Part 1
BACKGROUND AND EXISTING SERVICES

1. BACKGROUND AND EXISTING SERVICES

1.1 Hospitals

There are six general acute hospitals in SWSAHS.

Appendix 2 and Appendix 3 detail the bed state and roles as currently defined.

	Type	Classification	Beds [1]
Bankstown	Metro General	Principal Referral B	369
Fairfield	Metro General	Major Metropolitan B1	153[2]
Braeside	Specialty		72
Liverpool	Metro General	Principal Referral A	559
Campbelltown	Metro General	Major Metropolitan B1	243
Camden	Metro General	District C1	72
Bowral	Rural	District C1	75
TOTAL AREA			1,543[3]

Bankstown Hospital
Bankstown Hospital is a principal referral hospital providing services, primarily at role delineation level 5, in medicine, surgery, critical care, aged care, rehabilitation, mental health, obstetrics and paediatrics.

Fairfield Hospital
Fairfield Hospital is a metropolitan hospital providing services, primarily at role delineation levels 3 and 4, in medicine, surgery, critical care, obstetrics and paediatrics. Fairfield Hospital is the centre for elective orthopaedics for Liverpool-Fairfield and Macarthur.

Braeside Hospital
Braeside Hospital is a third schedule hospital managed by Hope Healthcare and is located on the Fairfield Hospital campus. It specialises in palliative care, rehabilitation and aged care psychiatry.

Liverpool Hospital
Liverpool Hospital is the principal referral hospital for SWSAHS and a major teaching and research hospital for the University of NSW. Serving both local residents in Liverpool LGA and the whole of SWSAHS, Liverpool Hospital provides a range of sub specialty services, primarily at role delineation levels 6 in medicine, surgery, critical care, aged care, cancer care, mental health, drug and alcohol, obstetrics and gynaecology, neonatology and paediatrics. Positron Emission Tomography commenced in August 2002. A new public MRI was commissioned in January 2003.

Karitane
Karitane provides support, guidance and information to families experiencing parenting difficulties, health professionals and the community. Karitane, located at Carramar, provides the following services: education unit; pre/post natal depression residential unit; volunteer home visiting; Family Care Cottages; 24 hour care line.

Campbelltown and Camden Hospitals
Campbelltown and Camden Hospitals operate under a common executive management structure.

Campbelltown is a metropolitan hospital providing a range of services primarily at role delineation level 4 in medicine, surgery, critical care (3), obstetrics, paediatrics, mental health and drug and alcohol. Stage 3 of the Macarthur Capital redevelopment (refurbishment of existing Campbelltown main block) is ongoing. This program will develop Campbelltown as a major metropolitan hospital with predominantly level 5 services.

1 Beds in use in 2004, not including unqualified babies and Emergency Department beds
2 Excludes 20 bed Corella Lodge – free standing detoxification unit
3 Excludes Karitane 24 bed mothercraft unit

A new cancer centre has been built which collocates chemotherapy and radiation oncology services. The first LINAC has been commissioned and commenced operations on the 22 September 2003. The second LINAC is due to be commissioned in 2005.

Camden is a district metropolitan hospital providing medical, surgical and obstetric services mainly at role delineation level 3. Camden also has specific roles in palliative care and aged care and rehabilitation for the Macarthur. The new Camden Hospital opened in 2001.

Bowral Hospital
Bowral Hospital is a rural district hospital providing services mainly at role delineation level 3 in medicine, surgery, critical care and obstetrics. Strong links exist with local general practitioners.

1.2 University Affiliations

SWSAHS's Principal partner for medical undergraduate teaching and post-graduate research and teaching is the University of NSW. Our hospitals are teaching campuses of the South Western Sydney Clinical School of The University of NSW.

The University of Western Sydney's Macarthur Faculty of Health is a Research and Teaching partner of South Western Sydney Area Health Service.

1.3 Residential Aged Care Facilities

SWSAHS contains two residential aged care facilities:

- Carrington Hospital is a third schedule hospital at Camden providing 94 aged care beds (high and low) with a substantial retirement village complex, hostel facilities and a dementia care hostel.

- Queen Victoria Memorial Home is a State Government Nursing Home at Picton, which provides 100 aged high care beds. It is planned to alter the mix to 70 high care beds (in the rebuilt home) and 30 low care beds (accommodated in a collocated new facility built by a not-for-profit provider).

1.4 Community Health Services

Community health centres are located at Narellan, Campbelltown, Rosemeadow, Tahmoor, Bowral, Bankstown, Liverpool, Cabramatta, Carramar, Prairiewood, Ingleburn, Miller, Moorebank and Hoxton Park. There are many other community based services not located in community health centres. These include youth services such as Traxside (Campbelltown), FLYHT (Carramar), The Corner (Bankstown), primary health nurse clinics in a variety of venues, alcohol and other drug services, living skills centres and dental clinics.

