

DISTRICT HOSPITALS

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BACKGROUND

During the consultation process undertaken by the GMSIG, a number of clinicians and administrators raised the issue of the role and function of District Hospitals. There has been considerable uncertainty over the function and future of these Hospitals for a number of years and it was felt that the greater metropolitan plan would be incomplete without some discussion and guidance in relation to these smaller Hospitals.

The Hospitals are a heterogeneous group and they are listed below with information in relation to bed numbers, occupancy and separations.

As can be seen from the above table, the hospitals range in size from just under 400 beds to less than 60 beds and from 38000 separations a year to 5360 separations per year. Clearly these hospitals vary from others which provide a very broad range of services to those which are quite restricted in what they are able to provide to their communities.

To examine this issue the GMSIG established a working party chaired by Dr Patrick Cregan a surgeon, with representation from a range of clinical and administrative staff from the Area Health Services and District and Teaching Hospitals. A questionnaire was sent out to the General Managers and Chairs of Medical Staff Councils of District Hospitals and the responses were analysed by the Working Group. The Working Group also reviewed:

- the New South Wales Health Services Comparison Data Book 1998/99
- Emergency Departments Strategy Directions – Priorities and Funding Guidelines for the New South Wales Health System 1997-2000, and
- Intensive Care Strategic Direction: The Framework for the New South Wales Health System.

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Hospital Name	Average Available Beds	Occupancy %	Separations
Auburn	145	71.6	13672
Bankstown/Lidcombe	382	86.6	28787
Blacktown	282	89.6	38379
Campbelltown	206	91.0	23352
Canterbury	144	95.4	13353
Fairfield	167	77.7	15840
Hornsby/Ku-ring-gai	249	86.0	18155
Manly	180	91.9	13917
Mona Vale	147	86.5	12464
Mt Druitt	137	99.3	18095
Sydney/ Sydney Eye Hospitals	72	82.3	7573 Eye 3683 General 3890
Ryde	156	79.0	11823
Sutherland	287	88.6	21660
Wyong	149	93.4	14806
Hawkesbury			7297
Blue Mountains	88	77.2	6833
Shoalhaven	131	86.0	12330
Camden	72	66.3	5360
Bulli	57	88.5	5292
Shellharbour	135	100.0	12891

This data is from the NSW Health Services Comparison Data Book 1998/1999.

A series of principles was established and a larger group met in February 2001 to which all of the Chairs of the Medical Staff Councils and Hospital Managers from District Hospitals were invited. The principles were then reworked and a final report prepared by the working party.

DISCUSSION

As stated above the District Hospitals are a heterogeneous group some of which provide a sophisticated service backed up by adequate staffing levels and equipment, whilst others provide more of a primary health care role to the local population. There is, of course, always the conflict between having a critical mass of population, staff and equipment for whom to provide a safe and high quality service and the need to provide access to health services for smaller population groups. District Hospitals are clearly subject to these tensions and for smaller hospitals there is a risk that because of lack of appropriate human or technical resources, health outcomes may not meet community expectations. Communities are not always aware of these issues and in many cases have a strong allegiance to their local hospital and will on occasion feel that these Hospitals should be able to provide a range of services which may not be realistically possible.

The District Hospitals themselves felt that they were excellent providers of a range of services including the delivery of clean, elective surgery, rehabilitation, palliative care, geriatric and general medicine. Smaller Hospitals felt that the lack of high-tech equipment and/or services was problematic for them, particularly where the facility did not have a spiral CT scanner.

In principle the working party agreed with the notion that a critical mass of population and human and technical resources was relevant and should be taken into account when describing the role and function of a District Hospital. They also agreed that the term "District Hospital" was unhelpful in that it covered a broad range of hospitals with clearly different roles and concurred that a new nomenclature was required. Other principles agreed to included that smaller Hospitals needed to be networked with larger Hospitals, particularly in relation to emergency services and that it should be made clear what the Hospital's role was in relation to the area-wide Emergency Department network to be set up under the recommendations of the Emergency Department Implementation Group. Further, District Hospital Clinicians would need access to major metropolitan Hospitals to ensure there was an equitable distribution of workload and resources between clinicians at all institutions, and that teaching and research should be continued and developed at District Hospitals.

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Areas should accept the principles outlined in our recommendations and immediately establish working parties which will report on their progress and planning to date by October 2001. Such planning and analysis would involve among other things:

- casemix data for each hospital, concentrating on the number of occasions of service for a particular DRG where evidence suggests volume affects quality and outcome
- data on the utilisation of any given hospital's emergency department so that the recommendations from the GMSIG Working Party on the "Efficient Use of Emergency Services", can be applied
- the need to create the specialised inpatient facilities that must be integrated with community efforts to better care for patients with chronic and complex cardiac, respiratory and cancer problems. In many hospitals, such responsibilities see an increasing number of hospital beds utilised by emergency admissions for such patients making efficient use of surgical inpatient facilities difficult
- the need to create surgical and medical inpatient facilities with guaranteed availability by freeing those beds from emergency department pressures
- the need to analyse and report on efficient use of infrastructure at major tertiary institutes in an Area. Any plan for better use of smaller hospitals must facilitate better use of major hospitals
- while there is alteration to the role of our hospitals, it is essential that clinical staff have guarantee of access to other facilities through networking and cross-appointment. Plans must facilitate the maintenance of clinical interest and skill
- the impact of flow reversal
- the need to maximise appropriate clustering of patients into an appropriate specialty area (vascular patients in vascular wards etc) to prevent nurses with specialist qualifications being asked to participate in general nursing duties and therefore leaving the hospital
- the appropriateness and need to discuss plans with adjacent Areas where considerable cross-border flows see smaller hospital services being relied on by patients from two or more Areas
- an appropriate timetable for change

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- a communication strategy for all clinicians and the public served by these hospitals
- methods to promote the concept of different roles for different hospitals representing a “first among equals” approach. Each hospital embracing a redefined role would provide a vital link in integration and networking of services and would be expected to participate fully in teaching and research programs.

The better use of our hospitals, as recommended here, is probably the most sensitive but most important of all GMSIG efforts to create greater quality, equity, fairness of access and cost effectiveness in our metropolitan hospital system. Many necessary changes will require commitment to the process and a major communication exercise to promote the benefits to all. Success will see unfair waiting times for surgery minimised, chronic and complex care improved and major hospitals using their expensive infrastructure efficiently. These improvements will result in an increase in patient satisfaction and a significant reduction in clinician frustration.

Reports from the overseeing committee to the Greater Metropolitan Implementation Group (GMIG) should occur four times a year to allow the Clinical Council to guide the entire process and provide adequate and timely reports to the Clinical Council and the Minister.

Finally it was agreed that there should be a public education process in which the community was provided with information in relation to the role and function of their District Hospitals, and that the whole issue of District Hospitals be reviewed again in five years time.

RECOMMENDATIONS

1. That the use of the term “District Hospital” be discontinued and replaced by the terms Metropolitan General Hospital, Specialty Hospital, Growth Area Hospital and Community Hospital.
2. **Metropolitan General Hospitals** would serve a defined population of between 200,000 – 250,000 people and should provide a reasonably extensive range of services including stroke, cardiac services, maternity, ED and ICU. These hospitals would be networked to major referral hospitals. Current examples of these Metropolitan General Hospitals include Canterbury, Blacktown and Sutherland Hospitals.

