South Western Sydney Local Health District

Strategic & Healthcare Services Plan

Strategic Priorities in Health Care Delivery to 2021

Leading care, healthier communities
Foreword

Planning for health services is essential to ensure that health facilities, clinical services and systems are all able to meet the current and future needs of the population.

In the South West of Sydney and for the Southern Highlands, this means working out how health services can best meet the needs of a rapidly growing and ageing community. It means understanding the unique health needs of members of the population who have a lower than expected health status, such as Aboriginal and Torres Strait Islander people, people who are refugees and people with a mental health issue or chronic disease. It also means defining the evidence based models of care appropriate for service delivery now and in the future to ensure effective use of public monies.

Members of the local community, stakeholder groups, clinical leaders, staff and management have all had an opportunity to contribute to designing this future healthcare plan for the South Western Sydney and Southern Highlands communities. The plan ensures that the NSW health system’s core values of collaboration, openness, respect and empowerment are built into all future systems and that by 2021 SWSLHD is achieving for the community its Vision of “Leading care, healthier communities.”

Sustained action across a broad range of fronts will be required to bring the vision to reality. “Leading care” will require a multilateral focus on issues such as quality improvement, safety, education, research, workforce development and training, to embed best practice and excellence in healthcare practice. “Healthier communities” will be achieved by placing patients and communities at the centre of care, providing holistic health that addresses social and cultural contexts across the spectrum of prevention and care. Centres of excellence will adopt best practice healthcare, translating research into clinical practice.

SWSLHD’s Mission outlines how the vision will be achieved, involving core elements such as collaboration and innovation. “Collaboration” will require embedding of multidisciplinary teamwork and partnerships with individuals, communities and agencies in healthcare practice. Teamwork and partnerships will grow from an understanding of community needs and values, with a shared aim of providing seamless continuity of care and an integrated approach to planning for the future. “Innovation” will require a culture of inquiry and exploring new ways in service delivery, with understanding of the drivers and opportunity for future change. The District will support this culture through systematic evaluation of work practices, active encouragement of health research, rewarding workplace initiative and service redesign focussed on solutions to local needs.

Importantly, all elements of the vision and mission in healthcare practice will be underpinned by a focus on equity. This will be at the forefront of service design and practice, with the aim of reaching the most disadvantaged, facilitating patient access to integrated networks of care and optimising the flow of privacy assured patient information between providers and settings of care. A fundamental focus will be on building the capacity of communities to address health issues.

We have great confidence that the many initiatives in this plan can bring the District’s vision for the future to reality, ensuring it develops as a leader in the health care industry, locally and nationally.

Professor Phillip Harris AM  
Chair  
South Western Sydney Local Health District Board

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Chief Executive  
South Western Sydney Local Health District
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1. Executive Summary

Over the ten year horizon for this Plan, the population of South Western Sydney Local Health District (SWSLHD) will grow by 20%, becoming the most populous LHD in NSW, providing healthcare services for over one million residents; population numbers twice that currently in Tasmania and just short of Adelaide’s current numbers (Section 6.1). With the population growing by 18,000 per annum, every three years there will be additional population greater than that currently residing in LGAs such as Wingocharribee or Wollondilly, metropolitan Sydney’s Ashfield or Manly, or regional NSW’s Albury, Orange, Dubbo or Bathurst. There will be even more rapid growth of older age cohorts that place disproportionately more demand on healthcare services, with 50% growth in those aged 70+ years expected (Section 6.1).

The impacts of population growth, better survival from previously-fatal illnesses and ageing will inevitably translate into high growth in demand for healthcare (Section 6.2), elevated well above the expectation for NSW overall e.g. 33% higher for acute bed days and 93% higher for sub-acute bed days. This increased demand builds from an existing deficit in capacity available to meet current demands, which for inpatient care is reflected in SWSLHD’s occupancy rates as the highest of any LHD, well above the benchmark of 85% and approaching 100% (Section 9.3). Capacity deficits extend to a paucity of private healthcare provision in SWSLHD, in private hospital beds, in private specialists in practice, in general practitioner availability in some regions and in private allied health services.

SWSLHD has socio-economically diverse communities (Section 5.2), some of which display high levels of disadvantage e.g. Fairfield, Bankstown, Campbelltown and Liverpool are in the ten most disadvantaged LGAs in metropolitan Sydney. Lower than State average median household income is reported in Fairfield, Bankstown and Wingocharribee. There are concentrations of social housing, notably in Bankstown and Campbelltown. Rates of homelessness are generally better than the State average, although of particular significance in Wingocharribee. Over 40% of all refugee humanitarian arrivals in recent years have settled in SWSLHD. There is higher than State average reported disability. Disadvantage is closely associated with higher health need and poorer health outcomes, elevating demand on healthcare services.

There is variation in health status across SWSLHD (Section 5.3). Overall, death rates are higher than the State average, with the standardised mortality ratio significantly worse in Campbelltown. SWSLHD residents have elevated rates of some behaviours that are linked to poorer health status and lower rates of health protective factors. This includes worse than State average rates for self-reported health status, psychological distress, adequate physical activity, consumption of recommended quantity of vegetables, current smoking, influenza immunisations, pneumococcal immunisations, pap testing, mammograms and antenatal visits before 14 weeks gestation.

Poorer health status than the NSW average is reported across SWSLHD for many of the health priority areas (Section 5.3) identified by governments for action. This includes stroke, diabetes, asthma, fall related and high BMI attributable hospitalisations; cardiovascular, lung cancer and diabetes related deaths; and pregnancy outcomes in perinatal mortality and low weight births. Poorer health status entails a higher burden and higher responsibility in healthcare provision across the spectrum from prevention to treatment to palliation.

The fundamental challenge for SWSLHD is in crafting a healthcare system that can meet the increased demands from population growth and ageing and improves health outcomes; that is responsive, timely and appropriate; using best practice models of care and enhancing capacity across all aspects of healthcare provision, including infrastructure; that new and innovative ways of health care prevention and treatment are investigated; that services contribute to the identification of best practice; that health services work collaboratively across disciplines, with patients, carers, families, communities and service and government
sectors; and to achieve better health for the community. This goal is encapsulated in the Vision of Leading care, healthier communities (Section 3.4). The Mission Statement outlines how that will be achieved – through delivery of high quality healthcare; centred on populations, communities and patients; evidenced as best practice and engaged with communities; respectful and sensitive to personal needs; learning and improving; and supportive of excellence in teamwork.

Service development directions to achieve the SWSLHD Vision and Mission have been identified in three fundamental focus areas of SWSLHD activity – corporate and organisational actions (Section 8.1); models of care for clinical streams and networks (Section 8.2); and actions to address the needs of priority population groupings (Section 8.3).

A framework for corporate strategic action (Section 8.1) has been developed, with corporate actions themed under eight areas of focus:

- Providing high quality health services
- Community partnerships
- Seamless networks
- Developing staff
- Research and innovation
- Enhancing assets and resources
- Supporting business
- Efficiency and sustainability

A five year planning horizon has been adopted for corporate action, as outlined in the companion document to this Plan, Directions to Better Health - South Western Sydney Local Health District Corporate Plan 2013 – 2017. Around 150 separate corporate actions are identified, with the Executive Sponsor and Responsible Manager for each action specified and a mapping undertaken to illustrate how each item of the SWSLHD Performance Agreement 2012-2013 will be primarily addressed within the Corporate Plan. This will be a living document, with an annual review of progress and updating of actions in tandem with the SWSLHD Performance Agreement to reflect changing government and local priorities.

Models of care for the future (Section 8.2) have been identified for all clinical streams and service networks (Appendix A18). Models of care have been developed with consideration of core concepts:

- Optimising partnerships with external providers of care to improve access and choice for patients to care
- Supporting all services in achieving excellence in care provision
- Enhancing and strengthening clinical networks to improve timeliness in access to high quality care

This includes consideration of models and options for private participation in healthcare delivery, defining features of centres of excellence and principles for clinical network development. Models of care reflect the operating principles for health care delivery of providing the right services by the right team in the right place at the right time (Section 8.2). Implementation of these models of care will entail significant service developments at all public healthcare facilities in SWSLHD (Appendix A19). This will potentially enable enhancement in the role delineation status of a number of clinical services at a number of sites of service provision (Attachment A3) and enhanced self sufficiency with a broader range of clinical services available within local communities, decreasing necessity for patients to flow to outside facilities for care (Section 3.8).

In addition to the service developments to be pursued through corporate action and enhanced models of care, a strong and sustained focus on equity will be advanced through specific actions addressing the needs of priority population groups (Section 8.3). Strategies are identified which build individual and community
capacity through health literacy, targeting priority health issues, with up-skilled staff developing collaborative partnerships in evidence based effectiveness.

The focus will be on working with individuals and communities experiencing disadvantage including:

- Aboriginal people and Torres Strait Islanders
- People with chronic mental illness and their children
- People in contact with the criminal justice system and their families
- People living in rural communities with poor access to health care
- People living in social housing with poorer access to basic health and social infrastructure
- People with drug and alcohol issues
- People on low incomes, who are unemployed or have lower educational attainment
- People who are homeless or in insecure housing
- Children in care or from families with child protection issues
- People with a chronic illness and their carers
- Refugees and recently arrived migrants
- People with a disability
- Carers

To support action on corporate initiatives, model of care developments and targeted work with priority population groupings; service development directions are also identified for clinical enablers, a range of services/activities which support clinical care (Section 8.4). These include activities as diverse as biomedical engineering, consumer and community participation, health language services, information technology, pharmacy, research, transport, volunteers, pastoral care, research, workforce development and education.

From the comprehensive range of service developments in models of care, for priority population groupings, in corporate activities and for clinical enablers, eight priority strategic directions (Section 9) have been identified that will underpin service developments, to enhance the way health care is delivered and organisations partner for better health in local communities:

- Build capacity to effectively service growing demands for health care
- Redesign of services bringing them closer to people and their communities
- Integrated action with the South Western Sydney Medicare Local
- Partnering with external providers to deliver public health care
- Enhancing service networks and growing centres of excellence
- Shared access to unified information for all the health care team
- An integrated focus on primary prevention for patients and communities
- Embedding education and research within service delivery

Within each of these eight priority strategic directions the highest priority actions SWSLHD will pursue to drive service development forward are also identified.

A sustained and rolling program of service enhancement, capacity uplift and infrastructure build will be required in SWSLHD (Section 10) to meet the increasing demands for healthcare from population growth and ageing, to improve the health status of local communities, to provide best practice evidenced models of care, to forge the partnerships and drive the innovation to realise the Vision, to sustain the equity focus in working with priority population groupings and to build the enabling structures that underpin clinical practice.
Enhancements to acute and sub-acute hospital capacity will be required, going beyond the five high priorities already identified in the current LHD Asset Strategic Plan (Sections 10.1, 10.3 & 10.5). Healthcare services provided in the community will also require significant enhancement including increasing provision of services previously centred on hospital campuses (Section 10.6). Many of the options identified in the State Infrastructure Strategy are consistent with the service development directions and models of care proposed in this Plan and the potential to move in these directions will be the explored through detailed business planning and economic appraisal (Section 10.2). This will include consideration of Public Private Partnership across the spectrum of potential models identified in the Plan (Section 10.7). Consideration of alternative mechanisms for capacity and infrastructure enhancement involving partnerships with external providers of care will only proceed in the context of fundamental principles identified as a prerequisite for detailed negotiation.

Implementation of these service development directions will proceed under the District governance frameworks, with oversight by the Board, Executive, Clinical and Quality Council and their supporting committees (Section 11). This will only occur after comprehensive consultation on proposals with the communities of south west Sydney and the Southern Highlands. Once agreed the service development directions will be reflected in detailed planning on specific areas of healthcare focus, for geographic regions, facility sites, high needs population groupings and for clinical streams and networks. All developments will be subject to funding availability, which in some instances will require additional commitment from government(s), to be facilitated through the Ministry of Health.
2. Introduction

There is a clear legislative imperative for Local Health Districts to undertake comprehensive strategic planning, with structured processes that facilitate the involvement of the community, the Ministry of Health and other organisations within the health arena. Under Section 10 of the Health Services Act 1997, the functions of a local health district include:

\[ g) \text{ to investigate and assess health needs in its area,} \]
\[ h) \text{ to plan future development of health services in its area, and, towards that end:} \]
\[   I. \text{ to consult and plan jointly with the Department of Health and such other organisations as it considers appropriate, and} \]
\[   II. \text{ to support, encourage and facilitate the organisation of community involvement in the planning of those services, and} \]
\[   III. \text{ to develop strategies to facilitate community involvement in the planning of those services and to report on the implementation of those strategies in annual reports and to the Minister} \]

Additionally, under Section 28 of the Act, the functions of a local health district board include:

\[ c) \text{ To ensure strategic plans to guide the delivery of services are developed for the local health district and to approve those plans} \]

At its meeting of 23 January 2012, the SWSLHD Board endorsed a strategic planning process that would build from a baseline of planning under previous administrative structures; be grounded in the advice of clinicians and staff across the LHD; involve structured consultation with the LHD’s consumer and community networks and more broadly with community members, consult with government and non-government organisations participating in health related activities; and reflect the guidance of the Ministry of Health. Further detail on the background to and conduct of the strategic planning process is provided at Section 4.

A broad remit for strategic planning was identified in the scoping paper. The intent has been to provide the planning groundwork across the spectrum of LHD activities, identifying service development directions for clinical streams, for facilities, for priority population groupings and for the corporate and organisational domains. Across all these areas a core focus has been on capacity and infrastructure building to ensure, sustainable, equitable and efficient service delivery for communities of south west Sydney and the Southern Highlands. As capacity and infrastructure building has inherent longer term timeframes for securing resources and implementation, the planning horizon adopted for priority service delivery developments has been ten years, to 2021. For corporate service delivery developments a five year planning horizon has been adopted, reflecting potential for action in a shorter timeframe through service growth, redesign and changed focus.

The approach taken has been that where comprehensive planning under previous administrations remains in currency and relevant, the planning focus will be building from that base, enhancing and expanding to cater for future demands and evolving evidence on best practice. Documentation of the strategic plan has adopted as many aspects of the Ministry of Health’s draft Template for a Health Care Services Plan as practicable. Furthermore it goes beyond the intent of that template by referencing corporate and organisational actions that under previous administrative structures were developed separately. This reflects the SWSLHD planning intent to focus on integrated planning so that all service development directions, corporate and clinical, reflect the core health system values and the District’s vision and mission, highlighted by an emphasis on collaboration and innovation to achieve better health.
3. South Western Sydney Local Health District

South Western Sydney Local Health District (SWSLHD) was established in January 2011 following Australian and state health reforms aimed at increasing local capacity to respond to local health needs, at both an individual and population level.

The District, shown in Figure 3.1, covers approximately 6,243km² and incorporates the seven local government areas (LGAs) of Bankstown, Liverpool, Fairfield, Campbelltown, Camden, Wollondilly and Wingeacarribee. From north to south and east to west, the District is approximately 100km at its widest point.

Figure 3.1 Map of South Western Sydney Local Health District

The creation of local health districts occurred at a time of significant reform of Australian and NSW health systems. A summary of the context and milestones in health reform, including the structure of the NSW Health system and important policy directions, is provided in Appendix A1.
3.1 Governance

South Western Sydney Local Health District is led by the Chief Executive who is responsible to the Local Health District Board which comprises clinical and community leaders, with a vast range of expertise in care delivery, research, innovation, education, financial management and community development. The Organisation Chart is provided at Appendix A2.

The decisions of the Chief Executive and Board are informed by formal structures established within the District to provide expertise and leadership. These include:

- the Executive Team comprising Chief Executive and Directors of Operations, Nursing and Midwifery, Finance, Medical Services and Clinical Governance
- the Clinical and Quality Council (CQC) and sub-committees which aim to ensure implementation of effective clinical governance and provides a forum for effective consultation with senior clinical staff
- Sub-committees of the Board (Research and Teaching; Health Care Quality and Safety; Finance; and Audit and Risk) which provide advice and other assistance to enable the District to perform its role
- the Consumer and Community Council and Networks (operating under the Consumer and Community Participation Framework 2012), which seek to ensure effective health consumer and community participation processes across the District
- Medical Staff Councils which facilitate care, provide leadership and a forum for information sharing
- Medical and Dental Appointments Advisory Committee which provides advice regarding appointments and clinical privileges.

Services are responsible for operating within the broader NSW policy framework.

3.2 Role of Local Health Districts

The primary role of local health districts is “to provide relief to sick and injured persons through the provision of care and treatment and promote, protect and maintain the health of the community”.

Health interventions occur across a range of settings including tertiary, metropolitan and rural hospitals, community health centres and in the community in patient homes, schools and communities. Health related activities are provided by a range of professionals including medical specialists, nurses, allied health, complementary health, health promotion and community development staff. Services include:

- emergency care provided in Emergency Departments (EDs) for people with a serious illness or injury requiring urgent attention
- inpatient care for people requiring admission to hospital. This may be related to diagnosis or treatment of a specific acute medical condition for which surgery may or may not be required and non-acute (sub-acute) conditions requiring rehabilitation
- outpatient and community based assessment, treatment and care, and monitoring of people with acute or chronic health conditions. This may include improving, maintaining or maximising quality of life.
- case management for people with chronic health conditions and support in accessing housing, educational, employment and social opportunities
- screening for the presence of health conditions such as childhood hearing problems or specific cancers in adults
- immunisation for high school children
- health promotion and prevention activities in partnership with other agencies and the community
surveillance and monitoring of the incidence of notifiable infectious diseases and environmental health hazards and taking appropriate action to control the spread of diseases and other health conditions

- health disaster preparedness and management at a time of crisis
- health research to identify better ways to prevent and treat disease, improve the care and treatment of people and address factors which contribute to poorer health and quality of life
- contribution to formal education of students undertaking undergraduate and graduate health and related qualifications.

Interventions are informed by research and best practice and by patient and community feedback.

### 3.3 Health Facilities in South Western Sydney

The District manages acute, sub-acute and community health facilities, each of which delivers designated services defined by factors such as classification, role delineation, size, configuration and local need. The following table provides an overview of the major health facilities in the District.

<table>
<thead>
<tr>
<th>Facility</th>
<th>Peer Grouping</th>
<th>Role delineation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bankstown-Lidcombe Hospital</td>
<td>Principal Referral Hospital Group A1b</td>
<td>5</td>
</tr>
<tr>
<td>Bowral and District Hospital</td>
<td>District Hospital Group C1</td>
<td>3</td>
</tr>
<tr>
<td>Camden Hospital</td>
<td>District Hospital Group C1</td>
<td>3</td>
</tr>
<tr>
<td>Campbelltown Hospital</td>
<td>Major Metropolitan Hospital Group B1</td>
<td>4</td>
</tr>
<tr>
<td>Fairfield Hospital</td>
<td>Major Metropolitan Hospital Group B1</td>
<td>3-4</td>
</tr>
<tr>
<td>Liverpool Hospital</td>
<td>Principal Referral Hospital Group A1a</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Affiliated Health Organisations</th>
<th>Role delineation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Braeside Hospital</td>
<td>Subacute F4</td>
</tr>
<tr>
<td>Carrington Centennial Care</td>
<td>Nursing Home F2</td>
</tr>
<tr>
<td>Karitane</td>
<td>Mothercraft F7</td>
</tr>
<tr>
<td>NSW Service for the Treatment &amp; Rehabilitation of Torture &amp; Trauma Survivors (STARTTS)</td>
<td>Does not provide inpatient care. It therefore does not require a hospital peer group classification</td>
</tr>
<tr>
<td>South West Sydney Scarba Service</td>
<td>As above</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Based Health Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health (including early childhood and youth health centres and other community based facilities e.g. mental health, oral health, etc.)</td>
<td>As above. Major centres are located in: Bankstown, Bowral, Cabramatta, Campbelltown, Carramar, Hoxton Park, Ingleburn, Liverpool, Miller, Moorebank, Narellan, Prairiewood, Rosemeadow and Tahmoor</td>
</tr>
</tbody>
</table>

1. Role delineation assists NSW Districts to determine the complexity of work which can be undertaken at each facility and the support services required to effectively and safely provide this work (e.g. staff profile, access to pathology, access to major diagnostic equipment). A detailed list of the role delineation level of each specialty and support service in each facility is in Appendix 3.

2. Affiliated health organisations are part of the public health system operated by non-profit, religious, charitable or other non-government organisations and are listed within the Health Services Act 1997.

3. Braeside Hospital is operated by HammondCare and the South West Sydney Scarba Service by the Benevolent Society

### 3.4 Values, Vision, Mission and Principles

Four CORE values are fundamental to provision of health services across NSW. These values are the foundation stones for building trust and underpin all activities of the District. They define how staff work together and
how health services collaborate with patients, carers, the community and service partners in delivering health care and improving the health of the community.

<table>
<thead>
<tr>
<th>Collaboration</th>
<th>Openness</th>
<th>Respect</th>
<th>Empowerment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working as one team with patients, carers, the community, and other service partners</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Services are transparent and open and explain the reason for decisions</td>
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<tr>
<td>Everyone involved in patient care or a health project can contribute and their views will be heard, valued and respected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff, patients, carers and the community can make choices and influence outcomes. Systems and processes will enable participation, supply necessary information, support delegation and ensure accountability.</td>
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</table>

The Vision SWSLHD will take forward is:

**Leading care, healthier communities**

Two fundamental goals underpin this Vision:

**Leading care** demonstrated by a robust quality improvement framework; surveillance and action on safety; academic alliances in education and research; workforce development and training; placing patients and communities at the centre of care models; a holistic health focus addressing social and cultural contexts across the spectrum of prevention and care; creating centres of excellence; adopting best practice models of care; and translating research into clinical practice.

**Healthier communities** where individuals, families and communities can enjoy the best health possible using evidence based programs, to prevent health problems and reduce disability; build the capacity of individuals and communities to improve their health and fully engage in health promoting activities; and create social and physical environments that are healthy and support healthy activities.

**Leading care, healthier communities** also assumes that there will be **collaboration** through multidisciplinary teamwork and partnerships with individuals, communities and agencies; grounded in an understanding of community needs and values; and supporting seamless continuity of care and integrated planning and service and program delivery. It also assumes that there will be **innovation** demonstrated by a culture of inquiry and exploring new ways in service delivery; horizon scanning of drivers and opportunity for change; evaluating work practices and fostering health research; a workplace culture rewarding initiative; investing in redesign and change management; trialling and developing solutions tailored to local needs; and building the evidence base for broader use.

Underpinning these goals is **equity** in healthcare planning and provision; tailoring services and initiatives to reach the most disadvantaged; creating integrated networks of care to facilitate patient access; enhancing the flow of privacy assured patient information between providers and settings of care; health information and communication to enable patients to self manage and take greater control of their healthcare; building the capacity of communities to address health issues; and understanding community values.

The way to reach these vision goals is outlined in the SWSLHD **Mission Statement** which articulates the organisation’s purpose, a combination of what it does and how and why it does it, and the values important to underpinning actions. This Mission Statement incorporates the abilities and strengths of the District contributing to long-term success.
The **Mission Statement** for SWSLHD is:

*Our mission is to promote the health of the residents of the District and patients using our health services through the delivery of high quality healthcare.*

We do this by providing health services that are population based, patient-centred and involve families and carers.

We use evidence to inform health practices; and consult, communicate, engage and collaborate with patients, local communities, agencies and care providers to improve the way we plan and provide health care services and programs.

We strive to deliver services that are respectful of personal dignity and autonomy; and sensitive to the needs of people from different cultures.

