



Health
Southern NSW
Local Health District

*Southern NSW Local
Health District*

COOMA HEALTH SERVICE
CLINICAL SERVICE PLAN 2016

This document outlines the future models of care and functional space requirements for Cooma Health Service to the year 2027

ADDENDUM TO
MONARO REGIONAL
HEALTH SERVICES CSP
2015-2019

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1. BACKGROUND

In March 2015 a media release from John Barilaro MP announced that ‘a re-elected Baird Government will invest \$10M in the redevelopment of Cooma Hospital’ ... ‘the \$10M investment will redevelop Cooma Hospital to enhance the emergency department, radiology services and the maternity ward, as well as fund the construction of a new ambulatory care centre.’

The Ministry of Health has asked Southern NSW Local Health District (SNSWLHD) to develop a Clinical Service Plan (CSP) for Cooma Health Service with estimated activity over a ten year planning horizon. It is understood that the service scope may exceed the current funding (\$10M) and SNSWLHD is to confirm the key priorities to be delivered within the available funding scope.

In 2014, SNSWLHD completed a *Monaro Regional Health Services, Health Care Services Plan 2015-2019*. The recommendations within the Plan are still current. In lieu of rewriting the Plan for Monaro Health Services (which includes Cooma Health Service), the District (with the Ministry of Health endorsement) has prepared this addendum to the original plan addressing the necessary information required for an infrastructure project at Cooma Health Service. The addendum should be read in conjunction with the *Monaro Regional Health Services, Health Care Services Plan 2015-2019*.

2. SUMMARY CURRENT, PROJECTED AND PROPOSED INFRASTRUCTURE REQUIREMENTS

The Cooma Health Service campus consists of nine (9) buildings over four (4) levels, which follow the slope of the site, most buildings are connected by enclosed linkways. The layout of the site results in disjointed services that no longer meet the needs of current health care requirements, and also results in security and compliance issues.

Buildings range from 1857 to 1980 constructs:

- In 1857, the original, now heritage listed, ‘Hospital Building’ was established. The building is currently used for community health services.
- In 1940/1950’s further buildings were constructed including the staff residence, kitchen and amenities block, Elouera Wing (currently community health and education) and the Jack Howard Centre (currently used for family care)
- In 1980, the ward block and services block were built
- 1986, construction of the main building
- 2014, renal unit construction

All buildings built prior to 1980 have over time been repurposed to accommodate changes in care needs. The following remain as constructed with minimal modification or upgrades: the ward block housing general ward on upper level A; maternity/oncology on lower level B; main building housing main entry, reception, administration, emergency department, perioperative suite and radiology on upper level A; hydrotherapy pool, physiotherapy and rehabilitation services located on lower B level.

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Finishes are mainly in poor condition:

- While external paint across the campus is in good condition, internal paint finishes are generally dated and in poor condition with the exception of Ward 'A' which is in good condition following some attention in 2014
- Floor coverings across the facility are in poor condition
- The majority of ceilings are suspended grid and tile in poor condition with mismatched and discoloured tiles
- The mechanical systems controlling air temperature, range from old boiler type systems to reverse cycle package type units, all of which are past their replacement periods
- Lighting remains a mix of fluorescent, halogen and incandescent fixtures
- Ward bathroom finishes are in average condition not having been upgraded since the building was constructed in 1980
- The radiology department has evolved with the advances of imaging services but minimal building works have been performed to better accommodate these services. The CT room was recently upgraded with the relocation of equipment from Bega Hospital, however the works did not extend to outside the CT room
- The perioperative suite remains as constructed in the 1980's; SNSWLHD are currently sourcing external funding from Asset Refurbishment and Replacement program for upgrade of the theatre suite including mechanical services replacement.

Table 1. Summary current, projected and proposed infrastructure requirements

Current		Projected						Proposed	
		Beds		2021/22 beds		2026/27 beds		BEDS	
		O/N	D/O	O/N	D/O	O/N	D/O	O/N	D/O
Beds	Acute General Ward	30		27		29		26	
	Short Stay unit								4
	Surgical d/o		4		4		4		4
	Obstetrics	7		3		3		2	Joined to general ward to allow for flex beds.
	<i>Birthing *Rooms</i>	2*						2*	Utilise the 2 birthing rooms as 'beds'
Total D/O & O/N Beds		37	4	30	4	32	4	28	8
Total Beds		41		34		36		36	
		Spaces		2026/27 spaces		Spaces			
Emergency Department	Emergency Bays	6				5		5	
	Resuscitation bays	1				1		2	
Perioperative	Operating theatres	1				1		1	
	Recovery	3				3		3	
Support	Pathology							Waiting room with radiology	As is
	Pharmacy							Redesign on level A or B	
	Radiology							As is	Future redesign
Rehabilitation	Gym								As is
	Hydro pool								As is

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Current			Projected				Proposed	
Chairs	Renal Chairs	4 chairs- 6 days/wk					4 chairs	Future possible expansion to 8 chairs (current location)
	Oncology Chairs	5 chairs- 3 days/wk					5 chairs	As is
	Oral Health Chairs	1 chair					1 chair	Future expansion to 2 chairs (current location)
Community services	Community Health	Community Health Centre					Ambulatory Care Hub located front of house (clinics only)	
	MHDA	Community Health Centre					As above	
Staffing	CH, MHDA, AH							Staffing- as is Future -located with Ambulatory Care Hub
Training facilities								As is
Accommodation								As is

* Not counted in bed total

Key:

- D/O = Day only
- O/N = Overnight
- Short Stay Unit = < 24 hrs
- MHDA = Mental Health Drug and Alcohol
- CH = Community health
- AH = Allied health

3. INFRASTRUCTURE PRIORITY LIST FOR COOMA HEALTH SERVICE

The \$10M redevelopment funds will not complete the full requirements of the Cooma Health Service redevelopment. Below is a list of the infrastructure priorities for the Cooma Health Service. Priorities 1-7 should be within the \$10M scope:

1. Relocate Maternity Unit to A level
2. Redesign Emergency Department (ED) + develop 4-bed short stay unit
3. New Ambulatory Care Hub at front of house
4. Locate admissions next to ED
5. Upgrade general ward
6. Relocate the administration centre
7. Relocate pharmacy to A level, or expand in current position
8. Redesign radiology department
9. Provide storage space for perioperative suite
10. Move Ambulatory Care Hub staffing into, or closer to, the Hub
11. Refurbish rehabilitation centre
12. Increase dental chairs to 2 (better work flow)
13. Increase renal chairs to 8 (reduce staffing costs)
14. Collocate primary medical records with ED

4. UPDATED MONARO POPULATION PROJECTIONS

The Monaro region, encompassing the Snowy Monaro Regional Council, has an estimated resident population of 20,700 people (2014). About half live in the former Cooma-Monaro Local Government Area (LGA) (10,210 people) followed by the former Snowy River LGA (8,070) and former Bombala LGA (2,420). During the winter ski season, there is a dramatic population increase (e.g. an extra 10,000 people in the Snowy River LGA in August 2011). Bombala and Delegate health services provide for a small catchment of 200 to 300 people from some small villages in Victoria. There is a small but growing Aboriginal and Torres Strait Islander population (about 480 people in 2011) based mainly in the Cooma district.

Table 2 shows a breakdown of the population by Statistical Area 2 (SA2) region (numbers do not completely align with LGA figures).

Table 2. Population of the Monaro region, by SA2 region and age group, 30 June 2014

Age group (years)	0-14		15-44		45-69		70-84		85+		Total
	No.	%	No.	%	No.	%	No.	%	No.	%	
SA2 region	No.	%	No.	%	No.	%	No.	%	No.	%	No.
Cooma	1,267	17.9%	2,485	35.1%	2,319	32.8%	772	10.9%	231	3.3%	7,074
Cooma Region	545	16.8%	886	27.3%	1,334	41.0%	413	12.7%	72	2.2%	3,250
Jindabyne - Berridale	1,425	19.9%	2,781	38.8%	2,368	33.0%	514	7.2%	85	1.2%	7,173
Bombala	420	17.3%	728	30.0%	925	38.1%	260	10.7%	94	3.9%	2,427
Monaro Total	3,237	16.2%	6,152	30.9%	6,021	30.2%	1,699	8.5%	388	1.9%	19,924

Source: ABS Population by Age and Sex, Regions of Australia (ASGS, 2011), released 18/8/15 (cat. No. 3235.0).