RECOMMENDATIONS

- 3. Specialty Hospitals** have an important role within the Health System. For example, they would provide “clean” elective surgery, some maternity, general medicine and other services at a high level. Access to these Hospitals should be by booked admission or by an acute access clinic on site and they would need to be “hard wire” linked to other larger hospitals so that access for their patients to more sophisticated or higher-tech services occurs automatically. The status of these hospitals in providing elective surgical services should be acknowledged and they should be permitted to pursue centre of excellence status e.g. in joint replacement or other forms of elective surgery.
- 4. Growth Area Hospitals**, are specific hospitals in growth Areas, which require special treatment, for example Wyong and Campbelltown. Provision of equipment and services, for example spiral CT scanning is needed for these hospitals so that as the populations expand rapidly, they are able to provide an appropriate range of services such as those provided at Metropolitan General Hospitals.
- 5. Community Hospitals** are smaller hospitals without the population base to support their role as a Metropolitan General Hospital or Metropolitan Specialty Hospital. These hospitals provide such services as a polyclinic and possibly geriatric assessment, treatment and rehabilitation services.
- 6. Special Cases**, such as Hawkesbury, Blue Mountains and Shoalhaven present challenges because of their relative geographic isolation and the need to provide access to services to their local communities. A strong network needs to be developed for these hospitals and novel strategies explored to ensure safety and efficient service delivery.
7. That Area Health Services consult with their District Hospitals and communities with a view to defining the roles of these hospitals into one of the categories listed above and make the necessary arrangements to ensure that the hospitals are able to fulfil their new role and function. It is recommended that Area CEOs relate to the Greater Metropolitan Services Implementation Group in late 2001 in relation to their plans for District Hospitals.
8. That where there is alteration to the role of the hospital, it is essential that staff have guaranteed access to other facilities through networking with major, adjacent, metropolitan hospitals in order that they can maintain their clinical interests and skills. Teaching and

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research should also continue at all levels of hospitals.

9. That the delineation of hospitals be reviewed within five years.

IMPLEMENTATION

10. That a subcommittee composed of at least some GMSIG members and the Chairman of GMSIGs subcommittee on "District Hospitals" be established to receive reports from Areas, advise and report to the Clinical Council on progress in implementing the major recommendations.

BACKGROUND

At the same time as the Greater Metropolitan Services Implementation Group was established to examine the needs of Greater Metropolitan Sydney, a Rural Services Implementation Group was also established with a similar role in relation to Rural Health Services in New South Wales. It rapidly became apparent to both groups that there were significant relationships between Health Service providers across the state and that decisions made affecting Metropolitan and Rural Health Service providers would have implications for consumers across the State. It was therefore decided by the two groups to set up a process which would examine the issue of networking between the Metropolitan areas of Sydney and the Rural Area Health Services and Hospitals.

The GMSIG subsequently set up a small working party under the Chairmanship of John Uther, Clinical Professor, Faculty of Medicine, University of Sydney. The working party considered relevant documentation including "The New South Wales Ministerial Advisory Committee on Health Services in Smaller Towns", Right Hon. Ian Sinclair, and "Health Services for Rural and Remote Communities", background paper New South Wales Health, May 2000. There were also a number of meetings with the Rural Health Implementation Group (RHIG) and a working party of that group which was established to work with John Uther's committee. The Rural Health Implementation Group also gathered and collated information from all rural areas on networking with Metropolitan facilities and this was completed and approved by the RHIG on 15 February, 2001.

Professor Uther presented the joint findings of the two Working Groups to the GMSIG and these were endorsed unanimously.

DISCUSSION

It is evident that there are a number of clinical, support, and service networks in operation between rural areas and the metropolitan area of Sydney. Many of these networks have evolved over the years and are reflected in a range of referral patterns, support service networks (eg. Pathology) and administrative arrangements. The work of the two working parties concentrated on the areas of clinical service delivery and referral patterns, with the rural areas clearly wanting to ensure that the networks which were either to be confirmed or established, were driven by Clinicians themselves in the rural areas. At the same time it was agreed that networks should not

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be exclusive, but that there should be default systems in place for rural clinicians to access metropolitan services for their patients.

Other issues raised included the need for support from the metropolitan area in relation to clinician work force issues including medical, nursing, pharmacy and allied health and the need for accreditation of country training for senior trainees where the necessary networks and supervision exist.

RECOMMENDATIONS

1. That formally recognised clinical networks be established by each rural Area with greater metropolitan hospitals in New South Wales. For regions near New South Wales borders, services provided most conveniently from adjacent States or Territories should be included.
2. That the Rural Area Clinical Councils advise the Area Health Service of the appropriate arrangement for each network.
3. That the networks described above not override existing informal networks but be a "non-exclusive default" system.
4. That a regional network involve a number of individual metropolitan centres, as one centre may not necessarily provide the full range of services but rather act as a "centre of excellence" for certain treatments. A mechanism for on-going re-negotiation of the network arrangements will be required to help ensure that treatment advances were made available to rural residents as and where they became available.
5. That the networks be backed up by training and staffing arrangements which build upon and contribute to local rural capacity and infrastructure. These arrangements should include rural rotations at consultant level and College training programs should allow accreditation of country training for senior trainees where the necessary networks and supervision are in place.
6. That there be more widespread standardisation across NSW of clinical practice protocols

RECOMMENDATIONS

for the admission of patients to metropolitan centres and for their subsequent discharge to rural communities. There needs to be standards for the provision by city hospitals of information, accommodation and other supports for rural patients referred to the city, and standards for rural basic support services for patients returning from metropolitan hospitals after major surgery, so that effective rehabilitation is certain regardless of region of residence.

7. That outreach services be set up using the following principles
 - they should be planned in conjunction with the relevant Rural Clinical Council
 - they should build upon and contribute to the local capacity and infrastructure
 - they should be organised from the regional centre with close links to outer communities
 - there should be continuity of service provider.

IMPLEMENTATION

Implementing the Plan for Acute Hospital Based Services for Greater Metropolitan Sydney will be a challenging process and one which will lead to a significant change in the distribution and management of health services in the Sydney area.

Sydney is unique geographically in that it has a wide spread of population with low-density housing and large distances between various areas. It is essential the Sydney Health Services are distributed in such a way that a range of core services are available close to the population which requires them. However more specialised acute services, eg. renal transplantation or complex gynaecological cancer surgery, which individuals may only need to access for a relatively short period of time, should be located where the clinical expertise and support will ensure a quality outcome. For these services, the key consideration must be the maintenance of high quality services, not the distance that patients may need to travel.

The changes to service delivery patterns proposed in earlier sections of this Report will require significant cultural and organisational change as well as changes to the distribution of services.

Cultural change will be necessary in that both health clinicians and administrators will be required to think increasingly in terms of the health of the population of the whole of Greater Metropolitan Sydney rather than considering the needs and interests of their own individual population or hospitals. This, for some, will require a major change in thinking and is essential if the vision of a range of networked and integrated services spreading across Sydney and into the rural areas is to be achieved.

Organisational change is required in that the proposed new specialty service clinical networks will necessitate the management of services across Area boundaries and beyond the walls of individual hospitals. Again this will be a challenge for clinicians and administrators alike.

