Policy Directive

Inter-facility Transfer Process for Adults Requiring Specialist Care

Summary To provide a process for the inter-facility transfer of adult patients requiring specialist care where existing clinical referral pathways do not exist or access to safe and timely care is delayed. Nominated tertiary referral centres are defined and require senior clinicians with facility Patient Flow Units to coordinate the safe and timely transfer of patients. NOTE: This Policy also applies to Local Health Networks until Local Health Districts commence on 1 July 2011.

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Distributed to Public Health System, Divisions of General Practice, Government Medical Officers, Health Associations Unions, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres

Audience Chief Executives;Hospital Executives;Nurses;Medical Officers

Secretary, NSW Health

Policy Directive

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Replaces Doc. No.	Transfer of Patients Between Public Hospitals - Guidelines [GL2005_038]
Author Branch	Agency for Clinical Innovation
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Applies to	Local Health Networks, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Public Health System Support Division, NSW Ambulance Service, Public Hospitals
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Policy Manual	Patient Matters
File No.	H11/6293
Status	Active

Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

NSW GOVERNMENT Health

POLICY STATEMENT

INTER-FACILITY TRANSFER PROCESS FOR ADULT PATIENTS REQUIRING SPECIALIST CARE

PURPOSE

The Clinical Excellence Commission (CEC) “Retrieval and Inter-hospital transfer” Report (December 2009) has demonstrated a need to improve the transfer of patients requiring specialist care. The report reflects an analysis of Incident Information Management System (IIMS) and Root Cause Analysis reports, as well as the outcomes of a CEC Clinical Council Workshop.

The NSW Department of Health agrees with the conclusions contained within the report. Safe, timely and efficient transfer of patients who are not critically ill or injured, but who clinically require urgent specialist assessment and care, is fundamental in the provision of safe medical services across NSW.

A seamless and integrated network of clinical services that best meets the needs of such patients is the aim of this document.

In order to achieve an efficient transfer of patients between primary, secondary and tertiary centres, a streamlined process must exist. Once the specialist care has been delivered a similarly efficient return transfer is essential. This preserves a hospital’s ability to provide specialist service to others in need, and ensures the most appropriate care can be delivered in the most appropriate location

MANDATORY REQUIREMENTS

Access to urgent specialist care and inpatient specialist care should be coordinated by a senior clinician and the Patient Flow Units within the nominated tertiary referral centre where clinical referral pathways do not exist.

Each Local Health District (LHD) must have a process in place by June 2011, outlining policy and operational guidelines on inter-LHD transfer for patients requiring access to specialist care

IMPLEMENTATION

Roles and Responsibilities

Chief Executive (CE) LHD

- Has the direct responsibility for ensuring the implementation of the policy directive and in the delegation of a single point of arbitration as per section 5.0 of the policy directive.

LHD :

- Formalise intra-LHD and inter-LHD referral systems and inter-state (if appropriate) for patients requiring referral for specialist care.

- Align inter-LHD networks for patient transfers within the existing critical care services adult tertiary referral networks, and clearly identify designated tertiary facilities according to the specialist services provided.
- Meet the needs of patients within the LHD, including the provision of clinical advice and access to appropriate treatment prior to transfer and on return to local LHD facility.
- Ensure clinical referral and support processes are clear and effectively communicated to all staff to ensure patients can access required specialist care in an appropriate time frame.

LHD and Facility Patient Flow Units:

- Establish a process whereby Patient Flow Units preferentially use all clinically appropriate options for placement of patients within the originating LHD.
- Develop LHD specific referral pathways utilising designated in-LHD specialist referral facilities.
- Ensure robust processes are in place to facilitate the co-ordination, communication and effective clinical handover of patients transfers within and across the LHDs.
- Develop and publish escalation pathways in the event of delay or disagreement regarding transfer.

NSW Ambulance Service:

- Support public health organisations with the implementation of the Inter-facility transfer process.

REVISION HISTORY

Version	Approved by	Amendment notes
June 2011 (PD2011_031)	Deputy Director-General Health System Quality Performance and Innovation	New Policy replacing GL2005_038
July 1983 (GL2005_038)	Director-General	Guidelines for the transfer of patients between hospitals originally issued as Circular 83/228.