Overall, the Monaro has a typical rural age profile, with features that have an impact on health service demand and workforce including:

- An ageing population
- An ageing workforce
- Outward migration of younger adults for education and employment in capital cities
- Regions with high proportions of older people (e.g. Bombala region, 22% aged 65+ years)
- Regions with growing populations of families with young children (e.g. Jindabyne region)
- Regions with declining populations (e.g. Bombala region)

Population growth in the Monaro is expected to be relatively small, with a population of 21,200 people projected by 2021¹. The bulk of the growth in the region is expected in the 65+ years age group, with less growth expected in the young or in working-age adults.

There is a broad spectrum of socio-economic advantage and disadvantage across the region: on *average*, residents of the Bombala region experience more disadvantage (fewer residents with high incomes, tertiary education and skilled occupations), Cooma-Monaro residents are closer to the national average, and Snowy River residents experience less disadvantage than the national average.

This pattern of socio-economic disadvantage provides some context to data on risk factors, hospitalisations and deaths.²

- Rates of behavioural risk factors such as smoking, and overweight and obesity are highest in residents of Bombala region, followed by Cooma-Monaro and Snowy River.

¹ NSW Department of Planning & Environment: NSW & LGA Population Projections, 2014 final

² Centre for Epidemiology and Evidence, NSW Ministry of Health. www.healthstats.nsw.gov.au

- Rates of potentially avoidable deaths (PAD) and potentially avoidable hospitalisations (PPH) in the region are highest for residents of Bombala region, followed by Cooma-Monaro and Snowy River. However all PAD rates are within the NSW average range, and PPH rates for Snowy River residents are below the average.
- Rates of smoking during pregnancy in 2012-14 were up to double the NSW average (21% in Cooma-Monaro, 20% in Bombala region, 16% in Snowy River residents, 10% in NSW).³

5. MODELS OF CARE AND PROJECTED FUNCTIONAL SPACE REQUIREMENTS

5.1. EMERGENCY

5.1.1. PROPOSED MODEL OF CARE

Cooma emergency department (ED) provides emergency services for a catchment population of about 20,000. Medical advice and telephone support is provided to Bombala and Delegate MPSs when medical officers are not available at these sites.

An efficient model of emergency care has evolved in Cooma with changes being made to meet demand. To further enhance the model, added emphasis will be placed on fast tracking the management of sub-acute ambulatory patients. The emphasis will be on clinical teams commencing care in the 'primary' treatment phase with the aim to discharge the patient within two hours of presentation. This will facilitate improved 'turn-around' of patients and reduce waiting times.

The location of aged care services (Care Navigators⁴) is currently on the ward and integrates aged care services with acute and community care and continues to facilitate the rapid assessment and management of older persons presenting to the ED.

The ED currently provides a short-term limited opioid replacement therapy dosing service for high priority patients. For reasons of safety and practicality, and assuming the Ambulatory Care Hub would not be open seven days a week, this service should remain in ED.

As the Cooma ED networks with the Canberra Hospital and Statewide retrieval service and is the regional service centre for Bombala ED, any future development must incorporate Telehealth equipment and videoconferencing facilities.

The design should take into account the:

- Declared mental health ED
- Diversion to Ambulatory Care Hub for outpatient and planned return visits
- Provision for Paediatrics within ED
- Telehealth capabilities

5.1.2. FUNCTIONAL SPACE REQUIREMENTS

The presentations for Cooma ED (*based on 3 year ED data 2012/13 to 2014/15 CaSPA Portal, 2015/16 Firstnet*)

- Have increased over the last 4 years.

³ NSW Perinatal Data Collection (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. www.healthstats.nsw.gov.au

⁴ Care Navigators provide short-term care coordination for older consumers with complex needs. The goal is to minimise hospitalisation and representations and readmission rates of older consumers, reduce non-medical delays to discharge and promote integrated community care

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- 2015/16 data indicates a shift in presentation Triage categories, with less Triage 5 presentation and increase in all other categories.
- Admissions in ED are increasing gradually from 12% in 2012/13 to 14% in 2015/16
- Time of day of presentations have remained consistent, with a very clear spike at 8.00 am and another small spike at 5.00 pm. The majority of presentations are between 8.00 am and 7.00 pm
- Planned return presentations are showing a clear decline
- Outpatient visits showed a decline in 2014/15, followed up required to see if decline is a trend
- Projections to 2027 are based on a 2% p.a. rate of growth

Treatments spaces required

Using the formula for peak occupancy for admitted and non-admitted patients based on an 85% occupancy and:

- Projected 12,526 attendances to 2026 – with 14% admitted (currently)
- Current arrival pattern – 95% between 7.00 am to midnight
- Current Length of Stay (LOS) admitted patients = 4.1 hours
- Current LOS non-admitted patients = 1.8 hours

The required space for **Admitted ED is 1.3**

$((12,526 * 95\% \text{ during } 17 \text{ hrs} * 14\% \text{ admitted}) / 365) / (17 \text{ hours} / 4.1 \text{ LOS}) / 85\% \text{ occupancy} = 1.3 \text{ treatment spaces}$

For **Non-admitted ED is 3.5**

$((12,526 * 95\% \text{ during } 17 \text{ hrs} * 86\% \text{ non-admitted}) / 365) / (17 \text{ hours} / 1.8 \text{ LOS}) / 85\% \text{ occupancy} = 3.5 \text{ treatment spaces}$

Configuration required:

- Projected configuration of the ED is 1 resuscitation bay and 5 treatment spaces which will include a designated paediatric bay. **Recommended configuration is 2 resuscitation + 5 treatment spaces**
- Designated triage and clerical work areas
- A MH safe assessment room, isolation room and private consult room/s to be determined in the infrastructure planning phase
- Multifunctional clinic rooms
- Separation of ambulance and public access
- Provision of patient privacy for flow to/from radiology
- Separation of patient triage and ED waiting area from the main entry of the facility
- Separate ED waiting area
- Key linkages to support services e.g. radiology, ambulatory care
- Collocation of medical records to enable timely access
- Consideration of Helipad access

5.2. SHORT STAY UNIT

5.2.1. PROPOSED MODEL OF CARE

A Short Stay Unit should be introduced (as per Policy Directive PD 2014_040, Emergency Department Short Stay Units or as a Medical Assessment Unit) for the short term treatment, observation, assessment and reassessment of patients with selected conditions, initially triaged and assessed in the ED. Short Stay Units are designed for patients who are to be discharged within 24 hours and are shown to improve the throughput of EDs and reduce admission length of stay.

The short stay unit will:

- Provide access to an interdisciplinary team, with the ability to put community supports in place, if required, and have nurse-initiated discharge, which will lead to decreased lengths of stay
- Aid in meeting Emergency Treatment Performance (ETP) targets by improving patient flows
- Decrease demand on the general inpatient beds allowing a reduction in the number of general IP beds
- Provide space for maternity to move to level A

5.2.2. FUNCTIONAL SPACE REQUIREMENTS

Flowinfo Vs 15: Admissions through ED for <24 hrs are around 590 to 600 per year. Assuming that with a short stay unit a proportion of the people admitted for <36 hours would be accommodated within the unit as well. The Unit could be expected to accommodate around 700 separations per year.

There is no formula for determining the optimum number of beds based on proposed separations for a short stay unit as some may stay only a few hours, others the 24 hours. Data over a 3 year period indicates there is only a slight seasonal difference in the number of people admitted through ED despite anecdotal evidence suggesting a large surge during the snow season.

A four (4) bed short stay unit is recommended. The placement of this unit will be decided in the design phase.

5.3. PERIOPERATIVE SERVICE

5.3.1. PROPOSED MODEL OF CARE

Cooma has a perioperative suite consisting of one theatre, 3 recovery bays, 4 day only chairs and sterilising. The theatre currently operates 12 days per month and is in the process of realigning to 3 days per week (Mon, Tues and Wed) with a change in practice to admitting day surgery patients on the day of surgery within the day surgery unit, and discontinue day/before admissions.

