

METROPOLITAN HOSPITALS REPORT

SERVICE ENHANCEMENT AND NEW ROLES
FOR METROPOLITAN HOSPITALS

AUGUST 2002



greater metropolitan
transition taskforce

NSW HEALTH DEPARTMENT
73 Miller Street
NORTH SYDNEY NSW 2060
Tel. (02) 9391 9000
Fax. (02) 9391 9101
www.health.nsw.gov.au

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For further copies:
Better Health Centre
Locked Mail Bag 5003
Gladesville NSW 2111
Tel. (02) 9816 0452
Fax. (02) 9816 0492

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LETTER TO THE MINISTER

The Hon Craig Knowles
Minister for Health
Level 33
Governor Macquarie Tower
1 Farrer Place
SYDNEY NSW 2000

Dear Minister

On behalf of the Greater Metropolitan Transition Taskforce (GMT²) I have pleasure in forwarding to you our Report detailing our strategies for improving the services offered by Metropolitan Hospitals (District Hospitals) in the Greater Metropolitan Region.

The District Hospitals of Greater Metropolitan Sydney are a disparate group. Their size, level of service and their relationship to their Area Health Service and community vary. However, they serve as an important point of entry to the hospital system for a large number of patients.

There is a great challenge in re-defining the role of District Hospitals. On the one hand they need to provide a high quality, safe and effective health care service to their local community. On the other, they need a critical workload large enough to ensure maintenance of clinical standards of expert clinical staff in each site. In addition, a number of Metropolitan Hospitals should broaden their service to assist patients beyond their local area.

Members of the GMT² Executive visited each Metropolitan Hospital individually except for those in the Hunter Area Health Service where a single well attended meeting was held. At each visit we emphasised the aim of GMT² was to help clinicians work better together, and listened to the clinicians describe what they saw as the strengths and weaknesses of their hospital.

Many clinicians (medical, nursing and allied health staff) considered themselves to be working in an environment that was not linked to the overall hospital system. Many also voiced concerns regarding the attitude of the Principal Referral Hospitals. They had difficulty in referring patients to their Principal Referral Hospital and in comparison they thought they were under-resourced. These views were not universal, the exceptions were Sutherland and Canterbury. Morale and attitudes appeared often to correlate with the degree of clinical leadership, networking and Area coordination.

Across the Metropolitan Hospitals there was a lack of knowledge of initiatives by colleagues in hospitals in other Areas.

LETTER TO THE MINISTER

GMT² has followed the main principles promulgated by the NSW Health Council and the Greater Metropolitan Service's Implementation Group (GMSIG) Reports.

These were:

- quality of care and safety of patients
- equity of access to and outcome within the health system
- clinician-driven planning.

In preparing this Report, GMT² did not feel restricted by Area boundaries and was mindful of the need to:

- work together with hospital managers and Area Chief Executive Officers
- allow clinicians to drive and thus feel ownership of the process
- achieve a critical mass and viable team of clinicians.

GMT² has worked hard to dispel fears of hospital closure. Not only will Metropolitan Hospitals survive, but their services will be enhanced. Many will have a specialised and broader role to play in a networked service.

We want clinicians to feel that not only are they serving the needs of their local community but they are also working in a truly integrated hospital system.

All Principal Referral Hospitals have special services for patients living outside their district, as well as providing for the needs of the local community. In other words they also act as 'District Hospitals'.

Networking will promote cooperation and collegiality. In some disciplines this will be facilitated by the appointment of a new position, called Area Director. A few Areas have already started to move in this direction – GMT² expects to accelerate the development of Area Networking.

In some instances, it is rational and is better practice for clinical services to be integrated between two hospitals – 'one hospital on two sites'. However, the identity of each Metropolitan Hospital is precious for both its clinicians and the surrounding community, and must be preserved. It is crucial to the success of a better networked health system.

The establishment of 17 Stroke Units across the Greater Metropolitan Region networked to five Neurosurgical hubs will be a major advance in patient care. Six Stroke Units will be located in Metropolitan Hospitals.

LETTER TO THE MINISTER

Planned surgery can be safely and efficiently performed in Metropolitan Hospitals. Following the example at Auburn (where a trial of planned day surgery has just been successfully completed) many Metropolitan Hospitals will foster the development of planned surgery (including orthopaedics and subspecialty surgery) for patients often from beyond their immediate district.

There is also inequity in the distribution of Registrars. Some Metropolitan Hospitals have difficulty in attracting staff. This will be helped in the long term by the appointment of 'Clinical Leaders'. These clinicians will aid supervision of trainees, contribute to the clinical governance of a hospital and help in attracting young clinicians to the staff. This initiative will inevitably contribute to improving patient care.

Transport, particularly moving patients quickly from one hospital to another, is a major and universal problem. Dedicated patient transport between hospitals in the priority areas we have recommended is a start to addressing this.

Workforce problems appear to be increasing. Many Metropolitan Hospitals have as 'on-site' medical workers a significant proportion of which are temporary overseas doctors and agency nurses. We were surprised to find that both doctors and nurses were very concerned about the inadequate numbers of allied health personnel and their workload. Our Report also addresses this issue.

Central to the concept of an overarching integrated hospital plan for the Greater Metropolitan Region is a change in the role of District Hospitals. This requires a change in the perception and the ethos of each hospital. Considerable work needs to be done to engender an attitudinal change in the perception of both clinicians and the community. This will enhance patient care and break down the isolation of Metropolitan Hospitals. The recommended renaming of District Hospitals to Metropolitan Hospitals is simply a symbol of this. Yet, it is essential that the identity of an individual hospital be maintained. To achieve this balance will be a major challenge and take some years of consistent and carefully monitored effort.

The GMT² process has allowed clinicians in the Metropolitan Hospitals to express their views. They will need to embrace and feel ownership of these changes for the concepts to be sustained over time. It will be an ongoing process over three years.

We stress that this Report and its recommendations are not about doing more with less. Nor is it about downgrading or closing hospitals. Indeed these changes will cost more and we acknowledge the government has already put funds aside to support these initiatives.

It is clear to us that District Hospitals cannot and should not work in isolation from each other. Historically this approach has led to hospitals competing for resources.

LETTER TO THE MINISTER

After extensive consultation we are recommending that District Hospitals should operate as a network. That will lead to a better and greater variety of services available to the community. It will also enable the creation of Special Units in many disciplines and it will mean a better standard of patient care.

I would like to thank you, Minister, for suggesting this process and for your encouragement and support.

Members of the GMT² executive and the full GMT committee gave up many hours to the process, particularly Patrick Cregan, who not only master-minded a great deal of the concepts but personally visited many hospitals.

The Secretariat of GMT² Lyn Lee, Mark Britt, David Peters and Paul Tridgell provided excellent support. The Chairs of the Medical Staff Councils facilitated this review, and both the Area Chief Executive Officers and Executive Directors of individual hospitals were always cooperative and supportive. The nine Area Chief Executive Officers played a major role.

I submit this Report to you and hope and trust that the new funding you have provided will kick start a change in the way Metropolitan Hospitals function within the Greater Metropolitan Region to provide an improved service for patients.

Yours sincerely



Professor Kerry Goulston

Chair

Greater Metropolitan Transition Taskforce (GMT²)

EXECUTIVE SUMMARY

1

- The *NSW Health Council Report*, released in March 2000¹, identified the need for metropolitan-wide planning of clinical services; this included the need to address the role and function of the District Hospitals within clinical networks.
- The need for increased engagement of clinicians in the planning and administration of health services was stressed by senior clinicians and endorsed by the *NSW Health Council Report*.
- In response, a clinician-led working group, the Greater Metropolitan Services Implementation Group (GMSIG), was established by the Minister. The *GMSIG Report* was released in June 2001², including detailed recommendations with respect to District Hospitals and was endorsed by the Government Response: Key Metropolitan Hospital Services³.
- A clinician-led taskforce, the Greater Metropolitan Transition Taskforce (GMT²), was established in November 2001 with the responsibility for implementation of the GMSIG recommendations.
- From March to May 2002, GMT² reviewed the District Hospitals of the nine Area Health Services comprising the Greater Metropolitan Region. This included extensive site visits and detailed consultation with over 500 clinicians (medical, nursing and allied health professionals in active clinical practice) and managers.
- The GMT² review focused on the ability of each District Hospital to provide its most appropriate role within the Area network.
- The GMSIG recommendation that District Hospitals be referred to as Metropolitan Hospitals was endorsed by GMT².
- The GMT² review revealed clear links between clinical leadership, morale and efficiency. Variation in the level of clinical leadership was noted. Clinicians at each hospital stressed the importance of enhanced resources for teaching and training of medical, nursing and allied health staff.
- Considerable variation was found with respect to coordination and network formation within the Area Health Services with impact on the function of Metropolitan Hospitals. The need to appoint Area Coordinators in selected key services was recognised.
- GMT² recommends clinical integration of departments at selected closely located Metropolitan Hospitals leading to a 'one hospital on two sites' approach. This clinical integration was mostly not in existence even where two hospitals have single administration. This aspect is relevant with respect to Blacktown/Mt Druitt, Camden/Campbelltown, Manly/Mona Vale, Ryde/Royal North Shore, Sydney/Prince of Wales, and Wyong/Gosford.

¹ *Report of the NSW Health Council*, NSW Health Department, 2000

² *Report of the Greater Metropolitan Services Implementation Group*, NSW Health Department, 2001

³ NSW Government Response: Key Metropolitan Hospital Services, NSW Health Department, 2001 (<http://www.health.nsw.gov>)

EXECUTIVE SUMMARY



- GMT² recommends clinical integration of departments at selected closely located Metropolitan Hospitals leading to a 'one hospital on two sites' approach. This clinical integration was mostly not in existence even where two hospitals have single administration. This aspect is relevant with respect to Blacktown/Mt Druitt, Camden/Campbelltown, Manly/Mona Vale, Ryde/Royal North Shore, Sydney/Prince of Wales, and Wyong/Gosford.
- GMT² recommended annual expense funding to Metropolitan Hospitals of some \$30.9 million (M) including patient transport (\$1.980M) and area networking (\$1.857M). The recurrent funding represents almost one half of the total enhancement allotted to GMT² initiatives across 19 service programs.
- GMT² recommended capital enhancements of over \$6M for service improvements. In addition, the NSW 2002/03 State Budget provided capital funding for:
 - Blue Mountains ANZAC Memorial (\$6M)
 - Hornsby/Ku-ring-gai (\$16.4M)
 - Shellharbour (\$5M).
- The allocation includes \$0.899M annually to enhance clinical leadership through part-time appointments at Belmont, Blacktown/Mt Druitt, Bulli, Fairfield, Hawkesbury, Hornsby, Maitland, Ryde, Sutherland, Shellharbour and Wyong Hospitals.
- Area coordination is to be enhanced by \$1.857M recurrent for appointment of Area Directors for cardiac services, emergency, intensive care, radiology and stroke services.
- In recognition of its special role, Auburn Hospital is to receive enhancement for the establishment of a Transcultural Health Centre with annual funding of \$0.288M.
- Planned surgery in selected fields is to be enhanced considerably in the Metropolitan Hospitals with \$9.441M annually. In addition to increased service provision, these funds are to be directed towards the establishment and/or enhancement of surgical networks across Area Health Services and, where appropriate, between Areas. This process is to be overseen by a surgical working party of GMT².
- In recognition of the pivotal role of Emergency Departments as a portal of entry to the health system, \$2.615M per annum has been allocated for the appointment of Area Directors of Emergency Services, additional staff at selected Metropolitan Hospitals and clinical integration of Emergency Departments at appropriate hospitals.
- Intensive Care Units are to receive \$0.870M annually for enhancement of Area coordination and specific services at several hospitals.
- The development of stroke services across the Greater Metropolitan Region is a major initiative of GMT². For their role in this network, the Metropolitan Hospitals will receive \$3.655M per annum for the development of Stroke Units and for clinical coordination and leadership.