1.5 General Practitioners

In 2003 there were some 800 General Practitioners across the south west of Sydney with 60% consulting in a language other than English. These are organised into five Divisions of General Practice – Fairfield, Liverpool, Bankstown, Macarthur (Camden, Campbelltown, Wollondilly) and Southern Highlands (Wingecarribee).

1.6 Area Services

SWSAHS operates some services under direct leadership of an Area Director:

- Renal
- Cancer
- Palliative Care
- Mental Health
- Population Health including Drug Health Services
- SWAPS (pathology)

1.7 Key Indicators of Acute Service Activity

SWSAHS hospitals in 2002/03 performed:

- 135,256 separations;
- 42,682 theatre operations;
- 10,011 baby deliveries; and
- Nearly 2 million outpatient patient contacts.

See Appendix 4 for more details.

1.8 Resident Use of Hospital Services

In 2002/03, there were 193,183 separations from SWSAHS hospital. Just over a quarter (27%) occurred in Private Hospitals (mostly for endoscopy, gynaecology, orthopaedic; and eye surgery).

SWS recorded 140,610 hospital separations in the Public Hospital system, and 77% of these were in SWSAHS hospitals (SWSAHS level of self-sufficiency). That activity leaving SWS is called outflow.

Outflow was 32,284 separations and 104,627 bed days, which are the equivalent of 301 or 337 beds at 95% or 85% occupancy respectively.

Most outflows occur from Bankstown (39%), Fairfield (20%) and Liverpool (17%). Bankstown outflow is matched by inflows from Canterbury LGA.

For more details refer Appendix 5.

1.9 Population Growth

Population growth is a key issue for the future of health service delivery in the region.

South West Sydney's growth is fast, off a high base (796,000 in 2001). Current population projections predict that 10,000 extra people will settle in SWSAHS every year. Nowhere else in the State, except for the north-west Sydney sector, will grow at this volume.

By 2006 (only 2 years away), South Western Sydney will be home to 842,000 people.

Commencing from 2006 the government plans to fast track the South West release areas, known as the Bringelly release in the west of Liverpool LGA, which means more lots will be released than previously included in population forecasts. It accelerates already planned land releases in the South West. Each year 18,000 extra people are predicted to reside in SWSAHS, and although there is no change to population forecasts over the life of this Plan, there are rapid changes beyond 2006:

- By 2009, SWS will be near the previously forecast 2011 mark i.e. 892,000 people;
- By 2011, SWS will be near the previously forecast 2016 mark i.e. 930,000 people;
- By 2016, SWS will be over 1 million people i.e. 1,020,000; and
- By 2030, a city of 250,000 to 300,000 will be west of Liverpool and North of Camden. SWS will be 1.2 million people.

Bringelly is not the only release land in SWS. Liverpool LGA and the three Macarthur LGAs are where most SWSAHS growth will occur. Fairfield LGA will remain stable but Bankstown will grow and age as the impacts of urban consolidation occur due to its larger block/lot sizes.

For more detail refer Appendix 6.

1.10 Resource Capacity

Hospital Bed Capacity[4] is assessed against seasonal demand variations, population growth forecast, and the level of self-sufficiency i.e. how many residents are served in SWSAHS against how many could be managed in SWSAHS given the role delineations of SWSAHS facilities.

Capacity exists in 2004 to cope with seasonal trends; 100 acute adult beds were opened for winter 2003.

By 2009, population growth will require an additional 103 beds (78 medical adult, 25 adult surgical) permanently opened.

SWSAHS's current self-sufficiency is 77%. An 85% self-sufficiency level has previously been assessed as realistic.

To raise self-sufficiency to 85%, manage all population growth and allow for winter seasonal demand, SWSAHS will need additional acute beds by 2009. (All the above figures assume a 95% occupancy level for adult acute beds. Lower occupancies would be desirable, and would only be achievable with further beds by 2009).

Most medical and surgical wards in most SWSAHS Hospitals are operating daily over a 95% occupancy level. It is widely accepted that operating acute beds at such high daily levels is a driver of inefficiency[5].

SWSAHS is revising its 2001 capital strategy to address bed requirements and to take into account recent planning initiatives for example:

- Transitional care beds/places; and
- Emergency mental health beds.

The current capital strategy (SWSAHS Strategic Resource Plan, 2001) has a 2011 horizon and was written prior to knowledge of the Bringelly release. Liverpool 2 is a key part of that Strategy.

For more detail refer Appendix 7.

Theatre capacity exists to enabled improved access for surgery. As at January 2004 SWSAHS had 1,197 people waiting longer than 12 months for surgery. In January 2003 the long wait list was 123 patients.

RECOMMENDATIONS

- A hospital bed capacity study be commissioned to underpin an integrated approach to health service acute care capacity to respond to growing congestion for access to emergency services and longer waiting lists for planned procedures.
- Feasibility planning commences in 2004 to assess the health service impact of the Bringelly urban release.
- A Capital Asset Plan be finalised to develop the capital assets of the Area Health Service and support the funding of capital items for service developments contained in this Clinical Strategy.
- The Macarthur Strategy Stage Three be concluded by 2006.
- A review of operating theatre utilisation and assignment be conducted to define where further efficiencies in theatre utilisation could be achieved.