The South East Regional Hospital (SERH) perioperative services will in the future provide a formal network for Cooma. The Bega Valley CSP is being developed over the next 8 months (2016/17) and the network will be explored during this time to strengthen the support services required.

5.3.2. FUNCTIONAL SPACE REQUIREMENTS

The perioperative suite is sufficient for the future, with some minor refurbishment. With sterilising being centralised at SERH, the sterilising space can be converted for storage.

5.4. INPATIENT WARDS

5.4.1. PROPOSED GENERAL WARD MODEL OF CARE

A priority for Cooma Health Services will be to ensure that patients are not admitted into hospital when they can be appropriately managed as outpatients, and that inpatients do not stay any longer than they need to. SNSWLHD is looking to standardise care across the LHD. Over the next five years we will see:

- Integrated and individualised care plans
- Expansion of clinical networks
- Decreased reliance on the ACT for provision of secondary and primary care

To begin the process the LHD will concentrate on reducing average length of stay (ALOS) for those Diagnostic Related Groups (DRGs) with above average LOS. With about 700 separations per year for < 36 hour stays, the service will look to further developing short stays with nurse-initiated discharge. This combined with enhanced integrated care models, the redesign of ambulatory care services and increased partnerships with GPs, Primary Health Network and other primary care providers, will see shorter inpatient stays and a shift from inpatient care to clinic and in home care.

To ensure that people can access care closer to home and to increase the self-sufficiency of the District, SNSWLHD will further consolidate specialist services in sites with increased capability. Cooma Health Service will be formally networked with SERH in the Bega Valley, which will provide the specialist input necessary for Cooma to operate services at the current levels. This will also mean that SERH will play a larger role in providing inpatient care for the Monaro population whilst access to tertiary health services will still flow to the ACT.

SNSWLHD will be reviewing the paediatric services in line with the 2016 NSW Ministry of Health Guide to Role Delineation of Clinical Services and the Office of Kids and Families, NSW Paediatric Service Capability Framework (once released). The review will determine the level of paediatric inpatient services for Cooma Health Service in line with the District direction.

5.4.2. PROPOSED MATERNITY MODEL OF CARE

The District is committed to the development of a clinical network wide approach to the provision of maternity services. There are at present a variety of maternity models of care across the District and the health service lacks continuity of midwifery care as an option. There are also some differences in evidence-based practice and workforce profiles. In order to ensure a quality and potentially expanded Maternity Services whilst reducing the caesarean section rate, the maternity services of SNSWLHD must have the capability to respond to the changing needs of women centred care, as well as emerging technology and medical developments.

The service needs to provide continuity of care and have strategies in place to refer care to specialist services for complex conditions that are outside the service capability/role delineation allocated to the service.

Links with partnership programs such as Aboriginal Maternal and Infant Health Service (AMIHS) will support the increasing number of women having Aboriginal and Torres Strait Islander babies.

Over the next 12 months SNSWLHD will develop a comprehensive Maternity Network. The project will inform and support a number of strategic initiatives aimed at maternity healthcare reform and will continue to implement recommendations of the NSW Ministry of Health PD 2010_045 – Maternity – Toward Normal Birth in NSW, 2010:

- The promotion of birth as a natural event for well women
- The need to minimise fear, particularly women's fear, and improve support throughout labour and birth
- The importance of consistent and balanced information for women and health care providers regarding vaginal birth after caesarean section operation and the potential risks associated with elective caesarean operation
- The need to develop programs of care, both midwifery and medical, that focus on providing continuity of care.

Although birthing numbers at Cooma Health Service are relatively low and are declining (deliveries, 2012/13= 165, 2013/14 = 157, 2014/15 = 151), the geography of the region and weather conditions in winter make it imperative to retain the service in Cooma. Data indicates that the birthing numbers will remain fairly constant

over the coming years. Although the (former) Snowy River Shire has a younger population, the (former) Bombala and Cooma-Monaro Shires show an ageing population with little growth.

The Cooma Health Service caters for about 80% of deliveries for the Monaro region (note that private ACT data are not available). The main flows out are to ACT with 18% flow to ACT public facilities. There are a number of babies and boarder mothers transferred back from ACT hospitals, however the numbers are low, with 10 babies over 2014/15 and 13/14, and with only one baby at any one time.

5.4.3. FUNCTIONAL SPACE REQUIREMENTS

The general ward, located on Level A, is a combined ward for both medical and surgical patients. Taking into account the current activity, the projected (aIM) requirement and the development of a Short Stay Unit, the combined medical/surgical ward should be built for 26 beds.

The maternity unit, located on Level B, is too large for the number of births. The ward is isolated from other inpatient wards, theatre and clinical support services which are located on the Level A. This creates resourcing inefficiencies, and security and compliance issues around staff working in isolation.

Projections utilising aIM indicate a requirement for 3 obstetric beds into the future. Given that the ALOS is still over 3.4 days for normal vaginal births and could be reduced and the aim of the District is to reduce the rate of caesarean sections (which is currently 29% of deliveries in Cooma), consideration should be given to utilising the birth rooms for stays i.e. 2 birth rooms + 2 beds to make the best use of space.

The general ward and maternity ward would benefit by being collocated, so that beds can swing and be utilised to best advantage. Adjoining location on level A would also allow for maternity staff to be utilised in ED and general ward when there are no maternity patients.

The following should be catered for within the bed stock:

- Close observation unit
- Dedicated space that can cater for short stay paediatrics (up to 48 hours) as per current policies. This space should also cater for paediatric patients with early onset mental health issues.
- Appropriate space to cater for palliative care clients
- Room suitable for local management of Mental Health Drug and Alcohol clients
- A number of single rooms with ensuites to maximise revenue raising
- 2 obstetric beds + 2 birthing rooms
- Telehealth capabilities throughout

Assumptions used to calculate bed requirement:

- By 2027, aIM projects the need for 38 inpatient beds, (3 day only surgical, 2 obstetric, 33 general)
- Scenario One projects beds (aIM) with the general ward operating at 80% occupancy = 37 beds required
- Scenario Two, utilising the current ALOS. The ALOS for Medical is projected in the aIM planning tool to rise from 3.4 days in 2016/17 to 4.1 days in 2026/27. Cooma medical is currently operating with an ALOS of 3.3. If we project beddays using the current 3.3 ALOS, the bed requirement is reduced = 31 beds required.
- Scenario Three: 2015/16 actual + 5% growth per 5 years * current ALOS = 35 beds required (75% occupancy) or 33 beds at 80% occupancy.
- Taking the above scenarios into account the following is recommended:
 - 26 bed general ward
 - 4 bed Short Stay Unit
 - 4 day only Surgical (as is)
 - 2 obstetric beds (with 2 birthing room to be utilised as beds as required)

5.5. AMBULATORY/COMMUNITY & INTEGRATED CARE

5.5.1. PROPOSED MODEL OF CARE

SNSWLHD community services have come from a stand-alone business model, providing a wide range of primary health care roles to the community. Local services and roles were based on historical recruitment and service patterns. Services have evolved differently across the LHD, with Models of Care not consistently designed with evidence based practice at the core, or priority access criteria, and with poor regulation of length of stay and fragmented transfer of care.

Our services internally are not integrated, with community and acute operating as separate business models; our hospital substitution programs are limited in flexibility and partnerships and integration with external providers are fragmented and unformed.

Over the next few years SNSWLHD will transform services with integration of ambulatory and acute services providing a seamless journey for the patient/client through the system meeting the needs of the patient and their carers and families. Primary care partnerships with GPs, private and NGO sectors will be developed ensuring support of service integration and connectivity.

By working as 'teams' people will be helped to manage their own health and remain independent. More people will access care within the community, in their home or within clinics as opposed to inpatient hospital care. The aim is to keep people healthy and out of hospital for as long as possible and reduce ED presentations, potentially preventable hospitalisations and hospital readmissions.