EXECUTIVE SUMMARY

1

- Enhancement of services in medicine including geriatric medicine, palliative care, rehabilitation, general medicine, and paediatric services, will strengthen the ability of Metropolitan Hospitals to provide patient care as appropriate to its role; this is to receive \$4.882M annually.
- The correction of variability of services in radiology across Greater Metropolitan Sydney is to be funded to \$3.754M annually to ensure appropriate service and reporting and to facilitate Area Radiology Networks.
- Maternity services in Australia are undergoing a significant period of change. GMT² recommends clinical integration of maternity services to establish a single maternity service across two sites at several hospitals and enhancement of existing services. These initiatives are to receive \$0.708M annually.
- GMT² identified significant issues in the clinical workforce in medical, nursing and allied health professions. These included the need for enhanced staffing at many sites, for the acceleration of clinical cross-appointments within Area Health Services, the appointment of an Allied Health Adviser to the NSW Health Department.
- Patient transport issues were identified by the GMT² review as a significant priority. Enhancement funding has been allocated to \$1.980M annually.
- The importance of Metropolitan Hospitals to their surrounding community and the perceptions that drive this were identified as important by the GMT² review. It is recommended that community groups be established for each of the 18 Greater Metropolitan hospitals consisting of clinicians, managers and community representatives in equal numbers. The details of this aspect require further review and consideration.
- GMT² identified the need for an ongoing process to ensure sustainability of the initiatives contained within this Report GMT² coordinated a Metropolitan Hospitals Clinicians' Forum on 1 June 2002 with a second planned for 24 August 2002. It is envisaged that this forum will continue into the future.
- The initiatives above cannot be seen in isolation. They form one part of the commitment by clinicians to provide services across the entire population of the Greater Metropolitan Region, which are aimed at enhancing equity of access whilst promoting continual quality improvement. These goals cannot be achieved without enhancing the role of the Metropolitan Hospitals.

INTRODUCTION

2

BACKGROUND

In 1999 the Health Minister, Mr Craig Knowles, commissioned a major review of NSW Health Services. The *Report of the NSW Health Council* released in March 2000 recommended the creation of a Metropolitan Planning Taskforce to create a structure for rapid, collegiate decision-making. It identified a number of issues needing to be resolved for the whole of Sydney, including the:

- uneven distribution of services and flow of patients between Area Health Services
- preparation of clinical plans for the entire population of Sydney – both for speciality services, and for secondary services which reflected the required volume of patient activity and infrastructure needed to provide the highest quality of care
- role and function of District Hospitals, to ensure they provided relevant and complementary services to a broader network of hospitals.

Hence, one of the issues identified in the *NSW Health Council Report* was the need to address the role and function of District Hospitals. The GMSIG was then established by the Minister. The group set up a Working Party, convened by Dr Patrick Cregan, to examine the role of District Hospitals.

The *GMSIG Report* was released in June 2001 and its recommendations were accepted and are now government policy.

The GMT² established by the Minister in November 2001 was given responsibility for the implementation of the GMSIG recommendations, including recommendations for District Hospitals.

CONSULTATIVE PROCESS FOR THE DISTRICT HOSPITAL PROGRAM

During March, April and May 2002 GMT² completed a review of Greater Metropolitan District Hospitals, principally achieved through a detailed consultation process with over 500 clinicians (medical, nursing and allied health professionals) and managers. Hospitals were visited and open meetings held with clinicians and hospital executives. GMT² worked closely with Area Chief Executive Officers and Chairs of Medical Staff Councils.

In addition, members of GMT² met with each of the Greater Metropolitan Area Health Service Boards, as well as with the Senior Executive Forum, the NSW Medical Staff Executive Council and Directors of Nursing from each of the sites.

While 20 sites were visited several small hospitals located on the fringe of the Greater Metropolitan Region have not been included within the GMT² review process.

INTRODUCTION

2

The strategies in this Report flow from the GMSIG process as well as visits to individual hospitals, input from many clinicians and frank discussions within the full GMT² Committee. Acknowledgment is given to the work and support of the clinicians and community representatives who were part of this process.

While GMT² does not support the closure of any District Hospital, it does recognise that due to the development of speciality services, increased networking and population growth, some District Hospitals must be supported as they change their functions to provide appropriate and enhanced health services for their patients.

GMT² supports the GMSIG recommendation that District Hospitals be referred to as **Metropolitan Hospitals**. In the Report that follows, the term Metropolitan Hospital and not District Hospital is used. This is symbolic of the change in their role and function.

GMT² RECOMMENDATION

- That the use of the term **District Hospital** be discontinued and replaced by the term **Metropolitan Hospital**.

PRINCIPLES

3

PRINCIPLES

GMT² based its strategy for the planning and delivery of health services by Metropolitan Hospitals on the following principles:

- **Quality of care and safety of patients**
- **Equity of access to and outcome within the health system**
- **Clinician-driven planning**

GMT² believes that Metropolitan Hospitals in the Greater Metropolitan Region should act as 'doorways' into a system which provides patients with the best health care possible. The complexities of providing health care now make it impossible to provide all health care services at all facilities. Certain types of services can only be provided at the highest quality if they are concentrated within a small number of hospitals. Other services can be provided in almost any facility safely and effectively.

GMT² is focussing on structuring Metropolitan Hospitals in such a way that it does not matter where the patient enters the system, the most appropriate services will be provided as quickly as possible. This provides an integrated safety net for the whole population and is not constrained by the boundaries of Area Health Services.

Many clinicians working in Metropolitan Hospitals suggested to GMT² that they feel relatively isolated, unrecognised and under-resourced. This situation has been contributed to by the unusual geography of Sydney, changes in population distribution across Sydney and the increasing cost of hospital equipment. It is accentuated by workforce shortages in many of the disciplines in medicine, nursing and allied health. In many instances it is a lack of collegial interaction between institutions that is seen to be a major factor.

GMT² initiatives aim to benefit patients by:

- providing services as close as possible to where people live
- formalising the networking of services to ensure that a consistent expert, effective and efficient service of the highest quality is available
- promoting clinical leadership.

GMT² believes that Metropolitan Hospitals in the Greater Metropolitan Region should act as 'doorways' into a system which provides patients with the best health care possible.

INITIATIVES

4

CLINICAL RESPONSIBILITIES

Clinical care of patients is the core business of Area Health Services and patients expect hospitals to meet their health needs. The Area Health Service Board as the governing body is accountable for the quality of care delivered by health services.

However, it is imperative that clinicians caring for patients should be involved in the process of planning of health services. During the GMT² review it became clear that clinical 'champions' were required to facilitate the planning and delivery of revised health services at Metropolitan Hospitals.

GMT² proposes the:

- establishment and/or enhancement of clinical networking services by the appointment of clinical leaders and Area coordinators to support this initiative
- establishment of a Metropolitan-wide surgical group to monitor the outcomes of new initiatives to improve planned surgical services.

Health care workers and the community must recognise that resources are limited. Different models of services need to be considered to ensure that Metropolitan Hospitals continue to provide quality services which are both accessible and safe for patients. This must be achieved while fulfilling their role in a Metropolitan-wide integrated hospital plan.

CLINICAL LEADERSHIP

An individual clinical department in a hospital works better where sound clinical leadership develops a close and mutually respectful working relationship with hospital administrative staff. Morale rises accordingly. This results in healthcare workers feeling empowered and keen to deliver better patient care. The GMT² review noted that morale and efficiency at Metropolitan Hospitals is variable, and appears often to be correlated with clinical and managerial leadership. Hence, GMT² sees the nurturing of clinical leadership as a key requirement for the change process it wishes to promote.

Some of the issues identified during GMT²'s review were:

- lack of resources for the training and supervision of medical, nursing and allied health staff
- variation in the standard of clinical leadership
- insufficient availability of clinical trainees in Metropolitan Hospitals.

Strong clinical leadership in Metropolitan Hospitals will provide:

- a reduction in the sense of isolation experienced by clinicians
- easier recruitment and retention of staff
- improvement in the morale of clinicians

INITIATIVES

4

- better opportunities to plan services based on information collected within the network
- developing closer relationships with Principal Referral Hospitals
- raising standards and quality assurance activities
- promotion of evidence based practice and development of clinical pathways
- fairer distribution of Registrars across all hospitals.

In the Metropolitan Hospitals, training and supervision of residents and registrars are more dependent on Visiting Medical Officers (VMOs) than is the case in Principal Referral Hospitals. This is because medical staff are predominantly VMOs in Metropolitan Hospitals. They do provide excellent supervision under great difficulty and with considerable self-sacrifice.

In a number of Metropolitan Hospitals there is currently a large workload with less supervision and training for Registrars and Junior Medical Officers (JMOs). JMOs (Post Graduate Years 1 & 2) feel disadvantaged, despite the outstanding work done by Directors of Clinical Training because of the paucity of supervising Registrars. Any attempt to ensure a fairer distribution of Registrars (so vital for JMO training and supervision) will not succeed unless specialists in Metropolitan Hospitals spend more programmed time on training. Therefore, GMT² places the greatest importance on the establishment of sessional salaries for training purposes for VMOs. In some cases the appointment of part-time or full-time salaried specialists to carry out this role is an appropriate alternative. Such appointments will also provide an opportunity for more clinical leadership. The same principle applies to disciplines other than medicine, that is, Nursing and Allied Health.

We believe that this initiative will inevitably improve patient care.

In recent years, significant advances in surgical and orthopaedic services have been made by increasing Registrar rotations. While JMO staff are reasonably evenly distributed throughout the Greater Metropolitan Region, Registrars in non-surgical specialties are not. Yet exposure of medical trainees to general medical and surgical patients is an invaluable training experience often better achieved in Metropolitan rather than Principal Referral Hospitals.

Clinical leadership will facilitate clinical networking and assist Metropolitan Hospitals to attract Registrars and JMOs. Initiatives to support the rotation of trainees within a network include:

- job descriptions for supervising clinicians so that they are aware of their roles and responsibilities, especially in relation to education, training, supervision and mentoring
- an expansion to the educational program for JMOs to include participation by all clinicians, not only supervisors
- access to improved educational facilities for all clinicians – nurses and allied health as well as medical clinicians

INITIATIVES

4

- expansion of training and research programs in Metropolitan Hospitals
- establishment of teaching programs for Career Medical Officers and overseas doctors in temporary salaried positions
- where desired, rotation of clinicians between hospitals.

To support these initiatives the appointment of clinical leaders will enhance the training and supervision of Registrars and JMOs.

CLINICAL LEADERSHIP RECOMMENDATIONS

- Appointment of part-time clinical leadership positions at:
 - Belmont
 - Blacktown/Mt Druitt
 - Bulli
 - Fairfield
 - Hawkesbury
 - Hornsby
 - Maitland
 - Ryde
 - Sutherland
 - Shellharbour
 - Wyong
- Job descriptions to be drawn up by GMT2 and discussed with Area Health Service Chief Executive Officers by 1 September 2002.
- Advertisements to be placed by 1 October 2002.
- GMT2 to be notified when positions are filled.
- Appointments be either a conjoint academic or a clinical academic position, fostering relationships with the universities.
- Universities be requested to ensure that each Metropolitan Hospital is considered by their Medical, Nursing and Allied Health Faculties to be a university teaching hospital.

TOTAL \$ = \$0.899M annually

INITIATIVES

4

NETWORKING

GMT² considers that improvements can be made to the planning and delivery of health service by effective networking of clinical services.

It was identified during the review that:

- health services are often provided within a 'silo' or 'facility based' attitude rather than within a networked service
- staff within Metropolitan Hospitals often perceive themselves to be the 'poor cousins' of the Principal Referral Hospitals and feel isolated
- access for patients to appropriate services needs to be better guaranteed.

A Clinical Network is composed of a collaborating group of clinicians and clinical departments working in a coordinated way to improve equity of access and outcome for people with the disorder which is the subject of the network. This is sometimes across Area Health Service and/or institutional boundaries.

The main goal of a Clinical Network is an improvement in the quality of patient care; the dimensions of which are access, appropriateness, effectiveness, safety and efficiency, and importantly consumer involvement.

A network does not replace a staff member's allegiance and loyalty to his/her primary hospital. Rather it provides the potential for an individual's contribution to be more significant.

Clinical networking by coordinating resources ensures that patients will be in the right place for the right treatment at the right time. This will involve the development of agreed principles of care, the establishment of relevant levels of infrastructure at specific sites, commitment to communication and acceptance of responsibility for provision of an appropriate level of care.

Consistent with the role delineation of sites, some clinicians may be credentialled to provide 'core' services in one site and more complex medical services at other sites. Clinical nurse consultants and registrars may work on more than one site. Formalising their rotations may become an important function of a network.

There will be a transition period in the establishment of new services on some sites in which clinicians in the network provide support while clinicians at a developing site are upgrading services.

Components of networking are already working to a significant extent within some Area Health Services. It should be emphasised that GMT² envisages networking as an equal partnership between clinicians in Metropolitan Hospitals and Principal Referral Hospitals.

"We believe that this initiative will inevitably improve patient care."

INITIATIVES

4

Benefits of networking in the Greater Metropolitan Region include:

- development of the concept that at any point of entry to the health system appropriate care will follow
- improvement in access for patients who require referral to Principal Referral Hospitals
- development of protocols for patient management and subsequent documentation which will improve the quality of health care provided
- more effective supervision of teaching and research
- more effective management of service delivery
- reduction in the duplication of services
- promotion of evidence based practice
- coordination and prioritisation of major equipment or technology purchases as advances demand
- clinicians at Metropolitan Hospitals and Principal Referral Hospitals developing a greater respect and value for each others work
- promoting the whole continuum of care for specified diseases – prevention, critical care, acute care, sub-acute care and maintenance throughout the network
- establishing a clinical quality framework for specified services, accreditation programs and the implementation of evidence based and well researched clinical practice standards.