ATTACHMENTS

1. Inter-facility Transfer Process for Adult Patients Requiring Specialist Care: Procedures

Inter-facility Transfer Process for Adult Patients Requiring Specialist Care

NSW GOVERNMENT Health

PROCEDURES

Issue date: June 2011

PD2011_031

CONTENTS

1 PURPOSE

1.1 About this document

The Clinical Excellence Commission (CEC) "Retrieval and Inter-hospital transfer" Report (December 2009) has demonstrated a need to improve the transfer of patients requiring specialist care. The report reflects an analysis of Incident Information Management System (IIMS) and Root Cause Analysis reports, as well as the outcomes of a CEC Clinical Council Workshop.

The NSW Department of Health agrees with the conclusions contained within the report. Safe, timely and efficient transfer of patients who are not critically ill or injured, but who clinically require urgent specialist assessment and care, is fundamental in the provision of safe medical services across NSW.

A seamless and integrated network of clinical services that best meets the needs of such patients is the aim of this document.

In order to achieve an efficient transfer of patients between primary, secondary and tertiary centres, a streamlined process must exist. Once the specialist care has been delivered a similarly efficient return transfer is essential. This preserves a hospital's ability to provide specialist service to others in need, and ensures the most appropriate care can be delivered in the most appropriate location.

This policy does not override:

1. Current referral networks established within the adult, paediatric or perinatal critical care referral network policy directives:
    - *PD2010_021 Critical Care Tertiary Referral Networks and Transfer of Care (Adults)*
    - *PD2010_030 Critical Care Tertiary Referral Networks (Paediatrics)*
    - *PD2010_031 Children and Adolescents – Inter Facility Transfers*
    - *PD2010_069 Critical Care Tertiary Referral Networks (Perinatal)*
2. Current established intra- and inter-Local Health District (LHD) referral pathways which have been established and enable timely access to specialist care. However, where referral pathways do not exist or delays in the transfer of care are experienced, this policy designates a nominated referral pathway to an appropriate facility to manage timely access to specialist care
3. Existing memorandums of understanding governing the transfer of mental health patients between facilities and LHDs.

The following table provides a summary of the referral process, contact pathways and responsibilities for staff when coordinating a patient transfer. Of note is the differentiation between PD2010_021 and PD2011_031.

Clinical Condition	Urgency of Transfer	Refer To	First Phone Call To	Responsibility for Bed Finding and Clinical Advice	Responsibility for Initiating Transport
Critical Care Tertiary Referral Networks and Transfer of Care (Adults) PD 2010_021	Patient has a time-urgent clinical condition needing transfer in the shortest time possible.	Linked Tertiary Hospital	AMRS 1800 650 004	Patient is automatically transported to the linked Tertiary Referral Hospital.	AMRS 1800 650 004
	Patient's condition is not time-urgent	Linked Tertiary Hospital	Linked Tertiary Hospital via documented LHD referral pathway	Linked Tertiary Hospital using Critical Care Resource System Patient Flow Unit AMRS if problems	Referring clinician contacts AMRS
Inter-facility Transfer Process for Adult Patients Requiring Specialist Care	Patient requires transfer for urgent specialist care (within 24hrs)	Linked LHD or Tertiary Hospital	Receiving specialty clinician via documented LHD referral pathways	Receiving specialty clinician via documented LHD referral pathways. Patient accepted at linked Tertiary Hospital if alternate bed cannot be found.	Patient Flow Unit
PD 2011_031	Inpatient requiring specialist care (within 24-72hrs)	Linked LHD or Tertiary Hospital	Receiving specialty clinician via documented LHD referral pathways	Receiving specialty clinician via documented LHD referral pathways. Patient accepted at linked Tertiary Hospital if alternate bed cannot be found.	Patient Flow Unit

1.2 Key definitions

In this document the term:

- **Must** – indicates a mandatory action that must be complied with
- **Should** – indicates a recommended action that should be followed unless there are sound clinical reasons for taking a different course of action
- **Urgent specialist care (<24hrs)** – indicates where patients require specialist intervention to prevent or manage further deterioration within a short time frame (immediate to within 24 hours).