4. Projecting Acute Inpatient Demand for Health Services – Background Paper, Aug 2003
5. Access Issues at NSW Public Hospitals: Key Strategies, 2003

2. KEY FINDINGS - GENERAL

The Clinical Strategy Group considered the following drivers of change in forming their recommendations:

- Safety[7] and medical coverage;
- The cohesiveness between current Hospital Roles in the current sector management structure;
- Adequacy of the hospital/community Interface in SWS;
- Equity of access;
- Acute patient seamless transfer;
- Cross accreditation and appointment;
- Clinical governance [6,7,8];
- Education and training; and
- Research.

The Clinical Strategy Group was aware of relevant NSW Health documents including:

- NSW Health Futures Project, 2003;
- Access Issues at NSW Public Hospitals: Key Strategies, 2003;
- IPART NSW Health Focusing on Patient Care, Aug 2003;
- Projecting Acute Inpatient Demand for Health Services – Background Paper, Aug 2003;
- Clinical Services Frameworks – Heart Failure Nov 2003, Optimising Cancer Care May 2003, Respiratory Disease Feb 2003;
- Guidelines for the Networking of Paediatric Services, Dec 2002;
- Clinicians Toolkit, Nov 2001;
- Mental Health Clinical Care and Prevention Model, Jul 2001;
- Shared Responsibility for Patient Care between Hospitals and the Community – An Effective Discharge Policy, Jul 2001;
- Report of the Greater Metropolitan Services Implementation Group, Jun 2001;
- Government Response to the Key Metropolitan Hospital Services Report, NSW, Jun 2001;
- Government Action Plan Oct/Nov 2000, Jun 2001;
- Healthshare – a Discussion Paper for NSW, Mar 2001;
- Strategic Directions for Health 2000/05, Oct 2000; and
- Quality Framework, Jun 1999.

6. NSW Health Quality Framework, June 1999
7. Clinicians Toolkit, Nov 2001
8. Clinical Services Frameworks – Heart Failure Nov 2003, Optimising Cancer Care May 2003, Respiratory Disease Feb 2003

2.1 Patient Safety and Medical Cover

This issue has been a foremost concern in considering every service plan. Issues examined more specifically were:

- Medical coverage after hours and on weekends - 24 hour on site Registrar/CMO medical cover is considered a minimum standard required across SWSAHS;
- Senior nursing cover and infrastructure to support the provision of direct patient care, facility and staff management; and
- Numbers of senior medical staff and their roles noting that these cover teaching, clinical work, supervision, research, leadership/advice for creating an Area approach to a service, management and administration of a hospital specific department, state-wide advice and college commitments.

RECOMMENDATIONS

- NSW Health take action to promote fairer access to registrar allocations to bring SWSAHS into line with other metropolitan Area Health Services by 2005.

2.2 Hospital Roles and Sector Management Emphasis

SWSAHS is currently managed under a "Sector Model". All the services in a defined geographic location report to a General Manager. This model has aimed to:

- Integrate hospital and community based services;
- Increase responsiveness to the diversity of local needs across SWS;
- Foster co-operative effort with other local agencies (e.g. DoCS, Police, Housing, Local Government, Education etc);
- Manage rapid and extensive clinical service growth and capital developments. (Each "Sector" has rebuilt its hospital and community health facilities - except Fairfield Hospital redeveloped pre-SWSAHS and Bowral (hospital had a co-located Private Hospital added); and
- Develop a local community participation response.

Whilst this model has overseen a series of large changes over the last 15 years, it has led to:

- Clinical services developing at different rates across the Area;
- Different models of care;
- Different minimal standards of care; and
- A geographic silo mentality that has hampered a service in one site getting help from the same service in another site.

Under the sector model, services across the geography are somewhat fragmented. The Sector model has not enabled a unified service or corporate culture to flourish.

The role of each Hospital has tended to 'emerge' and not be currently defined in order to provide a cohesive Area-wide service.

RECOMMENDATIONS

- Clinician-led Area-wide departments be formed to create a one service, multi-campus service delivery system across SWSAHS, led by an Area Director who may also be a senior (clinical) academic appointment.
- The Area adopt a clinical management structure for the purpose of implementing this Clinical Strategy.

2.3 Area Clinical Framework

Overcoming the service and facility silos that have developed requires a new vision for service delivery. This plan aims to:

1. Create Area-wide Services - one service, multi-campus delivery;
2. Define roles/ centres of expertise for each hospital that are complementary;
3. Create SWSAHS as a Teaching Area, not a series of disconnected teaching sites;
4. Create a new Area service camaraderie, so problems at one site are owned by the whole group;
5. Cross-appoint staff (as many already are) - but this is not a mechanism to spread resources thinner;
6. Ensure stronger hospital to Primary Care connections are in place;
7. Boost the training of and quality of our staff; and
8. Respond to the increasing specialisation of medicine by supporting General Medicine through an Academic appointment.