COMPONENTS OF NETWORKING

Area Coordination

The appointment of **Area Coordinators** will provide a capacity for planning and the delivery of health services by clinicians in partnership with managers at all levels. GMT² found that Area coordination was more effective between Metropolitan and Principal Referral Hospitals when clinical networks were in place and led by clinicians.

To facilitate and maintain such a structure it is necessary to have:

- clinicians who are Area coordinators having well defined functions and having an agreement with the Area Health Service on how they will manage coordination
- an agreement between Metropolitan Hospitals and Area Health Services supporting this structure.

GMT² recognises that there is already a degree of coordination of specific services in some Area Health Services. It is noted that in many Areas there are already Area Directors in such disciplines as mental health, medicine, surgery and maternity.

4

Area Directors will be appointed in five specific disciplines to support the promotion and development of Area coordination. There will be flexibility in how the Area Directors spend their allocated funds. They could accept extra remuneration, they could back-fill a clinical appointment to allow them time to achieve the objective, or they could appoint a part-time business manager to help them do so.

AREA COORDINATION RECOMMENDATION

- Area Directors be appointed for:
 - Cardiac services
 - Emergency services
 - Intensive care
 - Radiology
 - Stroke services

TOTAL \$ = \$1.857M

Integrating Clinical Activities

The concept of a model of health service in which two hospitals in close proximity better integrate their clinical services, in effect operating as one, is attractive. This involves sharing of resources to deliver better care for patients. Facilities in close proximity have an opportunity of providing more effective and efficient services by the integration of clinical components, with doctors, nurses and allied health staff working as a team over two hospitals. Cross-appointments would be voluntary.

Some linkages between or actual integration of clinical departments has already occurred or is in process. Clinical integration does not mean closing or downgrading an individual department. It does not mean amalgamation of two hospitals. It does mean that clinically integrated departments working together rather than separately will deliver more to patients. There is an opportunity for clinicians in a clinically-integrated department to provide a service predominately based at one site. The development of skilled and experienced multi-disciplinary teams would be expected to improve patient outcomes.

Benefits include:

- provision of safer and more effective and efficient health services for patients
- cross appointment/credentialing/performance management and rotation of clinicians to assist in improving service standards and staff morale
- more effective use of resources
- providing clinical services in partnership and within a clinical network

INITIATIVES

4

- improved standing of Metropolitan Hospitals
- improved collegiality between clinicians.

For these reasons GMT² believes that some Metropolitan Hospitals should be integrating clinical departments available at two closely located hospitals. With a 'one hospital on two sites' approach there is good reason to believe that the provision of specific services at both sites will be more appropriate, and can provide safer and more efficient health care. This model does generate a need for better inter-hospital patient transport which GMT² recognises and supports.

As the demographics change around the geographical areas of the two sites, service profiles will be adapted to meet changes. The strategy of 'one hospital on two sites' provides opportunities to facilitate this.

It is important that the individual identity and name of a Metropolitan Hospital be preserved and its community linkage nurtured while at the same time integration of clinical services is improved and broadened.

INTEGRATING CLINICAL ACTIVITIES RECOMMENDATION

- The concept of 'one hospital on two sites' be further developed at:
 - Blacktown/Mt Druitt
 - Camden/Campbelltown
 - Manly/Mona Vale (Northern Beaches)
 - Ryde/Royal North Shore
 - Sydney/Prince of Wales
 - Wyong/Gosford

CLINICAL SERVICES

Metropolitan Hospitals should be partners in an integrated system providing clinical services to a large number of patients in the NSW healthcare system while maintaining a close relationship with their local community. It is a reality of modern hospital care that Principal Referral Hospitals deliver hospital services for their local community. More Metropolitan Hospitals will broaden their role to provide specialised services.

The challenge of redefining the role of Metropolitan Hospitals lies in balancing the needs of communities and their right to access health care services close to home with the need for a critical mass of work to ensure the maintenance of clinical standards.

4

Special Units

The review identified that as effective clinical networks are established and some services integrated some Metropolitan Hospitals should be changing their role to provide some unique services by creating Special Units.

Benefits include:

- improved patient access to specialised services
- promotion of teaching and research in Metropolitan Hospitals
- improved identity and increased value of work by clinicians in Metropolitan Hospitals
- potential linkage to universities for multidisciplinary education
- post graduate centre for training in all health disciplines.

SPECIAL UNIT RECOMMENDATION

- A Trans-Cultural Health Education Centre be established at Auburn Hospital.

TOTAL \$ = \$0.288M annually

Planned Surgery

A coordinated approach to the planning and delivery of surgical services across the Greater Metropolitan Region will improve access by patients to appropriate services within an acceptable time frame.

Metropolitan Hospital clinicians believe that with adequate resources they can provide excellent general and orthopaedic surgery as well as some sub-speciality services effectively and efficiently. Some Metropolitan Hospitals have operating theatres and wards which are not fully utilised. If these are utilised waiting lists for planned surgery could be reduced, especially during the winter season when there is a peak in demand for health services.

Several benefits of establishing planned surgery centres would follow:

- improved access and decreased waiting time for patients on surgical waiting lists and therefore reduced cancellations of booked admissions
- improved clinical standards because of the critical mass required for certain procedures being achieved
- rotation and retention of clinicians
- improved networking within and across Areas
- development of expert multidisciplinary teams.

INITIATIVES

4

Enhancement of surgical services cannot be achieved in isolation, but can be achieved by networking both within and across Areas in a coordinated manner.

An example of how Metropolitan Hospitals can enhance surgical services as Area-wide services which are safer, more effective and efficient is provided by an analysis of the recent elective surgery trial at Auburn Hospital. This trial commenced by identifying specific procedures for which model clinical pathways were developed. Patients were guaranteed a date of surgery.

The outcome of the trial was:

- reduction in waiting time for gall bladder removal and hernia repair
- twice as many patients being cared for in a given time compared with standard procedures.

Enhancement of surgical services should be written into Area Health Service Plans as enhanced infrastructure must be available to support such initiatives.

It will be important to monitor and evaluate the implementation of these surgical initiatives. It is envisaged that more planned surgery (general, orthopaedics, sub-speciality) will be carried out in Metropolitan Hospitals as a result of more cross-hospital appointments, improved inter-hospital patient transport, and more infrastructure support.

PLANNED SURGERY RECOMMENDATIONS

- Surgical enhancements at the following hospitals:
 - Auburn
 - Belmont
 - Blacktown/Mt Druitt
 - Blue Mountains ANZAC Memorial and Springwood
 - Bulli
 - Camden/Campbelltown
 - Fairfield
 - Hawkesbury
 - Hornsby
 - Maitland
 - Ryde
 - Sutherland
 - Sydney
 - Wyong

4

PLANNED SURGERY RECOMMENDATIONS CONTINUED

- Strengthened planned surgical services, particularly for short stay surgery, in:
 - General Surgery
 - Orthopaedics
 - Ear Nose and Throat (ENT)
 - Ophthalmology
 - Urology
 - Gynaecology
- Refurbish the operating theatres at Ryde.
- A surgical Working Party of GMT² under the leadership of Michael Hollands and Patrick Cregan to monitor these initiatives.

TOTAL \$ = \$9.441M annually

Emergency Departments

Emergency Departments provide the point of entry for many thousands of patients. Patients presenting to Emergency Departments require a variety of care ranging from the management of serious trauma to provision of emotional support. Increasingly it is multi-system disease in aged patients that is a major focus in our Emergency Departments.

There needs to be a guaranteed minimum level of service at all hospital Emergency Departments. It is obvious that the comprehensiveness of the level of service will vary site to site. Hence, to provide emergency services in Metropolitan Hospitals more effectively and safely, Area clinical networks need developing. These will feature integration of services so that patients can experience access to the broader health care system to meet their needs.

GMT² recognises the inequality in the provision of radiology services. Improved diagnostic services means quicker assessment and treatment of patients in Emergency Departments. Therefore GMT² supports the purchase of CT scanners and the use of new technology in many Emergency Departments.

It was also identified that some Emergency Departments need refurbishing and better equipment if they are to provide emergency services within a clinical network model. Transport must also be available to transfer patients within the clinical network to the appropriate service.

GMT² suggests that clinicians and the Area Health Service executives consider different structures for emergency services based on population, attendance rates and infrastructure. For example, integrating emergency services at Camden/Campbelltown would enhance emergency services in the Macarthur Health Service.

INITIATIVES

4

To support the delivery of emergency services within Area Health Services an Area Coordinator needs to be appointed to facilitate effective networking.

In summary, the implementation of proposals by the GMT² will provide:

- better access to health services for patients
- improved care by development of common protocols and practices
- improved infrastructure to support emergency services
- potential rotations of medical and nursing staff allowing them to gain greater experience.

EMERGENCY DEPARTMENTS RECOMMENDATIONS

- Appointment of Area Directors for emergency services.
- Appointment of additional staff at:
 - Belmont
 - Hornsby
 - Maitland
 - Manly/Mona Vale (Northern Beaches)
 - Shellharbour
 - Wyong
- Refurbishment at:
 - Camden/Campbelltown – Camden site
 - Fairfield
 - Manly/Mona Vale (Northern Beaches)
 - Ryde
 - Shellharbour
- Clinical integration of Emergency Departments:
 - Blacktown/Mt Druitt
 - Bulli/Wollongong
 - Camden/Campbelltown
 - Ryde/Royal North Shore
 - Sydney/Prince of Wales
 - Wyong/Gosford
- Improved Emergency Department transport by establishing a Helipad at Blue Mountains ANZAC Memorial.

TOTAL \$ = \$2.615M annually

4

Intensive Care Units (ICU)

GMT² identified that expanded intensive care services are required to support some of the initiatives proposed. Intensive care services will need to be available to support the enhancement of planned surgery and the establishment of Stroke Units.

Area networking is occurring to some extent as seen by the increasingly effective transfer of patients requiring more than 24 hours of ventilation to the more sophisticated intensive care services. However, GMT² strongly supports further development of Area networking for intensive care services to ensure seamless care for seriously ill patients.

The *Report of the Intensive Care Group* provides two classifications of intensive care: the Departmental grading 1-6 and the Australian and New Zealand Intensive Care Society (ANZICS) grading 1-3. GMT² advocates the use of the ANZICS grading to enable it to be linked into the database that will be set up by the Intensive Care Coordination and Monitoring Unit (ICCMU). ICCMU will promote the understanding of the distribution, networking and management of clinical resources both locally and at a state level.

Most Metropolitan Hospitals will have a Level 1 Intensive Care Unit as described by the ANZICS criteria with some of the larger Metropolitan Hospitals, for example, Blacktown, Sutherland, and Hornsby having a Level 2 Intensive Care. Every other Metropolitan Hospital, except for Bulli and Shellharbour (which have excellent links to Wollongong Hospital), will have at least a Level 1 Intensive Care Unit.

Metropolitan Hospitals need to have an appropriate level of intensive care service to support the enhancement of their medical and surgical services.

A Level 1 Unit ICU should be capable of providing immediate resuscitative management for the critically ill, short term cardio-respiratory support, and have a major role in monitoring and prevention of complications in 'at risk' medical and surgical patients. It must be capable of providing mechanical ventilation and simple invasive cardiovascular monitoring for a period of at least several hours. It should be a self-contained area with easy access to the Emergency Department, operating theatres and organ imaging. There should be a nurse in charge of the Unit who has a post registration qualification in intensive care or in the clinical speciality of the Unit.

To enhance intensive care services the following are required:

- appointing Area Directors for intensive care to facilitate networking
- upgrading some Intensive Care Units
- providing the infrastructure for ready access to the Principal Referral Hospital within an Area for patients needing intensive care who are not able to be cared for at the Metropolitan Hospital.

INITIATIVES

4

INTENSIVE CARE UNITS RECOMMENDATIONS

- Appointment of Area Directors for intensive care services.
- Refurbishing existing Units at Hornsby and Manly/Mona Vale (Northern Beaches) – Manly site.
- Upgrade Hornsby to a Level 2 Unit.
- Purchase monitoring equipment for Sutherland and Shellharbour.
- Appointment of a Director of Critical Care and a Clinical Nurse Consultant at Manly/Mona Vale (Northern Beaches).
- Integration of ICUs at:
 - Blue Mountains ANZAC Memorial/Nepean
 - Ryde/Royal North Shore
 - Mater/John Hunter
 - Manly/Mona Vale (Northern Beaches)

TOTAL \$ = \$0.870M annually

MEDICINE

During the review it was noted that both Metropolitan Hospitals and Principal Referral Hospitals provide sub-speciality medical care – for example, to stroke patients and to acutely ill aged patients.

