA	Socio-economic Index for Areas
SHV	Sustained Home Visiting
SSWAHS	Sydney South West Area Health Service
SWISH	Statewide Infant Screening-Hearing
SWSAHS	South Western Sydney Area Health Service
STI	Sexually Transmitted Infection
TB	Tuberculosis
TIPS	Tips and Ideas on Parenting Skills
UHV	Universal Home Visiting
WHN	Women's Health Nurse
WHO	World Health Organisation

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