We emphasise learning and reflection and are committed to continuous quality improvement and innovation in delivering efficient and sustainable health care.

Our culture enables excellence and accountability, values our people and supports positive leadership and teamwork.

The **Principles** which guide how services are managed and developed into the future are:

1. All residents have equity in access to health care services. People who are disadvantaged will be provided with assistance to access services where necessary.
2. Health services across the District will be of high quality.
3. Patients, communities, staff and service providers will be treated with courtesy, dignity and respect. Communication and collaboration will be fundamental to engagement.
4. Health care will be patient and family centred and responsive to the culture and needs of individuals, families and communities.
5. Individuals and communities will be actively engaged in health care and programs. They will be provided with information and supported to make informed choices about their health. Autonomy in decision making will be respected.
6. Population health programs and strategies will be developed with communities and other agencies to improve the health of local communities. Strategies will be multifaceted to increase effectiveness and sustainability.
7. Services will be provided as close to home as possible and integrated across hospitals, community and primary health settings. Networks to centres of excellence and tertiary services will increase access to expertise when required and support timely care.
8. Collaboration and teamwork will occur within all health services and include patients, community members and service partners. New partnerships and opportunities to improve health and health care will be explored and developed.
9. The workforce is valued and will be consulted and included in the development and implementation of initiatives. Personal and professional development opportunities will be provided to enable staff to meet ongoing changes in the health system.

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1 Patient-centred is most commonly used in research and literature. It is seen as inclusive of other terms such as client, consumer or person-centred. It emphasises the central role of patients, family, carers and consumers in health care.
10. Services will be provided in a safe and healthy environment.

11. New models of care, health care practices and technology based on evidence will be used to ensure that patients and communities receive the best and most appropriate service available. Innovation and research will be encouraged to ensure safe and appropriate interventions.

12. Services will be provided in an efficient, sustainable and cost effective manner and will be evaluated and remodelled as required.

13. Environmental sustainability will be fundamental to the design and delivery of clinical and non-clinical services and infrastructure.

### 3.5 Clinical Stream and Networks

SWSLHD specialty services and programs are allocated to clinical streams and service networks to support effective clinical governance and direction. There are 17 clinical streams and networks:

- Aged Care and Rehabilitation
- Allied Health
- Cancer
- Cardiovascular
- Complex Care and Internal Medicine
- Community Health Services
- Critical Care
- Drug Health
- Gastroenterology and Liver
- Laboratory Services
- Medical Imaging
- Mental Health
- Oral Health
- Paediatrics and Neonatology
- Population Health
- Surgical Specialties
- Women’s Health

To date, some clinical streams, and individual services in some other streams, have been operated as a shared network across SWSLHD and SLHD, under an Inter District Agreement (IDA) i.e. Drug Health, Mental Health, Oral Health and Population Health. Streams that have operated subject to an IDA will be split in 2013-14.

BreastScreen Sydney South West also operates across SWSLHD. A list of the specialties and services provided by each clinical stream is provided in Appendix A4.

### 3.6 Workforce

Local health services have a large and diverse workforce, spread across the District, from tertiary care facilities to outreach programs delivered in homes and communities. In July 2012, there were approximately 11,980 people working in the District (including dental staff managed through Sydney Dental Hospital).

The workforce is predominantly female and comparatively young with 34% of staff aged less than 35 years. Approximately 17% is aged over 55 years although this older demographic varies across the District. For example in Bowral, more than one quarter of staff is aged over 55 years. The workforce is categorised into broad health occupations and includes 5,775 nurses, 1,402 medical and 985 allied and complementary health staff. The workforce profile of the District is reflected in the following diagram.
Workforce distribution across the District reflects the role of each facility and the peer grouping it has been allocated. A summary workforce profile for each health facility is included in Appendix A5.

### 3.7 Health Service Activity

Public health services in South Western Sydney have grown considerably in recent years, with continuing improvement of the quality, quantum and range of health services. To support this growth, there have been changes in the organisation and structure of services, the range and complexity of clinical care and the built capacity to provide care. These achievements are summarised in Appendix A7.

As outlined in Section 3.2, a range of services are provided to the community. The following provides a snapshot of some of the service activities. Additional detail about the inpatient, ambulatory and community activity of each facility is provided in Appendix A6 and A15.9.

In 2011/12, SWSLHD provided:

- 231,678 ED attendances
- 10,407 births
- 195,454 inpatient separations
- 40,991 surgical operations
- 717,229 occupied bed days
- 2.42 million outpatient services
- Health services in 6 acute hospitals, 4 affiliated health services, over 60 community centres and in the community and used 2,232 beds in public hospitals

The District has a formal Performance Agreement with the Ministry of Health which includes a range of targets. The targets are derived primarily from the National Health Reform Performance and Accountability Framework, the NSW State Plan NSW 2021: A plan to make NSW number one and NSW Ministry of Health requirements. The targets are identified in the Corporate Plan and relate to:

- Safety and quality (including outcomes such as mortality, readmission, hospital acquired infection and accreditation)
- Patient experiences
Strategic Priorities in Health Care Delivery to 2021

- patient flow (including timeliness of service for emergency care and surgery) and access and equity
- workforce
- finance and management including efficiency (such as length of stay and cost per case)
- population health (addressing health behaviours such as smoking and tobacco and emergency response planning)
- organisational performance (including community engagement and asset management).

The District measures its performance and reports to the Ministry of Health and the community against these targets. The following charts summarise the performance of District facilities over recent years against a number of key indicators.

Over the last seven years there has been almost 30% growth in the number of presentations to SWSLHD emergency departments as indicated in Figure 3.3. Presentations are divided into triage categories (i.e. waiting time to be seen by a specialised Triage Nurse). Triage (T) categories are T1: within 2 minutes; T2 within 10 minutes; T3 within 30 minutes; T4 within 60 minutes and T5 within 120 minutes. Growth has been uneven, with 140% growth in T5 patients and 76% growth in T2 patients. Least growth (4%) occurred in T3 patients.

![Figure 3.3 Presentations to SWSLHD Emergency Departments 2005/06 – 2011/12](image)

Source: Health Information Exchange 2012

Over the past six years, the number of operations conducted in the District has increased by 8.8% as reflected in Figure 3.4. Emergency procedures represent approximately 38% of all operations undertaken.
Readmission rates indicate the success of preventing or reducing unplanned readmissions. Over the last six years, SWSLHD readmission rates have been equal to or below the NSW average as indicated in Figure 3.5.

### 3.8 Resident and Patient Flows

Districts generally provide most health services that residents require, however in some cases residents use health services outside the District or residents from other parts of NSW use local SWSLHD services. This is referred to as resident and patient flow and generally occurs with adjoining Local Health Districts. Seven Local Health Districts (Sydney, South Eastern Sydney, Illawarra Shoalhaven, Southern NSW, Western NSW, Nepean Blue Mountains and Western Sydney) share borders with SWSLHD.
SWSLHD is relatively self sufficient in providing for the hospital needs of its residents within its borders. There is limited flow however to hospitals outside the District. For some highly specialised quaternary services, such as solid organ transplants, SWSLHD residents are required to travel outside of the LHD for care. Also, historical factors such as University teaching and training networks and the presence of long standing networked services have resulted in significant referral relationships to services in Sydney and South Eastern Sydney LHDs. In addition, there is a sustained flow to the specialist Children’s Hospitals at Westmead and Randwick, reflecting both the level of expertise available there and parent choice.

Appendix A8 details at an LGA and hospital level the flow of local residents for inpatient hospital (overnight stay separations) care and the residential origin of inpatients (overnight stay separations) treated at SWSLHD hospitals, for 2010-11. Appendix A8.1 identifies flow patterns for SWSLHD residents, summarised as:

- 82.6% of local residents requiring an overnight stay were treated in SWSLHD hospitals
- Liverpool Hospital provided 32.6% of overnight activity for local residents, followed by Campbelltown (21.6%) and Bankstown-Lidcombe (17.3%) hospitals
- Residents of Liverpool, Fairfield and Wingecarribee were most likely to travel within the District to access hospital facilities. This is consistent with the natural flow of patients to their nearest hospital, which for most of the residents in these LGAs is a SWSLHD hospital
- The greatest proportion of outflows were to the two Sydney based Children’s Hospitals (3.1% of all separations when combined – with the prime flow to Westmead) - 14% of overnight stay separations for children aged less than 16 years are provided at one of these hospitals
- 1.9% of patients went to each of Royal Prince Alfred Hospital (RPAH) and Westmead Hospital, consistent with historical referral patterns referred to above, the availability of specialized services at these hospitals and for Westmead Hospital an element of natural flow
- Hospitals located along the borders of the District (Concord, St George, Canterbury, Nepean and Auburn) accounted for around 1 – 1.5% of outflows each. The highest proportionate flows to out of district hospitals are from Bankstown LGA where 4.4% of LGA activity goes to RPAH, 3.6% to Concord, 3.4% to St George, 3.3% to Canterbury and 2.9% to Auburn hospitals. Other significant outflows across borders are 9.7% of activity for Wollondilly residents to Nepean and 4.0% of Fairfield LGA activity to Westmead.

Appendix A8.2 identifies flow patterns to SWSLHD facilities, summarised as:

- Bankstown-Lidcombe, Campbelltown, Fairfield and Bowral and District Hospitals predominately servicing a local residential catchment, with in all instances greater than 70% of the hospitals activity being for local residents
- Internal flows to Liverpool Hospital reflective of its historical development as the tertiary affiliated Principal Referral hospital for South West Sydney, with 25% of the hospital’s activity provided for Fairfield residents and 14% for Campbelltown/Camden residents. There is a less significant level of flow from Bankstown residents, representing 4.2% of the activity at Liverpool Hospital
- There is no public hospital within the Wollondilly LGA. Residents flow predominately to Campbelltown and Camden hospitals (47%), with 17% to Bowral and District Hospital and 10% to Liverpool Hospital
- There is generally a low level of patient inflow to SWSLHD facilities from external LHDs, mainly reflecting natural flows with the most significant being the 9% of activity at Bankstown-Lidcombe Hospital originating from Canterbury LGA.
- Greater than 50% of the activity at Karitane originates from outside SWSLHD borders, reflecting the broader regional catchment of this service.

In Wingecarribee, the community and Bowral and District Hospital staff have identified impacts for the emergency department and sometimes inpatient care from inbound tourists, particularly those attending
weekend events e.g. Bowral Tulip Time Festival and Christmas in July. Tourism NSW data identifies in excess of 1 million tourists visiting the Southern Highlands annually, including around 340,000 overnight visitors. Where tourists require hospitalisation, difficulties arise in transferring patients to hospitals close to their home when this is clinically appropriate.

3.9 Clinical Placements and Undergraduate and Post Graduate Education

Local health districts have a major role in undergraduate and post graduate education of health professionals. This includes nursing and midwifery, medicine, diagnostic radiography, nuclear medicine, nutrition and dietetics, occupational therapy, oral health/dentistry, pharmacy, physiotherapy, podiatry, psychology, radiation therapy, social work and speech pathology. There are 805 clinical placements available across these 14 disciplines, with students attending from partnering NSW, interstate and international universities. In addition, partnerships operate with Colleges of Technical and Further Education. These relationships are further outlined in Section 8.4.

3.10 Service Partners and Other Key Organisations

SWSLHD works with a multitude of service partners and organisations to improve health and to deliver health care services to individuals and communities. Most service partners are either: primary health care services or agencies which are the first point of contact for individuals with a health or related issue; or agencies with a role in prevention and community wellbeing or which provide a general service.

Collaborative work is undertaken to ensure appropriate referrals to specialist services, to strengthen the support provided for individuals and improve the general health and wellbeing of individuals, families and communities. It may also reduce demand on public health services. The following table identifies the main services and organisations which work collaboratively with SWSLHD services and programs.

Table 3.2 Services and Agencies which work with SWSLHD Services and programs

<table>
<thead>
<tr>
<th>Partner Group</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Health Services and Organisations</td>
<td>Tharawal Aboriginal Medical Service (AMS) provides management of acute and chronic health conditions; dental care; prevention and health promotion. Gandangara Local Aboriginal Land Council provides a general family practice; Marumali screening &amp; brokerage to specialist services program; and early intervention for children with a disability or learning difficulty.</td>
</tr>
<tr>
<td>Australian Government Departments</td>
<td>Departments of: Families, Housing, Community Services and Indigenous Affairs; Health &amp; Ageing; and Veterans’ Affairs provide cross government initiatives at a population level, particularly regarding at risk population groups; and collaboration regarding individual clients and patients across agencies.</td>
</tr>
<tr>
<td>Childcare</td>
<td>Includes preschools, kindergartens, childcare centres, out-of-school-care (OOSC) and family day care which provide high quality child care and early childhood education. Engage at an individual and population level in treatment and health promotion strategies.</td>
</tr>
<tr>
<td>Communities and residents</td>
<td>The local community of approximately 875,000 residents who may be recipients of care, partners in managing health conditions volunteers in health care and research and commentatoons on services received. Residents can participate in the five SWSLHD Consumer and Community Participation Networks which assist in planning, developing and evaluating services and systems.</td>
</tr>
<tr>
<td>Partner Group</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Educational Facilities</strong></td>
<td>Provide education and vocational training to people of all ages including early childhood centres, preschools, primary and secondary schools, Colleges of TAFE and universities such as the University of New South Wales, University of Sydney, University of Tasmania, University of Technology Sydney, University of Western Sydney and University of Wollongong.</td>
</tr>
<tr>
<td><strong>General Practitioners and Practice Nurses</strong></td>
<td>There are 392 Practices and 913 GPs in the District i.e. approximately 1 GP for every 958 people who provide primary health care to individuals and families. This ratio is below the Australian average of 1: 894 and is a particular problem for Wollondilly, Bankstown, Liverpool and Fairfield. Approximately 83% of residents report they visit a GP at least annually, with one third of visits relating to chronic disease management.</td>
</tr>
<tr>
<td><strong>Support and Lobby Groups</strong></td>
<td>These groups provide information, training and support to people with specific conditions and carers, undertake research and lobby for reform. They include agencies and groups such as the Cancer Council NSW, Alzheimer’s Australia and Carers NSW.</td>
</tr>
<tr>
<td><strong>Local Government</strong></td>
<td>Seven councils of in South Western Sydney Bankstown, Fairfield, Liverpool, Campbelltown, Camden, Wollondilly and Wingecarribee (and 3 regional organisations of councils) work with SWSLHD in collaborative strategic planning, public health initiatives, provide infrastructure for delivery of community based health services and support Healthy Communities initiatives e.g. smoke free environments, sport &amp; recreation infrastructure.</td>
</tr>
<tr>
<td><strong>Non-government organisations (NGO’s)</strong></td>
<td>NSW Health funded Non-Government Organisations (NGOs) (see Appendix A9) complement SWSLHD services, providing health care primarily focused on mental health, women’s health and drug &amp; alcohol. NGO’s funded through the Housing and Accommodation Support Initiative (HASI) provide housing linked to clinical and psychosocial rehabilitation for people with mental health issues. Non-Health funded NGO’s provide social and other support which complement health services. Services include Home &amp; Community Care (HACC) e.g. Community Transport and Homecare; Counselling; Recovery; Migrant Resource Centres; Carer Support Groups; Employment Support; domestic violence; targeted for at risk groups or populations; and information and referral. They maintain people safely at home, refer them to health care and engage them in community life.</td>
</tr>
<tr>
<td><strong>NSW Government Departments</strong></td>
<td>Key Government departments include the Department of Attorney General &amp; Justice, Department of Education &amp; Communities, Department of Family &amp; Community Services, Department of Premiers &amp; Cabinet, and Transport for NSW. Collaboration predominantly occurs via cross government population based initiatives, particularly targeted towards at risk population groups and shared clients.</td>
</tr>
<tr>
<td><strong>Ministry of Health &amp; related agencies</strong></td>
<td>The Ministry of Health and Pillar Agencies of the Clinical Excellence Commission (CEC), Agency for Clinical Innovation (ACI), Bureau of Health Information (BHI), Health Education and Training Institute (HETI) and NSW Kids and Families provide policy and planning direction, regulate services, support clinical and training initiatives, and monitor District performance.</td>
</tr>
<tr>
<td><strong>Other NSW Public Hospitals &amp; associated agencies</strong></td>
<td>Major health services include: Sydney Children's Hospitals Network (Randwick and Westmead) providing complex and acute care to children; Justice Health &amp; Forensic Mental Health minimising health consequences of incarceration and improving health status; and the Ambulance Service of NSW which provides emergency and non-emergency patient transport. Public hospitals in districts adjacent to SWSLHD i.e. Sydney, Western Sydney and South Eastern Sydney provide care to local residents due to distance or location at time of need, with hospitals such as Royal Prince Alfred, Concord and Prince of Wales hospitals accessed for specialist services e.g. spinal cord injury, burns, transplants. This is considered outflow.</td>
</tr>
<tr>
<td><strong>Other Private Health Providers</strong></td>
<td>Private providers including Allied Health, Dental, Pathology, Pharmacy, Radiography and Medical Specialists provide at cost to individuals and families. There is variable access across the District, subject to commercial decisions. These professions will be incorporated with the South Western Sydney Medicare Local. Relationships are variable across localities and streams.</td>
</tr>
</tbody>
</table>
Partner Group | Description
--- | ---
Private Hospitals and Day Procedure Centres | Three private hospitals (Campbelltown, Southern Highlands at Bowral and Sydney Southwest Private Hospital at Liverpool) are located in the District and are in close proximity to public hospitals. They provide only 4% of private beds in NSW. There are also seven private day centres in the District representing 6.5% of day procedure centres in NSW. There are no day procedure centres in Macarthur (Appendix A10).

Research Organisations | The Ingham Institute of Applied Medical Research is one of eight research hubs in NSW with a role in fostering and supporting local health research. Research units jointly funded by SWSLHD and the Universities of NSW and Western Sydney also support local research. Peak agencies such as the National Health and Medical Research Council (NHMRC), Aboriginal Health and Medical Research Council of NSW (AHMRC) and Australian Research Council (ARC) support and fund health research.

Residential Aged Care Facilities (RACF) | Fifty eight RACFs provide nursing and personal care for people assessed as unable to remain at home in 2,990 high care (22 respite and 456 secure dementia) and 2,779 low care places (57 respite and 498 secure dementia). The SWSLHD Aged Care Triage (ACT) provides advice/support to GPs & RACFs and facilitates appropriate transfer of residents to hospital. Joint initiatives with GPs address avoidable hospital admissions, continuity of care, palliative care, wound management, falls, and dementia care and behaviour management. As reflected in Appendix A11, distribution of RACF and community packages across the District is uneven.

South Western Sydney Medicare Local (SWSML) | Funded by the Australian Government, the South Western Sydney Medicare Local will be a change agent in primary health care. Key objectives are to improve the patient journey through developing integrated and coordinated care; support clinicians; identify local health needs; develop locally focussed and responsive services and facilitate primary health care initiatives and programs.
4. Planning Process

Planning for health services and healthy communities occurs continuously and is responsive to changes in the environment in which people live and in which services are delivered. Recent changes to the structure of health services and the establishment of the SWSLHD has provided an opportunity to review the way in which health services in south western Sydney and the Southern Highlands are delivered and to plan to more effectively meet the needs of patients and the growing community over the next decade.

Integral to this was the requirement in early 2011 for all Health Districts to provide the NSW Minister for Health with a description of the District’s vision, opportunities for clinical leadership, critical issues and plans to eliminate bullying and harassment, consistent within a framework of CORE values (Section 3.4).

The SWSLHD Statement of Intent, May 2011 was developed by the Board and District Executive. It integrated data, strategies and information derived from previous planning process with the Board and Executive’s directions to inform a Strategic Response to the Minister in May 2011. A key initiative identified in the Strategic Response was to develop a comprehensive Strategic Plan for the District, Strategic Priorities in Healthcare Delivery to 2021.

This plan is:

- Based on a ten year planning horizon, whilst remaining relevant to both the current situation and the longer term needs of the district;
- Consistent with the current national and state legislation and policy environment in relation to health and health service delivery;
- Patient centred and population based, with recognition of the vastly different requirements of our patients and communities
- Developed closely with the local community, key partners and stakeholders, service users, clinicians, staff, managers and the Board
- Enabling of the meeting of national and state targets for service delivery and health indicators
- Innovative and responsive to identified community needs and resources, to enable maximum returns on investment

The process to develop this plan is described in the following figure. Planning commenced in early 2012 with the approval of a scoping paper which defined the planning processes and timeframes and establishment of a steering committee. Consistent with the standards outlined in the NSW Health Governance Framework, 5 and as outlined above, planning involved consultation and communication with a wide range of stakeholders.
Figure 4.1: Process for developing the Strategic Priorities in Healthcare Delivery to 2021.

**SWSLHD Established January 2011**

- Strategic Intent priorities for the District identified at Board and Management Workshop
- Scope of the Plan approved by Board, Chief Executive and Clinical and Quality Council
- Steering Committee established including management, clinical and community representatives

**Community Consultation**
- Consumer, Community, Carer and GP forums
- Survey of service Partners eg. NSW & Local Government agencies and NGOs
- Summary of patient and carer experience surveys

**Summarising Existing Information**
- Data analysis (demographics, health status, service utilisation and activity projection)
- IMS
- Current plans

**Packages provided to Clinical Streams to inform planning**

**Clinical Streams develop proposed care models and Service Development Directions to 2021**
- multidisciplinary consultation
- identification of key issues, enablers, workforce, infrastructure requirements

**Clinical streams present directions to Clinical and Quality Council**

**Steering Committee considers the actions**

**Clinical Stream Directors and Executive consider overarching Issues**

**Draft Plans developed**

**Board Workshop considers draft Plans. Draft Plans revised.**

**Summary paper developed and released for consultation**

**Community and Staff Consultation**
- forums (forums)
- on line survey

**Steering Committee identify revisions required**

**Draft Plan revised and endorsed by Steering Committee**

**Final Plans Produced**

**Board endorsement**

**Plans released**

- multidisciplinary consultation
- involves consumers

**Draft Corporate Plan 2013 - 2017 Directions to Better Health**

**Executive identifies Corporate Directions**

- multidisciplinary consultation
- involves consumers

**Draft Corporate Plan 2013 - 2017 Directions to Better Health**

- multidisciplinary consultation
- involves consumers

**Draft plan - Strategic Priorities in Health Care Delivery 2021**

**Summary Paper**

**Record of consultation**

**Strategic & Healthcare Services Plan: Strategic Priorities in Health Care Delivery to 2021**

**November 2013**
5. Profile of Local Communities

The District combines urban, rural and semi-rural areas and significant national park and conservation. Warragamba Dam, Sydney’s main water supply, is located within South Western Sydney, highlighting the need for environmental protection associated with the health of the population.

A number of local health plans have been developed to improve the health of the community and address specific health problems. The plans that remain current or have recently expired timeframes are summarised in Appendix A12. These plans can be viewed at [http://www.swslhd.nsw.gov.au/publications.html](http://www.swslhd.nsw.gov.au/publications.html)

5.1 Population Size and Structure

The Australian Government endorsed estimate of a region’s population (and base data from which population projections are made) is the Estimated Resident Population (ERP), which link people to a place of usual residence within Australia. ERPs are based on census counts by place of usual residence (excluding short-term overseas visitors in Australia), with an allowance for census net undercount, to which are added the estimated number of Australian residents temporarily overseas at the time of the census. The ERP is based on the 2011 Census and estimates a population of 875,384 in SWSLHD for 2011, the majority of whom live in Fairfield, Bankstown and Liverpool. In contrast, the Census reports 840,602 people residing in SWSLHD.

