

ACHSM Australasian College of
Health Service Management

ACHSM

- Our vision

Better leadership. Healthier communities.

- Our mission

Recognise, develop and support effective health leadership and management to deliver quality services and improve health and wellbeing.

- Goals

- Develop and support health leaders and managers.
- Promote the profession of health and community leadership and management.
- Ensure a sustainable and vibrant College for the future.

achsm.org.au

HMIP

The Health Management Internship Program (HMIP) offers committed, high-potential Interns the opportunity to develop the skills, competencies and knowledge required to start a career in managing the challenges and complexities of health service delivery.

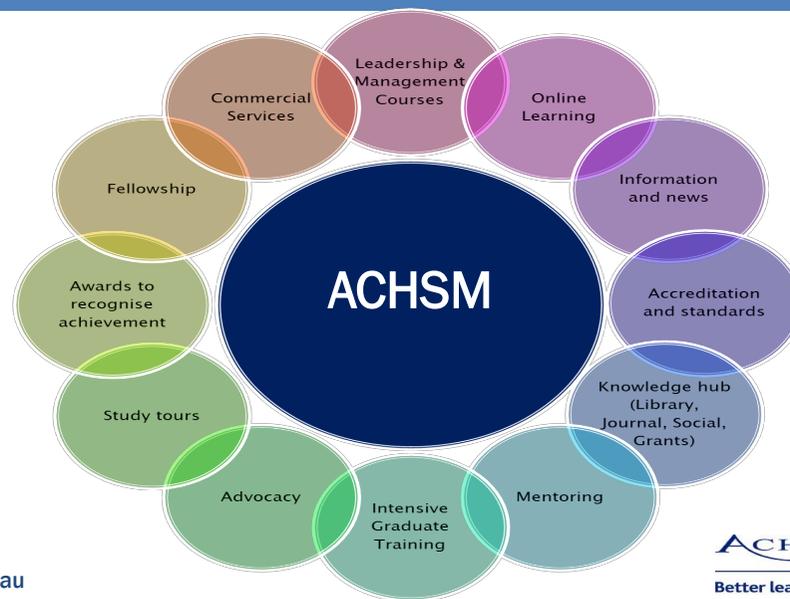


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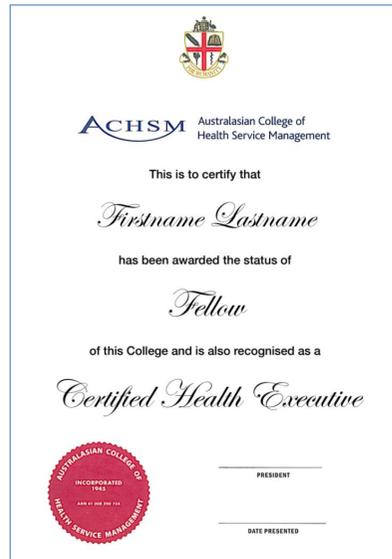
The ACHSM



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Credentialing



<https://www.achsm.org.au/membership/certification>



ACHSM Australasian College of Health Service Management

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Credentialing



Best regards,

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Australasian College of Health Service Management
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Health Service Competency Framework



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<https://www.achsm.org.au/education/competency-framework>

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Health Service Competency Framework

COMPETENCY DOMAIN: 2. HEALTH AND HEALTHCARE ENVIRONMENT

Short title	Competency statement
Partners with consumers	2.3.2. Partners with consumers (including family and carers) in the planning, designing and monitoring of care

Health Service Competency Framework

COMPETENCY DOMAIN: 3. BUSINESS SKILLS

Short title	Competency statement
Uses financial principles	3.2.2. Understands and effectively uses key accounting principles and financial management tools such as financial plans and measures of performance (e.g. performance indicators) [see also 3.1.1, 3.1.2]
Manages resources	3.2.4. Plans, organises, effectively uses and monitors the [non-financial] resources of the organisation to ensure optimal health outcomes and effective quality and cost controls [see also 5.1.2]
Plans workforce	3.3.1. Plans for an appropriate workforce at the health U/O/S level, within available resources
Leads strategic and business planning	3.5.1. Leads the development of key planning documents, including corporate and strategic plans, business plans, service plans and business cases for new services
Evaluates actions against plans	3.5.3. Evaluates whether a proposed action aligns with the U/O/S business/strategic plan
Plans for business continuity	3.5.4. Plans for business continuity in the event of disasters [See also 3.7.3]

ACHSM National Online Workshops 2021

Keynote speakers:

Day 1: **Prof Ian Hickie AO**, University of Sydney Brain and Mind Centre

Day 2: **Dr Stephen Duckett**, Grattan Institute

Held over two afternoon sessions, the event will feature two keynote presentations, two panel sessions and two inspirational guest speakers



25 & 26 March 2021, 3.30-5.30pm AEDT

Live online event! Registrations are now open!

achsm.org.au/events

ACHSM

ACHSM Facilitated Learning Groups (FLG)

10 x 90-minute virtual sessions, 1 every 2 weeks,
April 2021 > August 2021

Post COVID-19: What should we stop, restart, change and enhance?

Facilitator:
Paul White FCHSM, CHE

From Clinician to Manager

Facilitator:
Adj/Assoc Prof John Rasa FCHSM, CHE

For more information visit achsm.org.au/events

ACHSM



Only 20 places available
in each group!



Health Service Planning

From a LHD lens

Health Service planning?

- Who Is responsible?