Area-wide Services will follow these guiding Principles [9,10,11]:

1. Safety: The service must be able to guarantee safe and excellent treatment of patients;
2. Patient Focussed: The service delivery system must be patient-centred and enable care across the continuum of services a patient will require;
3. Simple Access: There will be seamless access from multiple entry points so patients access the right place for care no matter where they enter the SWSAHS system;
4. Seamless Phases: Seamless, automatic transfer if a patient has to be moved from one hospital to another;
5. Equity of outcome: no matter where patient lives or enters the system they should have they same opportunity to benefit;
6. Quality: Service quality be based on state of art decision making and on safe interventions;
7. Standardisation: An Area-wide service will have consistency in standards of delivery across its system;
9. Staff Sensitive: Services must factor in Recruitment and Retention factors relevant to their service;
10. Forward looking: Service delivery must account for tomorrow's diseases and service trends relevant to their service; and
11. Create Careers: Service delivery should enable career paths for junior medical officers in particular, but also for allied and nursing staff in the service.

Key operational aspects of the service delivery model for each Area-wide department will be that :-

1. Beds will be kept available for seamless transfers;
2. Communication systems and the attitude of staff across sites will need to be excellent;
3. Transport systems will need to be capable of responding;
4. A focus be given by all services to early intervention;
5. A focus be given by all services to how to effectively discharge; and
6. A focus be given by all services to smooth patient flow within and between hospitals.

2.4 Recommended Facility Roles Framework

Bed capacity analysis and uneven geographic distribution of population growth imply that SWSAHS hospitals must play much more complementary roles than has been the case to date.

9. Report of the Greater Metropolitan Services Implementation Group, Jun 2001
10. Government Response to the Key Metropolitan Hospital Services Report, NSW, Jun 2001
11. Government Action Plan Oct/Nov 2000, Jun 2001

These links between facilities and services across SWSAHS could occur in a number of ways. They could be devised so as to:

- Advance patient access, transfer patients so the needs of a catchment's population are met;
- Mentor and support services that are emerging but need help;
- Stratify risk so clinical safety and quality occurs at all sites;
- Promote professional development and idea sharing;
- Manage services;
- Support recruitment and retention; and
- Advance teaching and research.

By the end of this Clinical Strategy each hospital will have developed expertise as a centre for a specific service and be working in a complementary way with roles as follows:

Bankstown Hospital will continue as a principal referral hospital operating its services mostly at Level 5. Bankstown will be the centre for plastic surgery and colorectal surgery. The option of gynaecological oncology surgery at Bankstown should be explored.

Fairfield Hospital will continue as a major metropolitan hospital operating its emergency, medical, surgical, obstetric and paediatric services mostly at Level 4. It will be the centre for elective orthopaedic surgery and elective short stay, day only, low risk surgery. With Braeside Hospital it will develop as a centre for rehabilitation.

Liverpool Hospital will be the tertiary referral hospital, providing a comprehensive range of high-level emergency, medical, surgical, mental health, maternity, paediatric and newborn services. Research infrastructure will be centred at Liverpool and it will maintain its leading role as the academic centre for the Area Health Service.

Campbelltown Hospital will progressively develop towards principal referral hospital status operating its services mostly at Level 5. Sub-specialty capabilities in medicine and surgery will be developed. It will be the centre for academic general medicine and a lead site for SWSAHS in paediatrics and ambulatory care. It will be a major centre for Colorectal surgery and adult, adolescent acute & non-acute mental health.

Camden Hospital will maintain a complementary role with Campbelltown, offering rehabilitation, low risk obstetrics, palliative care, urgent care and an extensive day surgery program with ambulatory care.

Bowral Hospital will operate as a rural general hospital with more defined links to Campbelltown hospital as the latter develops. It will be linked with all the Area units to enable access for Wingecarribee residents into level 5 and level 6 services available at other SWSAHS hospitals. It will offer elective and emergency services to adults and children, for medical, surgical and obstetric care.

RECOMMENDATIONS

- Develop complementary roles rather than competitive service delivery across the Area.

2.5 Priority Service Developments

It is recommended improvements be made as a priority to a number of service areas. Some of these where there are workforce shortages will need staging over a number of years. These are in alphabetical order:

- Aged Care[12] and aged care psychiatry, Transitional Care, Rehabilitation, Palliative Care;
- Anaesthetics and Pain;
- Cancer;

12. NSW Health Futures Project, 2003

- Cardiology and cardiothoracic surgery;
- Diabetes services;
- Emergency & Trauma/ General/Vascular/Neurosurgery services;
- Emergency Departments;
- General Medicine at Campbelltown;
- ICU;
- Maternal and Foetal;
- Mental Health[12];
- Neurology;
- Paediatrics;
- Radiology and Imaging – including an Area-wide PACS system;
- Renal medicine;
- Respiratory medicine; and
- Rheumatology.