Unless otherwise indicated, data reported in the following sections is derived from the 2011 census. Overall, SWSLHD has a younger population profile than NSW. Across the District:

- In 2011, there were 13,028 babies born to local mothers. The fertility rate for all LGAs except Fairfield is higher than that of NSW (1.91). Wingecarribee and Bankstown have the highest fertility rates at 2.17 and 2.15 respectively and Fairfield the lowest at 1.83°
- There are 184,395 children aged 0-14 years (almost a quarter of the population - 22% compared with 19% for NSW)
- There are 120,737 people aged 15 – 24 years (14% of the population compared to 13% for NSW)
- 56% of people (468,496) are working age adults (25 – 70 years)
- People aged over 70 years (66,976) comprise 8% of the population (compared with 10% for NSW)
- There are 11,725 people aged over 85 years (1.4% of the population, compared to 2% for NSW)
- Liverpool and Camden have the youngest population profile, with 68% and 67% of residents respectively aged under 44 years
- Wingecarribee has the oldest population profile, with a lower proportion of children (19.4%) and a higher proportion of older people (2.6%)

The following provides an overview of the demographic characteristics of the local community, with detailed information available in Appendix A13.

Children

Children are generally categorized as aged 0-14 years and in NSW, most experience good health, with low morbidity and mortality. In the past decade, child mortality for those aged 1-17 years has decreased across the state, with less than 1 in every 1,000 dying with a disease or morbid condition. Health issues specific to babies are covered in Section 5.3.

The most significant health issues for young children in NSW and locally include:
The crude mortality rate for children in 2011 was 35.47 per 100,000 children with the majority of children very young. This is the lowest rate over the last fifteen years. The leading cause of death were perinatal conditions (36%) followed by congenital malformations (21%). Injury was the third major cause of death (17%). Between 2004 – 2006, infant mortality rate was below the NSW average in all LGAs except Liverpool.

Between 2003- 2008, almost 1/3rd of injury related hospitalizations in South Western Sydney and Sydney LHDs were due to falls. Transport related injury was also a major cause of disability. Pedestrian injuries were greatest in Campbelltown and pedal cyclist and motor cycle injuries in Wollondilly, Camden and Wingecarribee.

Falls accounted for the highest proportion (34%) of injury hospitalizations for local children aged 0-4 years followed by struck by/ against an object (13%) and fires and burns (11%). Although falls from furniture (45%) and slips, trips and stumbles (15.5%) were most common (45%), road traffic injuries and burns were the most serious injury related hospitalisations in pre-schoolers.

Poor oral health with almost half the children aged 5-8 years screened in local primary schools having experienced past tooth decay.

16% of children aged 0-17 years have a chronic condition or disability, such as asthma, autism, diabetes, physical or intellectual disability.

A small number of children (4.4 per 1,000 children) in 2010 in NSW still experience vaccine preventable diseases.

Food allergy occurs in almost 5% of children in NSW, with Australia having one of the highest allergy prevalence rates in the world.

Overweight and obesity among NSW school students was 17.1% and 5.8% and less than half the children meet the Australian guideline for physical activity. There was a strong association between combined overweight and obesity and socio-economic status.

In 2010/11, there were approximately 8,000 overnight separations from SWSLHD acute hospitals of children aged up to 16 years (excluding babies in utero or newborn). The largest numbers of admissions were for children with respiratory illnesses i.e. croup, bronchitis and asthma. Over the same period, there were 1,957 day only separations, the largest numbers of which were for non-sub-specialty medicine, injuries to limbs - medical and surgical, as well as dentistry.

Young People

Between 2011 and 2021 the number of young people aged 12-24 years in the District will rise from 133,467 to 149,068 (an additional 15,601 young people). This equates to approximately 15% of the District’s population, a proportion which will remain relatively static over the next 10 years. The vast majority of young people in Australia report themselves as having good health and as a result they utilise health services at a much lower rate than older people.

Consistent with general health equity issues, some groups of young people have poorer health than their peers, usually those from disadvantaged groups. The Australian Institute of Health and Welfare report Young Australians: Their Health and Wellbeing 2011 describes the key health issues for young people in Australia as:

- Increasing rates of diabetes, linked to low physical activity participation, inadequate fruit and vegetable intake and high levels of overweight/obesity
- Increasing rates of sexually transmitted infections, in particular Chlamydia
- High rates of mental health conditions (particularly in relation to psychoactive substance abuse, schizophrenia and depression)
- High road transport accident deaths for males
- Alcohol consumption at risky or high risk levels for short term or long term harm
High numbers of people as victims of violence related to alcohol or drug use

Poor oral health

Smoking rates are high in the District, particularly during pregnancy and for young mothers. Detailed local data is generally not available, however further information on youth health and associated services is available in the Sydney South West Area Health Service Youth Health Plan 2009 – 2013.

Older People

Health status generally declines with age, with older people more likely to report health problems and/or disability than those in younger age groups.

The Australian Institute of Health and Welfare Older Australians at a Glance 2007 and the NSW Ministry of Health documents report the key health issues for older people as:

- Low levels of physical activity and inadequate nutritional intake
- High rates of osteoporosis and arthritis, knee and hip replacements and hip fractures - with associated risks of and from falls (falls incidence 27% in 2006/07)
- High blood pressure and high cholesterol - present in over half of people
- High rates of chronic health conditions, including multiple conditions - associated links with polypharmacy
- Problems with vision, hearing, oral health and continence
- End of life care - palliative care and advanced care planning
- Mental illness, particularly depression linked to social isolation and high rates of suicide (13% of suicides in 2005 were by people aged over 55 years)
- High rates of dementia
- Reduced capacity to perform activities of daily living e.g. bathing, dressing and meal preparation

As people age and become frailer, they may require the additional support and accommodation provided through residential aged care facilities (RACFs) and related community packages. The 2011 Australian Government target for RACF is 113 places per 1,000 people aged 70 years comprising 88 places (44 high care and 44 low care) and 25 community places (4 high care and 21 low care). SWSLHD has a similar rate of RACF places to the target (87.1 places per 1,000) however it has fewer community places (20.3). Distribution is uneven with higher rates of RACF places in Camden and Campbelltown LGAs and community places in Campbelltown, Liverpool and Wingecarribee. Wollondilly and Liverpool LGAs are well below the target RACF rate and Campbelltown, Bankstown, Wollondilly and Fairfield LGAs are well below the target community place rate. Appendix 11 provides greater detail on this.

Household Structures in South Western Sydney

Consistent with the District’s relatively young age structure, as at 2011:

- The majority of families (52%) are couples with children, proportionately higher than state average (45.5%) for every LGA except Wingecarribee (38.9%), reflecting Wingecarribee’s older population;
- Wingecarribee has the highest proportion of lone person households in the District, a proportion slightly higher than the state (26% and 24% respectively). This again reflects the LGA’s older age profile;
- The proportion of single parent families is higher than the state average (16%) in Bankstown (19%), Campbelltown (22%) and Fairfield (23%).
Environment and Health

Urban design plays a significant role in the creation and maintenance of healthy communities. The NSW Health Healthy Urban Development Checklist identifies the key issues as healthy food, physical activity, housing, transport and physical connectivity, quality employment, community safety and security, public open space, social infrastructure, social cohesion and social connectivity and environment and health. These factors are being considered in the planning of new communities within South Western Sydney and in Community Renewal projects in Housing NSW areas.

Local residents perceive their community to be less safe than the average community in NSW. In 2008-09 only 60% of SWS residents reported that they felt most people can be trusted, 63% felt safe walking down their street after dark and 64% felt that their area had a reputation for being a safe place, compared to 72%, 73% and 76% respectively for NSW. There was poorer social cohesion reported in the community than the average across the state, with less than half of respondents (46.5%) feeling they could ask someone in the neighbourhood to care for their child and 55% saying they had visited someone in the neighbourhood in the last week (compared to 59% and 62% respectively for NSW).

In the period 2009-10, 23,291 local residents aged over 16 years reported that they had experienced food insecurity in the previous 12 months. This equated to an estimated 4.7% compared to 4.8% for NSW. Of note is that the pattern of food insecurity in the District was different to that of the state. At a state level, food insecurity is fairly evenly spread across age groups, however for the District there were greater reports of food insecurity for people in the 25-39 year age bracket (29%), compared to 19.4% for NSW. People aged over 80 years experienced the lowest levels of food insecurity at both the District and state level. Also of note is that locally there are differences between the genders, with men experiencing less food insecurity than women overall, but with the highest level in the District recorded for men aged 30-39 years.

Transport impacts on the accessibility of services and the general health of the local population. Public transport services include trains and government and private buses. Railway station accessibility and problems with bus routes, timetabling and frequency has been identified by local communities as requiring attention. The South West Rail Link between Glenfield (south of Liverpool) and Leppington is planned to be operational by 2016. Transport infrastructure will connect the major centres identified above, via the rail network.

5.2 Health Equity

The people of South Western Sydney are socio-economically diverse as highlighted in the demographic statistics provided in Appendix A13. There are however, significant pockets of disadvantage in the District and the evidence suggests that people from poorer socio-economic backgrounds tend to have worse health and were more likely to consult their general practitioner, had higher levels of disease risk factors and lower use of preventative health services.

The Australian Bureau of Statistics Socio-economic Indexes for Areas (SEIFA) (2011) indicate that South Western Sydney has some of the poorest communities in the State. The Index of Relative Socio-economic Disadvantage (IRSD) uses indicators of disadvantage such as income, unemployment and low levels of education, with disadvantage indicated by a low number. Fairfield, Bankstown, Campbelltown and Liverpool are in the ten most disadvantaged LGAs in metropolitan Sydney, with ISRD scores of 886, 946, 939 and 968 respectively, well below the Australian average of 1,000.

It is at a suburb level that the degree of disadvantage becomes most apparent. There are twenty nine suburbs in South Western Sydney which are in NSW’s ten percent most disadvantaged suburbs. These suburbs have an ISRD score of 900 or below and are located in the LGAs of Campbelltown, Fairfield, Liverpool and Bankstown.
Table 5.1 provides a summary of these disadvantaged suburbs. Of note is that 14 of the 20 most disadvantaged suburbs in Metropolitan Sydney are in South Western Sydney.

Table 5.1 Suburbs with the highest level of disadvantage in South Western Sydney (Source: ABS SEIFA 2011)

<table>
<thead>
<tr>
<th>Suburb</th>
<th>Rank in SWSLHD</th>
<th>SEIFA Score</th>
<th>Rank in NSW</th>
<th>Local Government Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claymore</td>
<td>1</td>
<td>576</td>
<td>5</td>
<td>Campbelltown</td>
</tr>
<tr>
<td>Airds</td>
<td>2</td>
<td>622</td>
<td>7</td>
<td>Campbelltown</td>
</tr>
<tr>
<td>Miller</td>
<td>3</td>
<td>734</td>
<td>14</td>
<td>Liverpool</td>
</tr>
<tr>
<td>Cartwright</td>
<td>4</td>
<td>763</td>
<td>24</td>
<td>Liverpool</td>
</tr>
<tr>
<td>Villawood</td>
<td>5</td>
<td>763</td>
<td>25</td>
<td>Blacktown / Fairfield</td>
</tr>
<tr>
<td>Ashcroft</td>
<td>6</td>
<td>763</td>
<td>26</td>
<td>Liverpool</td>
</tr>
<tr>
<td>Sadleir</td>
<td>7</td>
<td>775</td>
<td>31</td>
<td>Liverpool</td>
</tr>
<tr>
<td>Cabramatta</td>
<td>8</td>
<td>777</td>
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</tr>
<tr>
<td>Warwick Farm</td>
<td>9</td>
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<tr>
<td>Yennora</td>
<td>10</td>
<td>801</td>
<td>48</td>
<td>Fairfield / Holroyd</td>
</tr>
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<td>Heckenberg</td>
<td>11</td>
<td>802</td>
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<tr>
<td>Busby</td>
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<td>Canley Vale</td>
<td>13</td>
<td>820</td>
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<td>Fairfield</td>
</tr>
<tr>
<td>Fairfield</td>
<td>14</td>
<td>823</td>
<td>72</td>
<td>Fairfield</td>
</tr>
<tr>
<td>Carramar</td>
<td>15</td>
<td>830</td>
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</tr>
<tr>
<td>Cabramatta West</td>
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</tr>
<tr>
<td>Fairfield East</td>
<td>17</td>
<td>842</td>
<td>101</td>
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</tr>
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<td>Canley Heights</td>
<td>18</td>
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<tr>
<td>Liverpool</td>
<td>23</td>
<td>869</td>
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<td>Mount Pritchard</td>
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<td>887</td>
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<tr>
<td>Smithfield</td>
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<td>Fairfield</td>
</tr>
<tr>
<td>Old Guildford</td>
<td>26</td>
<td>888</td>
<td>253</td>
<td>Fairfield / Bankstown</td>
</tr>
<tr>
<td>Bankstown</td>
<td>27</td>
<td>891</td>
<td>273</td>
<td>Bankstown</td>
</tr>
<tr>
<td>Chester Hill</td>
<td>28</td>
<td>894</td>
<td>291</td>
<td>Bankstown</td>
</tr>
</tbody>
</table>

In summary,

- People aged 15 years and over who are no longer attending school have a lower level of formal education i.e. educated to year 10 or equivalent in all LGAs except Liverpool when compared with NSW as a whole
- Median household incomes in Fairfield, Bankstown and Wingecarribe are below that for NSW and only Wollondilly and Camden have median individual incomes higher than that of the State
- Camden and Wollondilly residents are generally of a higher socio-economic status than the rest of the District, with Wingecarribe also similar to the State average for most indicators

The 2010 Population Health Survey\textsuperscript{20} indicates that local residents report lower levels of private health insurance (50.3\%) than the NSW average (58.1\%). NSW Population Health Surveys (2005/07 - 2008/10)\textsuperscript{21}
indicate that consistent with other indicators of access to health services, rates were lowest in Fairfield and Liverpool and highest in Camden and Wingecarribee.

![Figure 5.1: Reported Rates of Private Health Insurance in SWSLHD (2005-07, 2008-10)](image)

Source: NSW Population Health Survey (2005/07 - 2008/10), HOIST 2012

The *NSW Chief Health Officer’s Report (2010)* has identified that the health gains achieved over the past few decades have not been equally shared across the entire NSW population. It notes there is a gap between those with good and poor health. Whilst some of these differences are attributable to ageing, biological and/or lifestyle factors, there is considerable evidence that social factors such as income, job and education also have a critical role in health outcomes.

Available evidence suggests that groups of people experiencing disadvantage (and multiple levels of disadvantage) are:

- Aboriginal people and Torres Strait Islanders
- People with chronic mental illness and their children
- People in contact with the criminal justice system and their families
- People living in rural communities with poorer access to basic health and social infrastructure
- People living in social housing
- People with drug and alcohol issues
- People on low incomes, who are unemployed or have lower educational attainment
- People who are homeless or in insecure housing
- Children in care or from families with child protection issues
- People with a chronic illness and their carers
- Refugees and recently arrived migrants
- People with a disability

The health status of each of these groups is considered in detail in this section and where information is available, it is provided at a District level. As described previously, babies and children, young people, older people and carers have also been identified as groups with unique health issues within South Western Sydney. Appendix 16 also provides a summary of key demographic information relevant to these sections.
An important issue in considering health equity is the influence of social determinants of health, which can be defined as the economic and social conditions that influence individual and group differences in health status, including the social environment, physical environment, health services, and structural and societal factors. The World Health Organisation has summarised the evidence on issues of importance for the social determinants of health in the *Social Determinants of Health: The Solid Facts*[^23]. Factors critical to overall health status are the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport. The relationship between these factors and groups experiencing health disadvantage in NSW is summarised in the following.

**Aboriginal and Torres Strait Islander people**

Aboriginal and Torres Strait Islander people (hereafter referred to as Aboriginal people) have been identified as an at-risk group due to an overall lower health status and shorter life expectancy than the rest of the population.

In 2011, 13,070 people identified as having and Aboriginal or Torres Strait Islander background, an increase of 2,867 from 2006. The highest numbers of Aboriginal people within the District reside in Campbelltown (4,729), followed by Liverpool (2,676) and Bankstown (1,388). The smallest Aboriginal population is in Wingecarribee. The District has a lower proportion of Aboriginal residents when compared with NSW (1.6% and 2.5% respectively).

The age profile for Aboriginal people is younger than the rest of the population. Notably the proportion of children aged 0-9 years (25.5%) is almost double that of the non-Indigenous SWSLHD population (14.6%), whereas the proportion of people aged 65+ years (3.7%) is around one third of the state (11.6%).

The [NSW Chief Health Officer’s Report 2010][27] indicates that Aboriginal people in NSW:

- Are more likely to die at a young age (under 25 years) than the non-Aboriginal population (10% compared with 2%)
- Are more than three times as likely to die as a result of diabetes and one and a half times as likely to die from injury or poisoning than non-Aboriginal people
- Have an infant mortality rate (for babies born to Aboriginal mothers) which is almost twice the rate for babies in NSW overall. Rates of prematurity and low birth weight are also higher
- Are more likely to be admitted to hospital, primarily for renal dialysis, diabetes, chronic respiratory disease, cardiovascular diseases and injury and poisoning
- Have reported smoking rates and lung cancer rates around double the non-Aboriginal population
- Experience cervical cancer rates at around 4 times the non-Aboriginal population
- Are less likely to present to receive antenatal care before 20 weeks gestation (70% compared with 79% for SWSLHD as a whole – at 14 weeks the rate reported is 54% for both Aboriginal and non-Aboriginal populations)

The rate of potentially preventable hospitalisations (overall, smoking attributable and diabetes related) for Aboriginal people in SWSLHD is around 50% higher than for the SWSLHD population as a whole. However, the rates for the SWSLHD Aboriginal population are significantly lower than the rates reported for the NSW Aboriginal population as a whole, indicating a significant disparity in health outcomes between regional and urban populations.

An [Aboriginal Health Plan 2010-2014][24] prepared by the former South Western Sydney Area Health Service provides additional information on local demographics and health status.
People with chronic mental illness and their children

Mental illness affects one in five people aged 16-85 years in Australia. In the Sydney and South Western Sydney LHD’s combined, over 220,000 people per year will be directly affected by mental ill-health. Family members, friends and other associates are also affected by the illness.

The National Survey of Mental Health and Wellbeing in Australia\(^{25}\) indicates that

- Prevalence of mental illness is highest in the 16-24 age group (26%)
- At any one time, 2-3% of the population will be affected by a severe mental illness, 4-5% by a moderate to severe mental illness and 9-10% by a moderate mental illness. This equates in South Western Sydney to 22,000 with a mild problem, 40,000 with a moderate and 84,000 people with a moderate problem
- Mental illness ranks 4\(^{th}\) as the major cause of life years lost, after heart attacks, stroke and cancer

People with a mental illness are more likely to have poor physical health, while some physical illnesses also increase the risk of developing a mental illness. The National survey and the NSW Health Physical Care of Mental Health Consumers\(^{26}\) guideline indicate that people with a mental illness often undertake high health risk behaviours such as smoking, high alcohol and/or other drug consumption, poor nutrition, low levels of physical activity, high use of psychotropic medication and associated high risk social behaviours (such as unsafe sex and injurious activity). These behaviours combine with an overall reduced level of access to the health system and poor health literacy result in high rates of coronary heart disease, diabetes, cancers, infections, obesity, respiratory disease, dental disease and poor outcomes following acute episodes. In addition, a number of health and other conditions also co-occur with mental illness. These include intellectual disability, organic brain disorders (such as dementia) and alcohol and drug related problems.

Approximately 20% of Australian children have at least one parent with a mental illness. Children of parents with a mental illness are at higher risk of developing a mental illness themselves\(^{27}\). These children may also experience barriers to accessing appropriate physical health services if they have no-one to monitor and manage their health appropriately.

People in contact with the criminal justice system and their families

In 2008, the adult custodial population in NSW was almost 10,000 people and there were over 5,000 juvenile justice admissions in 2007/2008 combined. There is one juvenile detention centre in the District - Reiby Juvenile Justice Centre. Around 20% of all offenders resided in Sydney and South Western Sydney prior to custody, with Aboriginal people disproportionately represented.

The 2009 Inmate Health Survey: Key Findings Report\(^{28}\) and 2009 Young People in Custody Health Survey: Full Report\(^{29}\) on the health status of adult and juvenile inmates highlights their complex health and social needs, requiring extensive, multidisciplinary support. Overall social disadvantage prior to incarceration is indicated by low educational attainment and employment, unstable housing, care and protection issues (including child abuse) and a history of parental incarceration.

Both groups display high rates of smoking; drug and alcohol abuse; obesity/overweight; hepatitis C; significant mental health problems; and head injury resulting in unconsciousness and disability and/or chronic disease. For young people, early initiation into sex and high rates of teenage pregnancy, hearing loss and intellectual disability are notable, together with poor nutrition and oral health.

Juvenile offenders generally are in custody for less than one week, highlighting the need for health services to actively engage with this at risk group. For adults, systems operate to link people to mainstream health services on release. However these may be inadequate to meet immediate needs, given the first 24 to 72
hours post release is identified as critical in relation to issues such as suicide and drug/alcohol relapse. Health services also have a role to play in prevention and early intervention to reduce crime rates.

The *Families Handbook* notes children of people in contact with the criminal justice system may have been the subject of abuse, violence or neglect. They may also experience a range of psychological and/or physical health problems which affect their ability to learn and interact. In older children, these problems may also manifest in anti-social behaviours and/or drug use.

Up to 80% of prisoners are incarcerated due to drug use or drug related crimes. Health focused, diversional programs developed to address this issue include MERIT (Magistrates Early Referral into Treatment) and Drug Court. Post release, ongoing demand and high priority access to opioid treatment programs (OTP) will require holistic assessment and treatment to address other chronic and acute health problems.

**People in rural areas with poorer access to health services**

The Accessibility/Remoteness Index of Australia (ARIA) classifications compare road distances to service centres and indicate that South Western Sydney is highly accessible when compared with the rest of the country. Some rural communities, however, are less accessible, primarily in outlying towns and properties within Wollondilly and Wingecarribee Shires. Camden, Campbelltown, Fairfield and Liverpool also have some less accessible areas, although this is expected to change as a result of the urban development.

Local residents living in isolated areas report barriers to service access related to transport and also the provision of services in local areas. For example, general practitioners and private allied health services are often not locally available and the range of specialist services in public hospitals and privately can also be reduced. Provision of public transport is variable, particularly after hours and on weekends and the time and cost associated with travel also may reduce access. As a result, residents in rural areas are more likely to own vehicles. The 2011 Census found that Wollondilly, Camden and Wingecarribee residents have the highest levels of car ownership in the District at 96.7%, 96.6% and 95% respectively, below the NSW level of 89.6%.

Within South Western Sydney, access to primary health care has been identified in Wollondilly as a specific problem compounded by the relative geographic isolation of its small towns and villages. Residents of Wingecarribee have reported difficulty accessing specialist medical care and time required to access services in other parts of South Western Sydney.