During discussions with clinicians it was identified that with effective networking medical sub-specialities can be enhanced in Metropolitan Hospitals. This will allow better access to appropriate health services by patients and improve opportunities for the recruitment and retention of staff. It was also recognised that infrastructure will be needed to support such an initiative.

GMT² suggests improving medical services in Metropolitan Hospitals by enhancement of staffing, improved transport, purchasing of relevant equipment and the establishment of Stroke Units. GMT² supports effective networking of all clinical services as well as the development of acute aged care services within some of the Metropolitan Hospitals. An increase in the number of Medical Specialist, Registrar, Nursing and Allied Health positions in palliative care, rehabilitation, paediatrics and some medical disciplines are part of this initiative.

An example of improving medical services in Metropolitan Hospitals involves the establishment of more Stroke Units – a major initiative of GMT².

4

Stroke Services

Evidence shows that the outcome for patients who have suffered a stroke significantly improves with the development of a specialised multidisciplinary model of care similar to that available for patients cared for in Coronary Care Units.

The establishment of integrated stroke services will provide patients with access to multidisciplinary specialised care in the acute, subacute, and rehabilitation phase of management.

As part of these initiatives, there will be 17 designated Stroke Units established throughout the Greater Metropolitan Area. Six of these will be in Metropolitan Hospitals.

Stroke Units will occupy a designated area consisting of at least four specialised beds with patients having access to CT scanning 24 hours a day, seven days a week.

Effective networking will support this model of care. For example there will be:

- links between each Stroke Unit to one of 5 neurosurgical/neuro-radiological centres, with access to 24 hour, 7 day a week MRI
- an Area Director and a senior nurse to coordinate care, education and training
- teams of medical, nursing and allied health staff with an interest in the speciality
- a 'one phone call' reality for clinicians needing help for their stroke patients
- transport available to transfer patients to the most appropriate health services
- complete integration of acute and rehabilitation services.

Benefits of such a model include:

- enhancement of best practice by the development of standard protocols and practice
- improved access by patients to an appropriate service in a timely manner
- rotation of clinicians for experience, thereby assisting in recruitment and retention
- a structure for regular meetings between clinicians within the speciality
- improved coordination of planning and delivery of the service through the facilitation of an Area coordinator
- improved morale for all disciplines.

INITIATIVES

4

STROKE SERVICES RECOMMENDATIONS

- Appointment of Area Directors of stroke services.
- Establishment and development of Stroke Units at:
 - Belmont
 - Blacktown/Mt Druitt – Blacktown site
 - Camden/Campbelltown – Campbelltown site
 - Hornsby
 - Manly/Mona Vale (Northern Beaches) – Manly site
 - Sutherland
- Appointment of Directors for each Stroke Unit.

TOTAL \$ = \$3.655M annually

General Medicine

The strength of general medicine in many Metropolitan Hospitals becomes more important with the increasing growth of sub-specialisation in the Principal Referral Hospitals. Each Principal Referral Hospital does indeed provide general medicine patient care for its surrounding community, but the number and the expertise of practicing general physicians in the Metropolitan Hospitals is impressive and, with networking they should play a more significant role in the training of Medical Registrars in general medicine.

MEDICINE RECOMMENDATIONS

Enhance:

- Acute geriatric services at:
 - Hornsby
 - Wyong
- Palliative care services at:
 - Belmont
 - Blacktown/Mt Druitt – Mt Druitt site
- Paediatric services at:
 - Belmont
 - Fairfield
 - Manly/Mona Vale (Northern Beaches) – Mona Vale site

4

MEDICINE RECOMMENDATIONS CONTINUED

- General medicine at:
 - Camden/Campbelltown
 - Canterbury
 - Blue Mountains ANZAC Memorial
 - Blacktown/Mt Druitt
 - Fairfield
 - Manly/Mona Vale (Northern Beaches)
 - Ryde
 - Sutherland
 - Wyong
- Rehabilitation services at:
 - Hawkesbury
 - Springwood
 - Maitland
 - Sutherland

TOTAL \$ = \$4.882M annually

RADIOLOGY

Radiology is an essential part of any hospital, in the diagnostic and increasingly, therapeutic components of clinical care for patients. It is recognised that currently there are difficulties in recruiting and retaining radiographers, radiology nurses and radiologists to the public health system.

Due to lack of radiographers, radiologists and equipment at some of the Metropolitan Hospitals it was identified that patients too frequently require transfer to Principal Referral Hospitals for radiology services. With adequate resources (equipment and staff) more radiology services could be provided by Metropolitan Hospitals, especially with improvements in technology. Tele-Reporting provides the opportunity for Metropolitan Hospitals to access the skills of radiologists without them being on site.

GMT² endorses the GMSIG recommendation that every hospital with an Emergency Department of Level 5 and above should provide 24 hour CT access on site for public patients. This will be achieved.

INITIATIVES

4

The benefits from enhancing radiology services are:

- quicker and more effective assessment of patients which leads to a more timely access to appropriate services
- reduction in delay to initiation of treatment
- fewer patients transferred between hospitals reducing the utilisation of services such as transport and escort personnel.

Improved Area networking of radiology services, the purchasing of equipment and enhancement of staffing levels will enhance diagnostic services in Metropolitan Hospitals.

RADIOLOGY RECOMMENDATIONS

- Appointment of Area Directors of radiology services.
- New CT scanners at:
 - Auburn
 - Blacktown/Mt Druitt – Mt Druitt site
 - Blue Mountains ANZAC Memorial
 - Ryde
 - Wyong
- Increase staffing for Auburn, Belmont, Blacktown/Mt Druitt, Blue Mountains, Camden/Campbelltown, Fairfield, Ryde and Wyong.
- Establishment and extension of Tele-Reporting at:
 - Blue Mountains ANZAC Memorial
 - Camden/Campbelltown
 - Fairfield
 - Maitland
 - Ryde
 - Sutherland
 - Sydney
 - Wyong
- Establishment of Area radiology networking.

TOTAL \$ = \$3.754M annually

4

MATERNITY SERVICES

Maternity services are available in many Metropolitan Hospitals with the number of annual deliveries varying from 360 to more than 2,000 per year. In the GMT² consultation with clinicians at Metropolitan Hospitals the quality and sustainability of maternity services were discussed in detail with emphasis being placed on safety for mothers and babies and workforce issues.

There is a patchy shortfall in the workforce of midwives and anaesthetists. Overall, there is an increasing shortage of obstetricians. These workforce shortages have a significant effect on the planning of Greater Metropolitan maternity services, particularly with regard to their sustainability.

Most hospitals have midwives and obstetricians working together in a most productive partnership and the review found a general appreciation of the importance for women of recognising the 'wellness' model of pregnancy. There is among the craft group (group of clinicians with expertise in maternity services) an appreciation of the reality that pregnancy can be associated with serious adverse affects for both mothers and babies. Given these realities there is a general acceptance of the benefits of having a midwife-led birthing centre where minimal medical intervention would be anticipated, co-located with obstetric and anaesthetic availability.

At individual hospitals the following issues were discussed with maternity service providers:

- workforce issues, namely the shortage of obstetricians, anaesthetists and midwives
- the location of private hospital maternity services in close proximity to public hospitals
- the availability of antenatal and postnatal services, as well as birthing services at individual hospitals
- networking arrangements with a Level 6 (High Risk) maternity service.

As the GMT² review focussed on service enhancement and in many instances a changed role of Metropolitan Hospitals in specific disciplines and the development of networking, maternity services were not looked at in isolation. In many situations suggestions involve the development of reciprocal arrangements with nearby hospitals allowing two organisations to create a 'one hospital on two sites' model. Both hospitals and their patients would benefit from such an arrangement.

GMT² recommendations for maternity services focus on safety and a desirability of having as many women as possible given the opportunity to birth in Level 4 or 5 rather than Level 2 or Level 3 maternity service, preferably with an attached midwife-led birthing centre providing choice between a wellness or medical model.

INITIATIVES

4

Two other major changes are required:

1. Creation of specific networks that link all Birthing Units to a Level 6 (High Risk) service for delivery of a safer service.
2. Enhancement of the Blacktown/Mt Druitt maternity service with an antenatal outreach service, with special focus on the Aboriginal and Torres Strait Islander population. This is in recognition of the need to reduce the mortality rate in this population.

GMT² suggests re-alignment for a small number of maternity services at the smaller hospitals. GMT² requests the proposed realignments be examined thoroughly by the clinicians at hospitals involved with a time table for implementation being reported to GMT² by December 2002. The Maternal and Perinatal Ministerial Advisory Committee and the craft group should meet regularly to implement a continuous improvement model for maternity services.

MATERNITY SERVICES RECOMMENDATIONS

- Clinical integration of maternity services to establish a single maternity service across two sites at:
 - Blue Mountains ANZAC Memorial/Nepean
 - Camden/Campbelltown
 - Manly/Mona Vale (Northern Beaches)
 - Ryde/Royal North Shore Hospital
 - Shellharbour/Wollongong
 - Sutherland/St George/Royal Hospital for Women
 - Wyong/Gosford
- Clinicians (obstetricians and midwives) at these six integrated services should work together with the aim of providing Level 4/5 maternity services for their population by June 2003. GMT² envisages that this may mean providing antenatal, postnatal care and gynaecology procedures at one hospital, with all planned deliveries at the other hospital, which ideally would provide both traditional obstetric care and a birthing centre. This model and other midwifery led models should be considered jointly by the Maternity and Perinatal Ministerial Advisory Committee and GMT².
- Western Area Health Service to develop an antenatal outreach service, with special focus on the Aboriginal and Torres Strait Islander population.
- Enhanced staffing at Hornsby.
- Research models of care for maternity services.

TOTAL \$ = \$0.708M annually

CLINICAL WORKFORCE

5

CLINICAL WORKFORCE

To provide high quality care, a hospital needs to have an adequate workforce of doctors, nurses and allied health staff. Without sufficient numbers a service may suffer in quality and the staff themselves are at risk of 'burning out' and deciding to leave the workplace. Many smaller hospitals, and even some larger facilities, are finding it increasingly difficult to recruit and retain the workforce needed to provide many services.

Through networking with Principal Referral Hospitals, some specific staff of Metropolitan Hospitals should be offered rotations in these hospitals, similarly rotations should be encouraged from the Principal Referral Hospitals to Metropolitan Hospitals. Such rotations, where desired, would promote collegiality and continuing education.

MEDICAL WORKFORCE

In some Metropolitan Hospitals there are significant deficiencies in senior medical staff particularly in anaesthesia, obstetrics and emergency medicine. Short term measures have to be introduced to deal with this problem.

The rotation of registrars and junior medical officers through Metropolitan Hospitals would both alleviate some workforce issues in these facilities and provide improved workforce training. These have been addressed in surgical and orthopaedic registrar rotations, however this has not occurred in non-surgical specialities. GMT² recommends that this issue be addressed as a matter of urgency. GMT² also recommends that such rotations be incorporated into Area Health Service Agreements.

NURSING WORKFORCE

Metropolitan Hospitals are facing the same challenges as is evidenced across the whole health system, that of a critical shortage of nurses, especially in particular speciality areas. The reasons are multi-faceted and it is a world-wide issue. The solutions to the shortages are also multi-faceted. It is widely acknowledged that the development of a well-funded learning infrastructure which features a structured educational program provided by clinical nurse educators, comprehensive orientation, mentoring and ongoing professional development opportunities are valuable strategies in attracting and retaining staff.

Not all hospitals have the same staffing shortages. What is evident is that all organisations must ensure that they provide an environment that demonstrates that they value their staff and their contribution to improving patient care.

CLINICAL WORKFORCE

5

With the growth of networking models within and across Areas, there are enormous opportunities for nursing staff to share expert knowledge, develop their skills, enhance professional development and research. This can be achieved through voluntary rotations through a networked service, the formation of professional practice networks, access to CIAP 24 hours a day at a Unit level, dedicated nursing research to be funded at a state departmental level, the development of research fellowships and links to universities for research and practice development purposes. Strong clinical and managerial nursing leadership is essential in implementing and monitoring the success of these strategies.

GMT² initiatives will assist with meeting some of these strategies, and it is recommended that Area Health Services and the NSW Health Department provide the funding and guide the implementation of the package.

ALLIED HEALTH WORKFORCE

Across Metropolitan Hospitals there is a serious deficiency in the number of allied health staff. This was repeatedly brought to the attention of the GMT² team during their visits, notably by medical and nursing staff.

Allied Health could be helped by the appointment within the NSW Health Department of a discipline head similar to medicine and nursing. The promotion of continuing education together with staff rotations to Metropolitan and Principal Referral Hospitals, improved and creative linkages to the private sector are essential initiatives for the next few years.

Closer linkage with universities with conjoint academic appointments and a recognition of the need for supervision and training positions in the disciplines of Allied Health in Metropolitan Hospitals should be developed as a matter of urgency.