Health
Needs

Available
Resources

NSW Health Guide to the
**Role Delineation
of Clinical Services**



Role Delineation – Public hospitals

- Since the mid-1980s role delineation has been applied in NSW to inform strategic service, clinical and capital planning at the local and State level
- Role delineation provides a framework that describes the minimum support services, workforce and other requirements for clinical services to be delivered safely. **It delineates the level of clinical services, not hospitals or health facilities as a whole**
- Focus is on planned clinical services not emergencies
- Does not describe all services
- It is a tool to describe the services and to assure consistent language



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1. ANAESTHESIA AND RECOVERY

Level	Service Scope	Service Requirements	Workforce	Minimum Core Services								
				Anaes	Ope Suite	COU	ICS	Nuc Med	Radiology	Pathology	Pharmacy	
NPS	No planned service.											
1	Analgesia and conscious sedation available. Excludes general anaesthesia.	Patient monitoring and oxygen available. Local Clinical Emergency Response System (CERS) protocol in place to facilitate escalation of care and patient transfer when required. Referral pathways to relevant Aboriginal programs and services. Quality and risk management programs in line with current National Safety and Quality Health Service (NSQHS) Standards.	Medical practitioner credentialed to provide sedation. Medical officer available on call or via telehealth 24 hours. Anaesthetic assistant (may be nurse, technician or other staff) available during procedures. Aboriginal hospital liaison roles available, preferably both male and female.	-	1	-	-	-	-	1	1	
2	As for Level 1. In addition, provide anaesthesia for ASA 1 and 2 ^a patients undergoing Minor* surgical procedures. [NB: These limits are intended as a guide only and do not replace clinical judgement. Patient selection should be determined following robust preadmission assessment.] Anaesthetic induction undertaken within procedure room.	As for Level 1. In addition, formal network arrangement so specialist anaesthetists are available for consultation, advice and support. Recovery area for post-surgical procedures may be combined with general ward, with trained recovery staff and facilities as required.	As for Level 1. In addition, medical practitioner credentialed in anaesthesia. Anaesthetist available for consultation.	-	2	-	-	-	2	1	2	
3	As for Level 2. In addition, provide anaesthesia for ASA 1, 2 ^a and selected ASA 3 ^a patients undergoing Common and Intermediate* surgical procedures. May provide anaesthesia for ASA 1 and 2 ^a patients undergoing selected Major* surgical procedures. Provide anaesthesia for ASA 3 and selected ASA 4 ^a patients undergoing Minor* surgical procedures.	As for Level 2. In addition, dedicated operating room. Separate recovery area.	As for Level 2. In addition, anaesthetist appointed for consultation and service.	-	3	3	-	-	3	3	2	
4	As for Level 3. In addition, provide anaesthesia for ASA 1, 2 ^a and selected ASA 3 ^a patients undergoing Major* surgical procedures. Provide anaesthesia for ASA 3 ^a and some ASA 4 ^a patients undergoing selected Common and Intermediate* surgical procedures. Provide appropriate care for ASA 5 ^a and ASA 6 ^a patients.	As for Level 3.	As for Level 3. In addition, medical head of service with considerable experience in anaesthesia, preferably a Fellow of the Australian and New Zealand College of Anaesthetists (ANZCA) or other registered specialist [may be networked access in rural centres]. Anaesthetist available 24 hours. Medical officer on-site 24 hours.	-	4	-	4	-	4	4	4	
5	As for Level 4. In addition, provide anaesthesia for ASA 1 and 2 ^a patients undergoing selected Complex Major* surgical procedures. Provide anaesthesia for ASA 3 to 5 ^a patients undergoing Common and Intermediate*, and selected Major* surgical procedures.	As for Level 4. In addition, specialty services on-site for consultation. Provide support for lower level networked services.	As for Level 4. In addition, anaesthetist on-site in business hours. Medical officer in anaesthesia with three or more postgraduate years of experience on call 24 hours, may be in training with the ANZCA.	-	5	-	5	-	5	5	5	
6	As for Level 5. In addition, provide anaesthesia for all levels of patient risk ^a undergoing Complex Major* surgical procedures. Subspecialty anaesthesia on-site, such as neurosurgery, cardiothoracic surgery and/or burns.	As for Level 5.	As for Level 5. In addition, subspecialist anaesthetists. Medical officer in anaesthesia with three or more postgraduate years of experience on-site 24 hours; may be in training with the ANZCA.	-	6	-	6	-	6	6	6	

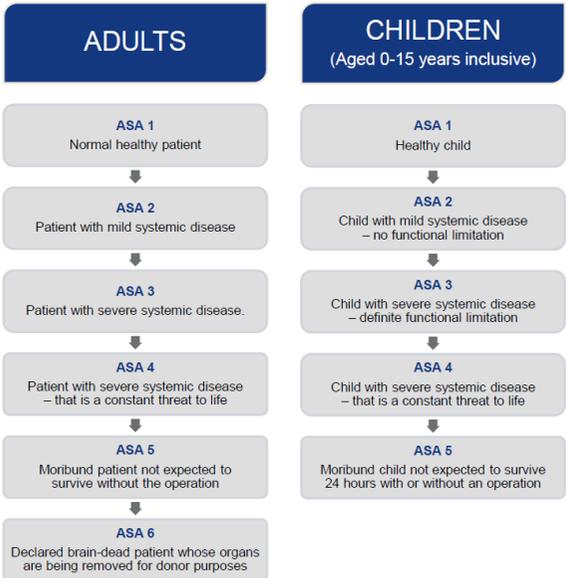
APPENDIX I: INDICATIVE LIST OF SURGERY FOR ADULTS

There is no widely accepted and validated system for classifying the physiological stressfulness of surgical procedures. The examples given below, drawn from different specialties, are intended to provide an indicative guide only and do not replace clinical judgement. Some procedures commonly provided on an emergency basis are included (e.g. closed reduction of fracture) as useful general indicators of surgical complexity.