<table>
<thead>
<tr>
<th>Table 5.2 Social Housing in South Western Sydney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Government Area</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>Bankstown</td>
</tr>
<tr>
<td>Camden</td>
</tr>
<tr>
<td>Campbelltown</td>
</tr>
<tr>
<td>Fairfield</td>
</tr>
<tr>
<td>Liverpool</td>
</tr>
<tr>
<td>Wingecarribee</td>
</tr>
<tr>
<td>Wollondilly</td>
</tr>
<tr>
<td>South Western Sydney</td>
</tr>
</tbody>
</table>

Source: *Housing NSW Expected Waiting Times for Social Housing 2013*

**People living in social housing with poorer access to basic health and social infrastructure**

Housing NSW has embarked on major renewal projects, aimed at changing some of the most disadvantaged areas in Sydney from almost completely Housing NSW properties to a mix of 30% public and 70% private housing. The focus is on creating greater diversity of tenure, ultimately providing mixture of home ownership, private rental and social housing accommodations within targeted neighbourhoods.

South Western Sydney still has high concentrations of social housing. On 30 June 2013, 18% of NSW’s social housing dwellings were located in the District. Table 5.2 shows the distribution of the 26,244 dwellings.
Social housing providers include Housing NSW, Aboriginal Housing and Community Housing. People living in social housing often experience overall social disadvantage. Factors such as poverty, poor housing, lack of education, violence and abuse, mental illness, a lack of affordable, accessible and appropriate health services and the lack of infrastructure such as public transport are common barriers to improved health status for people living in social housing.

**People with drug and alcohol issues**

People with drug and alcohol issues generally have a lower physical and mental health status than the general community. Often as a result of drug or alcohol issue, there is an increased risk of engaging in unsafe sex, of injury and of family violence or crime. Those with drug and alcohol issues are often those with a lower socio-economic status. Specific health concerns include mental health, oral health, and blood borne viruses spread through unsafe injecting equipment, poor nutrition and the use of drugs or alcohol during pregnancy.

Across South Western Sydney and NSW:

- In 2011, 26.3% of adults consumed 2+ alcoholic drinks per day (the state average is 29.6% and the state target is 25%)
- In South Western Sydney in 2010 - 11, there were 4,545 alcohol attributable hospitalisations, a rate of 536.0 per 100,000. Of these hospitalisations, rates were significantly higher for Aboriginal people than non-Aboriginal people (939.4 and 519.0 per 100,000 people respectively)
- In 2007, 113 District residents died from alcohol attributable causes, a rate of 14.6 per 100,000 compared to 16.6 per 100,00 for the state
- 17.9% of District residents aged over 16 years smoked in 2011, compared with 14.7% for the NSW
- In 2008, 8.6% of NSW students 12-17 years were current smokers
- In 2010-11, there were 4,607 smoking attributable hospitalisations in the District
- In 2010, 1,911 local women smoked during pregnancy. The rates were higher for Aboriginal women than for non-Aboriginal women (45.5 and 14.8 per 100,000 respectively). The District has a significantly higher proportion of women smoking during pregnancy in all local government areas than the state average
- In 2006-2007, 504 residents died from smoking attributable causes. Campbelltown with a smoothed rate of 115.5 was significantly above the NSW rate.
- The 2010 National Drug Strategy Household Survey\(^2\) indicates that illicit drug use across Australia is at 14.7%. It is most common in those aged 20 – 29 years, with marijuana/cannabis the most commonly used drug. The NSW target for illicit drug use is “containment below 15%”.

**People on low incomes, who are unemployed or have lower educational attainment**

In 2011, the median weekly household income in the District ranged from $1,022 in Fairfield and $2,199 in Liverpool. The median weekly household income in NSW in 2011 was $1,237. Three of the District’s LGA’s reported a median household income lower than this - Fairfield ($1,022), Bankstown ($1,091) and Wingecarribee ($1,094). Campbelltown at $1,251 was similar to the state.

Low income is linked to low educational attainment. The 2011 Census indicates that 40.8% of the District’s population no longer attending school were educated to a maximum of Year 10 or equivalent, compared with 37.1% for the State. All LGA’s in SWSLHD were below the state average for completing Year 12 or equivalent. Of note is that Wollondilly LGA residents were least likely to have remained at school beyond Year 10, with 51.1% of residents indicating Year 10 or below education.
Local unemployment at 7.2% was also higher compared to the state at 5.9%. Unemployment was greatest in Fairfield (9.7%), Bankstown (7.6%), Campbelltown (7.4%) and Liverpool (7.0%), and below the state average in other local LGAs.

Low income is a barrier to accessing health services due to the cost for direct services and transport to services. Cost is also a barrier to other commodities which improve health, such as nutritious food and services which reduce social isolation.

The NSW Chief Health Officer’s Report 22 identified that people with a low socio-economic status (SES) experience higher rates of potentially avoidable deaths and hospitalisations and a lower life expectancy at birth and at age 65 years, when compared with those of a higher SES.

The National Council on Social Services has identified specific issues in relation to poor oral health (tooth decay and total tooth loss) and high smoking rates and smoking related hospitalisations 33, 34. Lower health literacy is also an issue at a prevention level and also in involvement in health care, reading dosage instructions, adherence to treatment and participation in screening and diagnostic tests35. The link with educational attainment is also clear with people with higher levels of educational attainment demonstrating higher rates of better or adequate health literacy.

**People who are homeless or in insecure housing**

People who are homeless have inadequate access to safe and secure housing. It includes those sleeping rough, living in caravan parks and boarding houses, staying with family and friends as their only housing option and those accessing the Specialist Homelessness Services program (SHS). The SHS Program is a joint Commonwealth – State program which provides funding for a range of support and accommodation services to assist people who are homeless or at risk of homelessness, including women and children affected by domestic violence. These services include case management, support, outreach, advocacy, practical assistance and supported accommodation services, as well as linkages to other services such as health and housing. Community Services also provides fixed term funding.

The Regional Homelessness Action Plan for Greater Western Sydney 2010 – 2014 36 focuses on South Western Sydney excluding Wingecarribee. The report highlights that as at 2006:

- 1,774 were homeless including 91(5%) who were Aboriginal people
- The rate of homelessness in the South Western Sydney Region was 20 per 10,000 compared to 42 for NSW
- The majority of homeless households were in Bankstown (388) and Fairfield (325). Camden had the least number of homeless households (11)
- Most (54%) homeless people in South Western Sydney were staying with friends, followed by in SHS accommodation (24%). Both of these are proportionately more than the state rate
- Local clients are generally younger than the state average and are more likely to be female, either alone or with children
- The primary reason people sought SHS accommodation in the South Western Sydney Region was domestic violence (30% compared with 15% for NSW), time out from family and relationship breakdown. Eviction was also a reason in 7% of cases, compared with 4% for NSW
- Another 267 people in the District were marginal caravan park renters

The Regional Homelessness Action Plan 2010 - 2014 Illawarra 37 covers the Southern Highlands. It indicates that 184 people in Wingecarribee were homeless in 2006, one of the highest rates in the District.

People who are homeless experience numerous barriers in service access. They are also highly complex to support due to issues such as disengagement with health sector and lack of a GP, Medicare card or health insurance and no fixed address or contact details. The South East Health [Homelessness Health Strategic Plan](#)
2004 – 2009 indicates that the predominant health issues for this group include mental health problems, disability (psychiatric, intellectual, physical and sensory), self harm behaviours, acquired brain injury, chronic illness, oral health problems, poor nutrition, drug and alcohol issues, high rates of communicable disease and bacterial infection and low adherence to treatment regimes.

In South Western Sydney, health issues will be significant given the large proportion of women escaping domestic violence situations, with specific health issues including current and previous injury, experience of miscarriage, head injury and/or hearing/vision loss associated with blows to the head, depression, substance abuse, chronic illness associated with stress, sexual abuse and sexually transmitted infections 39.

**Children in care or from families with child protection issues**

Situations which give rise to children being at risk or placed in out of home care often also increase the child’s risk of developing health problems. This includes poor nutrition, limited access to health services, exposure to violence, alcohol and/or drugs, issues with attachment and an increased likelihood of accidental injury (as a result of poor parental supervision). Most families with child protection issues are those with lower overall health equity as previously discussed.

The NSW Bureau of Crime Statistics report *Trends and Patterns in Domestic Violence Assaults 2001 – 2010* indicates that Campbelltown, Liverpool and Fairfield ranked in the top 10 metropolitan LGAs for domestic violence (DV) reports. Figures show 1,042 reports in Campbelltown, 792 in Liverpool and 735 in Fairfield (rates of 680.1, 427 and 373.9 per 100,000 people respectively). Whilst domestic assaults were primarily reported against adult women, by adult, male partners, in 2010 across NSW 13% of domestic assaults occurred against people aged less than 18 years, a total of 3,766 incidents.

The NSW Office of Communities Commission of Children and Young People reports that as at 30 June 2010 there were 1,955 children living in out of home care in the Metro South West Region of Community Services (11.2% of the State total) and a slightly lower rate than the State. Aboriginal children are over represented in out of home care.

Whilst children with care and protection issues may not have up to date health records, the *NSW Community Services* has identified that children and young people in out of home care have a higher rate of health, dental, developmental, behavioural and emotional problems than those in the general population. Many also have physical or intellectual disabilities. Depending on the age of the child, drugs and/or alcohol may also be an issue. The situation is worse for Aboriginal children.

Most children reported to NSW Health Child Wellbeing Units (CWU’s) are under 4 years (and include babies in utero). This is reflective of the delivery of high intensity antenatal and postnatal programs. A further 44% of reports relate to carer concerns (substance abuse, mental health issues or DV), followed by situations of neglect at 16%. For example, inadequate provision of supervision, shelter, medical care or mental health care. Almost half of the child protection reports made by health staff in 2010/11 were for children at risk of significant harm (ROSH).

Children and youth in care are a high priority group in this District for assessment and treatment.

**People with a chronic illness**

By 2020, it is expected that 80% of the disease burden in Australia will be due to chronic disease. Chronic illnesses are prolonged conditions that often do not improve and are rarely cured completely. Diabetes, dementia, chronic obstructive pulmonary disease (COPD), congestive heart failure and asthma are examples of chronic diseases which have a significant impact on the health of the community. Many of these diseases result from lifestyle factors or social determinants of health including poor nutrition, overweight/obesity, lack
of physical activity and smoking. Others are caused by personal biological or genetic factors. Further information on the burden of chronic disease is provided in Section 5.3.

Because chronic illnesses can have a profound effect on the physical, emotional and mental well-being of individuals, many people experience difficulty in activities of daily living (including going to work) and in maintaining relationships. Many people require ongoing care and support to manage their disease and/or the disabilities which arise from that disease.

Physical and mental health improvements have been seen in people with a chronic illness when appropriate medical treatment is provided and treatment regimes are adhered to.

The Australian Institute of Health and Welfare information on chronic disease\textsuperscript{44} indicates that over 7 million Australians had at least 1 chronic disease in 2004-05. These were predominantly in older people. The number of chronic diseases per person also increased with age. Aboriginal people have a disproportionate experience of chronic disease than the general population.

The Connecting Care Chronic Disease Program operates in South Western Sydney. There are also specific chronic disease programs targeted to Aboriginal people to improve their access to services and treatment.

**Refugees and other non-English speaking people**

South Western Sydney is known for its cultural diversity. In 2011:

- 36% of people living in the District were born overseas (compared with 26% for NSW). 53% of the population in Fairfield were from another country
- 51% of families speak English only at home (compared with 73% for NSW). Since 2006 an increasing proportion of families speak another language at home. In Fairfield, over 70% of families (131,162 people) spoke a language other than English (LOTE) at home, whereas in Wollondilly and Wingecarribee the figure is less than 10%
- Overwhelmingly Arabic is the most commonly spoken language other than English (over 74,000 people), followed by Vietnamese (over 61,000 people) and Cantonese (over 19,000 people). 40% of the Arabic speaking people in NSW reside in South Western Sydney
- There are distinct areas where particular cultural groups will reside. For example, Assyrian speakers (from Iraq, Iran and Syria) primarily reside in Fairfield, whilst people speaking Korean and Indonesian are primarily in Bankstown
- Almost 8,000 people who were humanitarian arrivals settled in the District over the 5 year period 2008 to 2012 (37% of all NSW humanitarian arrivals, up from 34% in 2004-2009). Of these, the majority settled in Fairfield (4,249) and Liverpool (2,834)\textsuperscript{55}
- Humanitarian arrivals represented numerous countries of origin, reflecting conflict patterns around the world. However, the number of people coming from Iraq was overwhelmingly the highest (5,888 people or almost three quarters of humanitarian entrants). Other countries of origin in order of number of settlers included Iran, Egypt, China, Burma, Syria, Afghanistan, Kuwait, Sierra Leone and Pakistan.
- Across NSW, people from culturally and linguistically diverse (CALD) communities generally have a better health profile than the Australian born population. However, there are some notable statistics of relevance to the main communities residing in this District.
The NSW Chief Health Officer’s Report 2010 indicates that:

- People from Lebanon are more likely to self report they smoke, are overweight or obese, have diabetes, be hospitalised for coronary heart disease and cardiac revascularization procedures, have psychological distress and are less likely to receive antenatal care before 20 weeks than the Australian born population.
- People from Iraq are more likely to be hospitalised for coronary heart disease and cardiac revascularization procedures. They are also less likely to receive antenatal care before 20 weeks than the Australian born population.
- People from Vietnam have higher rates of tuberculosis and are less likely to receive antenatal care before 20 weeks than the Australian born population.
- People born in India, China and Hong Kong have higher rates of tuberculosis than the Australian born population.

Humanitarian arrivals often have complex health problems related to their prior access to health care and/or their individual experiences of persecution or trauma. General health issues for humanitarian arrivals include psychological problems, injuries, poor oral health, infectious and vaccine preventable diseases, health problems related to a lack of nutrition and child development issues.

**People with a disability**

In 2011, almost 48,000 people in SWSLHD reported that they had a profound or severe disability which required them to have assistance with at least 3 core activities. This equated to 5.7% of the population,
compared with 4.9% for NSW. Across the District, the largest numbers of people with a disability reside in Fairfield (13,180) with Wollondilly having the least number of people with a disability (1,624).

Disabilities include intellectual or physical issues, may be either congenital or acquired, and may be the result of a long term health issue or ageing.

People with a disability often have higher levels of illness than the general population such as multiple chronic and complex care issues. Further, people with a disability (particularly an intellectual disability) are more likely than the general population to be under-diagnosed or under treated. They also face significant barriers to accessing health services, including physical and financial barriers and discrimination.

The prevalence of disability in the community will rise in line with the ageing of the population. The SSWAHS Disability Action Plan 2008 – 2011 contains additional information on demography and needs.

Figure 5.4 People with Disabilities and Carers, South Western Sydney 2011

Source: Australian Bureau of Statistics, 2011 Census

**Carers**

Over 77,000 people in SWSLHD provide unpaid care or assistance to people with a disability, chronic long term health problem, or old age. These include carers of people with dementia and mental health conditions. The percentage of the population describing themselves as carers is the same in SWS and NSW (9.2%). Notably, there are 15,000 more people identifying as carers at 2011 than at 2006. The majority of carers are women and provide over 40 hours of unpaid care each week to people with a profound disability. Across the District and the State, there is approximately double the number of people reporting themselves as carers as there are reporting themselves as having a disability requiring assistance. The number of carers in South Western Sydney will increase in line with population growth and ageing.

*Caring in the Community, Australia* observed that only 24% of carers are satisfied with their caring role and half reported sleep interruption due to this role. A small proportion of carers also reported having a stress related illness due to their caring role or considered themselves angry or resentful about their role.

For the District’s health services, carers are integral partners in health care delivery in the planning and organising appointments and access, assisting with activities of daily living, and treatment and compliance. Supporting carers in their role should result in reduced demands on the health care system.
5.3 The Health of the Community

The health of the community is determined by a range of factors including behaviours and lifestyle, genetic predisposition, age, and life events. Based on data from 2006-2007, life expectancy at birth for District residents is 78.7 years for males and 83.5 years for females, slightly below the state. In 2005-07, the death rate in South Western Sydney was similar to NSW.

In relation to potentially avoidable deaths (including those amenable to health care), in 2005-07 SWS was similar to the state with a rate of 154.8 per 100,000 people aged under 75 years for potentially avoidable deaths compared to the state rate of 154.4. A decrease in potentially avoidable deaths has been seen in this District over the last 10 years, fairly consistent with that for NSW.

In 2006-07 the standardised mortality ratio was significantly worse in Campbelltown and significantly better in Wingecarribee than the state.

Potentially avoidable admissions to hospital are health conditions that could have been potentially prevented through the provision of appropriate non-hospital health services. There were 20,025 potentially preventable hospital (PPH) admissions in the District in 2010-11, a lower rate than that for the state (2,343 and 2,379 per 100,000 respectively). The greatest number (2,357) was for gastroenteritis and dehydration. In contrast, nutritional deficiencies affected a very small number. In total, these conditions accounted for over 77,000 bed days. In general the rate of PPH admissions has remained stable in the District over the last 15 years, although a decrease was recorded since 2009-10. The top five conditions resulting in potentially preventable hospital admission in 2010-11 were:

- Gastroenteritis and dehydration (2,357): an increase from 2001-02
- Urinary tract infections and pyelonephritis (2,074): an increase from 2001-02
- Chronic obstructive pulmonary disorder (1,948): a decrease from 2001-02
- Dental conditions (1,791): an increase from 2001-02
- Congestive heart failure (1,531): a decrease from 2001-02

The District runs programs to intervene in some of these health issues to prevent admission.

In 2008-10, 76.9% of residents described themselves as having very good, good or excellent health (compared to 80.2% for NSW). This picture was the case for every LGA except Wingecarribee and Wollondilly. Overall local residents have been identified as having elevated rates of certain behaviours which are linked to poorer health status and lower rates of health protective factors, when compared with the total NSW population. Appendix 16 provides detailed tables of health status indicators for the District compared with NSW. A District-wide snapshot summary is provided in Table 5.3. The underlying data for this table including detailed information about each LGA is provided in Appendix A16.1

Obesity rates are slightly above NSW and the rates overall represent a significant health problem. Across the District in 2008-10, 55.9% of residents were defined as overweight or obese based on their height and weight. Less than half described themselves an adequate level of physical activity (47.8%) and only 54.9% achieved the recommended daily fruit intake. Only 7% of residents achieved the recommended daily vegetable intake. In relation to obesity, residents of Campbelltown, Wollondilly and Wingecarribee were of particular concern.

In 2010-11, there were 3,870 hospitalisations of District residents for reasons attributable to a high body mass index (BMI). This equated to a rate of 464.2 per 100,000 compared to 454.6 per 100,000 for NSW. Over 2008-09 and 2009-10, Campbelltown residents are significantly more likely than NSW overall to have a high BMI attributable hospitalisation, whilst residents of Fairfield and Wingecarribee were significantly less likely. In 2006-2007, there were 282 high BMI attributable deaths across the District, rates were similar to those for the state and were highest in Campbelltown and lowest in Wollondilly.
Table 5.3  Health Behaviour Indicators for South Western Sydney compared with NSW

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Worse than State</th>
<th>Similar to State</th>
<th>Better than State</th>
<th>SWS Trend Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent, very good or good self rated health (2008-10)</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>High or very high psychological distress (2008-10)</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Adequate levels of physical activity (2008-10)</td>
<td></td>
<td></td>
<td></td>
<td>Improving</td>
</tr>
<tr>
<td>Overweight * (2008-10)</td>
<td></td>
<td></td>
<td></td>
<td>Improving</td>
</tr>
<tr>
<td>Obesity* (2008-10)</td>
<td></td>
<td></td>
<td></td>
<td>Worsening</td>
</tr>
<tr>
<td>Consumption of recommended quantity of vegetables (2008-10)</td>
<td></td>
<td></td>
<td></td>
<td>F - improving M - worsening</td>
</tr>
<tr>
<td>Consumption of recommended quantity of fruit (2008-10)</td>
<td>Men</td>
<td>Women</td>
<td></td>
<td>Improving</td>
</tr>
<tr>
<td>Current smoking 16+ years (2008-10)</td>
<td></td>
<td></td>
<td></td>
<td>Improving</td>
</tr>
<tr>
<td>Risk and high risk drinking (2+ per day 2008-10)</td>
<td></td>
<td>Green</td>
<td></td>
<td>F - worsening M - improving</td>
</tr>
<tr>
<td>Influenza immunisations (65+ years), 2008-10</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Pneumococcal immunisations (65+ years), 2008-10</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Pap test in last 2 years, women 20-69 (2008 and 2010)</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Screening mammogram in last 2 years, women 50-69 years (2008-10)</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: NSW Adult Population Health Survey (HOIST), Centre for Epidemiology and Evidence, NSW Ministry of Health 2008-2010

*State figure a significant concern

Important Health Areas

The NSW Chief Health Officer’s Report identifies nine health priority areas where significant gains can be made for individuals and the whole population from a personal health, social and economic perspective. Unless otherwise indicated, all information comes from the NSW Ministry of Health List of Indicators. Detailed tables are provided in Appendix A16.

Although the information provided compares SWSLHD to the NSW average, it should not be used to determine local priorities. Rather consideration should be given to absolute rates (reflecting the current and future burden of illness) and the availability of cost effective interventions.

Cardiovascular Disease

High rates of cardiovascular disease are consistent with the low levels of health promoting behaviours and high levels of health risk behaviours noted in Table 5.3.

Cardiovascular disease (CVD) mortality rates have decreased significantly across NSW and the District in the 20 years to 2007. However these diseases are still the most common form of death in NSW and were still responsible for 35% of all deaths in NSW in 2007. In 2006-07, 373 local residents aged between 25 and 74 years died from cardiovascular disease (a rate of 83.9 per 100,000 compared to 79.1 per 100,000 for the State). Stroke caused 341 deaths in 2006-2007, with over three quarters in people aged over 75 years. Stroke rates are lower in the District than NSW overall (50.1 per 100,000 compared to 52.6 per 100,000).
In 2009-10 to 2010-11, the rate of coronary heart disease hospitalisations was significantly higher than the State in Campbelltown but significantly lower in Bankstown, Fairfield, Liverpool and Wingecarribee.

A large proportion of hospitalisations for residents are attributable to cardiovascular disease. In 2010-11, there were 4,763 hospitalisations for coronary heart disease and 1,962 hospitalisations for stroke.

**Diabetes**

Diabetes prevalence increases with age and socio-economic disadvantage. It is also more prevalent in men, particularly for Aboriginal people and those from Mediterranean countries. The *Atlas of Diabetes Prevalence by LGA* indicates that diabetes prevalence, as measured by National Diabetes Services Scheme (NDSS) registrants, in the District for the period 2007 – 2011 increased by 33% from 39,803 to 53,132. In 2011, Fairfield had the highest number of people with diabetes in the District (13,535), whilst Wollondilly had the lowest number (2,050). Overall in NSW, the NDSS data reports that 5.3% of the population has diabetes. A higher prevalence is reported for most of the SWSLHD LGAs – Fairfield (7.2%), Campbelltown (6.8%), Liverpool (6.4%) and Bankstown (6.2%). Diabetes prevalence will continue to rise in line with population ageing (increasing incidence) and greater longevity of people living with diabetes.

In 2009/10 - 2010/11, the District’s highest rate of hospitalisations for diabetes per 100,000 people was in Liverpool (354.3) and the lowest in Wingecarribee (209.5). In 2010/11, the rate of hospitalisation for diabetes was higher in the District than in NSW (154.1 and 144.7 per 100,000 people respectively). In 2007, there were 1,092 diabetes related deaths locally, a rate of 154.2, again higher than the state rate of 142.2 per 100,000 people.