Clearly the distribution of services will change, some being concentrated in fewer locations whilst others will be more widespread and accessible to the broader population. This redistribution of services will need to be carefully planned and managed. In our view a number of principles will guide the implementation process of the organisational, cultural and distributional changes outlined above.

IMPLEMENTATION

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Firstly, changes to current service delivery patterns should be based on the recommendation of the Greater Metropolitan Services Implementation Plan. The Plan should provide the framework for the development of health services in Metropolitan Sydney for the next 3 - 5 years. While there may be service developments or changes occurring outside of the Metropolitan Plan, the very existence of the Metropolitan Plan and a systems commitment to it will provide a necessary level of certainty to Area Health Services and clinicians over the next few years.

Secondly, the Plan needs to be implemented over an extended period of time to enable the necessary changes to be made in a planned and organised manner. Some changes to the distribution of services will require considerable lead up and planning prior to implementation and it is essential that change is incremental if the interests of providers and consumers are to be properly safeguarded. With this in mind GMSIG recommends that many of the changes take place over a 3-5 year time frame.

Thirdly, implementation of the Plan will lead to changes in the roles of some individual hospitals and this needs to be recognised from the beginning. The GMSIG has not recommended the closure or significant downsizing of any hospital in the Greater Metropolitan Area. However, it is clear that there will be role changes for some hospitals with some relinquishing services and others gaining new ones. Again, it is important that role changes are managed carefully and that individual institutions are neither seen as winners or losers. Individual hospitals need to understand their roles as part of a broader service system for the population of greater metropolitan Sydney as opposed to a provider of the greatest possible range and complexity of services for their immediate population.

Fourthly, the Plan proposes the establishment of a range of service networks within and across area boundaries. In the body of our Report we have tried to define what we mean by a network and some of the features which individual networks may embrace. However, the networks themselves will not just happen. There is a need for clinicians and administrators to commit themselves to making networks work and, as indicated above, to embrace the culture of looking beyond the boundaries of their areas or institutions to find better ways of meeting the population health needs of Greater Metropolitan Sydney.

IMPLEMENTATION

Fifthly, the GSMIG has expressed strong support for the concept of budget holding. In this context it was felt that the need to achieve equity of distribution and access for consumers within a networking framework was unlikely to be achieved if funds associated with those flows continued to be held by private providers.

Finally, it is essential that Area Health Services take a lead role in planning, negotiating and actively managing the change process. In some instances it may not be possible for Areas to reach agreement between them and on occasion it will be necessary for the NSW Department of Health to become involved in the process and resolve any outstanding issues.

Whilst adoption of the above guidelines will enable a smooth transition process, there is a need to maintain the overall momentum for change. It is understood that the Clinical Council will continue to operate for a number of years to oversight the Government's Action Plan. It is recommended that there be an ongoing body which drives the specific implementation of the Greater Metropolitan Services Plan.

At this stage it is anticipated that the GMSIG itself will disband following the completion of its planning work in May of 2001. It is recommended that a Greater Metropolitan Implementation Group (GMIG) be formed with the express role of driving and overseeing the implementation of the Metropolitan Health Services Plan. This Group should be chaired by a clinician and comprised of several senior clinicians (including doctors, nurses, allied health professionals), consumers, some metropolitan Area Health CEO's as well as senior NSW Department of Health representation. It would have the standing of a Ministerial Advisory Committee with reporting lines to the Minister, the Director General and the Clinical Council. The GMIG would continue for the life of the Clinical Council and would ensure that the system was accountable for achieving agreed changes arising out of the Greater Metropolitan Health Services Plan. Given the importance of the work of this Group it is further recommended that it provide regular reports directly to both the Minister for Health and the Director General of NSW Department of Health. In many ways the implementation process is as important, if not more important, than the process of creating the Plan itself. The implementation process needs to be driven and accountable, and change needs to be managed in a timely, careful and measured way. Only a properly managed implementation process will ensure that the proposed gains for the population of greater metropolitan Sydney will ultimately be achieved.

IMPLEMENTATION

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The GMIG should be asked to prepare a comprehensive implementation plan, incorporating a detailed costing and timeframe. The Group's role would be to oversight the implementation phase, review the plan in 12 months, consider a mechanism for creating new or expanded services outside of the current plan, and provide feedback to clinicians and others working in the hospital system.

SUMMARY OF RECOMMENDATIONS

GENERAL

1. That there be, wherever possible and appropriate, an equitable distribution of, and access to, health services and resources.
2. That there be consolidation of services into one, or a small number, of units.
3. That higher level and quaternary services be provided in a relatively few number of locations.
4. That much can be gained by increasing the greater implementation of networked service arrangements across greater metropolitan Sydney (and into the rural area) with considerable potential to improve clinical outcomes, achieve better value for money, and enhance training.
5. That there needs to be greater equity in the distribution of services.
6. That there be improved organisation through networking of selected specialty services.
7. That a population health and evidence based approach to health service delivery be adopted.
8. That the concept of networking be better defined and implemented across the health system.
9. That considerable work on the establishment and refinement of a variety of data sets be undertaken.
10. That a working group of clinicians, managers and departmental officers develop definitions of statewide services and funding arrangements.
11. That focussed and carefully planned budget holding, based on the GMSIG specific recommendations be a fundamental building block for the achievement of the changes outlined in the Metropolitan Health Services Plan.
12. That flows of patients be reversed (whenever possible) from the current "providing" AHS to the area in which a patient resides.

LIVER TRANSPLANTATION

1. That the Liver Transplant Unit at Royal Prince Alfred Hospital continue to be the sole adult Unit in New South Wales, whilst The Children's Hospital at Westmead continue to provide a paediatric service.
2. That the situation be reviewed in three years with particular reference to the issue of organ donation rates.
3. That should another unit become necessary in the future, both Westmead and St George Hospitals be considered for such expansion.

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4. That a Living Related Liver Transplantation Unit not be established at this point in time. However, this decision should be reviewed in the future on advice from the Transplant Society of Australia and New Zealand.
5. That the ANLTU continue to refine its costing data and that the Unit continue to be centrally funded.

HEART AND LUNG TRANSPLANTATION

1. That St Vincent's Hospital remain the Heart and Lung Transplant Centre for New South Wales.
2. That a review be held in three years to determine whether an additional unit is warranted.
3. That no paediatric Heart and Lung Transplant Unit be established in New South Wales.
4. That emerging technologies be subject to health technology assessment prior to acceptance as treatment modalities.
5. That appropriate staffing levels for key positions be determined and maintained and that adequate training and education be provided to maintain levels of expertise.
6. That a detailed cost study be undertaken and that adequate funding be provided and allocated directly from the NSW Health Department.
7. That a monitoring and evaluation process be established.

PANCREAS TRANSPLANTATION

1. That the NPTU at Westmead Hospital continue to be the sole pancreas transplantation unit in NSW.
2. That the NPTU continue to be centrally funded by the NFC program. Should NFC funding cease, alternative arrangements will need to be established which continue to fund the Unit separately from the Area Health budget.
3. That the NFC Review, to be conducted in conjunction with the NSW Department of Health, incorporate consideration for the development of islet cell transplantation.

SEVERE BURNS SERVICES

1. That a single New South Wales Burns Service be established with units located at Concord, Royal North Shore and The Children's Hospital at Westmead.