Minor	Common and Intermediate	Major	Complex Major
<ul style="list-style-type: none"> • Cervix loop excision for dysplasia • Chalazion removal • Circumcision • Colonoscopy • Cystoscopy • Dental laser surgical procedure • Diagnostic endoscopy • Drainage of abscess • Hysteroscopy • Insertion of grommets • Minor amputation (e.g. toe) • Minor debridement • Minor dento-alveolar surgery • Minor periodontal surgery • Orthodontic anchorage screw placement/removal • Percutaneous wire removal • Simple orthopaedic implant removal • Skin biopsy • Skin lesion curettage and cautery • Skin lesion excision • Subcutaneous tumour excision • Suction curettage for miscarriage • Superficial corneal foreign body removal • Toe-nail surgery • Tooth extraction • Transrectal ultrasound (TRUS) guided prostate biopsy • Vasectomy • Wedge biopsy of eyelid skin lesion 	<ul style="list-style-type: none"> • Adenoidectomy • Appendectomy • Arthroscopy with meniscectomy/chondroplasty • Breast reduction • Carpal tunnel surgery • Closed reduction of fracture • Dental implant placement/removal • Diagnostic arthroscopy (knee/shoulder) • Diagnostic laparoscopy • Endodontic surgery • Excision of breast lump • Haemorrhoidectomy • Hemithyroidectomy • Herniorrhaphy • Inferior turbinate surgery • Laser skin surgery • Laser transurethral resection of prostate (TURP) • Lower Segment Caesarean Section (LSCS) • Major dento-alveolar surgery (e.g. cyst enucleation) • Major periodontal surgery (e.g. connective tissue grafts, bone block grafts, sinus lifts) • Mastectomy • Maxillo-facial surgery • Ocular lens extraction • Orchidectomy • Pterygium surgery • Septoplasty • Simple skin graft • Simple ureteroscopy • Skin excision with flap or graft closure • Tonsillectomy • Trabeculectomy • Uncomplicated hip/knee replacement • Vaginal prolapse repair • Varicose vein surgery 	<ul style="list-style-type: none"> • Abdominal pelvic floor repair • Bladder neck procedures for stress incontinence • Bowel resection • Carotid endarterectomy • Cerebral neoplasm (cortical convexity) surgery • Cerebral shunting • Complicated ureteroscopy • Craniotomy • Diaphragmatic hernia repair • Embolectomy • Epilepsy surgery • Exploratory laparotomy • Extensive or complicated skin graft (e.g. hand, perineal) • External and some middle ear surgery • Hysterectomy (e.g. laparoscopic, abdominal) • LSCS for major placenta praevia • Major amputation (e.g. below, above or through knee) • Major flap reconstruction • Mohs surgery • Nephrectomy • Open bladder surgery • Orbital exenteration • Osteotomy/Orthognathic surgery • Pacemaker insertion • Pressure area surgery • Prostatectomy • Revision hip/knee replacement • Sinus surgery • Thyroidectomy • Vascular access procedures for dialysis 	<ul style="list-style-type: none"> • Aortic surgery • Arteriovenous malformation (AVM) surgery • Caesarean section for placenta accreta • Carotid stents • Cerebral neoplasm (base of skull) surgery • Complex endovascular grafts (e.g. fenestrated aortic branch device) • Coronary artery bypass graft • Cystectomy • Gynaecological oncology surgery • Head and neck tumour resection and graft reconstruction surgery • Interventional endoscopy • Lung resection • Microsurgical tissue transfer • Modified radical mastoidectomy • Multidisciplinary surgery (e.g. cancer, major trauma) • Neck dissection • Oculoplastic surgery • Oesophagectomy • Pancreatic resection • Planned caesarean hysterectomy • Renal transplantation • Scoliosis surgery • Skull base surgery • Spinal cord injury surgery • Sternal reconstruction

Note: The actual range of procedures that may be performed by individual practitioners will be determined through the credentialing process where clinical privileges/scope of practice is granted.

APPENDIX III: LEVELS OF PATIENT RISK: ADULTS AND CHILDREN



Based on the American Society of Anesthesiologists (ASA) Physical Status Classification System.

Version	Date	Comment
1.0	Jan 2016	Original publication

Other reasons for planning

- Overcome power imbalance in service health consumption decisions
 - To prioritise competing demands for services
 - Planning provides control measures for the high cost high demand political health system
 - Create value
-
- Can be triggered by health emergencies, , public concern, resource shortage or funding availability

Identify three negative consequences if health service planning is not done properly.

Planners

- Consider and balance the needs of stakeholders

Skills

- Knowledge and experience of the health problems
- Research skills in epidemiology, social and behavioural science
- Fostering agreement across diverse constituents, capabilities and interests

Challenges for planners

Challenges for planners

- Health sector knowledge
- social, ethical considerations in decision making
- Political influences
- Practical complexity is greater than other sectors and planning decisions often include judgements on access and capacity within limited funds
- Can be considerable compromises in decisions
- There are unforeseen and constantly changing health sector priorities
- Keeping to the SMART goal

Types of Service Planning

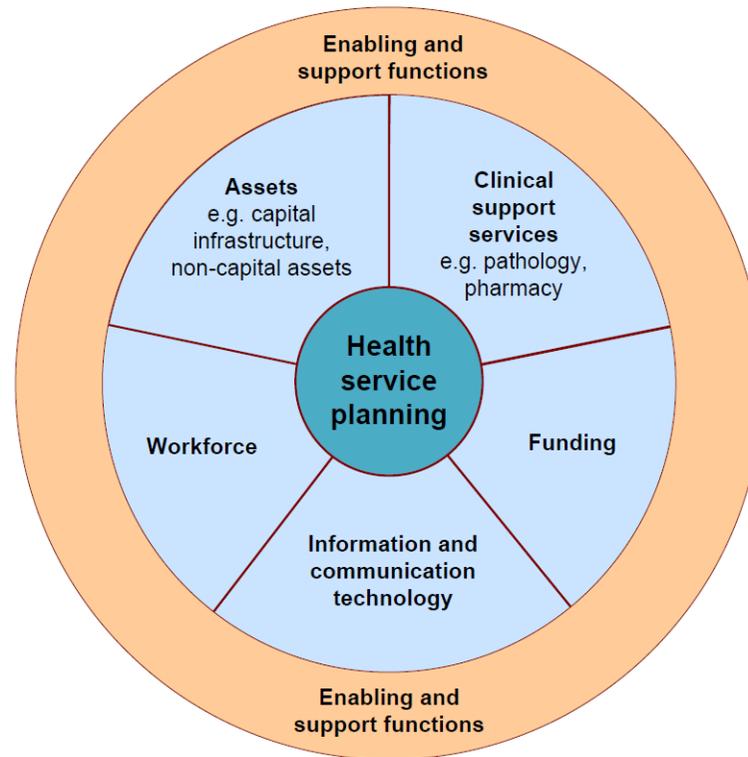
- Planning for a particular geographical catchment
- Planning for a particular population group
- Planning for a clinical service or stream/s
 - prevention, promotion and protection
 - primary healthcare
 - ambulatory care
 - acute care
 - sub-acute care
 - mental health.

What data are available in Australia that can be used for health service planning?