**Cancer**

Cancer is the leading cause of death in Australia. The NSW Cancer Institute’s Cancer Registry indicates that the standardised cancer rate in South Western Sydney is 450.1 per 100,000, lower than the state rate of 483.2 per 100,000. In the period 2004-2008, there were 16,609 new cases of cancer reported in South Western Sydney, accounting for 9% of the total new cases in NSW.

In South Western Sydney over the same period, five cancer types accounted for more than 50% of all new cancer cases. Incidence rates were highest for:

- Prostate cancer - 2,492 cases (15%)
- Colorectal cancer - 2,102 (12.7%)
- Breast cancer - 2,047 (12.3%)
- Lung cancer - 1,703 (10.3%)
- Melanoma - 1,254 (7.6%)

Despite a lower incidence of cancer than the state, standardised cancer mortality rates in the District are slightly higher than those of the state at 178.7 and 176.9 per 100,000 respectively. Across both South Western Sydney and NSW, mortality from lung cancer is considerably higher than any other cancer. Mortality from cancer between 2004 and 2008 for local residents was:

- Lung cancer - 1,337 (21.1%)
- Colorectal cancer - 790 (12.2%)
- Cancer at an indefinite/unspecific site - 447 (7%)
- Breast cancer - 429 (6.8%)
- Pancreatic cancer - 354 (5.6%)
- Prostate cancer - 354 (5.6%)
A colorectal cancer screening program commenced in mid 2006. Participation rates in NSW are still relatively low, with 19% of people aged over 50 reporting they were screened in the last 2 years.\textsuperscript{50}

The NSW Health (2012) Report into Cancer Screening\textsuperscript{51} identified that in 2009/10 only 48.3% of local women aged 50-69 years participated in breast cancer screening programs. This falls short of the state average (52.7%) and significantly short of the NSW target of 70%.\textsuperscript{22} Recent unpublished data for South Western Sydney shows a decline to 46.3% in the 2 years to March 2012 (which is lowest in Camden and Liverpool). However, self reported data from the 2010 NSW Adult Health Survey suggests a higher screening rate over 2009 - 2010 of 65.5% for local women and 76.4% for NSW.\textsuperscript{52}

NSW Health data indicates that 52.1% of local women aged 20-69 years were screened for cervical cancer biannually, less than the state average of 56.5%.\textsuperscript{51} Self reported data from the 2010 NSW Adult Health Survey showed a similar low rate, though with overall higher figures (59.1% for SWSLHD and 68% for NSW).\textsuperscript{53}

Of note are the rapidly increasing rates of primary liver cancer in NSW, 80% of which are associated with chronic viral hepatitis. In the period 1997 – 2006, rates increased at 5.3% for men and 8.3% for women.\textsuperscript{54}

**Respiratory Disease**

Respiratory diseases include lung cancer, asthma, chronic obstructive pulmonary disease (COPD), asbestosis and influenza/pneumonia. In the District in 2009-10, there were 15,080 hospital separations for respiratory disease, a rate of 1,763.8 per 100,000 people compared with a rate of 1,705.3 per 100,000 people for NSW.

COPD rates for hospitalisations in the District in 2010-11 are similar to the state. The District recorded higher influenza/pneumonia separation rates for children aged 0 - 4 years but lower rates for people aged over 65 years and the total population than the rest of the state. These two groups are still hospitalised at a significantly higher rate than the rest of the population. Asthma hospitalisation rates are similar to the state in all age groups.

**Injury and Poisoning**

Injury and poisoning is the leading cause of death for people aged 1 – 45 years in NSW. In 2006-07 in NSW, the most common cause of death in this category was suicide (22%), followed by falls (16%) and motor vehicle accidents (14%). In the District, suicide ranked highest at 25%, followed by motor vehicle accidents (17%) and falls (12%). The differences most likely reflect the relatively younger age structure of the local population. Across NSW between 1997 and 2007, falls-related deaths increased significantly.

The number of overnight separations related to falls in people aged 65 years and over has been increasing, consistent with population ageing. However the rate of increase appears disproportionate when compared with the state. Alcohol has been identified as a significant contributing factor in many hospitalisations.

**Mental Health**

Mental Health conditions vary from short term, episodic to long term chronic illness. Mental health conditions in younger people are of note, with almost 15,000 people aged 2 - 17 years in NSW taking drugs for attention deficit hyperactivity disorder (ADHD) in 2009.

In 2011, 12.9% of local residents considered themselves to have high or very high psychological distress, slightly higher than the state average of 10.3%. Women recorded high levels of distress than men. The recorded rate fluctuates annually but remains similar to that recorded in 1997.

Suicide rates have more than halved since 1997 however there were still 56 suicides recorded for local residents in 2007. In 2010-11 in the District, there were 1,019 hospitalisations for intentional self harm, a rate of 117.7 per 100,000 and less than the state rate (127.7 per 100,000).
Oral Health

Overall oral health in NSW is good, however some population sub-groups experience high rates of poor oral health.

Across NSW in 2005-2007, approximately 5% of adults had all their natural teeth missing. This rate was slightly worse across Bankstown and Fairfield. Approximately 12% of the Australian adult population have decayed, missing or filled teeth, showing an improvement in oral health over a period of 20 years.

The 2007 NSW Child Dental Health Survey found that approximately 60% of NSW children aged 5-6 years had no decay in their deciduous teeth, however those with the poorest dental health had 5 teeth affected. A similar situation existed for 11-12 year olds, with 65% having no decay but those with the worst dental health having 2.4 teeth affected by decay. The survey found that the children with the worst oral health were Aboriginal children and those with mothers from a non-English speaking country and from lower socio-economic groups.

The 2008-10 NSW Adult Population Health Surveys indicates that 56.8% of local residents visited a dental health professional in the previous 12 months, with only 47.5% indicating they had private health insurance to cover dental expenses. Both rates were lower than that of the State.

Pregnancy and the Newborn Period

In 2010, only 79% of pregnant women in the District had a first antenatal visit before 20 weeks gestation, compared to 92% in NSW. Similarly, only 54% of women had a first antenatal visit before 14 weeks gestation, compared to 79% in NSW. Each LGA in the District is significantly worse than the state and the situation is currently deteriorating.

Babies with a low birth weight (under 2.5kg) represented 7.4% of all births in the District in 2010, 1.3% higher than the NSW average. These babies are more likely to have developmental problems later in life, including learning difficulties, hearing and visual impairments, chronic respiratory problems and chronic diseases. In 2009-10, there were 588 pre-term births recorded in the District, and again, Aboriginal women reported a higher rate than non-Aboriginal women (10.8% and 6.7% respectively). Prior to 2010, most preterm and low birthweight babies were born to teenage mothers, however in 2010 this changed to mothers over 35 years.

In the period 2008-2010, 2,131 local women smoked during pregnancy. Prevalence was significantly higher than the state in every LGA. In 2010, Aboriginal women reported a significantly higher rate of smoking during pregnancy (45.5%) than non-Aboriginal women (14.8%).

Perinatal mortality is relatively high in the District compared to NSW (9.7 per 1,000 and 8.2 per 1,000 respectively). This accounted for 124 deaths in 2010.

Gestational diabetes mellitus (GDM) is a significant problem in pregnancy and is affected by factors such as weight, age and ethnicity, and social determinants such as education, income and how much an individual paid on their mortgage. Mothers and their babies who develop GDM during pregnancy are 50% more likely than average to develop type 2 diabetes within 10-20 years if they don’t maintain recommended healthy lifestyle changes. Six of the top ten postcodes ranked by GDM occurrence in NSW are in SWSLHD, with Liverpool and Campbelltown in the top three. Local data indicates that 14% of all babies in the last two years in SWSLHD are born with GDM compared to 5.5-8.8% across Australia.
Communicable Diseases

A range of communicable diseases are monitored by public health units, enabling detection of outbreaks and a timely response. Some diseases are preventable through the use of vaccines and others are easily treated. However, these diseases can have a significant impact on individuals (including death and long term disability).

Table 5.4 provides information about communicable diseases which are of concern within the District due to increased mortality and disability for the individual, high prevalence within specific local communities and/or increased demand on health services.

**Table 5.4  Significant Communicable Diseases in South Western Sydney**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Number of notifications 2011</th>
<th>Trend 2008 - 2011</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
<td>73</td>
<td>Decreasing</td>
<td>Infection predominately acquired overseas. Effective treatment has reduced morbidity, however treatment resistant strains are present international</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>494</td>
<td>Decreasing</td>
<td>Most chronic disease is in people from non-English speaking backgrounds, with some pockets of nearly 10% prevalence. Effective treatment can reduce morbidity</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>388</td>
<td>Decreasing</td>
<td>Prevalent in past and current Injecting drug users, people in contact with the criminal justice system and some non-English speaking communities</td>
</tr>
<tr>
<td>Measles</td>
<td>9</td>
<td>Minimal Change</td>
<td>Vaccine preventable. Infection may result in serious complications in particularly in young and immunocompromised people</td>
</tr>
<tr>
<td>Pertussis</td>
<td>1,228</td>
<td>Increasing</td>
<td></td>
</tr>
<tr>
<td>Chlamydial infection</td>
<td>1,763</td>
<td>Increasing</td>
<td>Higher prevalence in young people and men who have sex with men (MSM) - preventable and treatable</td>
</tr>
<tr>
<td>Gonococcal infection</td>
<td>249</td>
<td>Increasing</td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td>86</td>
<td>Minimal Change</td>
<td></td>
</tr>
<tr>
<td>Meningococcal disease</td>
<td>7</td>
<td>Decreasing</td>
<td>Rare though serious; may result in death or disability</td>
</tr>
<tr>
<td>Pneumococcal disease</td>
<td>46</td>
<td>Decreasing</td>
<td>Affects mainly young and older people; may result in death or disability</td>
</tr>
</tbody>
</table>

Source: NSW Conditions Information Management System (28 June 2012)

Over 2001 – 2006, HIV prevalence was lower in the District than NSW (1.4 and 3.4 per 10,000 people respectively). However in recent years, the proportion of all NSW diagnoses from South Western Sydney has increased. There were 113 notifications of HIV and 42 of AIDS. Further information regarding HIV/AIDS and other sexually transmitted infections is provided in the SSWAHS Strategic Framework for HIV/AIDS and Related Programs (HARP) Funded Services 2008 – 2012 and Appendix A16.

The District has relatively high notification rates of viral hepatitis. Since 1992, the District has recorded the 2nd highest number of hepatitis B notifications. Untreated, chronic hepatitis B will result in a 40% chance of premature death from cancer and liver failure. However there are an estimated 762-1,533 people in the District with chronic hepatitis B not on treatment who should be on treatment. In 2009, rates were highest in Fairfield and Bankstown LGAs. South Western Sydney also has the 4th highest rate of hepatitis C in NSW, with notification rates highest in Campbelltown LGA (approximately 40% above the state rate), followed by Fairfield, Liverpool and Wingeacarribee.
Although notifications for Chlamydia appear relatively low, it is estimated that in NSW 75% of infections are not diagnosed. Women with untreated chlamydia infections are more likely to develop pelvic inflammatory disease (PID) and in the most severe form have an increased likelihood of ectopic pregnancy and infertility.

Immunisation plays an important role in reducing morbidity and mortality. The NSW Population Health Survey indicated that in 2008-10 vaccination of older adults against influenza was below the NSW average (72.4%) in Liverpool (63.7%) and Campbelltown (69.2%). Vaccination for pneumococcal disease was below the NSW average (56.3%) in all LGAs except Bankstown and Wingecarribee.

There are a number of emerging pathogens, such as swine influenza (H1N1), severe acute respiratory syndrome (SARS) and avian influenza which cause illness and deaths in humans. Strains of common microbes are expected to continue to develop resistance to previously effective drugs.

**Dementia**

Dementia has been identified as a key health issue at a State and National level. *Dementia Across Australia: 2011-2050 Report* has estimated approximately 91,000 people were living with dementia in NSW in 2011 and projects that this will increase to 128,238 by 2020. Previous projections produced for South Western Sydney in 2008, estimated prevalence in the District to be 9,874 people (an increase of 39% over 10 years). Projections in 2010 indicated that by 2018 there will be 11,778 with dementia living in this District.

Dementia places a significant burden on carers, the community based care system and the hospital system, primarily where dementia is a comorbidity linked to increased length of stay. Further information is contained in the *South Western Sydney Dementia Plan 2007 – 2010*.

**Summary**

The table following provides a snapshot summary of the health needs of local residents compared with NSW on a range of key health priority areas. The detailed data for this table is provided in Appendix A16.5.

<table>
<thead>
<tr>
<th>Indicator (Rates)</th>
<th>Worse than State</th>
<th>Similar to State</th>
<th>Better than State</th>
<th>SWS Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potentially preventable hospitalisations 2010-11</td>
<td></td>
<td></td>
<td></td>
<td>Steady</td>
</tr>
<tr>
<td>Alcohol attributable hospitalisations 2010-11</td>
<td></td>
<td></td>
<td></td>
<td>Increasing</td>
</tr>
<tr>
<td>Smoking attributable hospitalisations 2010-11</td>
<td></td>
<td></td>
<td></td>
<td>Decreasing</td>
</tr>
<tr>
<td>High BMI attributable hospitalisations 2010-11</td>
<td></td>
<td></td>
<td></td>
<td>Decreasing</td>
</tr>
<tr>
<td>Coronary heart diseases hospitalisations 2010-11</td>
<td></td>
<td></td>
<td></td>
<td>Decreasing</td>
</tr>
<tr>
<td>Stroke hospitalisations 2010-11</td>
<td></td>
<td></td>
<td></td>
<td>Decreasing</td>
</tr>
<tr>
<td>Diabetes related hospitalisations 2010-11</td>
<td></td>
<td></td>
<td></td>
<td>Unclear</td>
</tr>
<tr>
<td>Fall related injury hospitalisations, people aged 65+, 2010-11</td>
<td></td>
<td></td>
<td></td>
<td>Increasing</td>
</tr>
<tr>
<td>Intentional self harm hospitalisations, 2010-11</td>
<td></td>
<td></td>
<td></td>
<td>Not available</td>
</tr>
<tr>
<td>Asthma hospitalisations, 2010-11</td>
<td></td>
<td></td>
<td></td>
<td>Decreasing</td>
</tr>
<tr>
<td>COPD hospitalisations, 2010-11</td>
<td></td>
<td></td>
<td></td>
<td>M-decreasing F - increasing</td>
</tr>
<tr>
<td>Influenza and pneumonia hospitalisations, 2009-10</td>
<td></td>
<td></td>
<td></td>
<td>Steady</td>
</tr>
<tr>
<td>Deaths from all causes, 2006-07</td>
<td></td>
<td></td>
<td></td>
<td>Decreasing</td>
</tr>
<tr>
<td>Potentially avoidable deaths (aged under 75), 2006-07</td>
<td></td>
<td></td>
<td></td>
<td>Decreasing</td>
</tr>
</tbody>
</table>
5.4 **Access to Health Services**

Access to health care is a fundamental requirement to preserving or improving health. Services not only need to be available but in sufficient supply to enable timely access. Access is also affected by affordability, physical accessibility and acceptability of services. Services also need to be relevant and effective if desired health outcomes are to be achieved.
Supply of Public and Private Services

Health care in Australia is provided by the public and private health sectors. Historically, access to NSW public health services in western Sydney was poorer than in other parts of Sydney. Over the last twenty years, efforts have been made to address this imbalance there were still approximately 24 few hospital beds per 100,000 population in SWSLHD and WSLHD combined in 2009 than in other parts of Sydney\(^6\).

Private hospitals also have an important role in promoting and preserving the health of the community, and also play an important role in reducing demand on public hospitals. A critical concern in South Western Sydney is that there are fewer private hospitals and other services than in other parts of Sydney. For example, only 4% of private hospital beds and 6.5% of day procedure centres in NSW are located in this District and there are over twice as many private beds in the northern, eastern and southern parts of Sydney compared with western Sydney. This significant gap in private supply together with lower levels of private health insurance in this District, has resulted in poorer use of private hospitals with 27% of care of SWSLHD residents occurring in private hospitals compared with 36% of NSW residents overall\(^6\),\(^6\) .

Anecdotally, there are also significant gaps in the number of medical specialists and allied health practitioners working in private practices in this District. The alternatives for the public are therefore to use outpatient services in local public hospitals or travel to other parts of Sydney to access their specialist health care.

Perceptions of Access

The NSW Adult Population Health Survey found that the overwhelming majority of SWSLHD residents believe that they can get health care when they need it (only 11% disagree), a slightly better result than for metropolitan Sydney and for NSW (14% and 18% respectively). Consistently the greatest difficulty in accessing health service related to GPs. However, 23% of local residents with difficulties accessing health services reported that they had problems with treatment quality, followed by difficulty in accessing specialists (16%).

In 2009-10, 75% of local residents who attended emergency departments (EDs) had a positive experience. This was similar to that for NSW as a whole (77%). The most significant issues in South Western Sydney ED’s were waiting times (55%), followed by poor service (21%) and inadequate or wrong medication or management (12%). Of those admitted to hospital in this period, 86% of residents had a positive experience (similar to the state at 89%). The most commonly reported issues for residents were inadequate or wrong medication or management (45%), poor service (37%) and poor technical skill of clinical staff (31%). This reflects a different pattern to that for NSW in which the three most commonly reported issues were poor service (45%), inadequate or wrong medication or management (34%) and poor attitude of clinical staff (26%). It is valuable to note that no respondents reported a problem with the care they required being available at that hospital, as opposed to 8% for NSW.

88% of local residents who accessed public dental services reported a positive experience. Poor technical skill of staff was the most commonly reported issue (39%). Waiting times were the least reported issue (25%) compared to 43% for NSW.

91% of SWS residents who accessed community health services reported a positive experience, the same as for NSW. The most commonly reported reasons for dissatisfaction with local community health services were

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**Table 5.6 Number of hospitalisations in Public and Private Hospitals by Place of Residence, 2010-2011**

<table>
<thead>
<tr>
<th>Type of Facility</th>
<th>SWSLHD residents</th>
<th>NSW Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospitals</td>
<td>206,775</td>
<td>1,677,601</td>
</tr>
<tr>
<td>Private Hospitals</td>
<td>75,936</td>
<td>952,543</td>
</tr>
<tr>
<td>Total</td>
<td>282,711</td>
<td>2,630,144</td>
</tr>
</tbody>
</table>

Proportion of treatment in private hospitals 27% 36%

staff attitude (53%), poor communication (44%) and poor technical skill of staff (30%). This reflects a different picture of that for NSW, in which the top three issues were waiting times (43%), insufficient services offered or staff shortages (36%) and poor attitude of staff (26%). Local community health services were perceived to be comparatively accessible with no respondents reporting insufficient services offered or staff shortages and only 3.5% reporting waiting times as an issue\(^\text{18}\).

### Access to Primary Health Care

The first point of access to health care for individuals is generally through their local general practitioners. Across Australia, the trends over the last ten years indicate an increased proportion of group rather than solo practices, an older medical workforce, a growing proportion of female GPs and a broadening of the range of services provided through general practices. Requests for a checkup, prescriptions and test results are the most common reasons for patient attendance. GPs are most likely to treat respiratory, unspecified, skin and cardiovascular problems.

There are 392 general practices in SWSLHD with 913 practising GPs and 237 practice nurses. The majority (56%) are solo GP practices and of the group practices, 10% contain 6 or more GPs. Solo practitioners are particularly prevalent in Fairfield (70%). Around 30% of GPs are female. A quarter of GPs are aged 60+ however in Fairfield, 56% of GPs are aged over 60.

The GP to population ratio in SWSLHD is reported (PHIDU 2012) at 1:953, indicating relative scarcity compared to the NSW ratio of 1:911 and the national ratio of 1:894. There is significant regional variation, from 1GP:606 in Wollondilly to 1GP:2,960 in Wollondilly.

As reflected in Table 5.7, people in all LGAs in SWSLHD except for Wollondilly have a higher use of GP services than the NSW rate (100). However there is poorer use of services designed to improve coordination of multidisciplinary care for people with complex care needs. For example, GP services for enhanced primary care items in 2009/10 were below the NSW rate (100) in all LGAs except Camden and Wollondilly and were particularly low in Fairfield. Use of allied health professionals under the Better Access Program (targeted to people with mental health conditions) tended to be below the state average in all LGAs except for Wollongarrie. It is unclear whether this reflects GP referral practices or availability of these health practitioners. Further details are provided in Appendix A16.6.

<table>
<thead>
<tr>
<th>Table 5.7 Use of GP Services 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGA</td>
</tr>
<tr>
<td>Bankstown</td>
</tr>
<tr>
<td>Camden</td>
</tr>
<tr>
<td>Campbelltown</td>
</tr>
<tr>
<td>Fairfield</td>
</tr>
<tr>
<td>Liverpool</td>
</tr>
<tr>
<td>Wollondilly</td>
</tr>
<tr>
<td>Source: Medicare Benefits Schedule Data sourced from the Public Health Information Development Unit 2012</td>
</tr>
</tbody>
</table>

After hours primary medical care is provided by general practitioners (GP), GP cooperatives, After Hours GP co-located clinics in some hospitals, Sydney Medical Services SMS (Deputising Service), Emergency Departments and specialist outreach services such as Palliative and Cancer Care. There is considerable variability in the hours of services provided across the District by General Practice and this is being threatened with the removal of GP incentive payments to provide after hours care as of 30th June 2013. Whilst some 194 GP practices are currently accredited to provide after hours care, there are GPs who provide such care and do not advertise this service due to demand issues. The lack of consistency in practice and the hours of care, means there are pockets of South Western Sydney where the demand on the acute sector is increased due to the lack of home visiting, deputising services and after hours clinics. As of 1st July 2013, the South Western Sydney Medicare Local is being funded to address the issues of consistency and coverage of after-hours primary care and will work with SWSLHD to address priority gaps.
6. Healthcare demands to 2021

Over the decade to 2021, population growth and changes in the community’s age profile will contribute to accelerating growth in healthcare demands. Recent ABS data confirms the trend for rapid population growth with an estimated additional 12,341 people added to the District’s population in 2011, a 1.42% increase compared to the growth rate for the rest of NSW of 1.10% 6. Growth was particularly evident in Camden (2.8%), Wollondilly (1.9%), Liverpool (1.8%) and Bankstown (1.6%), all well above the State average growth.

Planning to cater for population growth is outlined in the NSW Government Metropolitan Plan for Sydney 203667. The Plan is currently under review, with a Discussion Paper Sydney over the Next Twenty Years68 released in mid 2011. Until the review is completed, it continues as the planning framework for future growth. Under this Plan sub-regional strategies gave an indication of expected housing developments to 2021 (these subregional strategies will be updated following the release of the 2012 Metropolitan Strategy). Wingecarribee is not included within the Sydney Metropolitan Plan. This plan identifies strategies for the creation of a sustainable city, housing 6 million people by 2036, with an increase of 1.7 million people on 2006.

South Western Sydney has been identified as the largest growth area within this strategy. As a result of this strategy (and its predecessor the City of Cities: A Plan for Sydney’s Future69), significant urban development has commenced in the largely greenfield area known as the South West Growth Centre (SWGC).

Figure 6.1 South West Growth Centre

Source: NSW Department of Planning and Infrastructure

Additional greenfield development (approximately 1,400 new dwellings) is planned for Wollondilly Shire, while Bankstown and Fairfield will see development through urban infill.
Liverpool is and will continue to be, the regional centre for South Western Sydney in the provision of services and infrastructure, for both health and commercial services. In the Metropolitan Plan it is defined as a Regional City, along with Parramatta and Penrith. Campbelltown-Macarthur will be a major centre, with a similar role planned for the future centre of Leppington.