2.6 Proposed Enhancements to Hospital Roles

Bankstown Hospital

The following will be developed at Bankstown Hospital:

- ICU will partner Fairfield ICU with senior medical coverage;
- Obstetrics maintained as a level 4 service, with residents offered a choice of this service (with full information to inform that choice) and Liverpool, which is primarily a medically driven service;
- Paediatric inpatient service develops closer ties with Canterbury through a cross-appointed staff specialist and a new Canterbury-Bankstown ambulatory paediatric service;
- Thoracic surgery and implantable cardiac devices;
- Vascular surgery will be one of two main centres (with Liverpool);
- ENT will be consolidated at Bankstown for the Fairfield/ Liverpool/Bankstown catchment area;
- Plastic surgery will be consolidated at Bankstown for the Fairfield/ Liverpool/Bankstown catchment area;
- Orthopaedics - major centre for joint replacements with Fairfield and Bowral;
- Selected elective neurosurgery;
- Centre for Colorectal Surgery (other site Campbelltown);
- Level 6 Gastroenterology service with Liverpool;
- Upper GI surgery will be one of two main centres (with Liverpool);
- Gynaecological oncology (surgical component only) be considered for movement from Liverpool;
- Medical oncology will be enhanced through additional appointments.
- Haematology inpatient and outpatient services;
- Expand renal dialysis through additional chairs (from 8 to 10-12); and
- Develop a medical assessment unit to enable seamless transfers from Fairfield and Liverpool.

Fairfield Hospital

The following will be developed at Fairfield Hospital:

- The Emergency Department develop senior medical cover 12 hours per day 7 days per week and form as a single Emergency Department with Liverpool so that clearly defined admission criteria are developed for patient admissions from ED to each hospital;
- ICU will be linked to Bankstown ICU for senior medical coverage;
- Obstetrics and neonatal services to be Level 3;
- A paediatric emergency management unit or short stay unit attached to ED;
- Appointments of a cardiologist and respiratory physician to enhance the general medical service;
- Diagnostic equipment for cardiology (stress tests) be implemented;
- A centre for elective general surgery and selected procedures in the sub disciplines (colorectal, upper GI, vascular, head & neck, endocrine, breast), gynaecology, ophthalmology and urology;

12. NSW Health Futures Project, 2003

- Current orthopaedic role be strengthened and further consideration be given to whether the main focus of elective hand surgery could be established;
- Capital redevelopment for a peri-operative suite with another theatre for day-only surgical emphasis.
- Enhanced medical, surgical and anaesthetic cover (registrar);
- Future site for a dialysis unit of 12 chairs;
- An aged care service will be commenced and developed over time as a Liverpool/Fairfield service;
- Transitional aged care develop at Fairfield Hospital. Braeside's rehabilitation service and ward should be "webbed in" so patient risk/acuity/complexity between the two facilities can be effectively managed;
- Future site for additional mental health adult beds as per Adult Mental Health Plan endorsed by NSW Health; and
- Extend ambulatory care in beds, hours and staff.

Liverpool Hospital

Liverpool Hospital's tertiary service role will be given more emphasis.

Specifically Liverpool will continue to develop:

- Academic Centre for Emergency Medicine;
- Additional ICU beds;
- Obstetric services will move towards 4,500 deliveries per year over 5 years;
- Additional ventilated and non-ventilated beds in the Neonatal ICU;
- A forward capital strategy for a new paediatric ward;
- Non complex paediatric surgery as one of two main sites (with Campbelltown);
- Centre for clinical genetics;
- Cardio-thoracic surgery for increased volumes;
- Main centre for interventional cardiology with three cardiac catheterisation labs (up from two);
- Respiratory medicine;
- Trauma surgery;
- Expertise in endovascular and endoluminal vascular surgery including vascular access for renal patients;
- Endocrine and head and neck surgery;
- Oral and facio-maxillary surgery;
- Hand surgery as one of three main centres for NSW;
- Centre for rheumatology;
- Stroke services (also at Bankstown, Campbelltown);
- Neuroradiology;
- Endoscopy consolidates to three sites: Liverpool, Bankstown, Campbelltown
- Upper GI surgery as one of two main sites (with Bankstown);
- Radiation oncology and medical oncology so that three linear accelerators will treat a maximum number of patients;
- Selected cancer surgery (thoracic, upper GI, neurological, head and neck, urology, endocrine, orthopaedic, reconstructive surgery after cancer surgery);
- General Medicine;
- Clinical Immunology;
- Infectious Diseases;
- Aged Care will maintain its acute geriatric role and support Fairfield to develop a service that is complementary;
- Transitional care beds will be provided at Liverpool;
- Ambulatory Care;
- Allied Health;
- Dental surgery in theatres for inpatients;
- Pharmacy will develop to a Level 6 service;
- Radiology;
- Mental Health;and
- Centre for Pain Services.

There will be a general medicine roster and sub specialty rosters in:

- Cardiology;
- Respiratory medicine (new);
- Gastroenterology;
- Renal; and
- Acute geriatric.