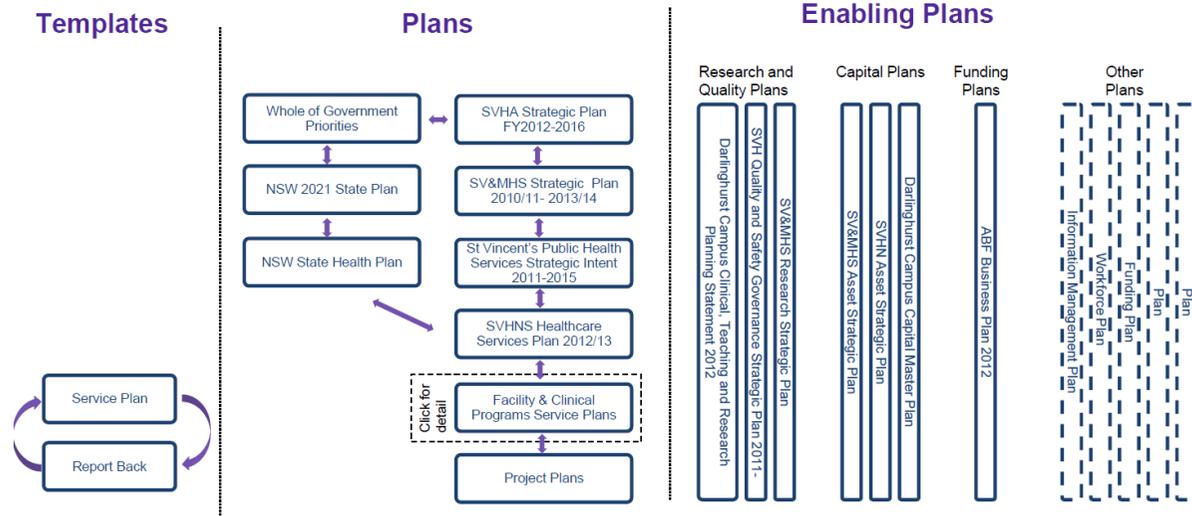
Planning for a particular geographical catchment

Planning for a particular population group

Planning for a clinical service or stream/s



1) Strategic Plans – Intranet Reference Page



The Process: Health service planning occurs in a complex environment, with changing public expectations and emerging new models of care and technological advances. However, a well designed health service planning process will be resilient enough to accommodate these pressures and use them as levers to improve service provision.

Strategic Plans – Intranet Reference Page proposal



Templates



Clinical Service Plans



References:
Auditor-General of Queensland 2009, [Report to Parliament No. 2 for 2009 Health service planning for the future A Performance Management Systems Audit](#), Auditor-General of Queensland, Brisbane.
S. Ardat, J. Butler, R. Edwards, L. Lawrie, *The Planning Process The Health Planner's Toolkit*, 2006, Ontario

Planning in NSW and WSLHD



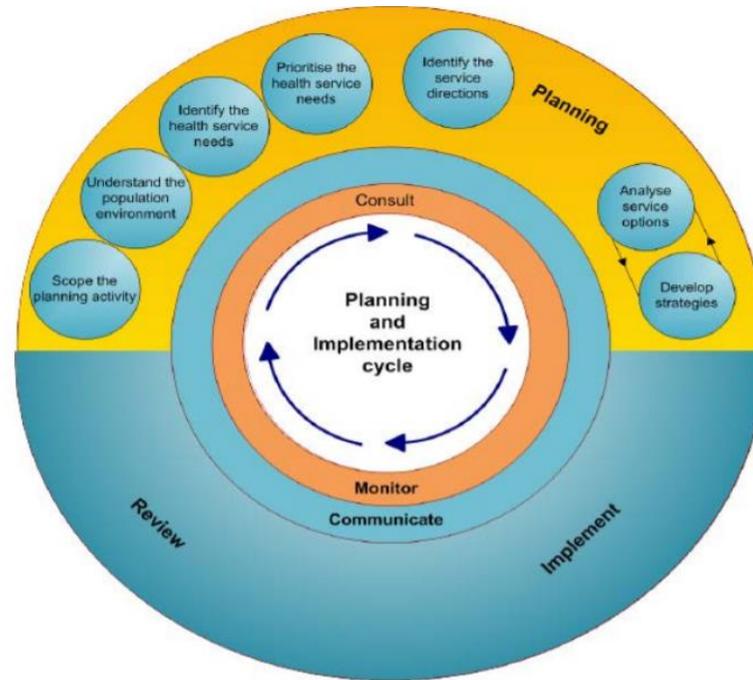
<https://www.health.nsw.gov.au/priorities/Documents/strategic-priorities.pdf>



<https://www.wslhd.health.nsw.gov.au/About-Us/Performance>



Planning Cycle



Source: https://www.health.qld.gov.au/data/assets/pdf_file/0025/443572/guideline-health-service-planning.pdf

Planning Phase

Component	Tasks involved
Scope the planning activity	<ul style="list-style-type: none">• Define the planning parameters• Manage changes to the scope
Understand the population and service environment	<ul style="list-style-type: none">• Scan the policy and service environment• Profile the population and current service delivery
Identify the health service needs	<ul style="list-style-type: none">• Identify the health needs and service needs/issues• Develop an approach to categorise needs/issues
Prioritise the health service needs	<ul style="list-style-type: none">• Determine the criteria for prioritisation of needs• Apply the criteria for prioritisation
Identify the health service directions	<ul style="list-style-type: none">• Develop the service directions• Measure the success of planning
Develop/analyse service options	<ul style="list-style-type: none">• Develop the service options and analyse feasibility• Identify the indicative resource implications
Develop objectives and strategies	<ul style="list-style-type: none">• Develop the objectives and strategies• Understand the impact of service changes

Implementation

Component	Tasks involved
Conclude the planning phase	<ul style="list-style-type: none">• Document and communicate the recommendations• Transition to implementation and review phase
Conduct additional planning to support implementation	<ul style="list-style-type: none">• Conduct additional planning to support the full implementation of the recommendations• Particular focus on detailed service enabler planning
Monitor, evaluate and review	<ul style="list-style-type: none">• Collect data to evaluate against service directions• Review ongoing relevance of recommendations

Planning to Plan

Program Strategic Plans

Background

St Alfonso's Public Health Services, as part of its strategic planning process, requires that all Program/Services have a strategic plan which responds to the Goals established within the Strategic Intent. Consistent with this requirement Programs/Services have submitted their plans, with Program plans reviewed at the Strategic Planning Workshop held in August. It is now necessary to finalise these plans covering the full goal set (Service, Quality, People, Finance, Growth and Research, Development & Innovation) and for the focus of 2011/12 to be detailed in the Annual Priority Plan.