- **Inpatient specialist care (24-72hrs)** – indicates where patients require specialist investigations or management of care not available at originating site (requires transfer within 24 to 72hrs).
- **Patient Flow Units** – represents dedicated patient flow units for the LHD or a facility or the person(s) responsible for patient flow depending on the resources within a given facility. This includes facility Bed Managers and After Hours Nurse Managers.
- **Senior Clinician** – A senior medical officer such as a Consultant, (Staff Specialist or VMO) or Senior Registrar

2 KEY PRINCIPLES

Each LHD must have a clear and readily available policy incorporating the following principles:

- **Good Communication and clinical handover**– between referring and receiving Senior Clinicians that involves the Patient Flow Units, resulting in the coordination of timely and safe patient transfer for ongoing care within medically agreed timeframes.
- **Patient Flow Responsibility** -all facilities have personnel tasked with coordinating patient flow, available 24/7 at all sites (e.g. Patient Flow Manager, After Hours Nurse Manager, Bed Manager).
- **Inter LHD Transfers** – where clinically appropriate patient transfers to occur within the LHD.
- **Existing Clinical Referral Networks**- where existing historical clinical referral networks are working well, these should be continued to facilitate timely access to specialist care. As part of the development of the new LHD Health Care Plans, formalised clinical networks will be determined.
- **Nominated Referral Centres** – accessing the nominated tertiary referral centre where existing clinical referral networks don't exist or where time is delaying the patient's access to ongoing specialist care as per Appendix 2.
- **Direct to inpatient bed** – the patient should be admitted directly to an inpatient bed and avoid the Emergency Department (ED) where possible unless deterioration in the patient's condition requires assessment in the ED.
- **Return Transfers-** on completion of specialist care patients are returned to the originating or other clinically appropriate facility within 24hrs or one working day.
- **Timely Escalation** – immediate escalation is to occur with the appropriate service managers for decision making, when an issue regarding patient transfer arises which will impact on the patient accessing safe and timely care within the medically agreed timeframe.

3 IMPLEMENTATION

3.1 Roles and responsibilities

Chief Executive (CE) LHD

- Has the direct responsibility for ensuring the implementation of the policy directive and in the delegation of a single point of arbitration as per section 5.0 of the policy directive.

LHD :

- Formalise intra-LHD and inter-LHD referral systems and inter-state (if appropriate) for patients requiring referral for specialist care.
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- Ensure clinical referral and support processes are clear and effectively communicated to all staff to ensure patients can access required specialist care in an appropriate time frame.

LHD and Facility Patient Flow Units:

- Establish a process whereby Patient Flow Units preferentially use all clinically appropriate options for placement of patients within the originating LHD.
- Develop LHD specific referral pathways utilising designated in-LHD specialist referral facilities.
- Ensure robust processes are in place to facilitate the co-ordination, communication and effective clinical handover of patients transfers within and across the LHDs.
- Develop and publish escalation pathways in the event of delay or disagreement regarding transfer.

NSW Ambulance Service:

- Support public health organisations with the implementation of the Inter-facility transfer process.

4 ACCESSING THE LEVEL OF CARE REQUIRED

LHDs are required to establish a single telephone contact number within 6 months of implementation. The purpose of this contact number is to provide all clinicians with clinical support and advice on clinical care and access to appropriate care and clinical referral pathways.

Patients who require transfer for specialist treatment fall broadly into two categories:

1. Those who require urgent specialist care (<24hrs) not available at the originating site

2. Those who require inpatient specialist care (24-72 hrs) not available at the originating site

The decision to transfer and determination of the urgency of transfer (medically agreed timeframe) must be made through discussion between the senior clinician at the referring site and a senior clinician from the specialist service at the receiving facility.

Patients and their representatives must be kept informed of any decisions to transfer a patient between facilities.

Delays in transfer of urgent patients must be minimised. If a bed is not available at the receiving hospital within a clinically relevant time or there is a disagreement regarding transfer, LHD policy must provide clear and immediate escalation pathways in advance of the transfer. This should not delay the transfer.

Escalation pathways should involve senior clinicians, facility and LHD executive and Patient Flow Units.