Campbelltown Hospital

The following will be developed at Campbelltown Hospital:

- ED service to have 16 hour / 7 days per week senior medical coverage;
- ICU expansion with support of Liverpool, as is currently occurring;
- Obstetrics at Level 4, neonatal Level 3;
- Lead site for paediatrics including academic appointment;
- New paediatric surgical services (with Liverpool);
- Acute fracture orthopaedic surgery for children;
- Establish a cardiology service;
- Expand respiratory medicine service;
- Urology;
- Colorectal surgery develops as the second main centre with Bankstown;
- In the future provide a neurosurgery list so that the neurosurgery network extends from Liverpool and Bankstown;
- Expand medical oncology as the radiation oncology service develops;
- Additional haematology clinics;
- Centre for general medicine through an Academic appointment;
- 20 bed non-acute mental health facility will develop by 2005; and
- A lead site for ambulatory care with Camden Hospital.

Camden Hospital

At Camden Hospital:

- ED becomes an Urgent Care Centre run by senior ED staff cross appointed with Campbelltown;
- A low-risk Level 3 obstetric service operates;
- Day Surgery role expands to include gynaecology;
- Satellite renal dialysis, chemotherapy chairs, haematology outpatients should all be planned for Camden over time.
- Transitional care beds to be included in the medical ward;
- The rehabilitation service has a Staff Specialist Rehabilitationist appointed; and
- Additional Palliative Care beds are required and these will require additional capital development.

Bowral Hospital

The following will be developed at Bowral Hospital:

- Closer links with Campbelltown Hospital for medical cover, ED and obstetrics;
- Surgery and Recovery in Southern Highlands Private should be explored;
- Satellite dialysis; and
- Chemotherapy to continue in Bowral Day Surgery.

2.7 Cross accreditation/appointments

The creation of Area-wide services across SWSAHS facilities will require staff linkages, staff movements between sites and appropriate site credentialling and hence cross appointments.

There is no intention to use cross appointment to increase workload on individuals. This plan is about achieving adequate resource levels and ensuring there is interchange between staff within the service across sites.

There is no reason why training to meet various clinical College requirements cannot also occur across several sites.

RECOMMENDATIONS

- There be cross appointment and cross credentialling of clinical staff consistent with service developments.

2.8 Clinical Governance, Common Protocols

SWSAHS's clinical services will become Area-wide, and with this opportunity comes a clear requirement for each service and each site to clarify its system for safeguarding high standards of health care.

Clinical Governance is the shared responsibility between senior managers and clinicians alike. Fostering a culture that promotes high quality health care through safety, compliance, clinical review, best practice, and risk management is fundamental to the pursuit of effective clinical governance. Growing a research culture, and facilitating innovation and continuous learning, are important steps towards this end. The current clinical governance structure will be reviewed and recommendations made to enable implementation of the proposed Area network.

There is a need under the future Area-wide services structure that each service develop clear admission policies and have governance mechanisms in place to assist monitor compliance to such practice. There is a need to develop agreed common protocols for patient management, as at present these differ from site to site in many cases.

RECOMMENDATIONS

- Each Area-wide clinical service develop clear admission policies, establish systems for monitoring the safety and outcomes of care, develop common agreed protocols for patient management and develop systems for monitoring compliance to policy and protocols.

2.9 Community Services, Primary Health and GPs

Much innovative, effective and inspiring work has occurred in community settings in SWS (e.g. Families First, Miller, GP liaison) yet the hospital-community interface remains an area for improvement with potential to unblock hospitals.

Links with the 5 Divisions of General Practice are positive with extensive collaborative programs. Improvements are possible by:

- Standardised systems that link primary care services with Hospital acute care;
- Effective communication for continuity of care – especially hospital discharge referral systems; and
- Improving access to community and allied health services, and a simpler single point of contact to access information about patients.

Co-operative effort with other State and Commonwealth Government Agencies is strong.

'Access block' in Federal funded services (eg Residential care, Community Aged Care Packages etc) or in State funded Agencies for example, Department of Ageing, Disability and Home Care (for Home Care services) as consequences for SWSAHS services.

A stronger, more accessible primary care delivery system and a smoother hospital to community interface for patients leaving hospital is required.

RECOMMENDATIONS

- The Area forms a new leadership position, a Director of Primary Health Care, to improve the functioning of the hospital-to-primary care interface.
- Collaborative effort with General Practitioners in SWS be accelerated for improved standardisation, effective communication and improved access of GPs to SWSAHS services.

2.10 Education and Teaching

The changing context of health care, changing technologies and the rapid growth in information requires continual growth in knowledge. Higher patient acuity drives a trend to increasingly specialise, and changing community expectations mean that staff need to continually acquire new skills.

A leading edge teaching program and continuing professional development is crucial to nursing, allied health and medical career options. This is a key factor in recruitment, retention and sustaining a professional, skilled workforce equal to the service needs/quality and requirements for safe health care provision.