The requirements and templates are outlined below.

Next Steps

The table below summarises the required actions and by when

Action	When	Template	Required
Complete Strategic Plan	Oct 30th 2011	Template 1: Strategic Plan	Finalise the overall Program Strategic Plan utilising the output of the strategic planning workshop. The other goal areas need to be completed using the Strategic Planning template.
Develop Annual Priority Plan for 2011/12	Dec 15th 2011	Template 2: Priority Plan for 2011/12	Using timelines identified by the strategic plan develop the priority plan for 2011/12. That is Strategic initiatives with a finish date falling within 2011/12 should be included within the priority plan. In addition the specific actions required to achieve the strategic initiatives should be added.
Status Report	Feb 28 2012	Template 2: Priority Plan for 2011/12	Traffic Light status against strategic initiative with comments against orange and red status items
Develop Annual Priority Plan for 2012/13	31 st March 2012	Template 2: Priority Plan for 2012/13	New priority plan for 2012/13 will need to be completed by March to be included in the budget for 2012/13
Annual Report	July 31 st 2012	Template 2: Priority Plan for 2011/12	Traffic Light status against strategic initiative with comments against orange and red status items

Planning Scope

In developing the scope of planning activity, the following should be articulated:

- reason/s for undertaking the planning activity
 - parameters of the planning activity (e.g. geographical boundaries, population cohorts,
 - scope of health services and time horizon
 - government policy and strategic directions that may impact on the planning activity
 - key deliverables (e.g. report, health service plan) and outcomes
 - potential risks/threats to the scope and mitigation strategies to address these.
-
- Manage the scope changes at the governance and leadership level

How to manage the process (A consultants view)

- Check your scope and check your scope and check your scope.....
- Who is the leader?
- Who are you making the plan for?
- Use Project management
- Communicate and consult more than you want to.

Population and service environment

Scanning

- existing policies, strategies, plans, commitments to which the planning should align
- strategic directions or goals related to the provision of particular services
- known issues that may impact the delivery of the health services in scope
- the status of implementation of previous plans (including lessons learned)
- general service trends in the literature (e.g. latest clinical evidence, guidelines).

Population and Service Environment

Population profiling information:

- estimated current and projected population, including identification of Aboriginal and
- Torres Strait Islander residents and culturally and linguistically diverse residents
- significant trends for the planning catchment or population in scope
- socio-economic status and social disadvantage of the community (health determinants)
- transient/itinerant population (non-resident workers, visitors)
- implications of population characteristics on health needs.

2016 Census Community Profiles

Australia | New South Wales | Local Government Areas

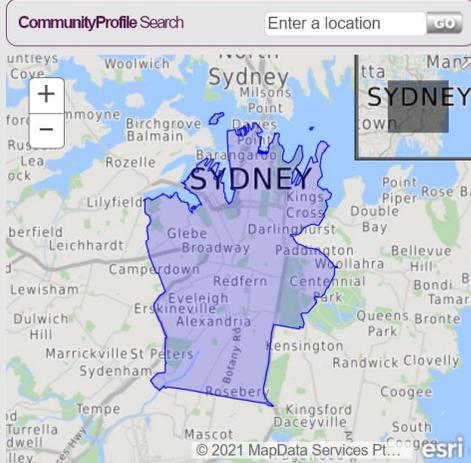
Sydney (C)

Code LGA17200 (LGA)
[View the Quickstat for Sydney \(C\)](#)

To download a **compressed Excel Community Profile** spreadsheet of this area, select one of the following profile types. **Median and average values may be affected by confidentiality in small areas.**

	General Community Profile	496KB
	Aboriginal and Torres Strait Islander Peoples Profile	271KB
	Time Series Profile	307KB
	Working Population Profile	816KB

CommunityProfile Search



© 2021 MapData Services Pt... 

Source: <https://www.abs.gov.au/websitedbs/D3310114.nsf/Home/2016%20Census%20Community%20Profiles>

Tutorial: <https://www.youtube.com/watch?v=rFTKEb75SaE&t=9s>

2016 Census QuickStats

Australia | New South Wales | Local Government Areas

Sydney (C)

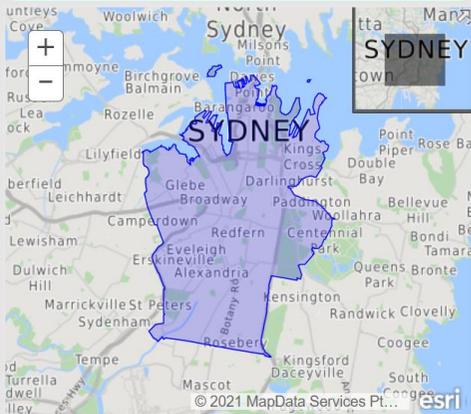
Code LGA17200 (LGA)

[Search for a Community Profile](#)

	People	208,374
	Male	51.8%
	Female	48.2%
	Median age	32
	Families	40,887
	Average children per family	1.5
	for families with children	
	for all families	0.2
	All private dwellings	109,496
	Average people per household	2
	Median weekly household income	\$1,926
	Median monthly mortgage repayments	\$2,499
	Median weekly rent	\$565
	Average motor vehicles per dwelling	0.8

QuickStats Search

Enter a location



✓ Latest release

↓ Data download

National Health Survey: State and territory findings

Summarises the general health, long-term health conditions and health risk factors of Australians for each state and territory

Reference period 2017-18 financial year

Released 12/12/2018

Next release Unknown

First release

Key statistics

- Western Australia was the only state with a decrease in daily smoking rates.
- Victoria, South Australia and Tasmania saw increases in overweight or obese adults.
- Physical activity rates varied with the highest proportion being Australian Capital Territory.