5

CLINICAL WORKFORCE RECOMMENDATIONS

- Appointment of an Allied Health Advisor to the NSW Health Department.
- Enhanced staffing, including nurses, doctors, allied health, support staff at:
 - Auburn
 - Belmont
 - Blacktown/Mt Druitt
 - Blue Mountains ANZAC Memorial and Springwood
 - Bulli
 - Camden/Campbelltown
 - Canterbury
 - Hawkesbury
 - Hornsby
 - Fairfield
 - Maitland
 - Manly/Mona Vale (Northern Beaches)
 - Mater, Newcastle
 - Ryde
 - Shellharbour
 - Sutherland
 - Sydney
 - Wyong
- Each Area to accelerate the establishment of clinical cross-appointments.
- GMT² to discuss with Area Health Service Chief Executive Officers, Medical Training and Education Council (MTEC) and specialist groups means of increasing Registrar rotations, particularly through Metropolitan Hospitals.

INFRASTRUCTURE

6

TRANSPORT

Concerns were expressed by a wide range of clinicians at many Metropolitan Hospitals regarding difficulties and delays in transporting patients from one hospital to another. At some hospitals clinicians spoke about difficulties for patients' carers and families travelling on public transport between hospitals. In a few hospitals even transferring pathology specimens and x-rays was considered an issue. GMT² initiatives will improve patient transport for ten Metropolitan Hospitals.

Implementing the networking initiatives of GMT² will place an increased demand upon transport services at Metropolitan Hospitals. Strengthening of existing patient and non-patient inter-hospital transport services is essential.

There are a number of key services provided by inter hospital patient transport services. These services directly affect the efficiency of hospitals in terms of bed availability. Delays for patient transfers can add sometimes hours and days to hospital stay. The main services currently provided by patient transport services can be broken down into three categories:

1. Non urgent one way transfers from one facility to another.
2. Time dependent transfers for medical investigations or treatments, including both patients from general wards and from Emergency Departments.
3. Acute transfers between Emergency Departments.

Some reduction in time dependent transfers will occur as a result of the GMT² initiated purchases of additional CT scanners. However, there is an increased requirement for non urgent one way transfers as Metropolitan Hospitals increasingly specialise in various aspects of care and upgraded networking between hospitals is established. Emergency Departments will have an increased need to admit patients to other hospitals.

The establishment of additional transport services provides other opportunities for the efficient use of these vehicles. These could include:

- movement of small cargo items between sites
- mail delivery services between sites
- pathology/specimen transport in appropriately secured containers
- movement of staff between sites.

Consideration should be given to purchasing the same type of vehicle across the Greater Metropolitan Region, and for this vehicle to be capable of being 'multi-purpose'.



PATIENT TRANSPORT RECOMMENDATION

- Enhancement of inter-hospital patient transport between:
 - Auburn, Blacktown/Mt Druitt and Westmead
 - Blue Mountains ANZAC Memorial and Nepean
 - Bulli, Shellharbour and Wollongong
 - Camden/Campbelltown, Fairfield and Liverpool
 - Hawkesbury and Nepean
 - Manly/Mona Vale (Northern Beaches), Ryde, Hornsby and Royal North Shore
 - Wyong and Gosford
 - Belmont and John Hunter

TOTAL \$ = \$1.980M annually

CAPITAL FUNDING

During visits to Metropolitan Hospitals, GMT² identified significant variation in the state of physical facilities. While relatively recently upgraded capital stock is evident in most facilities, decaying stock in a few hospitals impairs the capacity and morale of health care workers. Some wards were noted to be unused, some operating theatres under-utilised.

GMT² therefore recommends upgrading of capital works targeted at some specific hospitals, refurbishing of some clinical departments and purchasing specific equipment.

In addition, GMT² recognises the poor state of hospital buildings at Hornsby, Shellharbour and Bulli. Accordingly, it is urged that major capital works at these three hospitals be accelerated.

Capital is being provided to Metropolitan Hospitals through two processes:

1. Announced specific capital programs (NSW 2002/2003 State Budget).
2. GMT² capital initiatives.

GMT² capital initiative funds are for the financial year 2002/2003. The announced specific capital programs have a longer completion date.

INFRASTRUCTURE

6

CAPITAL FUNDING RECOMMENDATION

- Refurbish Radiology Departments at:
 - Auburn
 - Blacktown/Mt Druitt – Mt Druitt site
 - Ryde
 - Wyong
- Establish and develop Stroke Units at:
 - Blacktown/Mt Druitt – Blacktown site
 - Camden/Campbelltown – Campbelltown site
 - Hornsby
 - Manly/Mona Vale (Northern Beaches) – Manly site
 - Sutherland
- Refurbish Emergency Departments at:
 - Camden/Campbelltown – Camden site
 - Fairfield
 - Manly/Mona Vale (Northern Beaches)
 - Ryde
 - Shellharbour
- Refurbish Intensive Care Departments at:
 - Manly/Mona Vale (Northern Beaches) – Manly site
- Purchase equipment for Hornsby, Shellharbour and Sutherland.
- Refurbish the operating theatres at Ryde.
- Refurbish the birthing centre at Manly/Mona Vale (Northern Beaches) – Mona Vale site.
- Establish the Centre for Trans-Cultural Health Education at Auburn.
- Planning study for improvements to Bulli.
- Haemodialysis equipment for Mater, Newcastle.

6

CAPITAL FUNDING RECOMMENDATION CONTINUED

- Support for Tele-Reporting at:
 - Blue Mountains ANZAC Memorial
 - Camden/Campbelltown
 - Fairfield
 - Maitland
 - Ryde
 - Sutherland
 - Sydney
 - Wyong

- NSW 2002/2003 State Budget Announcement
 - Various capital works including installation of a Helipad at Blue Mountains ANZAC Memorial
 - Redevelopment at Hornsby – maternity, paediatric and the Emergency Department
 - Redevelopment at Shellharbour – Emergency Department

GMT² Initiatives = \$6.172M

NSW 2002/2003 State Budget = \$27.400M

PUBLIC INTERFACE

7

COMMUNITY RELATIONSHIPS

In general, the community sense of ownership of the Metropolitan Hospital is strong. In many instances it is very strong indeed, and the local community as well as displaying an immense interest in their local hospital, also provides significant funding, particularly for equipment and teaching facilities. Furthermore, the local hospital is a vehicle for community interaction and facilitates public access to related support services.

GMT² believes that the community's relationship with its local hospital needs to be nurtured and developed. This is happening well at some hospitals, not so well at others. There is a need for greater transparency and better communication. While the responsibility for this lies ultimately with the Area Health Board, clinicians at all levels and in all disciplines should be encouraged to improve linkages between Metropolitan Hospitals and their surrounding communities.

Individual Hospital Boards were abolished some years ago. A strong community group needs to be established at each Metropolitan Hospital with the involvement not only of managers (Metropolitan and Area Health Service level) but also a full range of clinicians. The community group must know what is going on in its hospital, and be able to influence initiatives and developments. It is recognised that work on community participation is being developed through implementation of the *NSW Health Council Report* and the *Report of the Consumer and Community Participation Implementation Group*. Because of these recent initiatives, some Areas have set up community groups and in these cases existing structures may serve the purpose adequately.

GMT² recognises that every Principal Referral Hospital provides services to its local community so a similar group is recommended for Principal Referral Hospitals.

COMMUNITY RELATIONSHIPS RECOMMENDATION

- A community group be established for each of the 18 Metropolitan Hospitals consisting of clinicians, managers (local and Area level) and community in equal numbers and meet on a regular basis with distinct reporting lines.

7

PERCEPTION

Perception of threat of closure or the downgrading of services need to be eliminated. No hospital needs to be closed. Every hospital has a role. This Report reinforces that fact. It is a challenge to preserve the identity of a Metropolitan Hospital for the staff and the surrounding community while improving networking and broadening the nature of services.

Public perception of Metropolitan Hospitals is important if the change process is to be successful as the public has to be convinced that each Metropolitan Hospital will not simply provide services for its local community, but rather be part of a wider integrated health service. No Metropolitan Hospital can continue working in isolation.

However, community ownership of its own hospital has to be preserved and encouraged. The change in philosophy for health care delivery described herein must preserve this sense of community ownership. It was suggested and agreed by GMT², for example that closer clinical cooperation and coordination would occur if Campbelltown and Camden Hospitals were considered as one Macarthur Health Service. However, to preserve the identity of each hospital, the term Macarthur Health Service – Camden Hospital, be used.

Metropolitan Hospitals should be encouraged to promote their 'Flag Ship' services. Examples of this are, day-only surgery at Auburn and Fairfield; trans-cultural health provision and education at Auburn; domestic violence and refugee medicine at Fairfield. In these two latter instances, there is an opportunity for University involvement in all disciplines (medical, nursing and allied health) to facilitate centres of excellence for teaching and training.

One Metropolitan Hospital Forum has been held by GMT², another is planned in August. Such a forum brings together clinicians (doctors, nurses and allied health) and hospital managers from all parts of the Greater Metropolitan Region. It enables sharing of problems, awareness of specific initiatives at various Metropolitan Hospitals, and raises issues which the system should confront.

METROPOLITAN FORUM RECOMMENDATION

- Establishment of a Metropolitan Hospital Forum to meet three times a year.

APPENDIX B – PROCESS OF PREPARATION

PROCESS OF PREPARATION OF THE 2002/03 BUDGET SUBMISSION

The funds underpinning the Metropolitan Hospitals initiatives detailed in this Report represent almost a half of the total funds allocated to GMT² initiatives in its first year of clinician-led advice to the government. None of the clinicians on GMT² is solely based at a Metropolitan Hospital. The large proportion of the funds allocated represents their understanding of the importance of the Metropolitan Hospitals in the development of effective clinical networks and their commitment to the Metropolitan Hospitals through the provision of the resources needed to ensure that this role is enhanced. In addition to supplementing clinical services, these initiatives are also aimed at enhancing the role of Metropolitan Hospitals in teaching, training and clinical leadership.

Recommendations were prepared by GMT² Specific Discipline Groups and by the GMT² Executive after visits to Metropolitan Hospitals. They were then discussed and ratified by the full GMT² Committee.

The nine Greater Metropolitan Areas were asked by the GMT² Secretariat to estimate the cost necessary – over and above growth funding, flow reversal, revenue generation – to implement specific programs in their Areas (some already had some aspects of an initiative established).

Subsequently, GMT² was required to compile a spreadsheet including, a total cost of each program initiative without consideration to growth funding, flow reversal or revenue.

The GMT² Executive prioritised the budget and this was ratified by the full GMT² Committee.

A draft spreadsheet of the costing of the implementation of these recommendations was discussed by the full GMT² Committee after discussions with Area Chief Executive Officers.

In discussions with the NSW Health Department a revised spreadsheet was prepared.

The final estimate was then referred to the NSW Health Department for a decision by the Minister for Health and the Director-General.

APPENDIX C – CHECKLIST OF METROPOLITAN HOSPITALS

KEY



Appointment of Clinical Leaders



Enhancement of Service



Clinical Integration



Establishment of Stroke Unit



CT Scanner



Inter-Hospital Transport



Continuation of Existing Service



Establishment of Tele-Reporting

PAGE	AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
44	Central Coast (pop. 300,000)	Wyong										
46	Central Sydney (pop. 496,000)	Canterbury										
47	Hunter (pop. 521,000)	Maitland										
48		Belmont										
50		Newcastle Mater Misericordiae										
51	Illawarra (pop. 345,000)	Bulli										
52		Shellharbour										
54	Northern Sydney (pop. 752,000)	Hornsby/ Ku-ring-gai										
56		Manly/Mona Vale (Northern Beaches)										
58		Ryde										
60	South Eastern Sydney (pop. 780,000)	Sutherland										
62		Sydney										
64	South Western Sydney (pop. 731,000)	Camden/ Campbelltown (Macarthur HS)										
66		Fairfield										
68	Wentworth (pop. 314,000)	Blue Mountains DAMH/Springwood										
70		Hawkesbury										
72	Western Sydney (pop. 690,000)	Auburn										
74		Blacktown/Mt Druitt										

APPENDIX D – HOSPITAL PROFILES

PROFILE OF METROPOLITAN HOSPITALS – INITIATIVES

The source of data for each of the profiles is from:

- The Department of Health Reporting System (DOHRS) year to date 30 June 2002 and Midwives Data Collection, calendar year 2001. The figures have been rounded off to closest multiple of five for admissions and Emergency Department presentations, and to a single number for number of beds.
- The individual profiles do not include funding for inter-hospital patient transport, which involves several hospitals within an Area Health Service. Annual funding for inter-hospital transport is \$1.980M.
- Funding on a hospital by hospital basis also excludes the \$1.857M being directed for the provision of area networking functions.