Projections of dwellings production are included in the Metropolitan Development Program (MDP) Residential Forecasts 2010/11 – 2019/20 which provide forecasts of housing delivery in the short term (within 5 years) categorised as greenfield i.e. new housing estates or urban infill i.e. renewal of existing built up areas. Excluding Wingecarribee, an additional 22,536 dwellings are forecast for South Western Sydney in the next five years (56% greenfield) and 23,317 in the five years to 2021 (58% greenfield).

The greenfield development will predominantly be in the SWGC, which is approximately 50:50 shared between Camden and Liverpool LGAs (with a small proportion in Campbelltown LGA). This will ensure continuation of high population growth rates. In 2011, there were 1,530 new residential building lot registrations in greenfield areas across Liverpool, Camden and Campbelltown LGAs, representing 40% of greenfield lot registrations for the greater Sydney region.

The NSW Government has indicated an intention to accelerate housing development, particularly in greenfield areas, with infrastructure investment through a Housing Acceleration Fund. The major infrastructure development project identified in the NSW Budget papers 2012-13 is the Camden Valley Way upgrade supporting the development of up to 41,500 new homes in Camden and Liverpool LGAs. Accelerated housing development in the SWGC has been supported by recent announcements of land release for precinct planning for 11,000 homes in Leppington and East Leppington, 3,000 homes in Catherine Fields and exhibition of plans for 50,000 homes in Austral and Leppington North.

The NSW Government has also established a review of potential housing opportunities on sites nominated by landowners to increase dwelling production in the short term (able to produce houses within 3 years) at no additional cost to government. Across NSW 31 sites are undergoing further evaluation, with 17 (55%) within SWSLHD in the LGAs of Camden (four sites), Campbelltown (three), Liverpool (one) and Wollondilly (nine). There would be significant implications for population growth (not reflected in current population projections) and healthcare demand if these sites proceed. For example, several sites identified in Wollondilly are around Wilton Junction (Hume Highway and Picton Road) which if fully developed in total, would support 10,000 – 11,000 dwellings and 30,000 – 33,000 people.

6.1 Demographic trends to 2021

Department of Planning and the Statewide Services Development Branch, NSW Health (March 2009) projections indicate that by 2011 the District’s population would be 879,674, representing almost 61,000 additional people (7% growth or around 12,000 people per annum). The 2011 Estimated Residential population (discussed in Section 5.1) however indicates a population of 875,384 people. Figure 6.2 following shows the projected population growth in South Western Sydney from 875,384 in 2011 to 960,000 people by 2016, 1.06 million by 2021 and up to 1.4 million in 2036.
Specifically, during the life of this Plan (2011 – 2021) it is projected that:

- The population will increase by 178,564 people, a growth rate of 20%, or almost 18,000 people annually
- The population of Camden, Campbelltown and Liverpool will increase by 135,991 people
- Camden LGA will almost double in population (87%), followed by Liverpool (25%) and 20% in Campbelltown
- Proportionately, the age structure is expected to be similar
- Infants and children aged 0-14 years will increase by 40,321 from 195,727 in 2011 to 236,048 in 2021 i.e. with an overall growth rate of 21%. Camden LGA will have the highest proportional growth of 82%, and absolute growth will be highest in Camden (13,477 people) and Liverpool (10,592 people).
- The youth population (i.e. 15-24 years) will increase to 149,068 people (an additional 15,601 people).
- Adults of working age population (25-65) will increase to 527,584, up 75,192. Those aged 65 – 70 years will grow by 45% with an additional 14,012 people.
- The largest growth will occur in the 70-84 age group (an increase of 50%, or an additional 27,726 people). The number of people in this age group in Camden will increase by 166% and in Campbelltown by 92%.
- In the 85+ year age group there will be growth of 48% or an additional 5,711 people. It will be most noticeable in Camden with a growth rate of 130%.

The figure following shows the number of people in each age group across the District in both 2011 and 2021. Detailed population projection data is provided in Appendix 14.

**Figure 6.4: Projected Population Structure 2021 – South Western Sydney and NSW**


### 6.2 Projected Healthcare Demand to 2021

Population growth, better survival from previously-fatal illnesses and ageing will be the major contributors to increased demand for healthcare through to 2021 with health status and health equity considerations also to a lesser extent influencing utilisation. For healthcare provided by local health districts, the Ministry of Health has endorsed methodologies to project future acute, sub-acute and non-acute admitted patient activity provided in NSW hospitals.

Sub and non-acute care is defined as that which has the predominant treatment goal of enhancement of quality of life and/or functional status. This includes rehabilitation, palliative care, psychogeriatric care, geriatric evaluation and management (GEM) and maintenance care (Australian National Sub-acute and Non-acute Patient [AN-SNAP] classification).

These methodologies are available as software tools that address the multitude of factors that impact on the likely future use of hospital inpatient services. The methodologies are:

- **alm2010** (acute care) uses historical trends of hospitalisation and projected population growth and structure to project future acute hospital admission rates and length of stay by age group, sex, Local...
Government Area of residence and clinical specialty. It uses the state-wide admission rates and applies various assumptions (e.g. public/private mix, proportion of urgent versus non urgent activity, hospital of treatment) to develop the base case projections. Base case supply projections assume that the current pattern of service delivery, e.g. where services are provided, will remain broadly similar into the future.

- **SiAM2010** (sub and non acute care) uses a projection methodology similar to alM2010, based on five age groups (0–15, 16–44, 45–69, 70–84 and 85+ years), with 57 age, same-day/overnight, clinical group cells for which projections were estimated. Like alM2010 the base case supply projections assume that the current pattern of service delivery will remain broadly similar into the future.

The alM2010 and SiAM2010 projections referred to are demand projections, provided to illustrate the expected increased public hospital demand in 2021 from south west Sydney residents. The extent to which this increased healthcare demand can be provided within SWSLHD facilities, and that existing flow of SWSLHD residents outside the district for inpatient care can be turned around, will depend on funding availability for the service developments and requisite capacity enhancements identified within this plan.

For some hospital based services alternative projection methodologies are used e.g. the MoH has indicated that alM2010 data should not be used to project qualified and unqualified babies, perinatology, chemotherapy and renal dialysis. With the exception of births, where advice is that the alM2010 projections reflect the MoH population projections incorporating the best projection of future fertility rates, alternative methodologies are used in this Plan to project demand in these areas, as outlined below.

The Mental Health Clinical Care and Prevention Model (MH-CCP Version 2010) is used to project mental health care requirements for populations, prescribing appropriate ‘care-packages’ or ‘interventions’ for individuals and relevant population groups identified through epidemiological mental health prevalence studies.

Chemotherapy requirements are projected on the basis of projected cancer incidence rates for catchment populations, derived from NSW Cancer Council data.

Renal Dialysis requirements are projected on the basis of prevalence rates derived from the ANZDATA Registry in the *Revised Projections of Demand for Renal Dialysis Services in NSW to 2021 (2009)*.73

Maternity cots, delivery suites and birth centre rooms are projected using information derived from the Australasian Health Facility Guidelines (AushFG).

Activity projections, separations and beddays, derived from alM2010 and SiAM2010 are converted to bed requirements consistent with target occupancy rates outlined in the Ministry of Health’s *Guideline for Bed Occupancy Use in Service Planning*.74 These are:

- 85% with 7-day week operation for general acute care overnight ward beds
- 90% with 7-day week operation for sub-acute care overnight ward beds
- 120% with 5-day week operation for same day beds
- 75% with 7-day week operation for maternity ward beds inc. antenatal and postnatal and for neonatal beds inc. Special Care Nursery
- 75% with 7-day week operation for paediatric ward beds
- 75% with 7-day week operation for intensive care beds

There is still a lack of clarity regarding the occupancy level to be used for new models of care such as extended day only and high volume short stay.

For some activity, there has been no agreement or endorsement from the Ministry of Health on a methodology for projecting activity. This is of particular relevance to non-admitted activity provided at
hospitals and in the community i.e. outpatient clinic, privately referred non-inpatient and ambulatory care. The exception is for emergency departments where a Ministry of Health endorsed projection methodology Activity Planning Guideline for Emergency Department Services, involves derivation of current attendance rates by age cohort and applying these rates to the projected population age cohorts.

For emergency departments, treatment space requirements are derived using the Ministry of Health planning guidelines of a ratio of 1 treatment space to 1,460 presentations. This guideline also endorses the Australasian College for Emergency Medicine (ACEM) recommendation of 1 resuscitation bay per 15,000 attendances. Areas such as procedure, plaster, interview and other specialised rooms, Emergency Medicine Units (EMUs) and Psychiatric Emergency Care Centres (PECCs) are not considered as treatment spaces in this methodology.

**Demand for Inpatient Care**

Comparison of the 2010-11 demand for inpatient care in public hospitals from SWSLHD residents with that projected for 2021 is outlined in Appendix A15, comprising the following tables:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>15.1</td>
<td>Acute day only separations by age &amp; clinical category</td>
</tr>
<tr>
<td>15.2</td>
<td>Acute overnight separations by age &amp; clinical category</td>
</tr>
<tr>
<td>15.3</td>
<td>Acute overnight bed days &amp; average length of stay by age &amp; clinical category</td>
</tr>
<tr>
<td>15.4</td>
<td>Sub acute overnight separations, bed days &amp; average length of stay by age &amp; clinical category</td>
</tr>
</tbody>
</table>

This demand data is presented in a tabular format consistent with that included the Ministry of Health’s draft guidelines for a health care services plan. Perinatology, chemotherapy and renal dialysis have been excluded from the dataset, consistent with the MoH guidelines as referenced above.

The projected change in age structure of the SWSLHD population to 2021 (Figure 6.3) will have significant influence healthcare demand. Whilst an overall increase in population of 20% is expected, older age cohorts are expected to grow more significantly. The number of children aged 0-14 years is projected to increase by 21%, whilst adults aged 15-44 years are projected to increase by 16%. The middle to retirement age cohort of 45-69 years is projected to increase by 19%, whilst the older age cohorts are projected to increase more rapidly i.e. 50% increase for those aged 70-84 years and 48% increase for those aged 85+ years.

It is well recognised that older age groups place proportionately more demand on healthcare services, both in-hospital and in the community. Hospital separations per thousand population have been reported at 1,102 for those aged 75-84 years and 1,036 for those aged 85+ years, around three times the average of 340 for the Australian population (p.114). An increased proportion of these separations are for overnight ward stays and average length of stay for these overnight stays is longer than for younger age cohorts (p. 115).

The following table compares the projected per annum increase in demand for acute and sub-acute care in public hospitals for NSW as a whole and for SWSLHD residents, as projected by SiAM2010 and SiAM2010. It indicates that population growth and ageing in the south west will result in significantly higher growth in demand for inpatient care than will be experienced across NSW as a whole. Acute day only separations growth is projected at 15% higher, overnight separations growth is projected at 21% higher and bed days

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Using NSW Ministry of Health endorsed methodology for demand, SWSLHD will require an additional:

- 611 acute and subacute beds
- 7 neonatal intensive care unit (NICU) and 29 special care nursery (SCN) cots
- 113 mental health beds to achieve the NSW benchmark (or 185 beds to achieve 100% of the model)
- Around 60 additional ED treatment spaces
- 28 chemotherapy chairs and 2.15 radiotherapy machines
- 43 renal dialysis chairs
- 750,000 non-admitted patient occasions of service
growth is projected at 33% higher. Sub-acute overnight separations growth is projected as more than double that experienced across the state and overnight bed days growth is projected at 93% higher.

### Table 6.1  Projected per Annum Demand for Acute and Subacute Care – NSW and SWSLHD

<table>
<thead>
<tr>
<th>Activity Parameter</th>
<th>Average per annum growth in demand to 2021 for residents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NSW</td>
</tr>
<tr>
<td>Acute day only separations</td>
<td>2.7%</td>
</tr>
<tr>
<td>Acute overnight separations</td>
<td>1.4%</td>
</tr>
<tr>
<td>Acute bed days</td>
<td>1.8%</td>
</tr>
<tr>
<td>Sub-acute overnight separations</td>
<td>3.1%</td>
</tr>
<tr>
<td>Sub-acute overnight bed days</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

Both aLM2010 and SiAM2010 recognise that SWSLHD will face the highest rate of growth in demand for inpatient care of any LHD in NSW. For acute demand the *NSW Acute Inpatient Projections – 2010* (p 53) notes:

“It is projected that by 2031-32, Liverpool Hospital will treat more patients than any other hospital in the State .... with an annual growth rate of 3.3 per cent for day only separations and 2.3 per cent for overnight separations.”

For sub-acute demand the report *Projecting Demand for Subacute Inpatient Care Services* (P 54) notes:

“It is projected that by 2031-32, Camden will treat more (sub-acute) patients than any other hospital in the State...” Overnight separations are projected to increase by 6.4% per annum and overnight patient days to increase by 5.7% per annum (p.55).

Significant increases in bed capacity will be required across SWSLHD hospitals if the projected increase in public hospital inpatient demand from SWSLHD residents is to be provided within the local communities of the South West. The increased capacity required can be summarised as an additional:

- 42 acute day only beds
- 387 acute overnight ward beds
- 182 sub-acute overnight ward beds

This data indicates that an additional 611 inpatient beds will be required to meet the expected increased demand from SWSLHD residents. If provided locally this would entail a 28% increase in the beds currently available (Attachment A5) and require an incremental growth in bed capacity of 2.5% per annum.

### Demand for Perinatology Inpatient Care

As recommended under the MoH guidelines perinatology demand has been projected separately. Inpatient perinatology care is provided through Neonatal Intensive Care Units (NICU) and Special Care Nurseries (SCN).

Currently in South West Sydney NICU resources are centralised at Liverpool Hospital (12 beds). This is expected to continue as the model of care for the foreseeable future. SCN beds are provided at all hospitals providing birthing (Liverpool 20 beds, Campbelltown 16 beds, Bankstown 10 beds, Fairfield 8 beds and Bowral 2 beds). SWSLHD hospitals report a significantly lower rate of usage of NICU and SCN beds (11.3% of live births admitted to NICU or SCN) than State average (14.2%) or metropolitan Sydney average (15.9%). The high
demand on NICU resources in SWSLHD is confirmed by occupancy rates (>90% for 2011-12) in excess of the MoH bed planning benchmark of 75% occupancy.

NICU beds are subject to Statewide planning in consultation with the Perinatal Services Network. The last published State NICU Service Plan was to 2006\textsuperscript{78} and identified a need for an increased bed allocation (both NICU & SCN) at Liverpool Hospital. The Liverpool Hospital Clinical Services Plan (LCSP) prepared in 2006 identified that agreement had been reached with NSW Health for provision of 14 NICU and 24 Special Care Nursery beds at the hospital by 2016. The LCSP had indicated that the usual ratio of NICU beds was 0.7 per 1,000 births; however, network wide planning was required to account for network and retrieval flows.

Alternative jurisdictions utilise different ratios e.g. the Queensland report of the Statewide Neonatal Intensive Care Services (NICS) Project (Queensland Health 2006) and the Evaluation Summary Report to the Minister\textsuperscript{79} identified a proposed benchmark of 1.5 NICU cots per 1,000 births at 80% occupancy and a benchmark from national and international literature of 1.2 NICU cots per 1,000 births at 80% occupancy. For the Townsville hospital redevelopment a population based ratio was used of 1.2 NICU cots per 1,000 live births and 5.6 SCN cots per 1,000 live births, both calculated at 70% occupancy. Note that 75% occupancy is the MoH benchmark, as outlined above.

In the absence of a current published State NICU plan, NICU beds at Liverpool have been projected as continuing to provide for all of the SWSLHD catchment to 2021. The previously agreed provision of 14 NICU beds in 2016, when applied to the projected 10,923 (aIM2010) births for SWSLHD mothers at 75% occupancy represents a population based ratio of 0.96 NICU cots per 1,000 live births. The previous estimate of 14 NICU cots by 2016 was derived from projections data not taking account of increased fertility trends, as has been incorporated in the MoH’s 2009 population projections. Therefore, a level of provision more in line with national and international benchmarks is required to take account of higher fertility. Provision of NICU cots is now proposed at 1.1 per 1,000 live births at 75% occupancy i.e. 16 NICU cots by 2016. As aIM2010 projects 12,986 births in 2021 for SWSLHD residents, using the above ratio and occupancy rate, 19 NICU cots would be required by 2021 i.e. an additional 7 NICU cots.

SCN requirements are much more closely aligned to local demand. The need for SCN resources is correlated to the complexity of birthing provided at each hospital. A population based ratio per 1,000 live births at the MoH benchmark occupancy of 75% has been used as the projection methodology, applied to the aIM2010 hospital supply projections for 2016 and 2021. The ratios used are:

- 5.6 SCN cots per 1,000 live births (as used in Queensland) for the role delineation Level 6 maternity service at Liverpool Hospital
- 4.6 SCN cots per 1,000 live births for the role delineation Level 4 maternity services at Campbelltown and Bankstown-Lidcombe hospitals (noting that proposals to increase role delineation to level 5 are under consideration for these sites)
- 3.6 SCN cots per 1,000 live births for the role delineation Level 4 maternity service at Fairfield Hospital and role delineation Level 3 maternity service at Bowral and District Hospital (noting the lower complexity, lower risk birthing service provided at these sites).

On this basis the 56 SCN cots available in SWSLHD in 2012 would need to increase to 69 by 2016 (25 at Liverpool Hospital, 19 at Campbelltown Hospital, 13 at Bankstown-Lidcombe Hospital, 9 at Fairfield Hospital and 3 at Bowral and District Hospital). By 2021, 75 SCN cots would be required across SWSLHD (27 at Liverpool Hospital, 22 at Campbelltown Hospital, 14 at Bankstown-Lidcombe Hospital, 9 at Fairfield Hospital and 3 at Bowral and District Hospital) i.e. an additional 19 SCN cots.
Demand for Mental Health Inpatient Care

Unlike the alM2010 and SiAM2010 projection methodology, future demand for mental health care is projected on the basis of benchmark care packages to meet the expected prevalence of mental illness in the population. Planning for mental health services in NSW has been undertaken for the past decade using the NSW Ministry of Health endorsed Mental Health Clinical Care and Prevention Model (MH-CCP Version 1.11). This tool provides projections by age group for inpatient (acute and subacute) beds and staffing and community based care. The tool did not include Adult Intensive Care or Psychiatric Emergency Care Centre (PECC) beds.

The MH-CCP V1.11 has been utilised to model demand from South Western Sydney residents in 2011 and 2021 compared to current service provision. It has been used as the basis for mental health capital infrastructure planning for the proposed Campbelltown Hospital Mental Health Redevelopment Stages 1 and 2, the proposed Liverpool Hospital Redevelopment Stage 2 Phase 3, the Bankstown-Lidcombe Hospital Clinical Services Development Plan (BCSDP) and the SWSLHD Asset Strategic Plan. It has also been used as the basis for projections in this Plan.

Appendix 15.1.1 outlines current public mental health bed capacity in 2012 and projected future demand for 2021 using MH-CCP V1.11. It identified that the SWSLHD mental health bed base was significantly less than the MHCCP benchmark of 80% provision. At 100%, current supply (excluding PECC beds) was 125 beds less than benchmark and at 80% provision, supply was 65 beds less than benchmark. In 2012, supply of mental health beds was at 58% of the MHCCP benchmark. The most significant short-fall was in beds for adults aged 65+ years and in non-acute beds.

MH-CCP V 1.11 projected that by 2021, demand will have increased by 20%, in line with overall population growth. Compared to 2021 capacity, SWSLHD should aim to provide by 2021:

- An additional 113 mental health beds (acute and non-acute) to achieve 80% of the benchmark
- An additional 185 mental health beds (acute and non-acute) to achieve 100% of the benchmark

In early 2013, the NSW Ministry of Health released MH-CCP V2010 which incorporates new models of inpatient and community based care such as PECC, adolescent subacute and adult inpatient intensive care services. Overall, the new MHCCP 2010 projects a 10% reduction in the number of inpatient mental health beds required in SWSLHD by 2021. The major changes include a substantial decrease in the number of adult nonacute beds; increases in acute beds for adolescents to 17 years, adults and people aged 65+ years and in subacute beds for adolescents and people aged 65+ years; and inclusion of PECC beds within the total bed projection. A revised National modelling tool will be released in 2014 similar to the MH-CCP V2010.

Of relevance to SWSLHD is that under MH-CCP V1.11 and MH-CCP 2010 modelling very long stay (VLS) bed requirements is included. This model of care is not proposed for NSW mental health services in the future and although currently provided in a number of NSW local health districts, is unavailable in SWSLHD. As a result, capacity locally compared to these other LHDs is reduced. Of further interest is that under both versions of the MHCCP model, 80% of the MH-CCP benchmark is the NSW Ministry of Health prescribed planning parameter.

Appendix 15.1.2 outlines current public mental health bed capacity in 2012 and projected future demand for 2021 using MH-CCP V2010. Using this new model, SWSLHD would require by 2021 an additional 76 mental health beds to achieve 80% of benchmark or 140 mental health beds to achieve 100% of benchmark.

Demand for Emergency Department Care

Using the Ministry of Health’s emergency department projection methodology, Appendix A15.6 outlines the current capacity (2012) of SWSLHD emergency departments compared to benchmark and the capacity that would be required in 2021 to meet the benchmarked level of ED spaces revealed by this methodology.
Projected activity is combined across the Macarthur hospitals – Campbelltown and Camden, given that under current models of care, the significant population growth in Camden LGA would be expected to predominately flow to Campbelltown Hospital for emergency care.

Areas such as procedure, plaster, interview and other specialised rooms e.g. Psychiatric Emergency Care Centres (PECCs) are not considered as treatment spaces in the Ministry of Health methodology. Emergency Medicine Units (EMUs) are also excluded from the 2006 methodology. This is an issue for Bankstown-Lidcombe Hospital, where the SWSLHD bed count report identifies 19 ED treatment spaces as currently provided, which is much less than the benchmark of 1 per 1,400 ED presentations (i.e. 30 spaces). However, an 8 space EMU is provided at Bankstown-Lidcombe Hospital under the management of the Emergency Department. Hence, the 8 space EMU has been added to the 19 ED treatment spaces, to reach the total of 27 ED spaces reported at Appendix A6.

The MoH is to undertake a review of the 2006 Emergency Department Planning Guideline. It is noted that the 1 treatment space per 1,400 ED attendances within that guideline provides for less ED treatment spaces than comparable jurisdictional guidelines:

- Australasian College for Emergency Medicine (ACEM) G15: Guidelines on Emergency Department Design (2.3)\(^{80}\) indicates that patient treatment areas should be at least 1/1,100 yearly attendances or 1/400 yearly admissions, whichever is greater in number.
- Victorian Department of Health Capital Development Guidelines Functional benchmark of 1 treatment cubicle per 1,100 presentations at hospitals providing services at mainly role delineation Level 6 (Principal Referral hospitals) and 1 per 1,300 presentations for other hospitals providing services at role delineation Levels 1-5 (with 10% of spaces resuscitation and 90% treatment) \(^{81}\).

Definitive planning of future requirements for ED treatment places will require MoH review of continuing applicability of the 2006 guideline. Using that guideline the current allocation of ED treatment spaces in SWSLHD would be considered sufficient only at Liverpool Hospital, with scope for enhanced capacity at other hospitals to meet current demand. The data at Appendix A15.6 using the 2006 guideline indicates an additional 28 ED treatment spaces to meet current demand, or an additional 20 if the BLH EMU spaces are considered as coming within the ambit of the guideline.