The potentially preventable hospitalisations for Cooma Health Service catchment residents are within the NSW average (except for Snowy River residents which was significantly lower than average). Rates per 100,000 population for 2013 to 2015 were 2,188 for Cooma Monaro LGA, 2,365 for Bombala and 1,696 Snowy River. The three most common potentially preventable hospitalisations are diabetes complications, iron deficiency anaemia and urinary tract infections.

5.5.2. FUNCTIONAL SPACE REQUIREMENTS

A new Ambulatory Care Hub is required to aid with the development of the integrated models of care. Collocation of services and multi-disciplinary teams is one strategy to improve procedures, processes, relationships and communication across often siloed sectors of the health system.

The Community/ambulatory services are located at the 'back' of all services connected by long undercover linkways, isolated from the mainstream services. The space is overcrowded with little opportunity to introduce new models of care that support hospital substitution. As the ambulatory care services will be the key driver in guiding patient journeys through the health service, the Hub needs to be highly visible, and in close proximity to the ED and acute wards to enhance integration and continuous models of care service to the clients.

The Ambulatory Care Hub will encompass flexible/ bookable clinic spaces for all ambulatory care. The Hub should be configured for flexible space to allow for changes of service provision over the coming years. To support ambulatory care, dedicated outpatient clinic space is required, with permanent and flexible work spaces for non-admitted services. Consideration will include: shared reception, consult rooms, treatment spaces (individual and small group rooms), bookable clinic spaces, outpatient group spaces.

Office space for service providers for the ambulatory care hub can remain within current occupied spaces within the Community Health Centre if space and funding are not forthcoming. Hot desks will need to be

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provided within the Hub and future developments should look to include service providers within (or close to) the Ambulatory Care Hub in the form of open plan office spaces.

5.6. ONCOLOGY

The oncology unit is new and community funding of approximately \$100,000 has been allocated for an extension and refurbishment. It is not envisaged that the redevelopment of Cooma Health Service will extend to further changes within this unit.

5.7. RENAL

The renal dialysis unit (4 chairs) is also new. Current service area configuration and available space prohibits the service from maximising current staffing per shift. The required staffing ratio of 1:4 should allow the service to treat 8 patients per shift however with only 4 chairs, only 4 clients can be treated per shift. With 4 chairs and the current 8 clients the unit operates 6 shifts per week, Monday to Saturday.

The unit currently has 8 patients. In order to accept further patients in its current configuration, the unit would need to open an afternoon shift Mon/Wed/Fri, resulting in an increase in FTE. A patient from Bombala has been redirected to the unit at South East Regional Hospital in Bega Valley to accommodate the 8 Cooma/Monaro patients.

Being mindful that the benchmark is 50% satellite unit, 30% peritoneal dialysis and 20% home haemodialysis and not to increase the number of people dialysing in units, for the future however it would be more cost effective to increase the number of chairs to 8. With 8 chairs the current 8 patients could be managed within the unit when open for 3 shifts per week as opposed to the current 6 shifts. This would also allow the unit to service up to 16 clients with the same staffing ratio as now.

The renal dialysis unit was designed to expand the number of chairs in the future with minimal cost. The main utilities have been placed so as not to require relocation and the unit was sited on the block with future expansion mapping.

5.8. DENTAL

The one chair dental clinic is located in the Community Health Centre. The service is staffed with a two days per week oral health therapist (child service) and a three days per week adult service (recruitment to the position has been difficult). The service needs to be maintained as there are approximately 5,032 eligible adults in the Monaro catchment and all children under 18 years (~4,700) are eligible to access general dental services through the dental clinic based in Cooma. An expansion to a two (2) chair unit would see better work flows and could increase the potential to attract permanent staffing for the unit.

5.9. SUPPORT SERVICES

5.9.1. PATHOLOGY

The pathology laboratory is located close to the ED, radiology and theatre, and shares a waiting room with ED. Preservation of the proximity to these services should be considered with any redevelopment of other services. A combined radiology/pathology waiting room would have the potential to utilise space and staff more efficiently and allow privacy for ED patients.

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5.9.2. PHARMACY

A clinical pharmacist is employed four days per week to provide advice and support to clinical teams. The pharmacy is located on B level in a very confined space. The preferred option is to relocate the pharmacy to A level, if this is not within scope then the current location would need expanding.

5.9.3. RADIOLOGY

Cooma radiology department provides general X-ray, orthopantomogram (OPG), computed tomography (X-ray CT), ultrasound, and theatre imaging services to Cooma and the surrounding region. The department performs an average of 12,500 studies per year with 33% of services for inpatient. The remaining 66% of studies are performed on outpatients who are referred by external practitioners throughout the region.

The number of studies performed per month is subject to seasonal variation with an increase in mid-winter due to the close proximity of the ski fields, however the number of studies performed per year remains relatively constant, with no substantial increase over time.

Recently, regular rostering of a Radiologist to the radiology department has allowed for the expansion of services, including musculoskeletal ultrasound, Interventional CT and ultrasound procedures. This additional service is well utilised by both hospital inpatient and the community, as the next closest practice to provide this service is located in Canberra.

In order to sustain this level of service, several key areas need to be addressed. The medical imaging modalities are generally of a high quality and are upgraded through the current replacement schedule however space allocation, appropriate floor design and private access to/from the emergency department is required to ensure efficient workflows, safe work practices and patient privacy and confidentiality are upheld.

As previously mentioned the waiting area could be shared with pathology.

5.9.4. MEDICAL RECORDS

Medical records are a hybrid of paper and electronic which will remain for the foreseeable future with no plans to scan all into electronic medical records (eMR). Currently the Health Information Clerk and primary storage (<12 months, living locals) are located on A Level in the main administration area. Primary storage overflow and secondary storage is located on B level. This allows ease of access for Nurse Managers after hours and meets the Australian Council of Health Care Standards (ACHS) that states, the complete medical record is to be readily available to clinicians.

Ideally medical records should be collocated with the ED and close to the clinical services for ease of access after hours.

6. ADMINISTRATION

The administration offices are located at the front entry of the health service on A level. These services/offices will need to be relocated into appropriate facilities to allow for collocation of clinical services on the A level.

7. EDUCATION CENTRE

The University of Canberra in conjunction with the Australian National University have committed to building an education centre on the grounds of the Cooma Health Service. The Cooma Health Service will have access to this facility.

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8. ROLE DELINEATION

The role delineation levels are as per the 2002 Guide to Role Delineation (*Monaro Regional Health Services Plan 2014-2019, pg 46*). The Role Delineation levels for all services across SNSWLHD are in the process of being reviewed. The levels are still in draft and have not been endorsed in time for this document.

9. DATA

9.1. EMERGENCY DEPARTMENT

Data sourced from CaSPA Portal, ED Activity Analysis Tool 2015 v1 and FirstNet for 2015/16

Table 3. Cooma ED presentations – triage categories

Triage	2012/2013		2013/2014		2014/2015		2015/16 FirstNet	
		%		%		%		%
0					2			
1	20	0.2	25	0.2	27	0.3	48	0.5
2	489	5.7	559	5.5	528	5.6	902	8.8
3	1,418	16.6	1,806	17.9	1,795	18.9	2,526	24.6
4	2,567	30.1	3,615	35.9	3,468	36.6	4,156	40.4
5	4,027	47.3	4,069	40.4	3,668	38.7	2,644	25.7
Grand Total	8,521		10,074		9,488		10,276	
	Total % triage 3 & 4	77.4		76.3		75.2		66.2