APPENDIX D – HOSPITAL PROFILES

WYONG HOSPITAL

CENTRAL COAST AREA HEALTH SERVICE

Profile	2001-2002
Number of Beds	160
Admissions	20,340
Presentations to ED	38,115
Births	366



BACKGROUND SKETCH

The hospital is undergoing a \$80m redevelopment which will add 150 beds for surgical, medical, short stay, theatres and mental health service beds. The hospital is in a fast growth area, the Warnervale/Wadalba estate is now released and will eventually hold 100,000 people. Central Coast has the second oldest population in the State. There is a challenge with public transport. 14 out of 20 operating theatre sessions are used. There is a staff radiologist, no CT scanner or Tele-Reporting services.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
Central Coast (pop. 300,000)	Wyong										

APPENDIX D – HOSPITAL PROFILES

INITIATIVES FUNDED WYONG HOSPITAL

RECURRENT OPERATING

Clinical Leadership

Appointment of a clinician to:

- further support teaching and research
- increase participation of clinicians in local clinical management.

Planned Surgery

Appointment of clinicians and support staff, and purchase of prostheses to:

- meet local needs for orthopaedic services
- increase general surgical services to meet local needs
- provide sustainable on call roster for acute general surgical services
- allow the commissioning of a 7 Day Unit to accommodate growth in surgical services.

Emergency Department

Appointment of additional clinicians and support for a Clinical Director to:

- enhance emergency services to meet local needs.

Integration of Emergency Department to:

- improve patient safety
- improve the provision of emergency services.

Medicine

Appointment of Registrars and a Resident Medical Officer to:

- improve general medicine and geriatric services.

Radiology

Support for the early commissioning of CT services to:

- enhance the diagnostic services provided to patients.

Maternity Services

Clinical integration of a single Maternity Department with Gosford Hospital to:

- provide improved birthing services for women.

Patient Transport

Enhancement of inter-hospital transport to:

- support the effective networking of clinical services between Wyong and Gosford Hospitals.

CAPITAL

Radiology

Support of early commissioning of a CT scanner and Tele-Reporting services to:

- improve diagnostic services for patients.

Recurrent Operating: \$2.786M

Capital: \$0.450M

APPENDIX D – HOSPITAL PROFILES

CANTERBURY HOSPITAL

CENTRAL SYDNEY AREA HEALTH SERVICE

Profile	2001-2002
Number of Beds	149
Admissions	15,150
Presentations to ED	25,345
Births	1,518



BACKGROUND SKETCH

Originally built in 1927, the hospital has been re-built in the last three years on the same site, with only part of the original building remaining. The hospital is part of a well developed clinical stream across the Area for delivery of integrated services. The hospital is port of entry to off-site clinical services. The hospital has four intensive care beds for 24 hour ventilation. Two of the four operating theatres are utilised. The hospital has a CT scanner and Tele-Reporting to Royal Prince Alfred Hospital.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
Central Sydney (pop. 496,000)	Canterbury	↻	↻	↻	↻	↻	↑	↻	↻	↻	↻

INITIATIVE FUNDED CANTERBURY HOSPITAL

RECURRENT OPERATING

Medicine

Appointment of two Medical Registrars to:

- promote the efficiency of flow of patients from the Emergency Department to the appropriate clinical service.

Recurrent Operating: \$0.140M

APPENDIX D – HOSPITAL PROFILES

MAITLAND HOSPITAL

HUNTER AREA HEALTH SERVICE

Profile	2001-2002
Number of Beds	161
Admissions	12,815
Presentations to ED	35,700
Births (2000)	1,299



BACKGROUND SKETCH

The hospital was founded in 1846 from the Caroline Chisholm Immigrants’ Home and Hospital. It provides Level 4/5 services including emergency, critical care, medical, surgical, obstetrics, paediatrics, rehabilitation and aged care.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
Hunter (pop. 521,000)	Maitland										

INITIATIVES FUNDED MAITLAND HOSPITAL

RECURRENT OPERATING

Clinical Leadership
 Appointment of a clinician to:

- further support teaching and research
- increase participation of clinicians in local clinical management.

Planned Surgery
 Appointment of clinicians to:

- enhance the provision of general and orthopaedic surgery.

Emergency Department
 Appointment of additional medical staff to:

- improve the provision of emergency services.

Rehabilitation
 Appointment of a Rehabilitation Physician to the Medical Rehabilitation Unit to:

- enhance the provision of medical rehabilitation.

CAPITAL

Support for Tele-Reporting to:

- improve diagnostic services for patients.

Recurrent Operating: \$0.768M
Capital: \$0.100M

APPENDIX D – HOSPITAL PROFILES

BELMONT HOSPITAL

HUNTER AREA HEALTH SERVICE

Profile	2001-2002
Number of Beds	67
Admissions	6,110
Presentations to ED	17,265
Births (2000)	668



BACKGROUND SKETCH

The hospital was opened in 1968 and is located on the eastern shore of Lake Macquarie. The hospital provides Level 3/4 services in medicine, surgery, obstetrics and gynaecology. Under the Newcastle Strategy, it is proposed to increase the number of beds to 132 by relocating existing beds from the Rankin Park and Wallsend campus. Construction of the first stage of the Belmont Hospital upgrade, which includes a new \$4M Emergency Department, has commenced. A \$1.5M Drug and Alcohol Detoxification Unit at the hospital was opened in July 2002. Cataract surgery has commenced at the hospital.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
Hunter (pop. 521,000)	Belmont										

APPENDIX D – HOSPITAL PROFILES

INITIATIVES FUNDED BELMONT HOSPITAL**RECURRENT OPERATING****Clinical Leadership**

Appointment of a clinician to:

- further support teaching and research
- increase participation of clinicians in local clinical management.

Planned Surgery

Appointment of clinicians to:

- enhance to provision of ENT, gynaecology and urology surgery.

Emergency Department

Appointment of additional medical staff to:

- improve the provision of emergency services.

Stroke Services

Establishment of rehabilitation beds to:

- facilitate the provision of an integrated Area-wide stroke service.

Paediatrics

Additional clinical hours of a paediatrician to:

- support the Level 2 nursery and provide paediatric outpatient clinics.

Palliative Care

Appointment of clinicians to:

- support a four bed Palliative Care Unit.

Patient Transport

Enhancement of inter-hospital transport to:

- support the effective networking of clinical services between Belmont and John Hunter Hospitals.

Recurrent Operating: \$2.176M

APPENDIX D – HOSPITAL PROFILES

NEWCASTLE MATER MISERICORDIAE HOSPITAL

HUNTER AREA HEALTH SERVICE

Profile	2001-2002
Number of Beds	170
Admissions	10,730
Presentations to ED	25,225
Births	n/a



BACKGROUND SKETCH

An affiliated hospital owned and operated by the Sisters of Mercy (Singleton). Provides an important district role with tertiary Level 6 cancer treatment services in medical oncology, clinical haematology, radiotherapy and palliative care, as well as general medical and surgical services supported by an Intensive Care Unit, a Coronary Care Unit and clinical pharmacology services. The local community strongly supports the NBN Telethon Mater Institute which consolidates a range of services and research relating to breast cancer and melanoma on one site. The Hospital is to be redeveloped.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
Hunter (pop. 521,000)	Newcastle Mater Misericordiae										

INITIATIVES FUNDED NEWCASTLE MATER MISERICORDIAE HOSPITAL

RECURRENT OPERATING

Intensive Care Services

Backfill and administrative support of an Area Director to:

- support the integration of intensive care services.

Stroke Services

Appointment of clinicians to:

- establish a Stoke Unit as part of an Area-wide stroke service.

CAPITAL

Purchase of equipment to:

- provide haemodialysis.

Recurrent Operating: \$0.150M

Capital: \$0.050M

APPENDIX D – HOSPITAL PROFILES

BULLI HOSPITAL

ILLAWARRA AREA HEALTH SERVICE	
Profile	2001-2002
Number of Beds	52
Admissions	5,075
Presentations to ED	9,726
Births	n/a



BACKGROUND SKETCH

The hospital is 100 years old and has strong links to the local community. It was originally founded by coal miners. The local area has a mixture of young families and older people. There are two operating theatres. There are no maternity or intensive care services, these services are provided at Wollongong Hospital.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
Illawarra (pop. 345,000)	Bulli										

INITIATIVES FUNDED BULLI HOSPITAL

RECURRENT OPERATING

Clinical Leadership
 Appointment of a clinician to:

- further support teaching and research
- increase participation of clinicians in local clinical management.

Planned Surgery
 Appointment of medical, nursing and allied health staff and purchase of theatre equipment to:

- develop a surgical centre in general surgery, ophthalmology, ENT and orthopaedics.

Emergency Department
 Development of a single Emergency Department with Wollongong Hospital to:

- improve the delivery of emergency services to the local community.

Patient Transport
 Enhancement of inter-hospital transport to:

- support the effective networking of clinical services between Bulli and Wollongong hospitals.

CAPITAL

A planning study to:

- facilitate improvement to the physical facility.

Recurrent Operating: \$1.044M
Capital: \$0.100M

APPENDIX D – HOSPITAL PROFILES

SHELLHARBOUR HOSPITAL

ILLAWARRA AREA HEALTH SERVICE

Profile	2001-2002
Number of Beds	139
Admissions	14,930
Presentations to ED	22,135
Births	383



BACKGROUND SKETCH

Built in 1988. The local area has a wide range of socio economic groups with a sizeable Department of Housing area, and development of rural areas into residential areas is proceeding rapidly. There are no intensive care beds and two operating theatres. CT procedures are done at Wollongong Hospital and currently there are no Tele-Reporting services. University of NSW Teaching Hospital.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
Illawarra (pop. 345,000)	Shellharbour										

APPENDIX D – HOSPITAL PROFILES

INITIATIVES FUNDED SHELLHARBOUR HOSPITAL**RECURRENT OPERATING****Clinical Leadership**

Appointment of a clinician to:

- further support teaching and research
- increase participation of clinicians in local clinical management.

Emergency Department

Appointment of additional clinicians and support for a Director of the Emergency Department to:

- enhance emergency services to meet the local needs.

Maternity Services

Clinical integration of a single Maternity Department with Wollongong Hospital to:

- provide improved birthing services for women.

Patient Transport

Enhancement of inter-hospital transport to:

- support the effective networking of clinical services between Shellharbour and Wollongong Hospitals.

CAPITAL**Emergency Department** (NSW 2002/2003 State Budget)

Refurbishment of the Emergency Department to:

- improve the provision of emergency services.

Acute Care

Purchase monitoring equipment for the Acute Care Unit to:

- improve patient safety.

Recurrent Operating: \$0.480M

Capital: \$0.100M (In addition, the NSW 2002/2003 State Budget provided \$5M for the expansion of emergency services by extending the existing Emergency Department)

APPENDIX D – HOSPITAL PROFILES

HORNSBY KU-RING-GAI HOSPITAL

NORTHERN SYDNEY AREA HEALTH SERVICE

Profile	2001-2002
Number of Beds	283
Admissions	16,810
Presentations to ED	21,520
Births	924



BACKGROUND SKETCH

Initially built in 1931 with strong links to the local community. Many buildings on the campus are in need of repair and upgrade. Has an 11 bed combined ICU/CCU and five operating theatres. There is no established Stroke Unit. Has 24 hour access to a CT Scanner. University of Sydney Teaching Hospital with a strong academic GP Unit and academic appointments.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
Northern Sydney (pop. 752,000)	Hornsby Ku-ring-gai										

INITIATIVES FUNDED HORNSBY KU-RING-GAI HOSPITAL

RECURRENT OPERATING

Clinical Leadership

Appointment of a clinician to:

- further support teaching and research
- increase participation of clinicians in local clinical management.

Planned Surgery

Appointment of a surgical clinical nurse educator and registrars to:

- provide additional sessions, with specific attention to ENT, urology, general surgery and orthopaedics.

Emergency Department

Appointment of clinicians to:

- enhance emergency services.

Intensive Care Unit

Appointment of clinicians to:

- support the development of a Level 2 Intensive Care Unit.

Stroke Services

Appointment of clinicians and establishment of a Stroke Unit to:

- enhance stroke services.

APPENDIX D – HOSPITAL PROFILES

INITIATIVES FUNDED CONTINUED **HORNSBY KU-RING-GAI HOSPITAL**

Medicine

Appointment of clinicians to:

- enhance the Aged Care Assessment Unit to meet the assessment and management of the acutely ill aged.

Allied Health

Appointment of additional allied health staff to:

- optimise earlier and safer discharge with improved health outcomes, including reduced hospital representation.

Maternity Services

Appointment of clinicians to:

- improve the safety and continuity of care for pregnant women through increased access to specialist assessment and management
- improve out of hours coverage
- provide additional training and education of medical and midwifery staff.

Patient Transport

Enhancement of inter-hospital transport to:

- support the effective networking of clinical services between Hornsby and Royal North Shore Hospitals.

CAPITAL

Redevelopment (NSW 2002/2003 State Budget)

Accelerated funding for refurbishment of Emergency Department, maternity and paediatric buildings to:

- improve the provision of emergency, maternity and paediatric services.