This data also indicates demand growth that by 2021 an additional 37 ED treatment spaces would be required across SWSLHD. Therefore, using the MoH’s current planning parameters, to address less than optimal ED capacity for current demand and the projected future demand, would require provision over the next decade of around 60 additional ED treatment spaces.

**Demand for Ambulatory Cancer Care**

Radiotherapy and chemotherapy are essentially provided on a non-inpatient basis and chemotherapy chairs are not included in official bed counts. Radiotherapy and chemotherapy requirements are projected on the basis of projected cancer incidence rates for catchment populations, derived from NSW Cancer Council data.

Appendix A15.7 indicates the increased demand for access to radiotherapy and chemotherapy from SWSLHD residents projected over the ten year period to 2021. Total new cases of cancer are expected to increase by 39% over that period. At benchmark levels of cancer treatment, access to an additional 28 chemotherapy chairs and 2.15 radiotherapy machines will be required to meet increased demand for ambulatory cancer care. Potential distribution of chemotherapy chairs across sites is outlined in facility profiles at Appendix A19.

**Demand for Renal Dialysis**

Demand for renal dialysis has been projected at Appendix A15.8, using prevalence rates derived from the ANZDATA Registry by Professor Gibberd\(^{73}\). Projections of renal dialysis chairs required have in the past been
Derived within the context of integrated management of renal disease across the South West through the South West Sydney Renal Service, centred at Liverpool Hospital. Gibberd projects a 42% increase in the prevalence of dialysis for SWSLHD residents over the decade 2011-21.

Currently, dialysis is provided at Liverpool Hospital (in-centre and satellite); in satellite units at Bankstown-Lidcombe, Fairfield and Campbelltown hospitals; and at Bowral and District Hospital for self-dialysing patients. On average over 2011-12, there were 70 renal dialysis chairs available across SWSLHD, capacity to meet 88% of the projected demand from SWSLHD residents identified at Appendix 15.8.1.

Although currently some residents close to borders may flow to neighbouring LHDs for renal dialysis, given the frequent and extensive treatment encounters required, as a planning parameter it is reasonable to aim for 100% self-sufficiency in renal dialysis provision within SWSLHD. This would entail the provision of 113 chairs across SWSLHD in 2021 as outlined at Appendix 15.8.2 i.e. an additional 43 renal dialysis chairs. The potential distribution of these chairs across sites is outlined in the facility profiles at Appendix A19.

**Demand for Outpatient and Ambulatory Care and Care in the Community**

Activity in outpatient, ambulatory and community settings is measured by Non-Admitted Patient Occasions of Service (NAPOOS). Equivalent NAPOOS is the measurement unit used, which takes account of group sessions and non face to face contacts. Reported outpatient activity has tended to contract over recent years. This is partly because some activity has migrated to Privately Referred Non-Inpatient (PRNIP) status.

Over time these services are expected to come within the ambit of ABF funding. This will occur within the context of National Weighted Activity Units (NWAU) and it is noted that the Independent Hospital Pricing Authority (IPHA) have released a national efficient price to apply in 2012-13 of $4,808 per NWAU with weights for outpatient services categorised under the Australian Government’s Tier 2 List, the weightings reflecting the relative resource intensity in service provision e.g. 0.4198 for minor surgical, 0.0588 for general medicine and 0.0278 for podiatry. It is expected that as this process proceeds, LHDs will be encouraged financially to optimise data capture for services provided within these settings. This would imply that trends for recording a decrease in outpatient activity may well turn around.

A prime direction in models of care development identified in this Plan is for increased ambulatory services in hospitals and in the community (including homes), supported by connectivity with the patient medical record.

The MoH methodology for projecting future outpatient clinic or community health activity cannot be undertaken as a software driven process (unlike for inpatient care). Rather it requires detailed analysis of population growth and site-specific assessment of adequacy of current supply and review of current and proposed models of care, by care type and profession. As a result, each process reflects the idiosyncrasies of site provision, with significant difficulties in applying the methodology consistently across the multiple settings for ambulatory and community care. The approach adopted in this Plan is to develop broad assumptions about key demand drivers and apply these to the projected catchment population for services in 2021.

Projected activity in 2021 has been derived through using growth in the population cohort or health indicator that best represents the patient catchment. This has been undertaken for each SWSLHD facility, using the geographic area that best represents the facility catchment. The categorisations used and the population/health status variables applied to the catchment population are:

- Medical: population aged 15-69 years
- Surgical: population aged 15-84 years
- Cancer related: estimated new cases of cancer i.e. 39% across the District
- Maternity: projected births (aIM 2010)
• Paediatrics: population aged 0-14 years
• Aged care & Rehab: population aged 70+ years
• Mental Health: MH-CCP modelled community MH staffing required
• Drug Health: population aged 15-44 years
• General Facility Services: population growth all ages
• Oral Health: Population growth – children 0-14 years, adults 15+ years

Appendix 15.9 outlines for each facility the 2011-12 outpatient, ambulatory and community care activity and 2021 projections to 2021 applying the above factors. These projections do not address issues such as unmet demand such as waiting lists for outpatient and community based services. In addition, no allowance has been made within the projections for the impact of changing models of care across a range of services which will increase outpatient, ambulatory and community services.

Based on these assumptions growth of 30% is assumed in total non-admitted patient activity across the District over the ten year period. Activity will increase from 2,593,695 occasions of service (including privately referred patients) to 3,342,724 occasions of service i.e. almost 750,000 more NAPOOS.

Population growth and ageing and new models of care will also increase demand on GP and other primary and secondary health care providers. This Plan does not address the impact of an additional workload on the primary health care sector.

Demand for Population Health Services

Population Health Services cover a broad range of activities including public health services focussed on preventing ill-health through immunisation, investigating disease outbreaks and reducing risks from infectious diseases, chemicals, toxins and germs; health promotion through community-based programs that improve and maintain population health and reduce inequalities in health outcomes; health services for people of refugee background living in NSW; undertaking projects which contribution to healthy urban development (including Health Impact Assessment) and reduce health problems in disadvantaged communities; coordinating funding and developing policies and services in HIV/AIDS and other blood borne viruses; and monitoring, evaluating and undertaking research focused on population health and equity issues.

There are no standard measures that quantify population health service provision. Impact is assessed by the contribution to the overall health of the community, and through process and outcome measures such as engagement of communities, partnerships with other agencies and changes in practice. Therefore, there are no standard tools available to project the quantum of population health services required into the future.

The focus of Population Health on equity means that these services are more proportionately required and have greatest potential for impact in disadvantaged communities, where poorer socio-economic background is associated with worse health. With 14 of the 20 most disadvantaged suburbs in Metropolitan Sydney in South Western Sydney, the demand for comprehensive Population Health services is high. Achieving the vision of “Healthier communities” for SWSLHD will require an increased and sustained effort in preventative health through population health programs.

For many of the health targets identified in NSW 2021: a plan to make NSW number one, population health initiatives are the prime means by which improvement can be made e.g. reducing rates of smoking, risk drinking and overweight and obesity; reducing potentially preventable hospitalisations and closing the gap in Aboriginal infant mortality. As identified in section 5, SWSLHD reports rates worse than the State average against most of these indicators. This indicates that high demand and high potential for benefit from preventative health initiatives will continue into the future.
Demand for integration of preventative health activities into clinical practice will also increase into the future, where there is evidence of a beneficial impact. This includes not only for specialist and secondary care services provided through the LHD but also for programs in primary care including general practice, which could be collaboratively developed with the SWSML.

Population Health services in NSW are block funded. For 2012/13, 0.56% of the SWSLHD Budget was provided for these services, excluding Refugee Health. A sustained increase in this proportion will need to be considered to maximise opportunities for beneficial impact on the priority targets in the NSW 2021 State Plan.
7. Issues and Challenges

The capacity for health services to meet the needs of local communities is affected by a range of factors. There are many perspectives about the current adequacy of services, the factors that influence service provision and the critical issues that will influence how health care is provided in South Western Sydney in the future. This section provides a broad overarching context for the future, outlining the core issues identified by communities, community partners and clinical services that impact on strategy formulation for SWSLHD.

7.1 Organisational Wide Perspective

A range of issues and challenges define the context in which health services are provided in South Western Sydney. These issues will continue to impact on the capacity of services to meet future need and include:

- **Significant population growth** – to 2021 with the population projected to grow by 20%. By 2036, it is projected that the local community will have grown by 60%. This is double the NSW rate

- **Ageing** – with the number of people aged 65 years and over projected to grow by 48%. Many diseases and health conditions increase with age with increased complications and co-morbidities. This in turn will impact on length of stay in hospital and demand for health care in the community

- **Lifestyle behaviours** of local communities which negatively impact on health – with lower levels of exercise, lower consumption of healthy foods, higher rates of smoking and lower rates of antenatal visit in the first 20 weeks of gestation. These all impact on the morbidity and demand for health care

- Significant pockets of **socio-economic disadvantage** in the community, with some communities having lower life expectancy and considerably poorer health associated with differing capacity and ability to access health care and engage in healthy lifestyles. In particular Fairfield, Campbelltown and Liverpool have some of the most disadvantaged communities in metropolitan Sydney

- **Heterogeneous** communities with differing challenges and issues e.g. highly urbanised centres and isolated rural communities, newly developing communities predominately with younger working age populations and established communities with high proportions of people on fixed incomes, including pensioners

- Ensuring that people from **culturally and linguistically diverse communities**, particularly those from non-English speaking backgrounds have equitable access to healthcare services and health literacy to engage in self management where appropriate

- **Expectations** from patients and the community that they will receive effective health care and be involved in decision making regarding their health care

- Sufficient health facility and equipment **infrastructure** to meet inpatient, outpatient and community demands. Although the first stages of the redevelopment of Liverpool and Campbelltown hospitals have been funded, further capital development is required to meet the demand projected by 2021. In particular, capacity to meet demand for mental health services will challenge all services

- Ability to attract and retain a **skilled workforce** in the context of an ageing health workforce, an increasingly competitive employment market, variable workforce supply and the geographic distance of South Western Sydney from traditional workforce markets

- Uncertainty about the impact of activity based funding (ABF) on the **local health budget**, and capacity to meet current and emerging demand. There is also a requirement for increased specialisation and service development and a need to ensure a balance of prevention and secondary and tertiary interventions

- Capacity to meet **national and state performance targets** for safety, quality, efficiency and other targets. place services and clinicians under increasing pressure
Growing number of health and other agencies at a national, state and local level, increases the complexity of health service direction and provision, and of developing and sustaining relationships needed for health maintenance and improvement

Increasing need to develop partnerships and collaborations to ensure that the needs of individuals, families and communities with complex health and social problems are addressed. Difficulties are experienced in maintaining sustained and responsive partnerships with other Government agencies and community support groups e.g. in child protection

The large geographic coverage of the District and variable public transport (particularly in rural areas and outside business hours) reduces access to health services. Outreach health service delivery is expensive, can be difficult to coordinate and may not be feasible where specialist resources are extremely limited

Increasing difficulty balancing the expectations for additional education and quality supervision for a growing number of health students with clinician time for meeting population driven health service provision

Translating research and clinical guidelines into everyday practice, in the context of rapidly changing technology and health information

The need for better information links and systems between the community, Medicare Local, GPs and local agencies and the LHD is required to improve patient care. A wide-range of communication technologies used in other health jurisdictions are not currently used in SWSLHD. Adoption of these technologies would support communication.

Physical assets e.g. buildings, equipment and beds which are unable to meet current and future needs. In some cases, health sites are small and will not easily support expansion.

7.2 Community and Consumer Perspectives

Consultations were undertaken in 2011 and 2012 with representatives from community and consumer networks, residents, patients, carers (including carers of people with a mental health issue), local agencies and general practitioners. The following provides a brief summary of the main issues identified.

Strengths of the South Western Sydney Local Health District Programs and Services

There was overall recognition that the District provides a high volume of high quality services, with a number of specific examples cited. These strengths should be built upon and where possible, incorporated into all activities. Particularly:

- Significant improvements to some health infrastructure
- Generally positive reported inpatient experiences
- Excellent individual staff members (attitudes, interpersonal and clinical skills)
- Engagement of consumers in planning processes
- Responsiveness of individual services
- Collaborative work at an individual, population and agency level.

Health Promotion, Health Education and Prevention

Health promotion was identified as particularly important at an agency level. Many successful programs were identified, with development required in relation to:

- Recognition of the ‘whole’ person i.e. their physical, social and mental health
- Sustained participation in relevant District and local initiatives to enhance coordination
- Improved health literacy, particularly in Aboriginal and non-English speaking communities
• Identification of priority populations and associated priority health issues
• Tailored programs to address priorities.

Issues requiring a health promotion focus include teenage pregnancy, food security, overweight and obesity, exercise, smoking, stress management, family/domestic violence, communicable diseases, immunisation and screening.

The Local Health Service System – Navigating and Delivering Care
The complexity of the local health system (public, private and non-government) was seen as a significant barrier to improving health, particularly in relation to:
• Variable awareness of internal and external services available (and how to find out what is available)
• Privacy and confidentiality
• Memorandums of Understanding to guide work with shared clients/groups
• Coordination of responses for at risk clients
• Complex eligibility (and exclusion) criteria which vary between facilities and services
• Complex referral systems and processes which differ between sites and services
• GP ability and knowledge in avoiding unnecessary out of area or private referrals
• Variable quality and information contained in discharge summaries
• Discharge processes which should consider the ongoing, holistic needs of patients and facilitate links to ongoing services post discharge or SWSLHD intervention
• Public access to service system information e.g. brochures and noticeboards, with information which needs to be easily accessible, up to date and in multiple formats
• Awareness raising which needs to be continuous (by staff and within the community)
• Variable attendance by health staff at interagency and in collaborative projects.

This was a particularly significant issue for disadvantaged and/or complex clients due to the range of services available in the local community and the complexity of the community service environment. Groups thought to have the greatest need for assistance in understanding complex service systems were people with a mental health issue, frail older people, people with a disability, people with dementia, people with chronic disease/multiple chronic conditions, people who are homeless, women and children experiencing domestic violence, people with a dual diagnosis (mental health issue with an intellectual disability or drug/alcohol issue), people with guardianship issues and carers.

Continuity of Care with Community Based Services
Breakdowns in continuity of care were identified with patients falling into the gaps, particularly at times of transition between inpatient and community based care and where multiple agencies were required to address patient need. It was considered that particular attention needed to be given to:
• Perceptions that patients are being discharged too soon and/or there is poor communication and use of community support services
• Work undertaken by NGOs and other agencies with patients is a shared responsibility with greater integration required
• There is poor knowledge by GPs and other health services, particularly acute services, about what community services are available and how they can be accessed
• Gaps in fundamental services e.g. RACFs, Community Aged Care Packages, Compacs, other ADHC programs. The increased emphasis on community based care means that community services need to grow at the same time health services grow and that community nursing services and facilities also grow.
The General Practitioner and SWSLHD Interface

General practitioners have a critical role in coordinating healthcare for patients. Issues identified focused on:

- Insufficient access to GPs in the community (including the location, hours of service, cost, cultural barriers and gender) which places increased demand on EDs
- Linking to GPs with an interest in specialty areas e.g. antenatal care, mental health
- Need for District health services to value work undertaken by GPs e.g. test results
- GP access to specialist advice and training
- Accessible surgical and outpatient waiting list information to aid referrals
- Comprehensive discharge summaries which include changes to medication
- Ongoing communication regarding people with a chronic condition
- Access to electronic health records
- Preventative initiatives by GPs e.g. falls assessments
- Variable ability of GPs to influence admission to hospital

Communication Systems

Some services or systems were identified as having excellent communication systems between all stakeholders. However, all stakeholders identified problems with the flow of information (either at an individual or service level) including:

- Coordination of discharge (timeliness, liaison with carers, services and supports required at home, follow up care, and links to GPs)
- Coordination between facilities i.e. transfers and step down units
- Coordination between Emergency Departments and inpatient units
- Ensuring people have somewhere safe to be discharged to.

Workforce including Staff Education and Training

The need for an expanded, skilled workforce to meet current and projected need was accepted. Specific workforce related issues raised were:

- Difficulty attracting and retaining staff, particularly with staff unique clinical skills
- Inadequate numbers of medical staff (i.e. resident medical officers and registrars)
- Perceived ageing of the health workforce (including GPs) and implications
- Availability of female clinicians
- Weekend workforce capacity and experience, particularly in mental health
- Difficulties in continuity of care and handover created by use of agency staff
- Lack of local training and education opportunities linked to local employment e.g. TAFE based Enrolled Nurse (EN) and Aides in Nursing (AIN) courses at Fairfield
- Supporting nurses to return to the workforce
- Roles of Clinical Nurse Consultants
- Clinical supervision of staff working in isolation e.g. during home visits
- Generic staff training addressing topics as diverse as communication, palliative care, dementia, people with a disability, carers, hand washing/hygiene, mental health, domestic violence, child protection, cultural awareness, and privacy and confidentiality

The quality of interaction between individual staff and patients, clients and service providers varied widely. Consistently, care recipients valued clinician honesty, active listening, kindness and professionalism along with thorough, easy to understand explanations followed by appropriate action. Issues identified included:

- Use of jargon or lack of clarity in explanations
Inaccurate information e.g. in relation to waiting times
- Gaps in basic interpersonal skills e.g. eye contact and empathy
- Attention to patient needs e.g. for food, drink and medication whilst waiting for services
- Respect for external service providers e.g. GPs and staff employed by NGOs

Service Access and Availability

Service accessibility was seen as important by all stakeholders. Barriers to access included:

Hours of service
- Extended hours services to improve accessibility
- GP after hours services, including weekends and public holidays
- Service closure during holiday periods
- Lunchtime closure of services e.g. Liverpool Hospital Pharmacy affecting discharge and planning of outpatient visits

Cost of service
- Lack of bulk billing by GPs, specialist services and private allied health
- Pharmaceutical costs (and availability of starter packs on discharge)
- Lack of clarity relating to gap payments for private health insurance
- High cost of private dental care and exclusion from Medicare
- Availability of EFTPOS technology

Location of service
- Outreach services and home visits, including joint home visits with partner services for identified clients and home delivery by community pharmacy
- Options to admit people with a mental health issue bypassing ED
- Limited services in outlying areas and not all services available in all areas. Difficulties in providing services to smaller fringe urban communities at the edge of the District and ensuring these communities have integrated access to the closest service which sometimes may be across the border e.g. Warragamba
- Youth health services poorly located - proximity to central Liverpool
- Co-location of SWSLHD and NGO services targeting similar groups.

Service availability (including gaps in)
- General physicians to manage people with multiple, chronic conditions
- Public and private dental services
- Mental health services – all levels/types of inpatient/community (all ages)
- Ambulatory care models e.g. day hospitals
- Variable waiting list management
- Long waiting times for treatment in Emergency Departments (with unclear triage systems); planned surgery; equipment through HealthEnable; community and outpatient allied health services including child and family services; geriatric assessment / Aged Care Assessment Team (ACAT); and basic specialist outpatient services e.g. ophthalmology, urology and diabetes
- Maintaining services for social housing tenants relocated as a result of Housing NSW’s renewal projects which aim to achieve 70% private and 30% Housing NSW properties in all estates. While health services are often targeted at whole communities, the deconcentration of Housing NSW areas means that these
high need tenants may not have access to services and programs previously provided as place-based strategies, particularly for those who move outside the LHD boundaries. Strong partnerships with Housing NSW Transition teams and GPs are required to ensure tenants receive the care they need once they have been relocated.

**Transport**
- Cost particularly for geographically isolated and disadvantaged people
- Access for frail older people, people with a disability, carers and people with chronic health conditions requiring frequent health service attendances (especially cancer patients who do not qualify for community transport); and for people who are geographically isolated (requiring transport coordination, appointment scheduling and block appointments)
- Availability of after hours and weekend transport services
- Inter-district transfers and referrals, transport advice and coordination
- Proximity of transport infrastructure to health services e.g. bus stops, drop off points and taxi ranks
- Hospital parking affordability and availability (including access for Community Transport)
- Awareness of support schemes including discounted parking and taxi vouchers
- Awareness of Transport Access Guides (TAG) available for each facility
- Infrastructure for alternative modes of transport e.g. helicopters at Bowral

**Facilities and Equipment**

There was recognition of improvements made in recent years and acknowledgement that further work is required to upgrade facilities and equipment to meet current and future need, such as:
- Better signage, parking and cleaning
- Variable implementation and understanding of No Smoking Policies
- Security particularly in mental health units and isolated clinics
- Comfort of ED waiting rooms (with areas to lie down) and separate waiting areas for adults, children and people with a behavioural disturbance
- Availability of appropriate equipment and facilities for patient stays e.g. adjustable beds, outdoor spaces, gym equipment, single rooms and single sex rooms
- Meeting spaces accessible for community based support groups
- Information technology to support clinical roles and improve communication
- Waiting rooms to incorporate opportunities for health education e.g. TV monitors
- Internal transport for people with a mobility impairment

**Inpatient Experience**

Issues relating to the overall quality of the inpatient experience were gathered from consultations, inpatient surveys and analysis of incidents. Issues primarily related to:
- Availability of reading materials for patients
- Provision of assistance with meals as required i.e. feeding, opening containers, ordering meals and culturally appropriate menus
- Extra support for people with special needs e.g. dementia and disability
- Educational and therapeutic programs such as teachers in paediatric units and diversional therapy
- Clinical management including management of falls and pressure ulcers
- Lack of dignity and respect engendered by continuing experience of accommodation in mixed gender wards
General Health Service Issues

- Duplication of services if people are accessing public and private care
- Duplication of tests undertaken in the community and repeated in hospital
- Electronic medical records including accuracy and integration of health records between hospitals, community health settings and GPs
- Shared learning with other health and community services sector staff
- Consumer and community engagement in planning, development and evaluation of services and initiatives, particularly for disadvantaged groups

Priority Populations

Children

- Access to community based therapy services for children with special needs
- Access to ambulatory care services
- Appropriate information sharing for shared clients and patients
- Consideration of whole family, not just child
- Assistance in transition to adult services
- Supports for people with chronic care needs and disability
- Interventions to reduce childhood obesity

Carers

- Variable responses by services and staff to carers and their caring relationship, particularly in sharing information, care planning and identification of carer stress
- Lack of policies, systems and workforce education to support carers
- Inadequate understanding by carers of the health system and services available
- Insufficient respite services, particularly dementia respite
- Need for additional carer support services including new models to enhance flexibility
- Need for carer advocates within inpatient units to support early identification of carer stress and appropriate referrals
- Additional physical, financial and emotional stress when the care recipient is in hospital i.e. hospitalisation is not a form of respite

People from Specific Cultural Groups including Aboriginal people, Religious groups and Non-English speaking

- Routine involvement in planning and decision making processes
- Need for targeted services to improve accessibility and utilisation
- Workforce training in cultural awareness, understanding and interpreter use and under-promotion of SWSLHD interpreter and translation services to support GPs and NGOs
- Liaison services for key target groups in hospitals and community settings
- Insufficient translating and interpreting services (particularly female interpreters and for emerging communities)
- Availability and skills of bilingual practitioners
- Health literacy and understanding of the local health system, including eligibility
- Collaborative focus on indicators related to Closing the Gap for Aboriginal people
- Specific subgroups requiring attention are newly arrived refugees, families (particularly with young parents), children and women

People with a Mental Health Issue

- In addition to mental health needs, recognition of physical needs
- Recognising the service continuum from wellbeing to acute to rehabilitation to community and supported accommodation and ensuring continuity of care for all ages
- Service coordination and case management
- Involvement and support of carers and family, including respite
- Liaison with other agencies e.g. Housing to support a quality life in the community

An additional source of feedback about patient issues is the NSW Patient Experience Survey which is generally conducted on a monthly basis. It considers service categories such as overnight and day only inpatient care, emergency and outpatient care, and the specialties of mental health (inpatient and outpatient care), and paediatric and adult rehabilitation inpatient care. Patients and carers are provided with an opportunity to comment on aspects of service such as overall care, courtesy, advocacy, trust in the healthcare worker, availability of staff, etc. The reports for each quarter in 2011 indicate that although satisfaction with SWSLHD services is improving, that the overall SWSLHD performance is still below the NSW average. The information obtained from these surveys generally reflects the consultation undertaken for this Plan. It is also consistent with information obtained through the patient journey interviews.