Key appointments of Clinical Academics will be made in:

- Emergency Medicine
- Maternal and Foetal
- Paediatrics
- Cancer
- Aged Care
- General Medicine
- Anaesthetics (interest in obstetric anaesthesia)
- Rheumatology
- Trauma and Emergency Surgery
- ENT

However, most, if not all services should be headed by senior academics.

Registrar and junior medical officer training must take an Area-wide focus. A dedicated teaching infrastructure is required with adequate time set aside from the clinical workload of the medical officers. Specialist training for registrars will aim to achieve training outcomes comparable to other teaching hospitals in NSW.

The SWSAHS nursing educator and clinical nurse educator workforce requires development to provide:

- quality undergraduate clinical education;
- effective transitional processes and support for graduates;
- structured preceptor/peer support/mentoring programs;
- clinical teaching/facilitation/coaching;
- clinical supervision/reflective practices;
- clinical leadership;
- a supportive and safe workplace; and
- a responsive workplace learning transfer climate.

Strengthening the academic and senior staffing infrastructure of allied health services across the Area, will enhance the provision of quality health care to both inpatients and non-inpatients in SWSAHS.

SWSAHS will develop as a Teaching Area not a series of disconnected teaching sites. Appointing Clinical Academic staff across the facilities of SWSAHS will assist in this regard.

RECOMMENDATIONS

- Clinical Academic leadership will be enhanced through appointments of Chairs including:
  - Emergency Medicine;
  - Maternal and Foetal;
  - Paediatrics;
  - Cancer;
  - Aged Care;
  - General Medicine;
  - Anaesthetics (interest in obstetric anaesthesia);
  - Rheumatology;
  - Trauma and Emergency Surgery; and
  - ENT.

However, most, if not all services should be headed by senior academics.

- Training registrar rotations will occur across all relevant sites.
- Directors of Physician Training, Clinical Superintendent, Senior Medical Registrars be appointed at Bankstown, Liverpool and Campbelltown to provide a leading edge teaching program for all registrars in SWSAHS.
- Nurse educators and clinical nurse educators be enhanced across SWSAHS.
- Clinical Academic leadership in Nursing and Allied Health be enhanced over the next 5 years.

2.11 Research

For an Area of the size, complexity and untapped opportunity of SWSAHS, research is relatively underdeveloped. Outstanding research being conducted in challenging circumstances in disparate research units and centres does not yet benefit from an overarching research strategy, including a clear agenda for capital works, strategic investment in research leadership, academic partnerships and workforce development.

Research attracts high-quality clinicians who, in turn, create an expectation for more research. A cohesive and strategically driven research strategy will enrich organisational learning and a culture of knowledge. SWSAHS current research strengths include:

- Pancreatic cancer, injury and fibrogenesis;
- Infectious diseases;
- New models of care and evaluation of service innovation;
- Mental Health research;
- Research transfer including resources and strategies for evidence-based practice in diverse disciplines;
- Cancer;
- Trauma; and
- Population Health.

SWSAHS will benefit from a research strategy, which respects the history and variety of research expertise in the Area; defines research priorities; imports new research expertise and strengthens existing research efforts. This will ensure a greater balance for clinicians between service provision and teaching, research and learning. Opportunities arising from the recently published review commissioned by the Minister for Science and Medical Research should be pursued. Recent announcements advising of a Medical School to be established by the University of Western Sydney will be taken into account.

RECOMMENDATIONS

- Establish a SWS Research Institute that progresses strategic development of health and medical research in SWSAHS.

Research in SWSAHS will produce a scientific basis for decision-making that promotes quality and safety, equity, health and well being with a particular interest in disadvantaged communities to improve services and systems of care. Research will focus on conditions that are most common, most challenging or most critical to the equity, health and well being of our communities and the individuals within them.

SWSAHS will build on its research strengths as follows:

- *Quality and safety research* for improved service delivery systems and practice methods enabling SWSAHS to play a statewide role in this research field.
- *Health services research* that drives organisational development, improved patient safety and evidence-based practice.
- *Population health research* to promote equity and reduce the burden of illness, focusing on interventional studies to identify effective ways at all levels of health policy and practice to respond to emerging health issues.
- *Clinical research* studies including becoming a major co-ordinating centre for clinical trials in relevant clinical problems such as cardiovascular disease, trauma, and cancer and for complementary therapies. Strengthen existing clinical research programs in trauma, surgery, medicine, mental health and psychiatry, nursing, allied health and intensive care
- Collaborations between *biomedical research* teams in SWSAHS and designated NSW research 'hubs' will ensure critical mass and accelerate the translation of biomedical discoveries into clinical applications.

3. KEY FINDINGS – SUPPORT

The Clinical Strategy Group identified a number of key supportive developments that must accompany the clinical service changes. These are referred to as glue issues:

- Workforce Recruitment, Retention and Culture
- Patient and family/carer transport
- Communication
- Revenue
- Clinical Information Management

3.1 Workforce Recruitment and Retention

Nearly every clinical service raises this as a key issue.