Table 4. ED presentations – projections using a 2% p.a increase

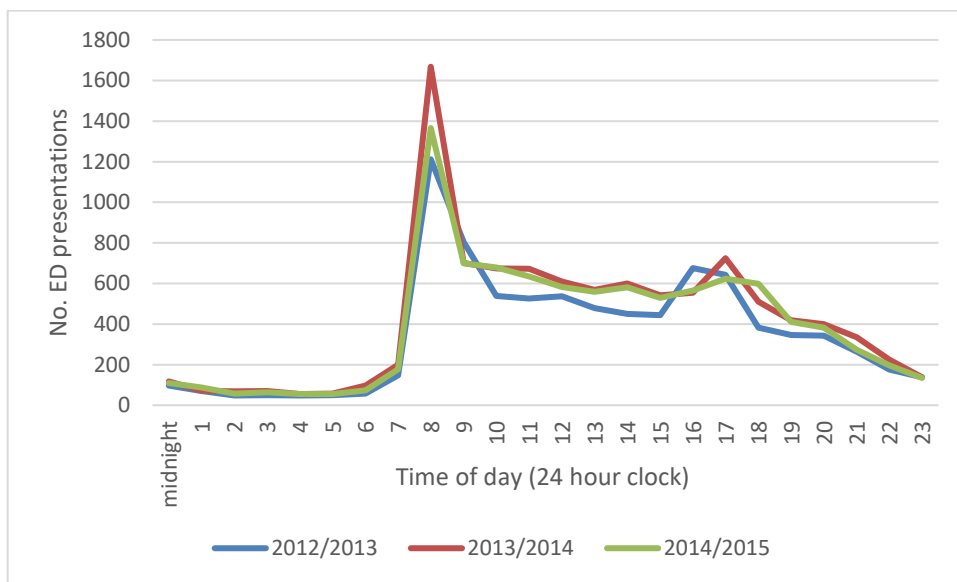
2015/16 actual	2016/17	21/22	26/27	31/32
10,276	10,482	11,572	12,526	13,830

Table 5. Cooma ED presentation – admitted/non admitted

Admitted	2012/2013	2013/2014	2014/2015	2015/16
No	7,518	8,813	8,296	8,886
Yes	1,003	1,261	1,192	1,390
Grand Total	8,521	10,074	9,488	10,276
% non admit	88	87	87	86
% admit	12	13	13	14

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Figures 1: Cooma ED presentations – Time of arrivals



Figures 2: Cooma ED Presentations by season.

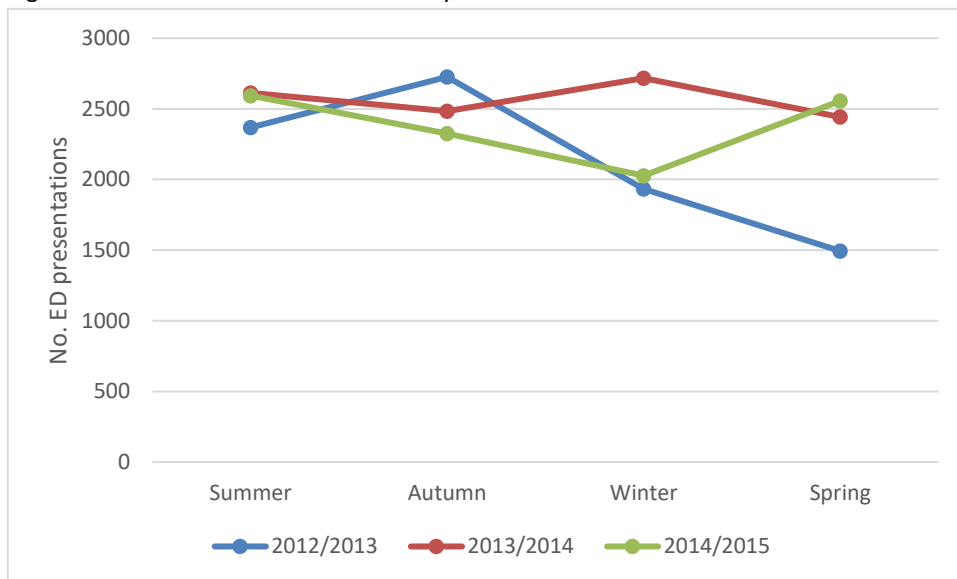


Table 6. Time of presentations percentage

Time	Total Presentations			Time in ED (hrs)			Total Presentations	Total Time in ED (hrs)	%
	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015			
Midnight	97	117	109	165.81	427.3	314.68	323	907.79	1.2
1	70	72	87	106.55	208.04	290.7	229	605.29	0.8
2	48	68	57	96.71	123.2	192.22	173	412.13	0.6
3	49	70	64	113.29	249.02	224.93	183	587.24	0.7
4	48	55	55	139.34	283.76	186.53	158	609.63	0.6
5	50	58	55	165.3	233.01	210.72	163	609.03	0.6
6	57	96	73	177.27	422.27	250.02	226	849.56	0.8

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Time	Total Presentations			Time in ED (hrs)			Total Presentations	Total Time in ED (hrs)	%
	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015			
7	147	200	177	374.5	631.7	608.96	524	1615.16	1.9
8	1212	1668	1366	1331.5	1340.54	1190.24	4246	3862.28	15.1
9	804	701	699	1102.19	1754.59	1705.37	2204	4562.15	7.8
10	539	674	678	1245.65	1960.33	1775.58	1891	4981.56	6.7
11	526	672	634	1159.02	1845.81	1658.9	1832	4663.73	6.5
12	536	610	583	1108.06	1726.3	1498.88	1729	4333.24	6.2
13	478	568	559	974.98	1626.59	1414.62	1605	4016.19	5.7
14	450	600	581	882.59	1617.42	1375.81	1631	3875.82	5.8
15	443	542	529	872.66	1274.9	1174.03	1514	3321.59	5.4
16	676	554	565	817.29	1299.39	1200.39	1795	3317.07	6.4
17	643	724	623	837.46	1008.92	1149.74	1990	2996.12	7.1
18	382	510	598	598.26	1018.75	931.44	1490	2548.45	5.3
19	346	419	410	540.59	761.25	744.23	1175	2046.07	4.2
20	342	399	383	475.09	640.99	542.04	1124	1658.12	4.0
21	264	335	273	350.7	577.42	394.84	872	1322.96	3.1
22	176	225	196	296.99	329.65	328.72	597	955.36	2.1
23	138	137	134	159.02	231.86	251.91	409	642.79	1.5
Grand Total	8521	10074	9488	14090.82	21593.01	19615.5	28083	55299.33	100.0

Table 7. Average time in ED admitted/non admitted

Admitted	Total Presentations			Time in ED (hrs)		
	2012/2013	2013/2014	2014/2015	2012/2013	2013/2014	2014/2015
No	7518	8813	8296	10800.15	15943.75	14759.74
Yes	1003	1261	1192	3290.67	5649.26	4855.76
Grand Total	8521	10074	9488	14090.82	21593.01	19615.5
Hours non-admit	1.4	1.8	1.8			
Hours admit	3.3	4.5	4.1			

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Figure 3: Three year average ED presentations/admissions

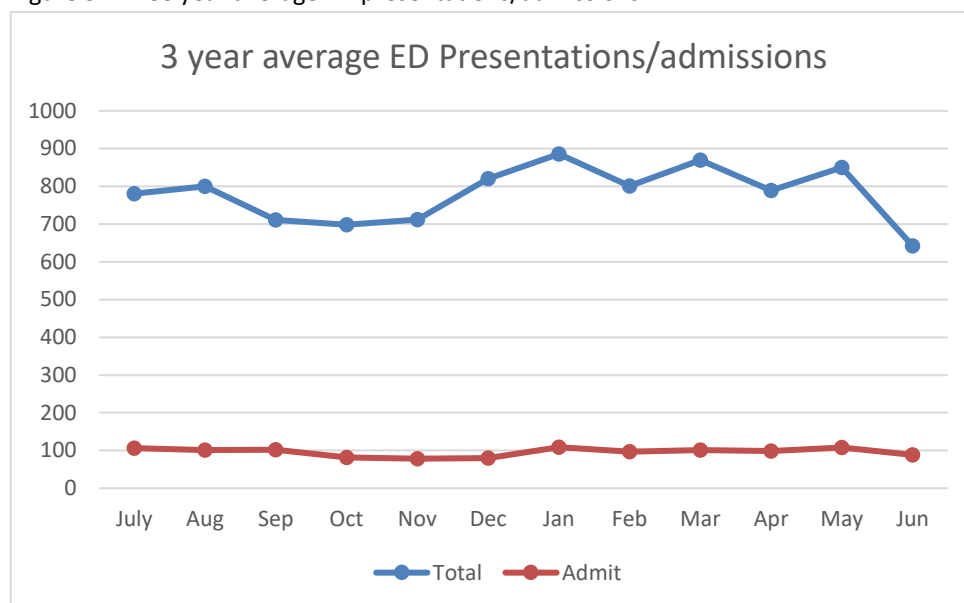


Table 8. Cooma ED presentation – Reason for presentation

Presentations	2012/2013	2013/2014	2014/2015
Dead On Arrival	11	13	16
Disaster			1
Emergency Presentation	6315	8311	8113
Not Recorded	5	2	
Outpatient Clinic	1001	1117	987
Person in transit	1	2	
Pre-arranged Admission: With ED Workup	16	30	40
Pre-arranged Admission: Without ED Workup			1
Return visit - Planned	835	510	291
Telehealth Presentation	337	89	38
Unplanned Return Visit for continuing condition			1
Grand Total	8521	10074	9488