Stroke Service

- Establishment of a Stroke Unit.

Recurrent Operating: **\$3.209M**

Capital: \$0.208M (In addition, the NSW 2002/2003 State Budget provided \$16.4M for new facilities for obstetrics, paediatrics and emergency services at Hornsby/Ku-ring-gai Hospital)

APPENDIX D – HOSPITAL PROFILES

MANLY/MONA VALE HOSPITAL (NORTHERN BEACHES)

NORTHERN SYDNEY AREA HEALTH SERVICE

MANLY SITE

Profile	2001-2002
Number of Beds	171
Admissions	13,400
Presentations to ED	17,555
Births	813



BACKGROUND SKETCH

University of Sydney Teaching Hospital with excellent training, research and academic appointments. Has strong community links. Well supported by local service clubs for equipment and special projects. Has very old building stock. Has a combined Intensive Care Coronary Care Unit – three ventilated beds and four operating theatres, of which three are commissioned and two used. There is no established Stroke Unit. There is a full private radiology service with Tele-Reporting after hours.

MONA VALE SITE

Profile	2001-2002
Number of Beds	143
Admissions	12,055
Presentations to ED	21,165
Births	633



BACKGROUND SKETCH

The buildings are well maintained and there is strong community involvement. A University of Sydney Teaching Hospital. The hospital has a five bed combined ICU/CCU with two ventilated beds. There are four operating theatres, three commissioned and two in use. There is a full private radiology service with Tele-Reporting after hours.

GMT² endorses the concept of a single Northern Beaches hospital and suggests a decision be made urgently regarding this and the determination of its site. Notwithstanding where the new Northern Beaches hospital will be sited, GMT² recommends that the functioning of a 'single clinical service on two hospital sites' be enacted immediately.

Such a clinical service would mean:

- joint appointments at both hospitals
- single clinical departments for Northern Beaches moving quickly towards effective provision of clinical resources at both sites with enhancements
- integrated Maternity Department.

The GMT² initiatives are for the immediate future and have no bearing on the decision of the site for a single Northern Beaches hospital.

APPENDIX D – HOSPITAL PROFILES

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
Northern Sydney (pop. 752,000)	Manly/Mona Vale										

INITIATIVES FUNDED MANLY/MONA VALE HOSPITAL (NORTHERN BEACHES)

RECURRENT OPERATING

Emergency Department

Appointment of additional medical and nursing staff to:

- improve the provision of emergency services.

Intensive Care Services

Appointment of a Critical Care Director and a Clinical Nurse Consultant for Manly/Mona Vale (Northern Beaches) and refurbishment at Manly to:

- improve the coordination of intensive care services and educational support
- improve the provision of intensive care services at the Manly site.

Stroke Services

Appointment of clinicians and the establishment of a Stroke Unit (Manly site) to:

- enhance the provision of stroke services.

Medicine

Appointment of medical staff to:

- enhance the provision of oncology and general medical services.

Paediatrics

Appointment of medical staff to:

- enhance paediatric inpatient services (Mona Vale site).

Maternity Services

Clinical integration of a single Maternity Department – Manly/Mona Vale (Northern Beaches) to:

- provide improved birthing services for women.

Patient Transport

Enhancement of inter-hospital transport to:

- support the effective networking of clinical services between Royal North Shore Hospital and Manly/Mona Vale (Northern Beaches).

CAPITAL

Emergency Department

Refurbishment of Emergency Department to:

- improve provision of emergency services.

Intensive Care Services

Refurbishment of the Intensive Care Unit (Manly site) to:

- improve provision of intensive care services

Stroke Service

- Establishment of a Stroke Unit (Manly site).

Maternity

Refurbishment of Birthing Centre to:

- support a Birthing Centre (Mona Vale site).

Recurrent Operating: \$1.455M

Capital: \$1.182M

APPENDIX D – HOSPITAL PROFILES

RYDE HOSPITAL

NORTHERN SYDNEY AREA HEALTH SERVICE

Profile	2001-2002
Number of Beds	173
Admissions	10,565
Presentations to ED	20,130
Births	564



BACKGROUND SKETCH

Ryde Hospital first opened in 1934 and has strong community links. Denistone House (original building) is heritage listed. The hospital serves a population that is older than the state average. 23% of the population are of a culturally and linguistically diverse background (major ethnic groups are Chinese, Italian, Arabic & Greek). University of Sydney Teaching Hospital with clinical academic appointments. The hospital has a six bed Intensive Care Unit which accommodates ventilated patients overnight only. There are three operating theatres plus a minor procedure room for Monday to Friday sessions (0800-1700) and after hours emergencies. The hospital has 24 hour access to a CT scanner and a staff radiologist but does not have Tele-Reporting services.

GMT² recommends an overall concept of clinical linkages with Royal North Shore Hospital while maintaining the identity of Ryde Hospital.

Increased Registrar rotation and development of cardiac rehabilitation.

Maternity Services

Clinical integration of a single Maternity Department with Royal North Shore Hospital to:

- provide improved birthing services for women.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
Northern Sydney (pop. 752,000)	Ryde										

APPENDIX D – HOSPITAL PROFILES

INITIATIVES FUNDED RYDE HOSPITAL**RECURRENT OPERATING****Clinical Leadership**

Appointment of a clinician to:

- further support teaching and research
- increase participation of clinicians in local clinical management.

Planned Surgery

Appointment of clinicians and purchase of prostheses to:

- develop a centre for general surgery, and in particular orthopaedic surgery.

Orthopaedic Surgery

Appointment of a Fellow in Orthopaedics to:

- support the centre for elective surgery.

Medicine

Appointment of medical, nursing and allied health staff to:

- establish a diabetic ancillary service.

Radiology

Purchase of a CT scanner as well as the infrastructure support to:

- improve the diagnostic services for patients.

Patient Transport

Enhancement of inter-hospital transport to:

- support the effective networking of clinical services between Ryde and Royal North Shore Hospital.

CAPITAL**Emergency Department**

Refurbish the Emergency Department to:

- improve the provision of emergency services.

Operating Theatres

Refurbishment of the operating theatres to:

- support the development of a centre for planned surgery.

Radiology

Support for Tele-Reporting to:

- improve the diagnostic services for patients.

Recurrent Operating: \$1.451M

Capital: \$2.150M

APPENDIX D – HOSPITAL PROFILES

SUTHERLAND HOSPITAL

SOUTH EASTERN SYDNEY AREA HEALTH SERVICE

Profile	2001-2002
Number of Beds	264
Admissions	19,375
Presentations to ED	28,670
Births	737



BACKGROUND SKETCH

Initially built in 1958 the hospital is currently being redeveloped and is due for completion in 2003 at a cost of \$82.5M. It has well integrated clinical services with St George Hospital. University of New South Wales Teaching Hospital with academic appointments. The hospital has six intensive care beds and six operating theatres. There is a staff radiologist. Radiology on call roster for radiologists and sonographers is being developed with St George Hospital. 24 hours access to CT scanner and has a Tele-Reporting service.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
South Eastern (pop. 780,000)	Sutherland										

APPENDIX D – HOSPITAL PROFILES

INITIATIVES FUNDED SUTHERLAND HOSPITAL**RECURRENT OPERATING****Clinical Leadership**

Appointment of a clinician to:

- further support teaching and research
- increase participation of clinicians in local clinical management.

Planned Surgery

Appointment of allied health staff to:

- enhance surgical services by comprehensive intervention at the pre-admission stage.

Stroke Services

Appointment of clinicians and establishment of a Stroke Unit to:

- enhance the provision of stroke services.

Medicine

Appointment of registrars and allied health staff to:

- enhance the provision of general medical services.

Rehabilitation

Appointment of allied health staff to:

- enhance rehabilitation of patients by early, comprehensive multidisciplinary assessments resulting in improved care and timely discharge.

Maternity Services

Clinical integration of a single Maternity Department with St George and Royal Hospital for Women Hospitals to:

- provide improved birthing services for women.

CAPITAL**Intensive Care Services**

Purchase of monitoring equipment to:

- enhance the provision of intensive care services.

Radiology

Support for Tele-Reporting to:

- improve the diagnostic services for patients.

Stroke Service

- Establishment of a Stroke Unit.

Recurrent Operating: \$0.982M

Capital: \$0.308M

APPENDIX D – HOSPITAL PROFILES

SYDNEY HOSPITAL (includes Sydney Eye Hospital)

SOUTH EASTERN SYDNEY AREA HEALTH SERVICE

Profile	2001-2002
Number of Beds	73
Admissions	9,080
Presentations to ED	19,220
Births	n/a



BACKGROUND SKETCH

Oldest hospital in Australia. Heritage listed. The hospital primarily serves residents and tourists to the inner city of Sydney as well as a large homeless population, (estimated at 3,000), with the associated problems of mental illness, alcohol and drug abuse. It also caters for the 250,000 people in and out of the city each business day, as well as major city events. University of New South Wales Teaching Hospital. The hospital has a High Dependency Unit. There are six operating theatres, one is not utilised. There are off-site private radiology services with access to CT scanner during business hours. Has an excellent Hand Unit and provides consultative service for the Sydney Eye Hospital.

GMT² proposes that Sydney Hospital functions as a combined clinical service with Prince of Wales Hospital within a timeframe to be determined by the Area Health Service.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
South Eastern (pop. 780,000)	Sydney										

APPENDIX D – HOSPITAL PROFILES

INITIATIVES FUNDED SYDNEY HOSPITAL**RECURRENT OPERATING****Planned Surgery**

Appointment of clinicians to:

- enhance the provision of surgical services in ENT, day of surgery, general surgery and orthopaedics.

Emergency Department

Development of an integrated Emergency Department service between Prince of Wales Hospital and Sydney Hospital to:

- improve patient safety.

Medicine

Progressive cross-appointments and networking to:

- ensure that the population of eastern Sydney and the CBD has its services appropriately networked.

CAPITAL**Radiology**

Support for Tele-Reporting to:

- improve the diagnostic services for patients.

Recurrent Operating: \$0.900M

Capital: \$0.100M

APPENDIX D – HOSPITAL PROFILES

CAMDEN/CAMPBELLTOWN HOSPITALS (MACARTHUR HEALTH SERVICE)

SOUTH WESTERN SYDNEY AREA HEALTH SERVICE

CAMDEN SITE

Profile	2001-2002
Number of Beds	46
Admissions	5,795
Presentations to ED	12,060
Births	n/a



BACKGROUND SKETCH

Expected rapid population growth at Narellan and Mt Annan. Sound building. The hospital provides antenatal and postnatal services and a successful Area ambulatory care scheme. A University of New South Wales Teaching Hospital.

CAMPBELLTOWN SITE

Profile	2001-2002
Number of Beds	243
Admissions	21,195
Presentations to ED	34,130
Births	2,617



BACKGROUND SKETCH

A large urban indigenous population. 90% of the local population is over 25 years and 30% from a culturally and linguistically diverse background. Redevelopment currently in progress at a capital cost of approximately \$85M. The hospital has intensive care beds, eight operating theatres are proposed. There is no established Stroke Unit. Tele-Reporting services are available. A University of New South Wales Teaching Hospital.

GMT² acknowledges the development of Macarthur Health Service over two campuses – Camden and Campbelltown. Because of projected population growth, particularly near Camden, a review of service distribution between the two campuses should occur in three years.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
South Western (pop. 731,000)	Camden/ Campbelltown										

APPENDIX D – HOSPITAL PROFILES

INITIATIVES FUNDED CAMDEN/CAMPBELLTOWN HOSPITALS**RECURRENT OPERATING****Planned Surgery**

Appointment of a fourth Neurosurgeon to the Area with cross-appointment to Campbelltown to:

- provide an additional surgical list (Campbelltown site).

Emergency Department

Integration of Emergency Departments to:

- improve patient safety
- improve the provision of emergency services.

Stroke Services

Appointment of clinicians and establishment of a Stroke Unit (Campbelltown site) to:

- enhance the provision of stroke services.

Medicine

Appointment of medical staff to:

- enhance the provision of services in medicine
- improve patient access.

Radiology

Provision of extended hours of CT services across both campuses to:

- improve diagnostic services to patients.

Maternity Services

Clinical integration of a single Maternity Department with a concentration of birthing activities at Campbelltown and continue antenatal and postnatal services at Camden to:

- provide improved birthing services for women.

Patient Transport

Enhancement of inter-hospital transport to:

- support the effective networking of clinical services between Camden/Campbelltown and Liverpool Hospital.

CAPITAL**Emergency Department**

Minor refurbishment at Camden Emergency Department to:

- improve the provision of emergency services.

Radiology

Support for Tele-Reporting (Camden site) to:

- improve the diagnostic services for patients.

Stroke Service

- Establishment of a Stroke Unit (Campbelltown site).