Should the senior clinician at the nominated *receiving* facility not support the patient transfer, they then have a clinical and professional responsibility to assist with patient placement to an appropriate alternative location for treatment and care.

Ongoing delays must be escalated to executive staff of the referring hospital. Communication amongst each facility executive may be required to assist with escalation processes. Such events should be routinely subject to audit and review.

Paramount to all communication between clinicians is the provision of adequate clinical information regarding the patient, sufficient to enable clinicians to make clinical decisions on the most appropriate care for the patient.

It is imperative that facility and LHD Patient Flow Units are involved in the discussions coordinating the patient transfer, and that the Bed Board Tool within the Patient Flow Portal is used to log transfer requests and facilitates good communication. This will allow for streamlined coordination of inter-hospital transfers.

LHDs must ensure a transfer checklist is in place. The use of an inter-facility transfer checklist will assist in standardising practice and ensuring an adequate level of information is provided, assisting clinical handover of the patient. (See Appendix 1 for an example of an inter-hospital transfer checklist.)

4.1 For urgent specialist care (<24hrs)

Transfer of patients for urgent specialist care must occur within 24 hours. The transfer of these patients requires a coordinated approach between the referring and accepting senior clinician (or their representative) and the receiving and sending Patient Flow Units. **Direct transfer to an appropriate inpatient bed should be the first preference**.

Prior to transfer, the referring senior clinician must:

1. Determine transfer urgency in consultation with the receiving senior clinician (the Patient Flow Unit at the facility should be working with the Clinicians to identify a transfer timeframe that best meets the patient's needs.
2. Contact the person responsible for allocating beds at the receiving hospital. (Bed Manager, After Hours Nurse Manager, Patient Flow Unit)
3. Ensure the transfer is made in a timeframe that is appropriate to the patient's clinical condition and provide an accurate estimated time of arrival.
4. Determine the appropriate form of clinical transportation and level of supervision for the patient in consultation with the receiving senior clinician
5. Provide copies of appropriate documentation with the patient which must include the patient's clinical notes, medication chart, current investigation results and referring and receiving doctor contact details.

A patient who is at risk of deterioration should be considered for early transfer to a facility where their care could be managed more effectively. At any time should the patient's condition deteriorate and become critical, *PD2010_021 Critical Care Tertiary Referral Networks and Transfer of Care (Adults)* should be utilised to ensure the patient has access to the appropriate level of care required in a timely manner.

Patients should be transferred directly to their allocated inpatient bed or a clinically appropriate area on arrival to the receiving facility (irrespective of time of day). It is the responsibility of the accepting team to conduct a timely review. If a patient's condition has deteriorated en route to the receiving facility, assessment may be required in the Emergency Department. The Emergency Department senior clinician should be notified, if this is required, and provided with a clinical handover prior to arrival at the receiving facility.

4.2 For Inpatient specialist care (24-72 hrs)

Transfer of inpatients for specialist care should occur within business hours wherever possible. The transfer process must be coordinated between the referring senior clinician, the accepting senior clinician and the Patient Flow Unit, and include agreement on timelines around the transfer.

4.2.1 In hours

Patients who are being transferred from a hospital ward/unit for the purpose of ongoing specialist care do not generally require clinical assessment or treatment by Emergency Department staff at the receiving facility unless the patient has deteriorated en route. Their admission should be managed by inpatient specialist teams in appropriate

inpatient/ward areas. This assessment should be carried out in a similar timeframe to transfers from the emergency department.

4.2.2 Out of hours

Outside business hours, and where specialist inpatient teams are not available within a reasonable time frame, local policy should clearly state arrangements regarding:

1. The specific location within the facility where the patient will be transferred for specialist assessment and management
2. The process for conducting the initial assessment and management.

Patient safety should guide the decision on where the patient is most appropriately placed.

4.3 For return transfer of care post specialist assessment review or intervention

All patients that require specialist care must be transferred with the understanding that when the specialty services are no longer required, care of the patient will be transferred back to the originating hospital, or a hospital with an equivalent level of care capability close to the patient's geographical home location.