SUMMARY OF RECOMMENDATIONS

2. That the management structures, planned facilities and range of joint activities be as outlined in the Burns Services Report.
3. That the Service be reviewed in three years.

SPINAL CORD INJURY

- 1) That a statewide spinal cord injury service be formed.
- 2) That the existing adult and paediatric units be maintained but become part of the statewide service. All appropriate staff would be cross-accredited and the statewide service would review the configuration of the current service based on data to be collected under a uniform system.
- 3) That the Directorate be responsible for:
 - a) the coordination of services in their existing units, including the paediatric units
 - b) the development of a uniform data collection system which would be used for the assessment of clinical outcomes, funding requirements and research
 - c) the development of transitional care and outreach programs
 - d) liaison with Area Health Services, Mental Health, the Department of Housing, MAA, Paraquad, Australian Quadriplegic Association, Spinal Care Foundation and other community support groups
 - e) coordination of the research effort
 - f) coordination of staff training
 - g) the development of uniform protocols
 - h) coordination of the development of prevention programs
 - i) budgetary matters.
- 4) That a Director be appointed who would provide both clinical and management leadership with a tenure of 5 years initially.
- 5) That the Director would have a conjoint appointment with The NSW Department of Health and the Universities of Sydney and New South Wales. The location of the directorate, method of funding and line of reporting, to be subject to further discussion.
- 6) That the Director be expected to give firm recommendations on the future configuration of the statewide spinal cord injury service for NSW including paediatric services in the next three to five years.

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OPHTHALMOLOGY SERVICES

1. That a Statewide Ophthalmology Service (SOS) be established. This service would have a Director (Clinician Manager) who would be accountable to the CEO of either South Western Sydney Area Health Service or Western Sydney Area Health Service. The function of the SOS would be to ensure that the population of New South Wales had excellent access to cataract and simple ophthalmology services, consultative services at major teaching hospitals, and equitable access to complex eye surgery when necessary.

The Director would be assisted by an Advisory Committee who would comprise ophthalmologists from both the public and private sectors as well as the metropolitan and rural areas, nurses with ophthalmology training and experience, consumers and one or two trainees.

It is further recommended that an outside contracted Consultant be appointed immediately to prepare an Eye Health Plan for New South Wales.

This plan would set benchmarks for service provision, develop standards, protocols and outcome measures. It would also be responsible for data collection and provide advice and guidance in relation to models of service delivery. The SOS would have responsibility for implementing the plan. The development of eye services at an Area level would continue to be the responsibility of Area Health Services which would develop their services in the context of the State Eye Health Plan. The SOS would also advise on prevention, public health and postgraduate training.

2. Currently tertiary care eye services, are largely centred within the South East Sydney Area Health Service. A transition period, which could see a more equitable distribution of these services develop in the metropolitan area, would embrace many of the principles put forward in the NSW Health Council Report. Formalised networks to facilitate the establishment of new services or the strengthening of existing services could be used for the advantage of patients requiring ophthalmological services.

It is important to develop a full range of eye services at Westmead Hospital and a networking arrangement between Sydney Eye Hospital and Westmead could best facilitate this development. Both Hospitals are academically linked to the University of Sydney. Similar arrangements could see the eye service at Prince of Wales Hospital helping to develop a greater range of secondary and tertiary services at Liverpool Hospital. Both of these Hospitals

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are academically associated with the University of New South Wales. A three year timetable could be developed to achieve these ends.

In both of the networking arrangements, cross-appointment of ophthalmologists could allow some patients necessarily referred to either Sydney Eye Hospital or Prince of Wales to be treated by an ophthalmic surgeon attached to either of the Hospitals in the strengthening program.

Undergraduate training should be delivered by the University of Sydney at Sydney Eye and Westmead Hospitals, by the University of NSW at Prince of Wales and Liverpool Hospitals, and by the University of Newcastle at John Hunter Hospital.

The SOS would work with partnering Hospitals to facilitate the further development of cataract services to Western and South Western Sydney particularly at Westmead and Liverpool Hospitals.

3. Given that Sydney Eye Hospital currently treats 50% of tertiary patients in New South Wales, it would be essential that it form a key component of the SOS.
4. That Prince of Wales Hospital continue to be recognised as a centre of excellence for ophthalmology services. Its outstanding training program is acknowledged, and its existing service levels should be maintained.
5. That there be one teaching program for postgraduate education, which would be delivered at a number of different sites.
6. That the SOS be required to present a statewide plan for cataract services as a matter of urgency. This plan would encompass the need for greater public patient access to cataract services close to where people live, possible rationalisation of services, and models of service delivery for the provision of cataract services.
7. That the SOS provide urgent advice on the further development of cataract services to greater Western Sydney, particularly at Liverpool and Westmead Hospitals.
8. That an ophthalmology committee be available at each teaching referral hospital. The need to build up services particularly in the West and South-West (especially at Liverpool) is a clear imperative.

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CARDIAC SERVICES

1. That all Area Health Services employ appropriate numbers of well-trained clinicians to provide cardiac services. Inherent in this recommendation is the need to also provide appropriate support services eg. rehabilitation, geriatrics, ICU beds, screening facilities for cardiac catheterisation, etc. Clinicians consulted in this process wish to express their support for initiatives taken in the ambulant management of cardiac failure and secondary preventative services. Areas of special need include Illawarra, Central Coast and Wentworth, all of which have populations of over 300,000 and high projected growth rates, but have limited public hospital access to angiography and no public cardiac surgical services.
2. That paediatric and quaternary services not change over the next three years, but at that time, possible need for a second cardiac transplant facility be considered, perhaps in conjunction with a paediatric facility.
3. That electro-physiological adult congenital heart surgery be based at Westmead Hospital because of its close proximity and shared staff with The Children's Hospital at Westmead.
4. That interventional angiography services provided at Concord Hospital continue. Additional interventional angiography services should be established at Nepean, Gosford, Wollongong and perhaps Bankstown. Establishment of a facility at Campbelltown should be included in forward planning by South Western Sydney Area Health Service in accordance with the Australian Health Ministers Advisory Council (1995) recommendations. A minimum of 900 cases per annum (inc.150 angioplasty) and 75 cases/individual should be maintained.
5. That acute cardiac emergencies be managed by a physician with a declared cardiology interest, especially in view of the increasing use of new drugs and interventions.
6. That networking arrangements be expanded and include acute cardiac and surgical services. A system of incentives for effective networking should be considered and perhaps quarantined funding could be considered for the establishment of satellite services. Networking with adjacent private facilities should also be encouraged especially as it provides joint experience, may assist with shared equipment and may provide surgical backup for stand-alone angiography facilities. The arrangement between Royal Prince Alfred Hospital and Liverpool Hospital was acknowledged as being well developed. The development of the network arrangement between Westmead and Nepean was to be advanced and more effort be made to develop a similar

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arrangement between Gosford and Royal North Shore Hospitals. Negotiations between Wollongong and either St George or Prince of Wales Hospital should be given added thrust as there appears a major need to service the population of the Illawarra (population 340,000) with improved services. Consideration should be given by South Eastern Area Health Service to developing an interventional angiography unit and perhaps satellite surgical facility at Wollongong along the lines of the successful model set up between Royal Prince Alfred Hospital and Liverpool Hospitals or provide specific beds/access for patients from the Illawarra Area Health Service. If the former option is adopted it is essential that access to emergency cardiac surgical facilities be provided at a specific South Eastern Area Health Service hospital. This recommendation is supported by the slightly greater growth rate of the population in Illawarra as compared with South Eastern Sydney (0.66% cf 0.88% annual growth).