Some services go through cycles of recruitment and retention difficulties which puts pressure on the long standing staff. There is a national medical workforce shortage and there are statewide shortages in many nursing and other clinical workforces.

The major requirement is to increase Medical Registrar numbers. A build up of senior medical staff is required for improved clinical governance, teaching, supervision and research. Supports for senior clinical staff eg clerical, data management are to be improved.

SWSAHS has many excellent initiatives to attract local students into nursing, to attract and retain nurses, however, nursing shortages that affect NSW also occur in SWSAHS. A dependency on agency nurses to fill shifts hampers better use of the funds spent. Nursing expertise through nurse consultants, nurse specialists, nurse educators and clinical nurse educators will need to be a focus as services develop. This will assist nursing recruitment and retention.

Our well-trained and locally developed allied health staff are lured to other Areas where opportunities for career progression are superior.

There is less opportunity to treat private patients given lower levels of health insurance, and this becomes an issue in attracting some doctors. This also limits the ability to build up Trust Funds that gives a certain flexibility to services. As SWSAHS cannot offer this as an attraction factor, other attractors such as the research potential will be developed.

This plan aims to make SWSAHS the employer of choice for clinical, support and administrative staff.

RECOMMENDATIONS

- A Strategic Human Resource Plan be developed, and a review of the organisation of Human Resources in SWSAHS be undertaken to improve recruitment and retention of the clinical workforce.

3.2 Patient and Family/Carer Transport

An essential component of a system where patients are to be transferred to the appropriate site for treatment is an internal transport system, for example the transfer of HDU patients between Fairfield and Bankstown.

Other issues include patient transport systems from community to non-inpatient services such as rehabilitation, renal dialysis etc.

Moving patients will also mean a service must exist to move their family/carers at our cost. Income levels of SWS residents mean that minimising travel would benefit residents. The cost of transport and the coverage/timetabling by private operators are key issues for residents.

RECOMMENDATIONS

- A centralised Area-wide transport system be designed to support acute patient transfer.

3.3 Acute Patient Seamless transfer

Liverpool Hospital has a Medical (MAPU) and Surgical (SAPU) assessment unit for rapid assessment emergency medical and surgical admissions. With hospital roles more closely linked to collaboratively manage incoming patient presentations, seamless patient transfer requires beds at Bankstown and Campbelltown be made available to receive transfers.

Such units will be planned on occupancy rates of 70% to handle daily fluctuations. Using Liverpool's experience to date as a guide, at occupancy rates of 70%, bed requirements are:

Hospital	MAPU Beds	SAPU Beds
Bankstown	13	8
Liverpool	18	14
Campbelltown	7	5

3.4 Communication - Single Phone System

For services to operate successfully as Whole-of-Area Services under the Clinical Services Plan, the organisational management of patient transfers must be addressed.

A singe phone call service will facilitate the smooth transition of patients between health service facilities across the Area. The single phone call service would provide clinicians with a 'one-stop service' that would make the responsibility for the management of a patient requiring transfer much simpler. Clinicians would be freed from contacting multiple hospitals and talking to multiple doctors, to transfer a patient to a higher level of care. The provider receiving the call would be privy to all relevant rosters, up-to-date bed information, access to transport bookings etc.

For more detail refer Appendix 8.

RECOMMENDATIONS

- A single phone-call system be implemented for inter-hospital acute patient transfer.

3.5 Revenue and Business Models

The need to explore all revenue opportunities has been recognised by the Area. Many services such as a public respiratory laboratory which could almost be self funding are not available in SWSAHS.

A number of services such as medical oncology and a sleep disorders and respiratory failure services consider that there are opportunities to investigate various business models for service delivery.

RECOMMENDATIONS

- All services explore opportunities for maximising revenue generation through the service model they adopt.

3.6 Clinical Information Management

Implementation of the Point-of-Care Clinical System (POCCS) will enable electronic diagnostic test reporting and diagnostic test ordering. Clinicians will then have access to a clinical view of all patient information including previous admissions in other SWSAHS hospitals. POCCS will take 20 months to implement from May 1, 2004 at a cost of $10.898M funded by NSW Health. Following this the automation of clinical pathways will build on a pilot underway in Palliative Care.

Opportunities for service improvement using information technology were identified in most clinical service submissions. Numbers of staff (20.7 FTE) were specifically identified for IT or clinical information support, however many did not state a staff requirement, as it was unclear what resources would be necessary. In conjunction with requests for staff and improved systems, greater access to IT hardware is required at a number of hospital and community sites. Mobile technology has potential to further improve efficiency and effectiveness of staff.

A range of needs were identified including area-wide database, electronic medical record, patient tracking, development and monitoring of key performance indicators, support for shared care programs and reduction in duplication and better resource allocation. Enhanced information management was identified as having significant potential to facilitate peer review and to meet the needs of better clinical governance and statutory reporting. Improved links to community providers were a high priority to facilitate the continuum of care.