This ensures that specialist services are available for others in need and that care is delivered to the patient in the most appropriate setting. The treating specialist team is responsible for initiating return transfers of care and should liaise with the admitting team at the receiving facility to negotiate the plan for transfer. The Patient Flow Unit must be included in the discussions and transfer information including contact details of individuals logged in the Bed Board application within the Patient Flow Portal.

LHD policy must clearly outline the return referral process. The policy must reinforce that:

1. The specialist hospital must notify the receiving hospital that the patient is ready for return transfer and provide a clinical handover informing them of the patient's clinical condition and management
2. Relevant details must be entered onto NSW Bed Board via the Patient Flow Portal
3. The receiving hospital should give the returning patient priority in bed allocation and avoid return transfer through the emergency department
4. The planned inter-facility return transfer should occur within 24 hours or 1 working day of notification
5. Transfers to rural areas must consider the availability of a medical officer to admit the patient back into a facility and relevant clinical health support when coordinating the patient transfer.
6. Escalation pathways should be in place to address transfer delays outlining the person(s) responsible for managing the escalation and action to be taken.

5 GOVERNANCE

The Chief Executive (CE) of the receiving LHD is responsible for ensuring coordination of inter-facility transfers for patients requiring access to specialist care.

If a situation arises where issues are encountered in coordinating appropriate care for patients requiring specialist care or return transfer patients, these issues are to be escalated via the hospital's and LHDs organisational management structure. In the event that a resolution cannot be reached the issues are then to be escalated to a position delegated by the CE LHD of no less than tier 2 level. The CE LHD or delegate is required to ensure a process is in place to:

I. Activate the nominated tertiary referral hospital pathway
II. Implement return patient transfer pathway

Resolutions of issues are to be managed at the CE LHD to CE LHD level to ensure policy compliance results in patient accessing safe and timely specialist care.

6 THE TRANSFER NETWORK

Due to the variety of indications for transfer for specialist review, specific clinical conditions cannot be described here. Transfer of patients may need to occur within LHD (intra-LHD transfer) and between LHDs (inter-LHD transfer). LHD Policy should reflect the need for intra-LHD and inter-LHD transfer of patient to access specialist care. Operational guidelines should include clear processes that link the transfer to an accepting clinician, Patient Flow Manager and transport at the same time.

In line with the *PD2010_021 Critical Care Tertiary Referral Networks and Transfer of Care (Adults)* the CE LHD or delegate is responsible for ensuring the appropriate referral arrangements are in place for all non-critical patients requiring referral for specialist care. Formalised specialist clinical referral networks and referral processes must be in place to guide and assist clinicians to ensure appropriate and timely patient referrals.

Where cross-jurisdictional border arrangements are in place i.e. Victorian, Queensland, Australian Capital Territory and South Australian borders, this policy supports existing arrangements. However where delays occur in accessing timely care for patients, transfer to the nominated referral hospital must be considered. These clinical referral networks are as per, PD2010_021 NSW Critical Care Tertiary Referral Networks & Transfer of Care (Adults), which defines the links between LHDs, and tertiary referral hospitals for specialist clinical care. (Appendix 2)

Justice Health does not have acute health care facilities, but seeks acute services from LHDs where necessary, generally through emergency departments. Liaison with Justice Health is critical prior to transfer of care back to Justice Health, to ensure ongoing care needs are met.

6.1 Intra LHD transfers

LHDs are responsible for developing intra LHD links to assist clinicians in transferring patients that require specialist care.

LHD policy must clearly identify

- The process for coordinating the transfer (which includes the Patient Flow Units)
- The facilities responsible for accepting particular patient cohorts by speciality need.

6.2 Inter LHD transfers

If intra LHD specialist services are not available it will be necessary to escalate the transfer to a facility in another LHD.

Local policy should indicate who is responsible for coordinating inter LHD transfer and reflect the following steps.

1. Unless an alternative clinically appropriate transfer is agreed, inter LHD transfers should follow the nominated clinical referral networks used for critically ill or injured patients to tertiary referral centres

2. If the nominated tertiary referral hospital has issues accepting the patient, and the patient has an urgent condition, transfer must not be delayed: LHD escalation pathways must be activated to ensure the patient has timely access to specialist care.

3. If a patient can receive equivalent and effective specialised care in a less acute facility within the tertiary referral LHD, the tertiary referral centre will arrange treatment in that facility.