7. That Area Health Services also investigate the development of formal links to rural areas.
8. That electro-physiological studies be available in every Area Health Service .
9. That the development of a statewide database be considered essential. If evidence subsequently demonstrates distinct advantage for emergency intervention in acute myocardial ischaemia planning of facilities including ambulance, nursing care, ICU beds will be impossible without accurate data collected prospectively.
10. That South Eastern Sydney Area Health Service establish a single cardiac surgical service for their population of 750,000.

BRAIN INJURY REHABILITATION

- 1 That NSW BIRP units maintain their role of meeting the behavioural, cognitive and psychosocial needs of people with TBI.
- 2 That a regional brain injury rehabilitation service have reasonable access to all of the following components:
 - specialised medical inpatient care
 - community rehabilitation programs
 - transitional living programs
 - services dedicated for children and adolescents

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- community development approach with family and carer support
- quality improvement programs
- education program, research and professional development
- appropriate data collection.

3. Inpatient BIRP Units

- That BIRP inpatient bed capacity of 52 beds throughout the NSW hospital system, be maintained, including dedicated BIRP beds for brain injury rehabilitation up to 2005
- the current number of adult inpatient BIRP Units should be maintained
- the number of BIRP inpatient beds required should be reviewed by 2005/2006 as part of revision of the BIRP Strategic Service Plan.

4. Non-TBI

That selected individuals with non-TBI be treated by BIRP Units. These admissions should be subject to the availability of resources and lack of alternative appropriate services, where these individuals' rehabilitation needs are consistent with the expertise offered by BIRP staff.

At the discretion of unit Directors, those individuals with non-TBI should generally be drawn from age range 15 to 35 years and with conditions resulting from cerebral haemorrhage, anoxia and post infection brain injury.

5. Networking

That tighter linking through preferred referral networks between metropolitan and rural units be required to ensure rural and city residents are provided with good access and best practice services.

Guidelines for operation of designated referral patterns should be formally considered and adopted by BIRP Directors and Area Health Services.

6. Paediatric Services

That the two paediatric TBI services be continued. A paediatric brain injury services coordinator should be appointed in all Brain Injury Rehabilitation Programs.

The NSW BIRP should adopt a best practice model of rehabilitation of children and adolescents

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who have sustained ABI across all NSW units. This model should be developed and implemented by the BIRP Directors.

Representatives of the Commonwealth Rehabilitation Service and other job network providers and BIRP Unit Directors should develop a close network and work towards meeting the needs of longer-term BIRP clients. Attention should also be paid to transitional support for young people leaving paediatric rehabilitation.

7. Data Collection and Research

That BIRP Unit Directors, in conjunction with the NSW Department of Health, develop a comprehensive data strategy for BIRP. The BIRP Unit Directors should appoint a chair from within their group to lead this process, perhaps on a rotating basis. Consideration should be given to funding a data coordinating support person managed through one of the BIRP Units with responsibility for supporting this service.

The NSW Department of Health implements a minimum data set commencing financial year 2000/2001.

The UAR and hospital costs data collection will be used in future years to collect financial data on the costs of BIRP units.

8. Other Recommendations

That a working party be convened to assess and cost options for the provision of specialist services for clients with challenging behaviours and make recommendations to the NSW Department of Health. Adult and adolescent problem clients should be targeted and there should be a link to adult and child/adolescent psychiatry.

Multiple representations were made to the chair about the plight of the non-TBI young patient. This is particularly a problem once the patient is in the community where there can be difficulty accessing services provided by the health system for these vulnerable and usually non-compensational patients. It is recommended that a group be urgently convened to advise further on the specific needs of this group of patients.

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BONE MARROW TRANSPLANTATION

1. Establishment of a Central Laboratory

That a central laboratory be established in NSW for the purpose of ex-vivo manipulation of blood products and data management. This is considered necessary because of the increasing complexity of technology, legislative requirements and data management required in bone marrow transplantation.

It is recommended that this type of laboratory be run by an independent organisation such as the Australian Red Cross Blood Bank. The laboratory should be equally accessible to all tertiary haematological units.

To facilitate the establishment of the central laboratory it is recommended that a working party be formed with representation from:

- NSW haematologists (adult and paediatric allografting and non-allografting units)
- a haematologist from outside NSW
- Australian Red Cross Blood Bank
- Australian Bone Marrow Donor Registry
- Therapeutic Goods Administration
- NSW Department of Health.

The Working Party should advise on:

- location of the Central Laboratory
- governance and management
- funding
- logistics for the provision of service.

2. Standardisation of patient selection protocols

That standard patient selection protocols be adopted across NSW that allow equal and uniform access to blood and bone marrow transplantation. Patient data should be collected as part of mandatory reporting to the Australian Bone Marrow Transplant Recipient Registry (see 11 below).

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3. Autologous bone marrow transplantation

That autologous bone marrow transplantation be considered an integral component of the treatment of acute leukaemia and be provided by all tertiary haematology units. These services are currently provided at all major sites except Nepean, Wollongong, Concord and Gosford Hospitals. Autologous transplantation at these sites is unlikely to incur significant additional costs if supported by a central laboratory facility.

4. Related allogeneic bone marrow transplantation

- That related allogeneic blood and bone marrow transplantation only be undertaken in units consistently performing at least 10 allogeneic grafts per year. Units performing less than 10 allogeneic grafts per year should not be reaccredited to undertake these procedures. Accreditation could be undertaken by the Australian Bone Marrow Transplant Recipient Registry or the Australian Bone Marrow Donor Registry. Services would be concentrated at Westmead and St Vincent's Hospitals with meaningful cross-appointments from present units.
- That cross-appointment of staff and sharing of clinical duties should occur in Area Health Services with more than one major haematology unit.

5. Matched unrelated donor allogeneic and non-HLA identical transplants

That matched unrelated blood and bone marrow transplantation (including cord blood transplantation) and related allogeneic transplants with a less than 6/6 HLA match be undertaken only in units accredited by the Australian Bone Marrow Donor Registry to undertake these procedures. Because of the agreed difficulty in managing these patients, a maximum of 2 adult units (Westmead and St Vincent's) in NSW should undertake these forms of blood and bone marrow transplantation.

6. Novel procedures in blood and bone marrow transplantation

That novel procedures in blood and bone marrow transplantation (eg 'mini-transplants') be undertaken only as research activities in units accredited for allogeneic bone marrow transplantation and with appropriate institutional ethical approval. Such activity should be publicised to all haematology units in NSW.

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7. Research protocols in blood and bone marrow transplantation

That collaborative national and international research protocols only be undertaken with appropriate institutional ethical approval.

8. Cord blood banking and transplant

That a single cord-blood banking facility be available in NSW providing equal access to patients from all haematology units. Cord blood transplantation should occur only in units accredited for matched unrelated donor transplantation.

9. Establishment of additional clinical services

That the establishment of any new allogeneic bone marrow transplant services in NSW only be considered after the establishment of the central laboratory service. It should only be considered if it can be demonstrated that current case-loads warrant an additional unit. Any new unit should be established with initial staffing support from an established unit for up to 2 years.