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9.2. COOMA OBSTETRICS

Data sourced from CaSPA Portal – Flowinfo V15

Table 9. Cooma Obstetrics IP data

Day Only Name	Values	ESRGv50 Code and Name	2012/2013	2013/2014	2014/2015
Day only	Total Separations	721 - Antenatal admission	20	13	13
		722 - Vaginal delivery	3	3	
		724 - Postnatal admission	1		
Total Bed days	721 - Antenatal admission	721 - Antenatal admission	20	13	13
		722 - Vaginal delivery	3	3	
		724 - Postnatal admission	1		
Day only Total Separations			24	16	13
Day only Total Bed days			24	16	13
Overnight(s)	Total Separations	721 - Antenatal admission	32	23	17
		722 - Vaginal delivery	108	117	117
		723 - Caesarean delivery	54	37	34
		724 - Postnatal admission	6	10	10
		Total Bed days	721 - Antenatal admission	42	27
		722 - Vaginal delivery	367	382	413
		723 - Caesarean delivery	267	163	161
		724 - Postnatal admission	19	27	43
Overnight(s) Total Separations			200	187	178
Overnight(s) Total Bed days			695	599	642
Total Separations			224	203	191
Total Bed days			719	615	655

Table 10. Flow for Obstetric Care

Residence LGA 07 Name	LHD of Hospital Code and Name	2012/2013	2013/2014	2014/2015	% of flows
Bombala (A)	X980 - A.C.T.	6	6	6	14
	X720 - South Eastern Sydney			1	
	X830 - Southern	26	27	36	84
Bombala (A) Total		32	33	43	
Cooma-Monaro (A)	X980 - A.C.T.	27	21	21	19
	X710 - South Western Sydney			1	
	X740 - Western Sydney	1			
	X830 - Southern	102	96	90	80
	X840 - Murrumbidgee		1		
Cooma-Monaro (A) Total		130	118	112	
Snowy River (A)	X495 - Other Private	1			
	X980 - A.C.T.	12	18	18	21
	X720 - South Eastern Sydney			1	
	X740 - Western Sydney		1		
	X750 - Nepean Blue Mountains	1			

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Residence LGA 07 Name	LHD of Hospital Code and Name	2012/2013	2013/2014	2014/2015	% of flows
	X830 - Southern	85	78	67	78
	X920 - Victoria	1			
Snowy River (A) Total		100	97	86	
Grand Total		262	248	241	

Table 11. Cooma Obstetrics Projections utilising aIM 2012 v 2.2

ESRG_name	Data	2011	2017	2022	2027	2032
721 Ante-natal Admission	Sum of seps	56	62	62	62	63
	Sum of beddays	68	87	85	85	85
	Sum of beds	0	0	0	0	0
722 Vaginal Delivery	Sum of seps	132	146	147	147	147
	Sum of beddays	475	436	429	423	417
	Sum of beds	2	2	2	2	2
723 Caesarean Delivery	Sum of seps	40	43	43	43	43
	Sum of beddays	169	173	168	165	161
	Sum of beds	1	1	1	1	1
724 Post-natal Admission	Sum of seps	16	14	13	13	13
	Sum of beddays	41	34	32	31	30
	Sum of beds	0	0	0	0	0
Total Sum of seps		244	265	265	266	266
Total Sum of beddays		753	729	714	704	693
Total Sum of beds		3	3	3	3	3

9.3. COOMA IP MEDICAL/SURGICAL

Data sourced from CaSPA Portal – Flowinfo V15 Tabular Data Model
 – Less renal dialysis, unqualified neonates, chemotherapy
 Less Treated solely in ED (where applicable)

Table 12. Total Separations – Where from –

Total Separations	Financial Year			
	2012/2013	2013/2014	2014/2015	14/15 %
Other NSW LHDs	158	138	162	5
X830 - Southern	2610	2,621	2,800	91
X980 - A.C.T.	41	29	33	1
X920 - Victoria	38	34	33	1
X930 - Queensland	21	14	26	1
Various	28	30	31	1
Grand Total	2896	2,866	3,085	100

Table 13. Sub-acute activity

SiAM 2010 Care Type Name	SiAM 2010 Clinical Group Name	2012/2013		2013/2014		2014/2015		2014/15
		Seps	b/day	Seps	b/days	Seps	b/days	ALOS
Maintenance	Maintenance	8	94	9	49	13	158	12.2
Palliative	Palliative Care - Cancer Related	19	186	8	120	10	116	11.6
	Palliative Care - Non-Cancer	9	56	4	25	3	6	2.0
Palliative Total		28	242	12	145	13	122	9.4
Rehabilitation	Arthritis			1	19			

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SiAM 2010 Care Type Name	SiAM 2010 Clinical Group Name	2012/2013		2013/2014		2014/2015		2014/15
		Seps	b/day	Seps	b/days	Seps	b/days	ALOS
	Cardiac			1	8	1	6	6.0
	Neurological Conditions			1	15			
	Orthopaedic - Fractures	19	397	16	223	8	148	18.5
	Orthopaedic - Joint Replacement	8	62	7	59	4	24	6.0
	Orthopaedic - Other	2	26	1	19	2	66	33.0
	Other Rehabilitation	14	97	15	77	6	64	10.7
	Spinal Cord Injury					1	26	26.0
	Stroke	3	26	2	8	6	92	15.3
Rehabilitation Total		46	608	44	428	28	426	15.2

Table 14. Admission to ED and wards

Values	ED Only Name	2012/2013	2013/2014	2014/2015
Total Separations	(Non ED only)	2628	2590	2763
	entirely within ED	268	276	322
Total Bed days	(Non ED only)	8059	7557	8091
	entirely within ED	268	276	337
Total Separations		2896	2866	3085
Total Bed days		8327	7833	8428

Table 15. Separations and Beddays

AR-DRG 70 MedicalSurgicalProcedural	Values	Day Only Name	Financial Year		
			2012/2013	2013/2014	2014/2015
Medical	Total Separations	Day only	211	194	250
		Overnight(s)	1561	1583	1632
	Total Bed days	Day only	211	194	250
		Overnight(s)	6609	6316	6709
Medical Total Separations			1772	1777	1882
Medical Total Bed days			6820	6510	6959
Procedural	Total Separations	Day only	461	462	482
		Overnight(s)	36	40	50
	Total Bed days	Day only	461	462	482
		Overnight(s)	115	58	98
Procedural Total Separations			497	502	532
Procedural Total Bed days			576	520	580
Surgical	Total Separations	Day only	211	189	210
		Overnight(s)	148	122	139
	Total Bed days	Day only	211	189	210
		Overnight(s)	452	338	342
Surgical Total Separations			359	311	349
Surgical Total Bed days			663	527	552
(Non ED only) Total Separations			2628	2590	2763
(Non ED only) Total Bed days			8059	7557	8091
entirely within ED Total Separations			268	276	322
entirely within ED Total Bed days			268	276	337
			2896	2866	3085
			8327	7833	8428

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Table 16. Estimated bed requirements based on activity