4. Any patient transfer should take into account the receiving hospital's distance from the patient's home and the impact this may have on the patient's relatives and carer(s).

5. The final decision must be made by the receiving senior clinician in consultation with the referring senior clinician and the Patient Flow Units.

6. If an alternative provider cannot be found within an appropriate time frame, the nominated tertiary hospital must accept the patient.

7 FEEDBACK

LHDs should incorporate feedback loops into inter-facility transfer procedures. T his should manifest in a monthly or more frequent teleconference or face to face meetings with the LHD's Patient Flow Managers.

There must also be a well documented and immediate escalation process if issues arise at any stage, whether it is in forward or return transfers.

A post implementation checklist (Appendix 7.3) is to be completed at 3 and 6 months after Policy Directive implementation and be forwarded to the Director, Health Services Performance Improvement Branch.

8 ATTACHMENTS

8.1 Appendix 1 EXAMPLE of an Inter-hospital Transfer Checklist

FOR MEDICAL RECORD USE ONLY -MEDICAL RECORD COPY –	SURNAME: MRN: OTHER NAMES: DOB: SEX: AMO: AFFIX ADDRESSOGRAPH LABEL HERE
South Eastern Sydney Illawarra Area Health Service	
INTERHOSPITAL TRANSFER SUMMARY	**Original to remain in patient's medical records, Copy to transfer with patient.**

Transfer Details

Transfer Date: ____/____/____ Transfer from: _____ To: _____
Diagnosis: _____
Patients current condition: _____
Accepted by Dr _____
Mode of transport: SVH Transport □ NSW Ambulance □ NSW PTS □ Air Ambulance □ Wingaway□ SHSEH Transport □
Bed availability confirmed by receiving facility: yes □ no □ date: ___/___/___ time: _____hrs

Management/ Intervention/ Assessments

Oxygen therapy: yes □ no □ Specify: _____	**IV therapy:** yes □ no □ Type: _____ Site: _____
Dietary requirements: NBM: yes □ no □ NGT/PEG: yes □ no □ Type: _____ TPN: yes □ no □	**Mobility Issues:** yes □ no □ Falls risk score: _____ Walking aid: yes □ no □ type _____
Incontinent: yes □ no □ Specify: _____ Urinary Catheter: yes □ no □ Specify IDC □ SPC□ Other: _____	**Risk of cross infection:** no □ yes □ → precautions: _____ Contact □ Droplet □ Airborne □ **Infection (Type):** _____

Assessment prior to transfer

	Yes No	Comments
Patient ID bands in place	□ □	
Alert Bands in place	□ □	
Pain management on route	□ □	*Score: /10, last dose given at: ,Pain medication due:*
Observations		*Obs on discharge: Time:*
		T P Resp BP
Glasgow coma scale if required	□ □	*Score:*
Blood sugar level if required	□ □	*Current BSL: Next due:*
Wound care chart Pressure Ulcer Assessment	□ □	*Waterlow score:*
Dentures	□ □	
Prosthesis	□ □	
Communication deficit	□ □	
Personal / Valuables / Spectacles	□ □	
X-rays/ scans (pts own)	□ □	
Appropriate Sustenance provided	□ □	*Sandwiches and drinks required for road travel outside metro Sydney*