10. Registrar and nursing training

That registrar and nursing staff be rotated between hospitals which have mutually agreed to provide a balance in general haematology (laboratory and clinical) and bone marrow transplantation.

11. Collaborative data collection

That all units must provide data to the relevant national blood and bone marrow transplant databases on a collaborative basis.

NEUROSCIENCES

Neurosurgery

1. That there be **four integrated services** as follows.

Southern - Prince of Wales, St Vincent's, St George and the Illawarra Hospitals

Northern - Royal North Shore, Gosford and John Hunter Hospitals

Central – RPAH and Concord Hospitals

Western - Westmead, Nepean and Liverpool Hospitals

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These service groupings would be revised in two years time and serve as networks as outlined earlier.

2. That super-specialised neurosurgery, such as epilepsy, interventional, functional and radiosurgery be concentrated in one or two units within greater metropolitan Sydney.
3. That levels of staffing including medical, nursing and paramedical staff be reviewed, with a view to addressing the issues of recruitment, training and retention.
4. That an MRI scanner with 24 hr access for public patients be required for greater metropolitan Neurosurgical Units; that any hospital that accepts a patient with neurosurgical trauma have access to a CT scanner, again on a 24 hr basis.
5. That Heads of Department of Neurosurgery meet on a regular basis to review changing patterns of service provision, plan for the future and develop quality and outcome measures for Neurosurgery.

Neurology

1. That there be four integrated services with the same boundaries and networking arrangements as for neurosurgery. The grouping of services should be revised in two years time.

Southern - Prince of Wales, St Vincent's, St George and Illawarra Hospitals

Northern - Royal North Shore, Gosford and John Hunter Hospitals

Central - Royal Prince Alfred and Concord Hospitals

Western - Westmead, Nepean and Liverpool Hospitals

Each of the above four integrated services should have at least one major stroke unit.

2. That **Major Stroke Units** require:
 - a full-time neurologist director, or director recognised to have the appropriate experience and training, plus administrative support
 - a minimum of 4 associated full-time neurologists (to enable 24 hr on-call service)
 - dedicated nursing unit
 - dedicated monitored high dependency beds and dedicated intermediate beds
 - an associated neurosurgical unit

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- neuroradiology services for interventional neuroradiology (minimum of 4 interventional radiologists to enable 24 hour on-call service)
 - CT, Angiography and MRI services on a 24 hr basis
 - associated Geriatric and Rehabilitation Services
 - neuropathological services (not necessarily co-located)
 - allied health services (social work, physiotherapy and occupational therapy)
 - associated outreach services (community support)
 - a catchment population of greater than one million.
3. That all Stroke units require:
- a neurologist director or director recognised to have the appropriate experience and training
 - a minimum of 4 associated neurologists or general physicians for 24 hour on-call service
 - 24 hour CT capability
 - dedicated beds and associated nursing unit
 - allied health services
 - associated aged care, rehabilitation and outreach services
 - an associated major stroke unit
 - a catchment population of greater than 250,000.
4. That patients in the younger age group (less than 45 yrs) suffering stroke be cared for, where possible, in major stroke units.
5. That the Royal Australasian College of Physicians be requested to review the rotation of advanced trainees in Neurology and ensure placement at the peripheral centres of Gosford, Wollongong, Nepean and Liverpool.
6. That dedicated nursing and allied health staff be an essential component of neurological services and that recruitment, training and retention of these staff be reviewed.
7. That comprehensive epilepsy services be limited to Westmead, The Children's Hospital at Westmead, RPAH, and POW and The Sydney Children's Hospital.

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RENAL SERVICES

Dialysis

1. That the guidelines for the appropriateness of dialysis, drawn up by the Australian Kidney Foundation and approved by the NH&MRC be followed.
2. That provision for a global increase in the number of people requiring dialysis of 7% per annum be adopted.
3. That home dialysis be the preferred option for adults. However for children and for specific indications, the provision of adequate peritoneal dialysis be available for utilisation in the appropriate clinical setting. Any plan for global dialysis services must look at a relative increase in the number of satellite positions available.
4. That whilst there are adequate numbers of machines for home dialysis, haemodialysis and peritoneal dialysis at the present time, a continual process of upgrading and renewal must be followed. It is also recommended that there be an increased number of hospital and satellite machines provided.
5. That a centre for renal dialysis be resourced for Nepean Hospital
6. The working party seeks to have input into any proposal which deals with the funding of renal dialysis, and which may arise out of the current consultancy.

Transplantation

1. That the guidelines for the selection for transplantation as formulated by the Australian Kidney Foundation and currently being assessed by the NH&MRC form the basis for selection of patients to receive transplantation.
2. That all efforts to increase cadaveric donations be supported and consideration given to the appointment of funded directorships at each major teaching hospital.
3. That laparoscopic surgical services for renal transplantation be properly accredited and with adequate training in laparoscopic techniques evidenced.
4. That transplant services be consolidated at Westmead, Prince of Wales, Royal Prince Alfred and John Hunter Hospitals, and The Children's Hospital at Westmead, and that clinicians from Royal North Shore, St George and St Vincent's Hospitals be offered full appointments to these services.

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5. That in the event that levels of renal transplantation in New South Wales approach 220 per year, Liverpool Hospital be considered as the next centre for transplantation, if another centre is required.
6. That a model be developed for return of patients in the immediate post-transplant period to their referring renal treatment units, either in the metropolitan or country areas.
7. That Registrar training involve a rotational program with all trainees passing through large units doing renal transplantation as well as structured pathways through those units not undertaking renal transplantation.
8. That all transplant units be required by the NSW Department of Health to report statistical outcomes to the levels required to the ANZDATA collection base.

RADIOLOGY

1. That benchmarking be utilised to ensure that District and Tertiary Hospital staffing levels are appropriately adjusted with the changing activity
2. That the tertiary referral hospital Radiological Director be designated at least 0.2 FTE for administration, with an extra 0.3 FTE for those appointed Area Directors. There should be recognised time for teaching, research, and quality assurance activities, for all teaching staff radiologists
3. That MRI Scanners be available 24 hours for public access at all tertiary referral hospitals
4. That there is a need to explore public/private work arrangements which would allow improved financial incentives whilst retaining excellent people in the public system. Appropriate career structures need to be developed as well.
5. That a statewide strategy for digital imaging and PACS would appear essential both between the metropolitan areas and with country links. Many areas will require supplementary funding to allow the movement toward PACS.
6. That the increasingly computerised nature of Radiology Departments with the various RIS, PACS, and other computing needs mandates the need for Systems Administrators located within Radiology Departments, supernumerary to existing staff.

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MATERNITY

1. That the recommendations of “The NSW Framework for Maternity Services” be implemented as a priority.
2. That the distribution of, and allocation of resources to Level 6 Maternity units be reviewed and adjusted according to the changing demographic of maternity services in the Sydney Metropolitan Area.
3. That the issue of recommended standards of maternity services in Metropolitan Suburban hospitals be reviewed by another body, ie: Maternity Services Review Committee.
4. That the recommended standards of maternity services and resources, as outlined above, be implemented.
5. That Metropolitan Suburban Hospitals and Community based or outreach style maternity services be networked on a formal basis with Area Health Service Maternity operations. Clear lines of responsibility, authority and role delineation be established across the maternity services overall. The networks should have the aim of enhancing a collaborative, integrated model of maternity care which offers continuity of care and clear protocols for risk assessment, appropriate patient referral or transfers, equitable resourcing of Suburban Metropolitan maternity services and community services and a skills maintenance program.