General health

- In 2017-18, over half (56.4%) of Australians aged 15 years and over considered themselves to be in excellent or very good health with the highest rate in Western Australia (60.7%) and the lowest rate in Tasmania (51.2%).
- Rates of high or very high levels of psychological distress among adults aged 18 years and over ranged from 11.1% in Australian Capital Territory to 13.9% in Queensland and (13.0%) in Australia.

Chronic conditions

Source: <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey-state-and-territory-findings/latest-release>

community profile | population forecast

Home

Service age groups | Five year age groups | Age-sex pyramid

Area profiles

About the profile areas

Population

How old are we?

Who are we?

What do we do?

How do we live?

Communities of interest

Indigenous profile

Supporting Information

About community profile

Explanatory notes

Site map

Sign in

Downloads

Reports

Data exporter

Other resources

Latest updates

Training videos

Help centre

Nat'l Demographic Indicators

Nat'l Economic Indicators

Related sites

Resource centre

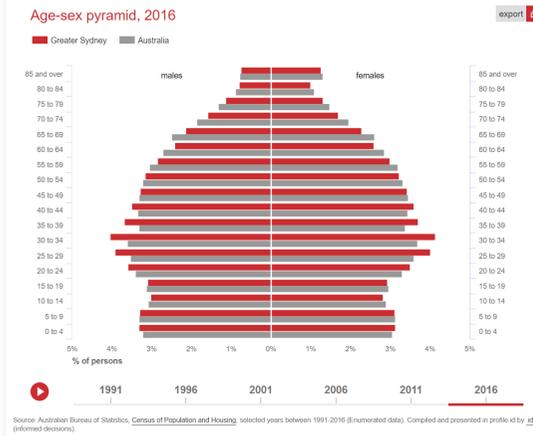
Blog

Greater Sydney

Age-sex pyramid

Share | Export

Area: Greater Sydney | Benchmark area: Australia | reset



Population and Service Environment

geographical profiling information:

- size, boundaries and major centres of the planning area
- key economic, environmental and social factors that impact health of the population
- areas within the catchment that may have difficulties accessing services
- geographic conditions or infrastructure that present difficulties for service delivery
- remoteness of the region.

Population and Service Environment

Health status profile information:

- self-reported health status
- population at risk identification (e.g. incidence and prevalence)
- mortality data (e.g. rates and causes of death, life expectancy)
- morbidity data (e.g. rates of illnesses, hospitalisations)
- burden of disease and injury (e.g. disability adjusted life years).

Population and Service Environment

Service profile information:

- information on service types, capability levels and modes and models of delivery
- information on how services work together (e.g. service and referral networks, visiting
- services, transfer and retrieval arrangements
- for each service, consider information on:
 - hours of service, location, target population
 - service delivery models (and effectiveness of these)
 - clinical support and service enabler requirements.

Population and Service Environment

Health service demand information include:

- volumes of activity between public sector, private sector and other services
- rates of service utilisation compared to other regions (known as 'relative utilisation')
- levels of 'self-sufficiency' (an indicator of how local services meet local needs).

Health service supply information include:

- volumes of procedures, hospital separations, beddays and occasions of service
- volumes of same day and overnight admissions and average lengths of stay
- transfers and referral patterns for particular services.

Health Service Data at a Local District (some more)

- current and projected local health service utilisation (seps and bed days, occupancy rates, patient flow; surge capacity, direction of service provision etc. etc.);
- prevailing public policy;
- available internal and external support resources, partnerships, organisations and structures;
- management and provider consultation data;
- evidence based/informed interventions,
- systems, service delivery approaches and models of care.

Identify the service needs

- felt need—refers to what people say is needed
- expressed need—refers to need inferred by service utilisation patterns (data)
- normative need—refers to ‘expert opinion’ (e.g. a decision by a surgeon that a patient requires an operation for a condition, based on available evidence)
- comparative need—refers to need identified by comparing services or resources or similar communities

Prioritise Health Service Needs (example criteria for decision making)

Element	Questions
Validation of need	Has the need been identified using more than one method (e.g. consultation, community profile, literature review, data analysis)?
Magnitude of need	How widespread is/what is the extent of the need? Is it associated with the greatest historical growth?
Risk of unmet need	What are the potential consequences if the need is not addressed? For example, will existing health inequalities/ inequities persist or exacerbate over time if not addressed?
Planning principles	Does the potential solution for this need align with the health service planning principles detailed in Section 2.5?
Government direction	Does the potential solution for this need align with government strategic directions, targets, election promises or other commitments or formal obligations?
Corporate consistency	Does the potential solution for this need align with the identified organisational strategic directions or targets?
Urgency	Does the potential solution for this need have to be put in place immediately, or are longer term solutions possible?
Feasibility	Can the potential solution for this need be implemented within available resources? Can it be implemented within the particular geographical, political, social and financial conditions?
Sensitivity	Is the potential solution for this need likely to be accepted by stakeholders? If not, why not?
Innovation	Can the potential solution for this need be implemented via a new service delivery model?

Decision making

Difficult decisions and priority setting

1. Comprehensive rational
2. Incremental
3. Apolitical
4. Advocacy
5. Communication Action
6. Strategic planning

Leggat, S. Day g., (2015), Leading and Managing Health Services, Chapter 30
Health service planning, Cambridge University Press 2015

Approach	Description	Advantages	Disadvantages
Comprehensive rational	A textbook-written idealistic planning approach, with a systematic and logical sequence of thought processes and actions	Obtaining information from all stakeholders; taking into account all contingencies and peripheral influences; addressing issues facing the entire service delivery system	Failure to consider individual values; separation of planners from political reality; heavy reliance on planner's understanding of means and ends that may not be substantiated or endorsed by others
Incremental	Isolated and disjointed efforts addressing small and immediate concerns, with a hope that accumulated effect will eventuate	Strong tolerance of uncertainties and knowledge gaps; rapid response to concerns	Lack of coordination and integration that is likely to lead to conflicting or mismatched programs
Apolitical	An evidence-based practice that is built on best available scientific knowledge	Strong focus on technical aspects for high efficacy; dependence on objective information	Ignoring of political aspects and subjective experience of those with the health problem; difficulties in dealing with evidence bias and knowledge gaps
Advocacy	A planning approach that is pushed by experts who speak for or on behalf of those with certain health problems	Raising awareness and acting on behalf of those disadvantaged who are not empowered to convey their concerns	Likelihood of misinterpretation of the problem of those concerned and of conflicts and confrontations with other interested parties
Communication action	An approach of working in partnership with those with the concerned health problem through communication and empowerment	Interactions between those who are affected and those who are managing and delivering services, with a hope of achieving consensus through mutual adaptation of attention, beliefs and trust	Time-consuming; high requirement of communication and negotiating skills in those involved in the planning
Strategic planning	A service-planning process that is guided by and aligned with a strategic plan of the organisation	Consideration of organisational contexts, both internal and external; services aligned with the vision and future direction of the organisation	Lack of flexibility to respond to new environmental opportunities or threats