Recurrent Operating: \$1.795M

Capital: \$0.308M

APPENDIX D – HOSPITAL PROFILES

FAIRFIELD HOSPITAL

SOUTH WESTERN SYDNEY AREA HEALTH SERVICE

Profile	2001-2002
Number of Beds	180
Admissions	15,520
Presentations to ED	25,675
Births	1,856



BACKGROUND SKETCH

The hospital is situated in an area comprising a diverse culturally, linguistic population, with a significant refugee population. It is perceived by many locals that the Emergency Department is the point of entry for all health services. The hospital plays a significant role in the provision of primary health services to the local community. Strong maternity and paediatric services. Public transport to the hospital is lacking. There are ten high dependency beds with overnight cover by the Emergency Department, Career Medical Officer. Patients in intensive care are ventilated for up to 48 hours. There are four operating theatres with an average use of 2.5- 3. The hospital has a CT scanner on site. University of New South Wales Teaching Hospital.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
South Western (pop. 731,000)	Fairfield										

APPENDIX D – HOSPITAL PROFILES

INITIATIVES FUNDED **FAIRFIELD HOSPITAL****RECURRENT OPERATING****Clinical Leadership**

Appointment of a clinician to:

- further support teaching and research
- increase participation of clinicians in local clinical management.

Nurse Education

Appointment of a Clinical Nurse Educator to:

- assist in providing ongoing nursing education
- assist with the delivery of safer nursing services.

Planned Surgery

Appointment of clinicians and the purchase of prostheses to:

- enhance elective general and orthopaedic services
- improve the assessment and follow through of aged care patients.

Medicine

Appointment of Medical Registrars to:

- enhance and support the delivery of general medical services.

Paediatric Services

Appointment of a Paediatric Registrar to:

- enhance and support the delivery of paediatric services.

Radiology

Provision of extended hours of CT services to:

- improve diagnostic services to patients.

Patient Transport

Enhancement of inter-hospital transport to:

- support the effective networking of clinical services between Fairfield and Liverpool Hospitals.

CAPITAL**Emergency Department**

Refurbishment of Emergency Department to:

- improve the provision of emergency services.

Radiology

Support for Tele-Reporting to:

- improve diagnostic services to patients.

Recurrent Operating: \$1.510M

Capital: \$0.350M

APPENDIX D – HOSPITAL PROFILES

BLUE MOUNTAINS DISTRICT ANZAC MEMORIAL HOSPITAL (KATOOMBA) AND SPRINGWOOD HOSPITAL

WENTWORTH AREA HEALTH SERVICE

BLUE MOUNTAINS DISTRICT ANZAC MEMORIAL HOSPITAL (KATOOMBA)

Profile	2001-2002
Number of Beds	86
Admissions	6,485
Presentations to ED	16,205
Births	386



BACKGROUND SKETCH

Blue Mountains District ANZAC Memorial Hospital is 76 years old, with some buildings being heritage listed. It has very strong links with the community. 26 townships spread in ribbon development along the central ridge of the Blue Mountains for 100km, which with climatic conditions makes patient transport challenging. The hospital has four intensive care beds with a new Unit being built. The hospital has two operating theatres, with the average of only one being used. The hospital has access to an old CT scanner but does not have Tele-Reporting services.

SPRINGWOOD HOSPITAL

Profiles	2001-2002
Number of beds	29
Admissions	1,405
Presentations to ED	n/a
Births	n/a

BACKGROUND SKETCH

The hospital focuses on providing rehabilitation, respite, palliative care and day-only surgery services. There is no Emergency Department.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
Wentworth (pop. 314,000)	Blue Mountains /Springwood										

APPENDIX D – HOSPITAL PROFILES

INITIATIVES FUNDED BLUE MOUNTAINS ANZAC MEMORIAL/SPRINGWOOD HOSPITAL**RECURRENT OPERATING****Planned Surgery at Blue Mountains ANZAC Memorial and Springwood**

Appointment of clinicians (anaesthetists, critical care clinicians, surgeons, nurses) to:

- provide additional surgical services five days per week.

Critical Care Services

Establish a pilot project with internet technology (cooperation with CSIRO) using tel-presence/virtual intensivist on site at Blue Mountains ANZAC Memorial Hospital to:

- enhance the critical care services at Blue Mountains ANZAC Memorial Hospital with critical care link to Nepean operating as one Unit on two sites.

Medicine

Appointment of a fourth physician to:

- enhance general medical services.

Rehabilitation

Appointment of medical staff to:

- enhance the rehabilitation service at Springwood Hospital.

Radiology

Purchase of a CT scanner and the infrastructure support to:

- improve the diagnostic services for patients.

Maternity Services

To develop a single Maternity Department across Wentworth Area Health Service. Working parties are to explore innovative options for 2003 by researching models of maternity services to:

- provide improved birthing services for women.

Clinical Services

Registrar rotations from Nepean to:

- provide a wider scope of training
- enhance medical services.

Patient Transport

Enhancement of inter-hospital transport to:

- support the effective networking of clinical services between Blue Mountains ANZAC and Nepean Hospitals.

CAPITAL (NSW 2002/2003 State Budget)

Construction of a Helipad to:

- improve the provision of emergency services to patients entering the Blue Mountains ANZAC Hospital.

Radiology

Support for Tele-Reporting to:

- improve the diagnostic services to patients.

Recurrent Operating: \$0.669M (\$1.890M will be shared across Wentworth Area Health Service for planned surgery services)

Capital: \$0.100M (In addition the NSW 2002/2003 State Budget provided \$6M for a major redevelopment of clinical and inpatient units, including \$1.300M for construction of a helipad)

APPENDIX D – HOSPITAL PROFILES

HAWKESBURY HOSPITAL

WENTWORTH AREA HEALTH SERVICE

Profile	2001-2002
Number of Beds	127
Admissions	6,225
Presentations to ED	20,730
Births (2000-2001)	972



BACKGROUND SKETCH

Hawkesbury Hospital provides an integrated health service located at Windsor, 40km north west of Sydney, treating public patients under contract to Wentworth Area Health Service. Managed by Catholic Health Care Services. The hospital has three operating theatres, 24 hour Emergency Department, Day Surgery Unit, Maternity, Neonatal, combined Intensive Care/Coronary Care Unit, palliative care, medical and surgical services as well as extensive community and allied health services. This hospital serves a community of over 60,000 on the edge of one of the fastest growing areas in Sydney.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
Wentworth (pop. 314,000)	Hawkesbury										

APPENDIX D – HOSPITAL PROFILES

INITIATIVES FUNDED HAWKESBURY HOSPITAL

RECURRENT OPERATING

Clinical Leadership

Appointment of a clinician to:

- further support teaching and research
- increase participation of clinicians in local clinical management.

Planned Surgery

Appointment of clinicians to:

- enhance planned surgery, particularly in orthopaedics.

Rehabilitation

Appointment of a Rehabilitation Physician to:

- enhance the provision of rehabilitation services.

Patient Transport

Enhancement of inter-hospital transport to:

- support the effective networking of clinical services between Hawkesbury and Nepean Hospitals.

Recurrent Operating: \$0.440M (Planned surgery service funding will be shared across Wentworth Area Health Service)

APPENDIX D – HOSPITAL PROFILES

AUBURN HOSPITAL

WESTERN SYDNEY AREA HEALTH SERVICE

Profile	2001-2002
Number of Beds	109
Admissions	13,605
Presentations to ED	20,295
Births (2000)	1,444



BACKGROUND SKETCH

The hospital is situated in a culturally and linguistically diverse community. The hospital has developed expertise in transcultural health issues, particularly women’s health, community and chronic care, and innovative models of management of planned surgery. It has a strong local presence and strong community support. There is a four bed Intensive Care Unit which ventilates for 24 hours. There are six operating theatres with an average 3.5 available for use. Currently the radiology services are under development for linking with Westmead. Has access to CT scanner.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
Western Sydney (pop. 690,000)	Auburn										

APPENDIX D – HOSPITAL PROFILES

INITIATIVES FUNDED AUBURN HOSPITAL**RECURRENT OPERATING****Planned Surgery**

Appointment of nursing staff, administrative support and prostheses to:

- enhance surgical services with an emphasis on a centre for short stay/day surgery, particularly in general surgery, orthopaedics, plastic surgery, ENT and gynaecology.

Trans-Cultural Health Centre

Establish a Special Unit by appointment of staff and infrastructure to:

- provide an innovative approach to cultural equity in health, to be incorporated into mainstream management and service delivery structures
- improve the quality of service delivery and provide community education and health promotion, as it will increase the degree to which health services reflect community needs.

Radiology

Purchase of a CT scanner and the infrastructure support to:

- improve the diagnostic services to patients.

Patient Transport

Enhancement of inter-hospital transport to:

- support the effective networking of clinical services between Auburn and Westmead Hospitals.

CAPITAL**Radiology**

Works associated with installation of CT scanner to:

- improve the diagnostic services to patients.

Trans-Cultural Health Centre

Establishment of the centre to:

- provide an innovative approach to cultural equity in health to be incorporated into mainstream management and service delivery structures
- improve the quality of service delivery and provide community education and health promotion, as it will increase the degree to which health services reflect community needs.

Recurrent Operating: \$0.738M (\$2.164M will be shared between Auburn and Blacktown/Mt Druitt for radiology services)

Capital: \$0.250M

APPENDIX D – HOSPITAL PROFILES

BLACKTOWN/MT DRUITT HOSPITALS

WESTERN SYDNEY AREA HEALTH SERVICE

BLACKTOWN SITE

Profile	2001-2002
Number of Beds	250
Admissions	27,560
Presentations to ED	26,330
Births (2000)	2,776



BACKGROUND SKETCH

Blacktown Hospital was established in 1965 to meet the needs of a semi-rural community on the metropolitan fringe. The community has maintained a rate of growth that places it as one of the fastest growing cities and largest local government areas in Australia. There is a culturally and linguistically diverse population. It also has a significant indigenous population. Networking between the two hospitals led to the linking of services across the sites into a single organisational structure that spanned the two campuses in 1996. The Blacktown site has intensive care beds, five operating theatres and no established Stroke Unit. There is a staff radiologist and a Tele-Reporting from Westmead.

MT DRUITT SITE

Profile	2001-2002
Number of Beds	159
Admissions	16,975
Presentations to ED	26,655
Births	n/a



BACKGROUND SKETCH

Health facilities at Mt Drutt were established as a Polyclinic in 1972. Establishment of this service was primarily targeted at the very rapidly developing population associated with a major development of public housing. Services for children are in high demand for the significantly younger population. It also has a high demand on emergency services. The Mt Drutt site has no maternity services or CT scanning capacity on site and has no local private CT service. It provides two intensive care beds and four operating theatres. There is Tele-Reporting to Westmead.

AREA HEALTH SERVICE	HOSPITAL	CLINICAL LEADERSHIP	PLANNED SURGERY	EMERGENCY DEPART	INTENSIVE CARE	STROKE UNIT	MEDICINE	CT SCANNERS	TELE-REPORTING	MATERNITY SERVICES	PATIENT TRANSPORT
Western Sydney (pop. 690,000)	Blacktown/ Mt Drutt										

APPENDIX D – HOSPITAL PROFILES

INITIATIVES FUNDED BLACKTOWN/MT DRUITT HOSPITALS

RECURRENT OPERATING

Clinical Leadership

Appointment of a clinician to:

- further support teaching and research
- increase participation of clinicians in local clinical management.

Planned Surgery

Appointment of clinicians and purchase of instruments to:

- enhance the Mt Druitt site as a surgical centre for elective general and orthopaedic procedures and sub-speciality services.

Emergency Department

Integration of Emergency Departments to:

- improve patient safety
- improve the provision of emergency services.

Stroke Services

Appointment of clinicians and establishment of a Stroke Unit (Blacktown site) to:

- enhance stroke services.

Medicine

Increase the range of medical activity to:

- enhance the provision of general medicine.

Palliative Care

Commission further beds at the Mt Druitt Palliative Care Unit by the appointment of clinicians as part of an Area-wide service to:

- improve provision of palliative care services.

Radiology

Purchase of a CT scanner as well as the infrastructure support to:

- improve the diagnostic services to patients (Mt Druitt site).

Maternity Services

Development of a outreach antenatal program at the Mt Druitt shopping centre to:

- improve access to antenatal care, especially for the Aboriginal and Torres Strait Islander community.

Patient Transport

Enhancement of inter-hospital transport to:

- support the effective networking of clinical services between Blacktown/Mt Druitt and Westmead Hospitals.

CAPITAL

Radiology

Works associated with installation of a CT scanner to:

- improve the diagnostic services to patients.

Stroke Service

- Establishment of a Stroke Unit (Blacktown site).

Recurrent Operating: \$2.365M (Radiology service funding will be shared between Auburn and Blacktown/Mt Druitt)

Capital: \$0.308M