GYNAECOLOGICAL ONCOLOGY

1. That there be four networked **Gynaecological Oncology Services for NSW**, centred around:
 - **John Hunter** and Gosford Hospitals (Central Coast and Hunter)
 - **Royal Hospital for Women** and St George Hospital (South East Sydney and Illawarra)
 - **Westmead**, Royal North Shore, Nepean Hospitals (Northern, Western, Wentworth)
 - **King George V** and Liverpool Hospitals (Central and South Western)

Each service would establish a coordinating committee which would be chaired by a clinician. The chair would rotate every 12 months. Each service would strive to centralise specialised gynaecological oncology surgery at the first named hospital within each Service.

2. That the gynaecological oncologists undertake a review of the delineation of place of care for

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specific rarer tumours, e.g. vulva, vagina, and of the more complex procedures, e.g. evisceration associated with ovarian cancer. This review should also detail those cancers which would not routinely be managed by general gynaecologists. The results of this review should be in place by January 2002.

3. That there be formal discussion with the Rural Health Implementation Group to move towards specific linkages with gynaecological oncology centres and rural gynaecology units.
4. That there be urgent implementation of a statewide data system for gynaecological cancer cases, their management and outcomes.
5. That there be a review of the models of care provided by each Service in 2005. By this time relevant outcome data should be available. In addition, trends in population growth and disease incidence will become clearer.
6. That enhancements for the statewide Gynaecological Oncology Services be required with priorities for:
 - funding of the data collection
 - expansion of the Hunter/Central Coast service with an additional gynaecological oncologist, with appropriate infrastructure, e.g. psychologist, specialist nursing staff
 - funding of operating and/or outpatient sessions in a number of the current hospitals that provide gynaecological oncology services to ensure that cross appointments within each Gynaecological Oncological Service are achieved.

TRAUMA SERVICES

GMSIG discussed trauma systems formally on 1 December 2000 and again in detail on 2 February 2001 and made the following recommendations:

1. That there be six adult major trauma networks covering New South Wales, each with their own hub and director. That there be five major adult trauma hubs in Metropolitan Sydney and one in Newcastle.
2. That St. George, Liverpool, Westmead, John Hunter and Royal North Shore Hospitals be immediately identified as major adult trauma hubs in Sydney for the foreseeable future.

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3. That an additional hub be identified to serve the centre of Sydney and that this be Royal Prince Alfred Hospital, noting that existing services at St Vincent's and Royal Prince Alfred Hospitals remain until construction of all new capital works are completed, which is estimated to be approximately two years.
4. That Prince of Wales Hospital be recognised as a centre of excellence for acute spinal injury.
5. That Nepean Hospital remain a regional trauma centre and form part of the broader Western Sydney Trauma Service.
6. That the Paediatric Major Trauma Service configuration for New South Wales be the Children's Hospital at Westmead, Sydney Children's Hospital and John Hunter Children's Hospital.
7. That a virtual New South Wales Trauma Institute be established with broad responsibilities for the oversight of trauma teaching, research, outcomes-based data collection and analysis and establishment of 'best practice' protocols. That a working party be established, consisting of members of TSAC, and other relevant committees formed by NSW Department of Health, academic trauma surgeons, Retrieval and Transport representatives, intensivists, emergency physicians and specialist nurses, to develop a proposal over a 3-month timeframe for a virtual NSW Trauma Institute.

DISTRICT HOSPITALS

1. That the use of the term "District Hospital" be discontinued and replaced by the terms Metropolitan General Hospital, Specialty Hospital, Growth Area Hospital and Community Hospital.
2. **Metropolitan General Hospitals** would serve a defined population of between 200,000 – 250,000 people and should provide a reasonably extensive range of services including stroke, cardiac services, maternity, ED and ICU. These hospitals would be networked to major referral hospitals. Current examples of these Metropolitan General Hospitals include Canterbury, Blacktown and Sutherland Hospitals.
3. **Specialty Hospitals** have an important role within the Health System. For example, they would provide clean elective surgery, some maternity, general medicine and other services at a high level. Access to these Hospitals should be by booked admission or by an acute access clinic on site and they would need to be "hard wire" linked to other larger hospitals so that

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access for their patients to more sophisticated or higher-tech services occurs automatically. The status of these hospitals in providing elective surgical services should be acknowledged and they should be permitted to pursue "centre of excellence" status e.g. in joint replacement or other forms of elective surgery.

4. **Growth Area Hospitals**, that is, specific hospitals in growth Areas, will require special treatment, for example Wyong and Campbelltown. Provision of equipment and services, for example spiral CT scanning is needed for these hospitals so that as the populations expand rapidly, they are able to provide an appropriate range of services such as those provided at Metropolitan General Hospitals.
5. **Community Hospitals** are smaller hospitals without the population base to support their role as a Metropolitan General Hospital or Metropolitan Specialty Hospital. These hospitals provide such services as a polyclinic and possibly geriatric assessment, treatment and rehabilitation services.
6. **Special Cases**, such as Hawkesbury, Blue Mountains and Shoalhaven present challenges because of their relative geographic isolation and the need to provide access to services to their local communities. A strong network needs to be developed for these hospitals and novel strategies explored to ensure safety and efficient service delivery.
7. That Area Health Services consult with their District Hospitals and communities with a view to defining the roles of these hospitals into one of the categories listed above and make the necessary arrangements to ensure that the hospitals are able to fulfil their new role and function. It is recommended that Area CEO's relate to the Greater Metropolitan Services Implementation Group in late 2001 in relation to their plans for District Hospitals.
8. That where there is alteration to the role of the hospital, it is essential that staff have guaranteed access to other facilities through networking with major, adjacent, metropolitan hospitals in order that they can maintain their clinical interests and skills. Teaching and research should also continue at all levels of hospitals.
9. That the delineation of hospitals be reviewed within five years.

IMPLEMENTATION

10. That a subcommittee composed of at least some GMSIG members and the Chairman of GMSIGs subcommittee on "District Hospitals" be established to receive reports from Areas, advise and report to the Clinical Council on progress in implementing the major recommendations.

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METROPOLITAN/RURAL NETWORKING

1. That formally recognised clinical networks be established by each rural Area with greater metropolitan hospitals in New South Wales. For regions near New South Wales borders, services provided most conveniently from adjacent States or Territories should be included.
2. That the Rural Area Clinical Councils advise the Area Health Service of the appropriate arrangement for each network.
3. That the networks described above not override existing informal networks but be a “non-exclusive default” system.
4. That a regional network involve a number of individual metropolitan centres, as one centre may not necessarily provide the full range of services but rather act as a “centre of excellence” for certain treatments. A mechanism for on-going re-negotiation of the network arrangements will be required to help ensure that treatment advances were made available to rural residents as and where they became available.
5. That the networks be backed up by training and staffing arrangements which build upon and contribute to local rural capacity and infrastructure. These arrangements should include rural rotations at consultant level and College training programs should allow accreditation of country training for senior trainees where the necessary networks and supervision are in place.
6. That there be more widespread standardisation across NSW of clinical practice protocols for the admission of patients to metropolitan centres and for their subsequent discharge to rural communities. There needs to be standards for the provision by city hospitals of information, accommodation and other supports for rural patients referred to the city, and standards for rural basic support services for patients returning from metropolitan hospitals after major surgery, so that effective rehabilitation is certain regardless of region of residence.
7. That outreach services be set up using the following principles
 - they should be planned in conjunction with the relevant Rural Clinical Council
 - they should build upon and contribute to the local capacity and infrastructure
 - they should be organised from the regional centre with close links to outer communities
 - there should be continuity of service provider.