		2012/2013	2013/2014	2014/2015	Beds	
Surgical Total Separations	Day only	674	652	693		
	Overnight(s)	184	162	189		
Total Bed days	Day only	674	652	693	4	
	Overnight(s)	567	396	440	1.6	at 75% occupancy
SurgTotal Separations		858	814	882		
Surg Total Bed days		1241	1048	1133	5.6	
Medical						
(Non ED only) total seps	Day only	211	194	250		
	Overnight(s)	1561	1583	1632		
(Non ED only)Total Bed days	Day only	211	194	250	0.9	at 75% occupancy
	Overnight(s)	6609	6316	6709	24.5	at 75% occupancy
(Non ED only) Total Separations		1772	1777	1882		
(Non ED only) Total Bed days		6820	6510	6959	25.4	22.4 + 3 obstetric
entirely within ED Total Separations		266	275	321		catered in ED
entirely within ED Total Bed days		266	275	336		catered in ED
Total Separations		2896	2866	3085		
Total Bed days		8327	7833	8428	31.8	
Bed base	Current	on 14/5 activity				
Surgical Day Only (chairs)	4	4				
Obstetrics	7	3				
Medical (22) and Surgical (2)	30	24				
total	41	31				

Table 17. Admissions from ED <36 hours

	FY13 -Jan	FY13 -Feb	FY13 -Mar	FY13 -Apr	FY13 -May	FY13 -Jun	FY13 -Jul	FY13 -Aug	FY13 -Sep	FY13 -Oct	FY13 -Nov	FY13 -Dec	TOTAL S
1 - ED only	23	20	23	21	19	17	16	21	19	8	17	22	226
4 - ED and Ward <24 hrs	33	17	31	17	27	32	36	43	30	29	27	25	347
ED & ward <36 hrs	16	9	4	13	13	14	5	11	11	9	9	13	127
2013	72	46	58	51	59	63	57	75	60	46	53	60	700
	FY14 -Jan	FY14 -Feb	FY14 -Mar	FY14 -Apr	FY14 -May	FY14 -Jun	FY14 -Jul	FY14 -Aug	FY14 -Sep	FY14 -Oct	FY14 -Nov	FY14 -Dec	0
1 - ED only	26	9	13	22	17	12	28	26	17	27	16	18	231
4 - ED and Ward <24 hrs	41	32	21	30	24	30	37	27	28	20	34	17	341
ED & ward <36 hrs	7	13	9	11	9	11	15	20	16	8	14	13	146
2014	74	54	43	63	50	53	80	73	61	55	64	48	718

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	FY15 -Jan	FY15 -Feb	FY15 -Mar	FY15 -Apr	FY15 -May	FY15 -Jun	FY15 -Jul	FY15 -Aug	FY15 -Sep	FY15 -Oct	FY15 -Nov	FY15 -Dec	0
1 - ED only	19	18	19	22	65	20	18	22	14	17	11	22	267
4 - ED and Ward <24 hrs	29	23	23	22	21	33	46	40	38	27	27	28	357
ED & ward <36 hrs	11	7	8	14	6	16	16	12	11	6	14	4	125
2015	59	48	50	58	92	69	80	74	63	50	52	54	749

9.4. FUTURE BED REQUIREMENTS

Assumptions used to calculate beds required

- By 2027, aIM projects the need for 38 beds, (3 day only surgical, 2 obstetric, 33 general)
- Scenario One projects beds (aIM) with the general ward operating at 80% occupancy = 37 beds required
- Scenario Two. The ALOS for Medical in aIM is projected to rise from 3.4 days in 2016/17 to 4.1 days in 2026/27. Cooma medical is currently operating with an ALOS of 3.3. If we project beddays using the 3.3 ALOS, the bed requirements are reduced = 31 beds required
- Scenario Three: 2015/16 actual + 5% growth per 5 years * current ALOS = 35 beds required (75% occupancy) or 33 beds at 80% occupancy.
- Taking the above scenarios into account the following is recommended:
 - 26 bed general ward
 - 4 bed Short Stay Unit
 - 4 day only Surgical (as is)
 - 2 obstetric beds (with 2 birthing room to be utilised as beds as required)

Table 18. Projected bed requirements (aIM 2012.v 2.2) base case + scenarios

			Year			
	M S P	Data	2011	2017	2022	2027
ED Only	2 Medical	Sum of seps	291	291	291	291
		Sum of beddays	291	291	291	291
		Sum of beds	1	1	1	1
		Year				
ED_only_label		Data	2011	2017	2022	2027
Surg/procedural	Surg Proced.	Sum of seps	883	842	900	944
		Sum of beddays	1189	1161	1224	1273
		Sum of beds	4	4	4	5
	less Surgical obstetrics	Sum of seps	43	44	43	42
		Sum of beddays	182	174	167	159
		Sum of beds	1	1	1	1
		Sum of seps	840	798	857	902
		Sum of beddays	1007	987	1058	1114
	TOTAL SURG	Sum of beds	4	4	4	4
	Day only		3	3	3	3
Medical	Medical	Sum of seps	1,912	2,042	2,172	2,299
		Sum of beddays	6,451	8,032	8,567	9,146
		Sum of beds	24	29	31	33
	less Medical obstetrics	Sum of seps	201	215	211	207
		Sum of beddays	571	538	519	502
		Sum of beds	2	2	2	2
		Sum of seps	1,711	1,827	1,961	2,092

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			Year			
	M S P	Data	2011	2017	2022	2027
		Sum of beddays	5,880	7,494	8,048	8,644
	Total Medical @ 75%	Sum of beds	21	27	29	32
	Total Medical @ 80%		20	26	28	30
Obstetrics	1 Surgical	Sum of seps	43	44	43	42
		Sum of beddays	182	174	167	159
		Sum of beds	1	1	1	1
	2 Medical	Sum of seps	201	215	211	207
		Sum of beddays	571	538	519	502
		Sum of beds	2	2	2	2
	total obst @75%		3	3	3	2
Aim Project	TOTAL beds	obstetrics	3	3	3	2
		Surg d/o	3	3	3	3
		Surg o/n	1	1	1	1
		medical	21	27	29	32
			28	34	36	38
Scenario One	medical @80% occupancy	obstetrics	3	3	3	2
		Surg d/o	4	4	4	4
		Surg o/n	1	1	1	1
		medical	20	26	28	30
	Total beds		28	33	35	37
Scenario two	medical projected @ 3.3ALOS	Sum of seps	1,711	1,827	1,961	2,092
	and 80% occupancy	Sum of beddays	5,646	6,030	6,470	6,904
		Beds 75%	21	22	24	25
		beds 80%	19	21	22	24
	Total beds					31

Table 19. Scenario Three: 2015/16 actual + 5% growth per 5 yrs * current ALOS.

Scenario Three	Volume	2015/16	2016/17	2021/22	2026/27
Acute scenario - actual+5%/years	Seps	3866	3866	4059	4262
(Acute Care Type) *actual ALOS 2.13	Bed Days	8258	8235	8646	9079
Subacute scenario - actual +5%/5yr	Seps	51	51	54	56
(Other Care Types) * actual ALOS 11.35	Bed Days	579	579	608	638
Total Inpatient scenario- actual +5%/years	Seps	3917	3917	4113	4318
* actual ALOS	Bed Days	8837	8813	9254	9717
	Beds @ 75% occ	32	32	34	35
	Beds @ 80% occ	30	30	32	33

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All Potentially Preventable Hospitalisation rates are within NSW average, except Snowy River in 13/14 -14/15 which was significant lower than avg.