Decision making example

St Alfonzo's Public Health Services
Strategic Plan Template

Program:
Key Result Area (e.g. the Strategic Intent Goal Quality):

Goal Statement	Strategic Objective	Strategic Initiatives	Start	Finish	Project Manager	KPI
The strategic goal represents SAH's statement of what we want to achieve over the next 4 years to deliver on the KRA taken from the Strategic Intent Document (ie. One of Mission; Service; Quality; Finance; Growth; Research, Development and Innovation).	The specific and high level objective to <u>support the</u> achievement of the goal .	The <u>particular initiatives</u> required to achieve the objectives.	Start date for initiative as a project	Finish date for initiative as a project.	Person responsible for project	Should include prescribed KPI's from Strategic Intent Goal wherever possible. <u>Also</u> should be quantitative. Process KPI's can be <u>used</u> if quantitative KPI's not applicable
Example To deliver the highest quality of care, ensuring the right treatment is provided in the right place at the right time for each individual	Establish a deep a thorough understanding of the nature of variation and errors within a clinical care <u>systems</u>	<ol style="list-style-type: none"> 1. Analyze the impact of human factors/<u>behaviours</u> in critical incidents. and create response systems based on this <u>knowledge</u> 2. Undertaken an analysis of errors and determine if any consistent patterns of human errors are <u>evident</u> 3. Create response systems based on this knowledge gained in relation to 1 and 2 above. 	25/09/11	30/11/11	<u>Ghandi</u>	Hospital standardized mortality rate < 60 (can be more than one)

Develop and Analyse Service Options

developing service options, the following should be considered:

- ability of the option to provide a solution to the health service needs
- sustainability of the option in the long term
- extent to which the option can be implemented within existing resources
- need for additional resources for the option, and where the resources could be sourced
- need for approvals from government for the option (e.g. proposal to divest services)
- impact of proposed changes in the option on service enablers
- implementation challenges and risks for the option.

1.a. Program	1.b. Department / Service	1.c. Activity	2. Need	3.a. Strategic Alignment	3.b. Immediacy	4.a. Physical space required	4.b. Physical infrastructure required	5. Resource implication
Acute Program	Surgery	Overnight on call	Room for overnight Surgical Registrar on 24 hours shifts			Room with access to shower	Bed, phone and computer	nil
	Gastroenterology	Endoscopy	Procedure services	TBA	TBA	TBA	TBA	TBA
	Medicine	Transit Unit	Medical Surgical Transit Unit	TBA	TBA	10 Bed spaces need to relocate	TBA	TBA
	High Dependency Unit	HDU	Increased ICU bed day demand from increases in Heart and Lung and elective Surgery patients	Acute program strategic plan to meet NEAT and NEST	Since July 2010 an average of 3.0 HDU beds have been in use in ICU, and an average 4.13 HDU beds have been in use since Feb 2011	8 HDU Beds Clinical work station Patient and staff facilities Education room (700m ²)	Some single rooms, Gases, electricity water for each bed space, clinical call system, ITSC at each bed space and throughout clinical areas	Form existing establishments, medical model for training needs more detail, Goods and services TBC.
Cancer and Immunology	Renal	Renal dialysis	Need to split in -centre renal dialysis and satellite renal dialysis patients because of <ul style="list-style-type: none"> Growth Infection control Patient preference 	growth in patients requiring dialysis	Operating above current capacity now	expect 5 new patients pa	Home training room	approximately\$ 171,600 revenue pa
	Haematology and Bone Marrow Transplant	Inpatient care of transplant patients	Safer environment for Immunocompromised patients	Growth bone marrow and stem cell transplant	priority to reduce number of new MROs	Number to be not defined	Negative pressure single rooms	Business case to be developed

Surgical clinical stream planning

Identify the health service directions

- Make the recommendations

Well written service directions should provide:

- a vision for the future
- a clear picture of intent
- realistic aspirations
- explicit and transparent goals
- an achievement horizon
- alignment with government, Department of Health and LHD strategies and objectives.

Market assessment

- Five dimension to be considered.
 - Propriety
 - Economic feasibility
 - Acceptability
 - Resources
 - Legality

Strategic Planning Exercise

WSLHD is considering building a new hospital at Rouse Hill, in the North West of Sydney

Conduct a SWOT analysis of this proposal and determine whether a new hospital should be built, or whether the existing hospitals in the LHD (Westmead/Cumberland, Blacktown, Mt Druitt, Auburn) should be further redeveloped



Western Sydney

Western Sydney Local Health District (WSLHD) is responsible for providing primary and secondary health care for people living in the Auburn, Blacktown, The Hills Shire, Holroyd and Parramatta Local Government Areas (LGAs) and tertiary care to residents of the Greater Western Region.