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EMERGENCY DEPARTMENT SERVICES

1 PLANNING PARAMETERS

That metropolitan services be planned using the following parameters and that the parameters be used collectively, not in isolation:

- throughput: 20,000 ED cases per yr (minimum)
- travelling distance/time: 20kms/30mins by private car (maximum)
- population base: 1:200,000 (min)
- equity factors (including transport, social factors, geography)

2 NETWORK MODEL

- That all existing Area Health Service emergency department (ED) services be configured in a hub-and-spoke network model that works to provide a minimum standard of care in every ED within the network.
 - That there be one designated hub in each Area Health Service.
 - That an Area Director of Emergency Department Services be appointed to facilitate the co-ordination and management of ED services in the Area Health Service.
 - That the role of the Area hub site and the Area Director be that of oversight, coordination and communication rather than direct line-management – the new structure should not cut across local departmental ED management, but work with it.
 - That there be regular communication between the various NSW Area Directors of Emergency Department Services. It is recommended that, as a minimum, a statewide forum be held 3 monthly.
 - That whilst the hub site hospital may have a concentration of some critical care and super-specialty services, it is not intended that all severely ill patients be transferred to the centre. While the spoke site hospitals may sub-specialise in providing certain inpatient services for the network, each ED should retain an appropriate profile and resources to appropriately manage all patients presenting there.
 - That Area wide and cross-Area appointments and rotations of staff be considered and encouraged.

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- That rural areas be linked with a metropolitan site based on the default critical care networks (though they may maintain existing links outside this framework if they are efficient and effective).
- That a communication strategy be developed to inform the community of the ED network function and why patient transfer may occur following stabilisation.
- That there be a mechanism to allow a statewide overview of the AHS emergency network performance.

3 ED RESOURCES

- That Emergency Departments be resourced with a minimum standard of staffing, operational structure and back-up services in conformity with the ACEM role delineation document
- That all Areas examine their current ED nursing roles and responsibilities and seek appropriate opportunities to implement advanced nursing practice and the nurse practitioner role. All level 5 and 6 EDs should have direct access to both a Clinical Nurse Consultant (CNC) and Clinical Nurse Educator (CNE), and smaller departments should be networked with a centre employing CNCs and CNEs.
- That all level 4 and above EDs have direct access to a specialist emergency physician, and smaller departments be networked with a centre employing emergency physicians.
- That all level 4 and above emergency departments should have provision for point of care diagnostics and radiology.

4 COMMUNICATION

- That a web-based communication system be implemented in all networks including such items as notification of restricted access periods (LTOs) in the network, notification of patient transfers, clinical support, clinical review and educational support.
- That a webpage be developed outlining local community and other services available that can be accessed by both emergency department staff and General Practitioners.
- That a communication system be established between EDs and the ambulance service to allow ready communication of information about bed occupancy, incoming patients and clinical issues.

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5 EDUCATION

- That all clinicians working in emergency departments maintain their emergency medicine knowledge and skills through participation in the network educational activities as well as specialised courses.
- That an integrated education model for medical and nursing staff, and general practitioners be developed to deliver basic emergency and acute care education.

6 DATA COLLECTION

- That data collection be undertaken in all emergency departments. Smaller departments should utilise the minimum data set (Emergency Department Data Dictionary V3.0) and an information system applicable to the setting.
- That a complexity tool be developed to address workload and inform both nursing and medical staffing levels for quality patient care. The tool also needs to be suitable for use in a funding model.

7 SERVICE CONFIGURATION

- That all components of the Area emergency department network be linked under the overall coordination of the Area Director of Emergency Department Services.
- That “walk in” clinics for lower acuity patients be planned where this type of service is shown to be appropriate and cost-effective. Such clinics should be under the overall coordination of the Area Director of Emergency Department Services, and should have close linkage with the Area ED network.
- That where acute services with different roles exist, there be public education campaigns to inform consumers of the role, capacity and access of each service.

8 OPERATIONAL PRINCIPLES

- That EDs, hospitals and Areas examine their workpractices to ensure that they are appropriate and efficient in each service. Relevant principles for consideration include review of unnecessary tasks, re-thinking clinical roles, efficient employment of ancillary staff and effective use of communication technology.
- That networks facilitate rotation of both clinical and ancillary staff between sites.
- That strategies to improve bed access be addressed hospital-wide and implemented as a matter of urgency.

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INTENSIVE CARE SERVICES

1. That available data, based on projected population numbers, age profiles and current practice, indicate that the peak intensive care bed capacity required within the state will be:

in 2001 - 549 beds

in 2006 - 582 beds

in 2011 - 619 beds

2. That an integrated network of intensive care units based on the hub and spoke model be adopted on an Area/Rural Critical Care network basis
3. That rural areas be linked with a metropolitan site based on the default critical care networks.
4. That each Area Health Service or Rural Critical Care Network have an Area Director of Intensive Care. Some Area Health Services may need to consider funding this position up to 0.5 FTE
5. That each Area Health Service (AHS) be ultimately responsible for meeting the intensive care needs, superspecialty services withstanding, of the Area and agreed network services. This means that each AHS make an appropriate contribution to the state's intensive care bedstock.

The number of non superspecialty "out of Area" transfers and "no intensive care bed" transfers should be kept to a minimum. Such transfers should be considered a critical incident and reviewed by the Area Health Service and clinicians on a regular basis.

"No IC Bed" transfers out of Area should only occur after direct 'consultant to consultant' discussion.

Intra Area networking of hospital services be encouraged where appropriate.

6. That effective intensive care services be developed by concentrating units in major hospitals within each Area.

The optimal number of beds for a single unit depends on its role. A workable unit size is within the range of 12 to 15 beds. This allows for appropriate intensivist/nursing infrastructures at NSW Department of Health level 5/6 or FICANZCA Min Standards level 3.

7. That the utilisation of high dependency units (HDUs) become widespread. They should form part of the continuum of critical care rather than existing as separate HDUs which have

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evolved in a piecemeal fashion in some hospitals. HDUs should be rationalised and aligned with intensive care services. This encourages maximum flexibility and utilisation of such services without the extra step of another admission/discharge process to a separate HDU. This will alleviate exit block in busy times. This will also avoid the issue of variable occupancy in a number of smaller HDUs.

It may be more useful not to make the distinction between IC and HD beds and consider all beds as 'multipurpose'.

High dependency units should have appropriate information systems, clinical indicators and formal audit processes in place.

8. That Area Health Services be required to have a minimal increase in ICU beds by 2011, maintain the current Area bed stock, to ensure that service delivery can be maintained while other Areas increase the level of service provision. ie. there should be no decrease in ICU capacity.

Where increases in bed numbers are recommended, these increases should occur as a staged progression over the projection period.

9. That an Intensive Care Coordination and Monitoring Function is required at a statewide level.
10. That an improved data collection and verification process be implemented.