Table 20. Potentially preventable hospitalisations by Local Government Area, NSW 2011/12 to 2014/15

Former LGA	No. seps			Rate per 100,000 population		
	2011-12 to 2012-13	2012-13 to 2013-14	2013-14 to 2014-15	2011-12 to 2012-13	2012-13 to 2013-14	2013-14 to 2014-15
Cooma-Monaro	231	239	225	2,251	2,331	2,188
Snowy River	137	145	136	1,744	1,823	1,696
Bombala	51	54	56	2,154	2,292	2,365

Table 21. PPH Data from PAU webi reports

	2 year data, 2014/15 + 2015/16	Cooma HS	Bombala MPS	Cooma HS 14/15	Cooma HS 15/16
	Pneumonia & Influenza	1	0		
	Vaccine preventable disease	2	0		
Chronic	Asthma	1	0		
	Congestive Heart failure	0	0		
	Diabetes complications	44	12	22	22
	COPD	0	0		
	Bronchiectasis	1	0		
	Angina	0	0		
	Iron Deficiency Anaemia	68	1	32	36
	Hypertension	0	0		
	Nutritional deficiencies	1	0		
	Rheumatic Heart Diseases	0	0		
Acute	Pneumonia not vaccine-prevent	0	0		
	UTI	70	8	33	37
	Perforated/Bleeding Ulcer	5	1		
	Cellulitis	0	0		
	Pelvic Inflammatory Disease	0	0		
	ENT infections	0	0		
	Dental Conditions	0	0		
	Convulsions and Epilepsy	0	0		
	Eclampsia	0	0		
	Gangrene	0	0		
	Total	193	22		

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Table 22. Way forward for community and Ambulatory Care Services

	What we do now	Where we are going
Models of Care (the way services are delivered)	Models of Care are inconsistent across the LHD and are not automatically linked to current evidenced practice; staff configuration and skills vary; there is no evidence that resources are used efficiently	<ul style="list-style-type: none"> ▫ Models of Care standardised across the LHD with core service definitions and established clinical and operational pathways and indicators ▫ Staff skill requirements aligned with the models ▫ Operating as Hub and Spoke model with equitable supports to Spokes
	Services mainly operate Monday to Friday, business hours.	Workforce is integrated through increased care collaboration between disciplines, acute services, primary care and external service providers
	Few clinical outcome indicators	Well-developed clinical outcome measures in place
Workforce	Workforce has been developed historically based on local service staff profile, assigned budgets and perception of community need. Limited capacity to change.	<ul style="list-style-type: none"> ▫ Increased workforce capacity, utilisation and productivity ▫ Workforce planning systems ensure that workforce structures meet current service requirements
	Limited advanced practitioner opportunities and few allied health and nursing assistants	Community and Ambulatory Care is recognised as an essential component of the changed health care environment. <ul style="list-style-type: none"> ▫ Advanced practitioners are an essential part of the clinical governance framework in rural areas with limited access to specialised medical services. Advanced practitioners increase and improve service capability. Educate and enhance knowledge for generalist nurses. ▫ A valued component of the workforce is 'assistant' workforce (both AH & nursing)
	Inadequate clinical supervision systems for new graduates	New graduates are an integral component of the workforce which helps build a workforce for the future
	Workforce planning based on budget and existing staffing establishments	Workforce planning utilises proven methodologies and based on need
	Limited workload management and monitoring across all disciplines	Services have established workload measures and workload monitoring systems
Governance	<ul style="list-style-type: none"> ▫ Operational management by CH allied health and nurse managers, general managers and health service managers ▫ Strategic management linked to LHD program managers ▫ Clinical governance linked to clinical lead ▫ Oversighted by Director of CH 	<ul style="list-style-type: none"> ▫ Strategic management and clinical governance provide clear direction for Community and Ambulatory Care across the LHD ▫ Day to day management only by local managers ▫ Joint executive for each model meet regularly to ensure there is no 'silo' creep. ▫ Community and Ambulatory Care managers are part of local executive teams
Activity, budgets & ABF	Limited alignment between activity targets, budgets and ABF non-admitted Tier 2 services, and limited understanding amongst staff	Understanding and alignment are business as usual
Data & records	Mix of electronic and paper systems with limited standardisation	Full electronic systems in place with LHD Centralised Intake service
Hospital Substitution	<ul style="list-style-type: none"> ▫ Services are not integrated by design (with exception of MPS's), CH and 	Business processes are established to support integration between Community and Ambulatory

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	What we do now	Where we are going
	<p>acute services operate as separate business models</p> <ul style="list-style-type: none"> ▫ Current hospital substitution programs such as HITH, TACP, ComPacks are designed to provide alternatives to inpatient acute care, however, are limited in flexibility ▫ CH does not have the clinical capacity or business structures to meet other hospital substitution demands. 	Care and acute services, with a seamless journey for the patient/client through the system
Partnerships and Integration	<ul style="list-style-type: none"> ▫ Partnerships and integration are both fragmented and unformed. Limited awareness of capacity of other service providers, few shared business processes. Little evidence of shared responsibility, information and decision making for client care. ▫ Emerging understanding within LHD of importance of transdisciplinary collaborative care 	Primary care partnerships with GPs, private and NGO sector are well developed, ensuring support of service integration and increased capacity
Clinic based care	<ul style="list-style-type: none"> ▫ Majority of allied health services delivered through clinic based care ▫ Majority of community nursing delivered in the client's home 	<p>Greater emphasis on clinic based care (home visits limited to those who are unable to access clinic care, restricted to mandated programs or standardised clinical need)</p> <p>Greater focus on care commencing in the ED to facilitate timely access to care and coordinated discharge planning</p>
Services for priority populations	Aboriginal Health struggles to integrate with mainstream services.	Services are integrated, with collaboration around care provision
Community and Ambulatory Care Indicators	Indicators to measure service performance and clinical outcomes have been developed locally in some services and/or linked to individual or population health programs. There is currently no Health Outcomes Framework in the LHD	<p>A suite of indicators contribute to the evidence that strengthen performance and accountability and demonstrates improved clinical outcomes and captures the patient/client experience of care.</p> <p>Incorporation of clinical teams to facilitate discharge planning that is coordinated and sustained.</p>

Table 23. Estimated Resident Population by Age, by Local Government Area, Persons – 30 June 2014 under 18 for Dental services

Former LGA	0-4	5-9	10-14	15-17 estimate	Total 0-17 years
Cooma-Monaro (A)	568	655	637	413	2,273
Snowy River (A)	463	536	547	407	1,953
Bombala (A)	112	159	149	90	510
Monaro total	1,143	1,350	1,333	910	4,736

Australian Bureau of Statistics

3235.0 Population by Age and Sex, Regions of Australia

9.5. COOMA RADIOLOGY ACTIVITY

Year-Month	14-09	14-10	14-11	14-12	15-01	15-02	15-03	15-04	15-05	15-06	15-07	15-08	15-09	15-10	15-11	15-12	16-01	16-02	16-03	16-04	16-05	16-06	Grand Total	
CR	487	679	583	567	584	620	698	608	658	655	769	770	594	613	620	534	601	638	658	623	703	725	13987	
Emergency	109	110	115	160	121	120	148	102	145	142	153	185	137	99	122	132	121	110	122	123	137	125	2838	
Inpatient	106	129	112	103	97	81	120	99	106	104	147	159	115	108	111	119	110	94	107	129	98	144	2498	
Outpatient	272	440	356	304	366	419	430	407	407	409	469	426	342	406	387	283	370	434	429	371	468	456	8651	
CT	138	140	133	130	151	154	145	136	164	172	221	233	210	126	176	162	156	167	157	28	219	172	3490	
Emergency	33	21	14	21	24	21	16	22	18	20	29	46	28	19	31	28	15	12	20	6	36	23	503	
Inpatient	28	43	41	43	39	37	40	23	48	51	80	72	52	27	50	47	51	49	41	15	57	50	984	
Outpatient	77	76	78	66	88	96	89	91	98	101	112	115	130	80	95	87	90	106	96	7	126	99	2003	
II	1	2	6			3		3	2	1	1	1	1	3	2						1	1	28	
Inpatient	1	2	6			3		3	2	1	1	1	1	3	2							1	1	28
MO				1	2	1	2	3	1	1		2	2	1	1		3	4	3	1	2	3	33	
Emergency						1				1													2	
Inpatient				1	2		2	3		1		2	2	1	1		2	4	3	1	2	3	30	
Outpatient																	1						1	
US	174	83	49	201	203	202	216	242	243	257	262	268	248	241	262	156	190	258	268	197	279	268	4767	
Emergency	6	3	1	18	17	13	13	9	13	11	14	14	16	12	10	7	17	24	9	9	13	13	262	
Inpatient	29	12	7	20	17	20	23	28	26	25	25	20	15	19	15	13	22	27	14	15	20	22	434	
Outpatient	139	68	41	163	169	169	180	205	204	221	223	234	217	210	237	136	151	207	245	173	246	233	4071	
Grand Total	800	904	771	899	940	980	1061	992	1068	1086	1253	1274	1055	984	1061	852	950	1067	1086	849	1204	1169	22305	