Handover of Patients condition

Nursing Mangement: _____

EXAMPLE ONLY

REVISION Date: Page 2 of 3

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INTERNAL ONLY

8.2 Appendix 2 LHD and Nominated Tertiary Referral Centres for Urgent and Non Urgent Specialist Care

Metropolitan NSW LHDs

LHD	Central Coast	Illawarra Shoalhaven	Nepean Blue Mountains
Nominated Tertiary Referral Centre	Royal North Shore	St George	Nepean
Hospital	Gosford Long Jetty Woy Woy Wyong	Bulli Coledale David Berry Kiama Milton Ulladulla Port Kembla Shellharbour Shoalhaven Wollongong	Blue Mountains Hawkesbury Lithgow Portland Springwood
LHD	**Northern Sydney**	**South Eastern Sydney**	**South Western Sydney**
Nominated Tertiary Referral Centre	Royal North Shore	Prince of Wales St George Royal Hospital for Women	Liverpool
Hospital	Greenwich Hornsby Macquarie Manly Mona Vale Neringah Royal Rehabilitation Ryde	Calvary Healthcare Gower Wilson (Lord Howe Island) Sutherland Sydney & Eye Hospital War Memorial	Bankstown Lidcombe Braeside Bowral Camden Campbelltown Fairfield
LHD	**Sydney**	**Western Sydney**	
Nominated Tertiary Referral Centre	RPAH/Concord	Westmead	
Hospital	Balmain Canterbury	Auburn Blacktown Mount Druitt St Josephs	

Rural LHDs

LHD	Hunter New England	Mid North Coast	Murrumbidgee
Nominated Tertiary Referral Centre	John Hunter	John Hunter	Prince of Wales St George St Vincent's
Hospital	Armidale Barraba Belmont Bingara Boggabri Bulahdelah Cessnock Denman Guyra Inverell Kurri Kurri Maitland Manilla Merriwa Moree Murrurundi/Wilson Muswellbrook Narrabri Tomaree Community (Nelson Bay) Calvary Newcastle Mater Quirindi Scone Singleton Tamworth Warialda Wee Waa Werris Creek Wingham	Bellingen Coffs Harbour Dorrigo Kempsey Macksville Port Macquarie Wauchope	Albury[1] Balranald Barham Koondrook Batlow Berrigan Boorowa Deniliquin Coolamon Cootamundra Finley Griffith Gundagai Hay Henty Hillston Holbrook Jerilderie Junee Leeton Lockhart Murrumburrah-Harden Narrandera Temora Tocumwal Tumbarumba Tumut Urana Wagga Wagga West Wyalong Young

[1] Albury is networked with clinical services in Victoria however referral to a NSW facility may be required due to clinical need.

LHD	Northern[2]	Southern[3]	Western	Far West
Nominated Tertiary Referral Centre	John Hunter	The Canberra/ Prince of Wales*	Royal Prince Alfred	Royal Prince Alfred
Hospital	Ballina Bonalbo Byron Casino Coraki Grafton Kyogle Lismore Maclean Mullumbimby Murwillumbah Nimbin Tweed Urbenville	Bateman's Bay Bega Bombala Braidwood Cooma Crookwell* Delegate Goulburn* Moruya Pambula Queanbeyan Yass	Baradine Bathurst Blayney Bourke Brewarrina Canowindra Cobar Collarenebri Cudal Dubbo Dunedoo Eugowra Forbes Gilgandra Gulgong Lake Cargelligo Lightning Ridge Molong Mudgee Narromine Nyngan Oberon Orange Tottenham Trangie Trundle Tullamore Wellington	Broken Hill[4] Ivanhoe Menindee Tibooburra Wilcannia

Sydney Children's Hospital Network
Randwick Westmead *(State-wide referral role)*

[2] Northern LHD maintains a clinical referral with Queensland
[3] Murrumbidgee, Southern maintains a clinical referral network between The Canberra Hospital and the following hospitals: Bateman's Bay, Batlow, Bega, Bombala, Boorowa, Braidwood, Cooma, Delegate, Moruya, Pambula, Queanbeyan, Tumut, Yass and Young.
[4] Broken Hill maintains clinical referral networks with South Australia

8.3 Post Implementation Checklist

Assessed by:		**Date of Assessment:**	
IMPLEMENTATION REQUIREMENTS	**Not commenced**	**Partial compliance**	**Full compliance**
1. Evidence of documented clinical referal pathways established across and between the Local Health Network	❑	❑	❑
	Notes:		
2. Establishment of a single point of telephone contact providing support to clinicians with issues relating to access of appropriate care and clinical referral pathways	❑	❑	❑
	Notes:		
3. Single LHD arbitrator designated for the resolution of escalated patient inter-facilty transfer issues	❑	❑	❑
	Notes:		
4. Number of patients requiring arbitration at tier 2 level to successfully occasion an inter-facility transfer to a higher level care facility	❑	❑	❑
	Notes:		
5. Number of patients breaching >24hr for a return transfer time at 3 and 6 months	❑	❑	❑
	Notes:		