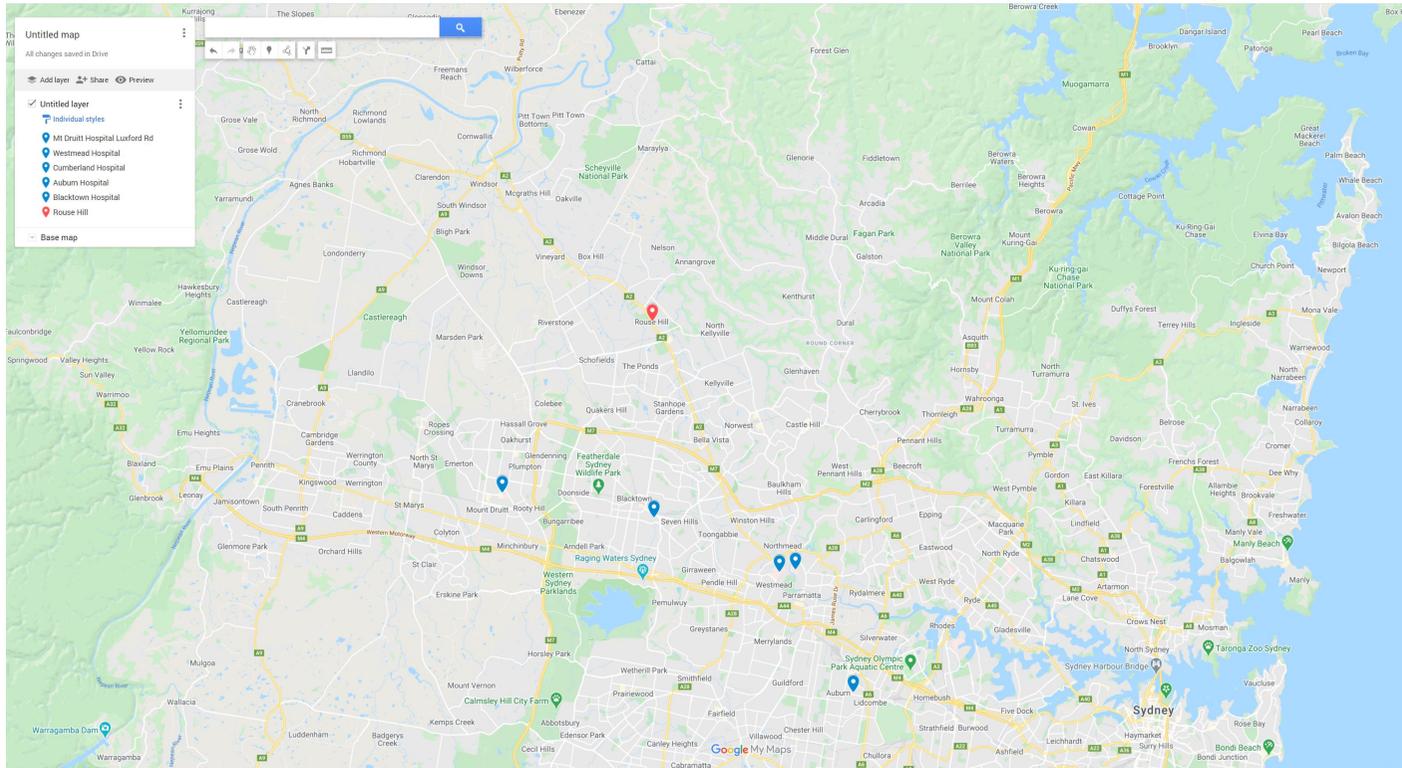
One of 15 local health districts (LHDs) in the NSW Health system, WSLHD is one of the State's fastest growing areas with more than 1.3 million residents estimated by 2031.

Visit the [Western Sydney LHD website](#) for more information or join the conversation on [Facebook](#), [Twitter](#), [YouTube](#) and [Instagram](#).

Public hospitals

- Auburn
- Blacktown
- Cumberland
- Mount Druitt
- Westmead





2016 Census QuickStats

Australia | New South Wales | State Suburbs

Rouse Hill

Code SSC13429 (SSC)

[Search for a Community Profile](#)



People

7,965

Male

50.3%

Female

49.7%

Median age

34



Families

2,081

Average children per family

2.1

for families with children

for all families

1.3



All private dwellings

2,537

Average people per household

3.4

Median weekly household income

\$2,401

Median monthly mortgage repayments

\$2,600

Median weekly rent

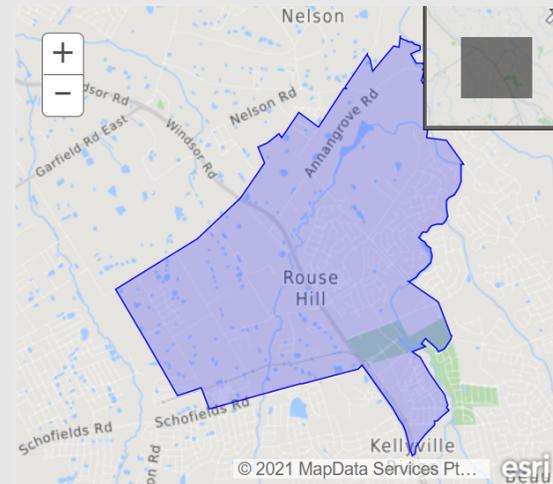
\$595

Average motor vehicles per dwelling

2.2

QuickStats Search

GO



Why is it important to develop an evaluation plan in health service planning?

Concluding the plan

A final planning product (such as a health service plan) that is well designed will:

- communicate clear service directions to stakeholders
- provide feasible, cost effective solutions to meet the identified need
- clearly articulate objectives and strategies to guide service provision
- prioritise strategies that best accommodate changing health needs of the population
- guide changes in service delivery models in line with existing and emerging best practice
- articulate links between services and service providers to coordinate care
- identify partnerships and collaborative approaches between service providers.

Strategic Plan - Report Back Template



Program: *(e.g. Geriatric and Ambulatory Medicine)*

Key Result Area: *(e.g. Quality)*

Report Area	Description	Report
Identify any changes to the service issues and priorities	Identify the gap between service needs and services currently available	
What are the strategies to address issues and priorities	The service issues and priorities should provide a practical and clear basis for identifying changes that are required to improve service delivery and ensure future needs are met.	
Implementation Strategies	Implementation strategies should include specific actions, performance indicators, assigned responsibilities and timeframes.	
Monitoring and Evaluation	Effects and learning's of implementing previous plans.	

Conduct additional planning to support implementation

Service enabler planning activities to consider include:

- assets—including capital infrastructure and non-capital assets
- clinical support services—including imaging, pathology, pharmacy, central sterilising
- funding—including funding for new or expanded services
- information and communication technology—including technology to facilitate

communication between service providers and service users

- workforce—including clinical and non-clinical staff

Resources

Leggat, S. Day g., (2015), Leading and Managing Health Services, Chapter 30 Health service planning, Cambridge University Press 2015