7.3 Clinical Stream and Service Network Perspectives

Clinical Stream Directors identified the key issues impacting on the stream’s ability to deliver the types of services required by the community, in terms of quantity, quality and comprehensiveness and the stream’s plans for the future. Input from staff, management, associated services and the community was requested.

The following sections summarise the issues identified by each stream, now and over the next ten years. Common themes identified across streams include:

- **Population growth** which will increase demand for both services and facilities, particularly created by the South West Growth Sector
- **Population ageing** which will increase demand for most services due to greater prevalence of disease and disability in older age groups
- **Increasing complexity of patients, particularly high rates of chronic disease and obesity** which will require more complex and coordinated interventions and involvement of multidisciplinary teams
- Unique health needs of high needs populations such as Aboriginal people, people from diverse cultural backgrounds and frail, older people
- Insufficient access to interpreter services and appropriate translated material, culturally appropriate service models and cultural awareness training for staff
- The need for an increased holistic approach to the treatment of patients and health care consumers, with a greater use of multidisciplinary care models addressing physical and psychosocial health
- Growing patient and community expectations in services location, time and range
- A lack of equity across the District due to historical funding patterns, externally funded programs with unique eligibility criteria and the presence of pilot and time limited programs. In some services, equity imbalances exists in local care models and systems, policies and procedures
- **New and emerging therapies** to treat health problems such as hepatitis will place an increased demand on ambulatory services
- A heavy reliance on both Sydney Children’s Hospitals and a lack of local expertise and appropriate treatment spaces for paediatric health care (medical and surgical) which requires attention to cater for the demand generated by population growth
Distribution of residential aged care facilities (providing long term care to older people with more complex needs and requirements) is uneven across the District. Difficulty finding a suitable RACF close to the patient’s or carer’s home prolonging hospital stays.

Gaps in key infrastructure including insufficient theatre capacity and capability (including interventional and endovascular suites and recovery spaces) to meet demands for emergency and elective surgery within treatment benchmarks and community accepted timeframes; insufficient access to cutting edge surgical technology which enables higher volume surgery and/or less invasive surgery, and the need for timely replacement and upgrade of existing equipment; and insufficient clinical and associated space (including beds) to deliver enhanced models of care and the quantity of care required for the future. There is a compounding effect on the ability to provide sufficient infrastructure from the large geographic size of the District, variations in population density, the number of small isolated communities and lumpy distribution of infrastructure as services are aggregated into sites of critical mass that optimise efficiency and networking potential.

A need to expand models of ambulatory, outpatient and community based care to provide a more timely and responsive service to patients and alternatives to hospitalisation.

Potential to reduce high numbers of avoidable Emergency Department presentations and hospital admissions through stronger preventative care and alternative models, such as GP after hours clinics.

Limited access to private health services locally in hospitals, day procedure centres, GPs and allied health, with availability worse in some areas than others. Rates of private health insurance are also comparatively low in many areas resulting in a greater reliance on the public system.

Limited after hours services at some sites and in some streams or disciplines.

Current workforce shortages and concerns about the ability to recruit and retain suitably qualified staff in the future. Although an issue for all streams, it had greater impact in specialties in high demand.

A lack of administrative support for clinical staff which reduced clinical services due to the additional administrative duties for clinical staff.

An inability to secure staffing to cover leave (annual and maternity), impacting on service sustainability and delivery.

A lack of clinical academics to drive research and the development of expertise in specific areas of clinical care required to develop a reputation for excellence and enhance recruitment and local care delivery.

Limited data management and analysis support capacity to evaluate service models and success and ultimately deliver evidence based practice.

A need for faster implementation of information technology (IT) projects and support to improve patient responsiveness and enable access to technology such as PACS/RIS and eMR telehealth.

Lack of clarity about the impact of activity based funding and NEAT targets creating workplace uncertainty.

Clinical stream specific issues were also identified. The following summarises some of the key issues identified by each stream, in some instances specific to individual specialties within a stream.

**Aged Care and Rehabilitation**

Significant increased demands are expected with projected growth in the population aged 85+ years and government policies to keep people at home. The local population is not wealthy, is heavily reliant on public health care, and does not have strong community or family support networks and few residential aged care facilities (RACF) places.
Nationally, structural reform is occurring in the aged care and disability sectors. The impact of these reforms on SWSLHD aged care and rehabilitation services is unclear creating uncertainty, particularly for programs delivered through targeted funding.

Subject to the outcomes of these reforms, community based services need to be expanded and better coordinated to meet growing demand in both sectors. Partnerships need to be strengthened with general practice and RACFs to improve the health of residents and prevent avoidable hospital admissions. A greater focus on needs across the continuum of care is required, from prevention to post-acute care.

Timely, comprehensive geriatric assessment and management as a model will enable the planning and delivery of requisite care and will reduce demand on hospitals. In addition, reducing duplication in assessments by varying agencies and disciplines will provide efficiencies in the community sector and in hospital.

Improvement to aged care services in Emergency Departments is required to address the increase in presentations. For hospital based services, there are insufficient acute and sub-acute beds, including aged care psychiatry beds, to meet current demand. Additional sub-acute beds will be required, both at stand-alone subacute hospitals and in acute facilities for patients still requiring some acute medical support. This is particularly evident at Liverpool Hospital. Systemic growth of sub-specialised models of care trending away from General Medicine is also problematic for aged care.

Patterns of bed availability vary across the District and are not necessarily reflective of population profiles. After hours services are limited, particularly at Camden and Braeside hospitals. Patients often have a longer than necessary length of stay due to inadequate management of cognitive behavioural problems (delirium and chronic organic brain injury), inability to provide early and coordinated rehabilitation (reducing hospital acquired deconditioning) and availability of medical staff to discharge on weekends. Demands on rehabilitation beds mean that patients are discharged when safe to discharge rather than when they achieve their rehabilitation goals i.e. the traditional discharge trigger. There are also concerns in surgical care for older people with delayed flows to subacute beds, consequent de-conditioning of patients and delayed investigations preventing early transfer.

The NSW Brain Injury Unit is experiencing increasing demand for acute and transitional/community services.

**Allied Health**

Allied health services support other clinical services through multidisciplinary teams and are also provided as unique clinical services in both hospital and community settings.

Demand for allied health services is closely linked to the models of care provided by other services and as a result it is difficult to undertake proactive planning and to appropriately develop and grow the workforce to meet the changing care requirements of other clinical services. Evolving service delivery models with ongoing focus on hospital avoidance, reduced length of stay and residential aged care avoidance will continue to add pressures on admitted and non-admitted services and the ability for allied health departmental services to cover entire spectrums of care.

Many allied health services have been developed through external funding programs, or targeted local initiatives, and as such there is a lack of equity across the District and varying degrees of access to clinical services. In some cases externally determined eligibility criteria affect access to services.

Currently there are long waiting times to many allied health services. Attention is focussed on addressing the immediate workload due to its high volume with insufficient capacity to implement evidence based care and deliver a full suite of preventative services. Locally, there have been increased referrals from out-of-District
tertiary hospitals for patients requiring high intensity, long term care close to home, from staff with specialised skills, training and equipment. This is placing a considerable, unanticipated drain on existing resources. As services are generally only provided 5 days a week in business hours, there is added pressure to meet demand. Outreach models are problematic for the limited workforce due to the additional travel time.

Allied health services are also experiencing the trend to more complex patients in all settings. This includes higher numbers of babies and children with developmental issues, children in out of home care, people with chronic and complex care needs and those in post-acute phases. In some cases, improved access to support from other clinical services is required to meet the needs of these complex clients/patients, in particular to paediatric mental health. Improved access to equipment through HealthEnable is also required.

**Cancer**

Current cancer services are insufficient to meet existing demand and will require considerable expansion in facilities and services into the future. For example, there is a need to expand or develop service availability in haematology, paediatric oncology, medical oncology, radiation oncology, chemotherapy, melanoma and sarcoma surgery, breast surgery and prostate brachytherapy. Associated with this is the need to provide comprehensive support services such as allied health, care coordination and psycho-oncology.

Cancer services should be delivered in locally based integrated cancer centres which offer diagnostic, treatment and after care support. At present, capacity is not available to provide after care support, despite increasing demand and community expectations for this model of care. To support these centres, appropriate infrastructure will be required and existing infrastructure for example linear accelerators must be maintained and upgraded as required.

BreastScreen services are currently unable to meet state targets for screening and require staffing enhancements and support in recruiting and retaining staff. Permanent accommodation collocated with other services is also required.

Palliative care services require expansion in inpatient settings, day hospitals, outpatient and community based services. End of life care planning should be incorporated into these services.

**Cardiovascular**

Cardiovascular services are experiencing high demand, unmatched by additional resources. Greater patient complexity is also being experienced, particularly for people with diabetes, Aboriginal people and recent immigrants. At present, managing acute demand means that there is insufficient capacity to focus attention on primary and secondary prevention/rehabilitation and hospital avoidance programs. Patient flows in and out of the District for specialty services also make demand hard to manage.

Challenges exist in meeting the current need for comprehensive diagnostic services, ablations, dialysis (in centre and satellite), rehabilitation and palliation. There is also insufficient access to ICU/HDU beds which in turn impacts on surgical throughput. There is no dedicated cardiothoracic/vascular ICU/HDU.

Diagnostic equipment is ageing and requires upgrade or replacement to ensure demand can be met now and in the future. Technology in theatres and endovascular suites also requires upgrade and renewal, with capacity to purchase new technology as it becomes available. Public private partnerships are lacking.

Cardiovascular services are not equally distributed across the District and the community/patients have expressed concerns about networked arrangements. There is confusion about admission protocols across hospitals (cardiovascular or general medicine) and in some cases a lack of after hours medical cover.
Community Health

Community Health facilities (from which the majority of community based services are provided) are inadequate to meet demand (with a lack of treatment and meeting rooms, office areas and car parking) or specific needs e.g. needle and syringe program facilities. With the exception of Tahmoor CHC, there is no spare capacity available that would enable additional or expanded services to be provided. IT systems are not well developed and are often incompatible with the rest of the primary care sector. For the mobile staff, access to vehicles and IT systems (point of care record keeping) is variable.

There is increased patient vulnerability and complexity due to social and/or health circumstances. Populations with particular issues include Aboriginal people and non-English speaking people. Whilst the development of targeted interventions for some groups is positive in addressing health disadvantage, this has occurred at times at the expense of generic services, particularly in family services. Staff skills and experience to appropriately meet the needs of more vulnerable clients also require development.

Some services like child protection and sexual assault remain fundamental to community health practice, however for services which have aspects of care provided through Community Health and also through other clinical streams, more clarity is required on best practice models of care to ensure continuity. The relationship and linkages with Population Health in preventative health activities and how that relates to services such as Community Paediatrics also requires attention. A framework for evolving the services profile would assist in ensuring a rational development path rather than ad-hoc consideration of potential add-ons.

Despite a move to greater community based acute and post-acute care, community health services experience difficulty accessing support from GPs and hospital medical specialists, especially after hours. Strengthening these and other partnerships and colocating services will assist community health services in more effectively and efficiently meeting demand.

High demand for immediate services reduces the capacity of services to deliver evidence based practice.

Complex Care and Internal Medicine

Ambulatory Care

Capturing and projecting ambulatory care activity is difficult as it relates to a model of care rather than to a particular diagnosis. Ambulatory care models are increasingly popular as new technologies and treatment methodologies are developed which reduce the need for overnight admissions. As an emerging and variable model of care, it is also difficult to determine benchmarks of activity and staffing levels.

Services currently operate primarily during business hours, with no capacity to operate after hours. Extended hours may provide greater flexibility for patients and enhance throughput. This cannot be achieved without addressing current issues in accessing support services and equipment such as interventional radiology, treatment chairs and infusion pumps; and medical specialist services and appropriate nursing support.

Although ambulatory care services could be provided outside of hospitals (such as within residential aged care facilities), there is currently limited capacity. In developing such a model attention to quality and safety and access to technology would be required.

Clinical Genetics

At present, there are long waiting lists to access clinical genetics clinics and genetics counselling. Demand is likely to increase in line with adoption of emerging technology in exome testing and next generation
sequencing. Similarly, the possibility of online personalised genetic testing will require services to interpret, counsel and potentially screen at risk family members.

Service complexity is increasing, with no associated coordination, hampering the effectiveness of the service. Local capacity to extract DNA and undertake molecular genetic testing currently does not exist. This will be required as services expand.

**Connecting Care**

Connecting care is a relatively new way of treating and managing chronic diseases, primarily in community and ambulatory settings. It focuses attention on those people with unique clinical needs. There is high demand from Aboriginal people (though this may be under enumerated) and rehabilitation patients. Demand for the program is high and needs to be monitored to ensure the most appropriate people are targeted and receive access to the program. Attention is required to manage program access primarily through Medical Assessment Units, Ambulatory Care and Emergency Departments in hospitals, and the SWS Medicare Local, Aboriginal health services and GPs in the community. Relationships with these organisations must be strengthened to ensure patient needs are addressed across the acute and community settings, regardless of the hour.

The Connecting Care program is unable to access the level of community based health services required to meet current demand (e.g. hospital in the home and allied health). There is also difficulty in providing necessary equipment and supports for patients, in accessing pharmacy supplies, pathology services and 24/7 nursing and medical support. Within the community, there is insufficient space and capability to deliver chronic disease rehabilitation programs (e.g. pulmonary, cardiac and diabetes). Carer support and respite services are also unable to meet demand.

Relationships with the residential aged care sector in particular need to be improved to more effectively implement the program. For example, through the development of clinical pathways, use of telehealth facilities, and providing more education on chronic disease management to residential aged care staff.

**Diabetes and Endocrinology**

Incidence and prevalence of diabetes is increasing alarmingly for people with potentially preventable Type 2 diabetes and also to people with complex diabetes such as those who are Type 1 insulin pump dependent and those with complex care issues (e.g. obesity, multiple comorbidities and mental health problems). Treatment and management of Aboriginal people with cardiovascular disease and diabetes in the community is an emerging area of concern.

At present, the models of care for low acuity patients (including location of services) are inflexible and not sufficiently responsive to effectively meet demand. Those with more complex needs experience long delays in accessing the services they need. This is particularly notable in relation to ophthalmology for diabetic retinopathy assessment and obesity management/bariatric surgery services, osteoporosis and investigations for thyroid cancer. An ability to respond to new technology in diabetic patient management is also required.

Most sites have insufficient space to deliver the quantum of services required and in some cases services are located away from hospitals. Diabetic patients in hospital often have a longer than average length of stay and avoidable complications as their diabetes has not been appropriately managed or is made more complicated as a result of their admission. Improving the capacity of inpatient staff to respond to the needs of diabetic patients is imperative, as is assessing elective surgery patients prior to admission.
General Medicine

The role of general medicine in each hospital, including defining the relationship of general medicine to subspecialty teams is required. Clarity of roles and functions will support efforts to recruit to general medicine vacancies (medical) at all levels (specialist, registrar, residents, and VMO positions). Associated with this is the ability to provide 24/7 medical coverage at the smaller hospitals at Bowral and Fairfield, to address increasing after hours on call demand and activations.

Immunology

At present there are long waiting lists for allergy and immunology clinics (including food challenge services) which are experiencing exponential demand. No allergy specific dietician service is available.

In HIV/AIDS services, there is limited capacity to deliver specialised clinics e.g. primary immunodeficiency diseases, neuroimmunology and an increasing demand for neuropsychologists/clinical psychologists to support this client group.

Immunology services currently lack capacity to undertake preventative care and to actively collaborate with other clinical services in joint models, particularly for complex patients. This is in part due to a lack of medical and pathology staff.

Infectious diseases

Infectious disease services are experiencing an increase in demand (associated with both prevalence and complexity) due primarily to large numbers of new migrants and humanitarian arrivals with infectious diseases; increasing multi-resistant organisms and microbial resistance; and increasing medicalisation and complexity of medical treatment with a consequent increased risk of infection. There is limited data to quantify infectious disease issues or to monitor quality of services or outcomes.

The infectious disease service operates on a hub and spoke model, though with limited, if any, capacity at some sites. Supporting the increase in demand is a significant issue for the service, both at an individual level and in terms of prevention and control initiatives.

Due to a lack of alternative models, some people are admitted to hospital and utilise an acute care bed unnecessarily. Increasing existing outpatient service capacity would assist in addressing this issue, as would building the workforce to provide greater consultation and liaison with facilities, streams, GPs and the community based providers.

Medical Assessment Unit (MAU)(and Ambulatory Care)

Medical assessment or acute assessment units is a relatively new model which require strengthening to meet NEAT targets. To deliver efficient and high quality care, MAU’s should be established in close proximity to EDs, with ED staff educated and supported to rapidly assess and transfer appropriate patients. Current physical constraints and MAU service’s inability to deliver comprehensive services 24/7 make this problematic.

MAU’s are currently experiencing delays accessing diagnostic services (radiology and pathology) and in meeting targets to transfer patients to wards due to bed block in some cases. Improving access to medical coverage both internally and via improved communication with GPs to support ongoing care is required.

Neurology

Neurology services are experiencing demand which is unable to be met with the current supply of services. Although variable across hospitals, long waiting lists often exist to access neurology outpatient clinics (for
example for multiple sclerosis, dementia, epilepsy and neuroimmunology); EEG, nerve conduction and EMG services; and neurointerventional radiology, neuroaudiology, neuropsychology, clinical psychology and outpatient or community based allied health services. At present there is no capacity to provide paediatric neurology services within the District.

To supply these additional services there is a need to recruit medical and nursing staff and also technicians to perform specialised tests and to provide associated equipment e.g. nerve conduction, EMG and EEG. Additional physical space for outpatient services is required and additional inpatient beds (acute and rehabilitation). Enabling access to 24/7 inpatient EEG telemetry monitoring is necessary as is improved 24 hour access to stroke thromblyosis. Further, developing capacity to manage post stroke thromblysis patients on a neurology ward would free ICU space.

**Respiratory**

Respiratory services require additional inpatient beds and the establishment of high dependency beds to support inpatients on wards rather than in ICU. Outpatient service development and expansion is required, particularly sleep and respiratory failure (acute and chronic) and tuberculosis services. Enhanced access to community based nursing is required to reduce avoidable hospital presentations and admissions.

**Rheumatology**

Rheumatology services are primarily delivered in outpatient/ambulatory settings. Service demand and associated waiting times is increasing. Access to ambulatory care infusion services (hospital, community or home based) is limited and the service experiences difficulties in accessing the requisite level of allied health support. Particular areas of clinical demand unable to be adequately addressed include chronic vitamin D deficiency and osteoporosis case finding, investigation and management. Urgent assessment clinics to bypass ED are also required.

As there is little inpatient demand in rheumatology, nursing expertise is limited and the service has low attractiveness to the nursing workforce due to difficulties in accessing locally (Australian) based training.

**Critical Care**

Emergency Department services are variable across the District and are tied to the overall role of the hospital in which they are located. ED roles need to be re-determined, consistent with the future of the hospital and facilities designed, resourced and accredited accordingly. At present and to varying degrees, EDs experience high demand and overcrowding (often associated with bed block within the hospital system). This applies to the general population and to people with mental health problems in particular.

EDs can be expected to experience significant increased demands into the future, driven by population growth and ageing. Under current models of care it is not likely that the trend line for increased ED attendances (Figure 3.3) could be altered. The options for workload management within the ED are essentially to reduce length of stay e.g. earlier ward discharges freeing capacity for admissions or MAU/AAU capacity providing for earlier transfer of care to assessment teams; or through multilateral approaches in the community that alleviate necessity for ED attendance. Models such as the Ambulatory Care service including a HITH component provided in Macarthur have an impact, however this model is not provided outside that region.

Trauma patients and those requiring resuscitation demand significant clinical time at the expense of less urgent patients. Many of these less urgent patients could be more appropriately treated in alternative settings or through alternative models, if available. There is debate about what proportion of ED attendances could be treated in community general practice, with estimates ranging from 3% - 14%. Other studies have
demonstrated that the proportion of ED attendances that could potentially be treated in community general practice has decreased over time.\(^3\)

The Camden Hospital ED could be regarded as underutilised under the current model of care of ambulance bypass. Walk in patents however, require the presence of medical staff with emergency medicine experience.

EDs place a high demand on imaging and pathology services and experience long delays in getting results, particularly after hours. Meeting NEAT targets will be a significant issue without changes to current ED facilities and systems.

Maintaining paediatric expertise within the ED workforce, particularly with the high level of paediatric presentations at Liverpool and Campbelltown hospitals, remains an important consideration.

Anaesthetic services are required to be responsive to demand generated in other streams, both elective and emergency, both in and out of theatre. There are a high number of surgical presentations in ED after hours and on weekends which places strains on the system. Increasing patient complexity is also being seen, particularly in relation to drug and alcohol, pain management and paediatric services.

ICU/HDU services are also experiencing high demand and problems with intra-hospital and intra-District transfer. Opportunities to establish high dependency, specialist units (respiratory, neurology) on wards need to be explored.

**Drug Health (shared IDA network across SWSLHD and SLHD to be split 2013-14)**

Drug health services in SWSLHD are less developed than those in SLHD, with a small, specialised workforce; services which are physically isolated from each other and hospitals; and limited access to inpatient beds. Recruitment and retention of staff is a significant issue, particularly for medical staff. This situation is exacerbated by the fact that 50% of funding is project related and temporary (primarily targeted to illicit drugs through the 1999 Drug Summit and the Cabramatta Anti Drug Strategy).

Current deficits in service provision relate to inability to expand hospital consultation and liaison services, no after-hours medical cover at the District’s only inpatient detoxification unit (at Fairfield Hospital) and limited capacity for staff to manage medically complex patients. Previous planning has identified a need to develop services targeted to those with unique needs, delivered in partnership with other clinical services, for example to pregnant women, people with mental health issues and people with a chronic pain problem. Detoxification and needle syringe program capacity needs to be enhanced to meet current demand.

Managing the increasing number of intoxicated people presenting to EDs is also a significant and growing issue. There are no designated beds available and this can impact on achieving NEAT targets. However, a model for management of acute toxicology patients is under development, using a hub and spoke approach from beds co-located with Liverpool Hospital ED. Dedicated toxicologist staffing will be required, with the model seeking to link ED, mental health and drug health expertise in the management of patients.

**Gastroenterology and Liver**

Gastroenterology and liver services are experiencing a significant increase in demand for surgeries/procedures such as colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), gastro surgery, surgery to treat hepatocellular carcinoma (often associated with chronic viral hepatitis) and inflammatory bowel disease. Patients are increasingly presenting with comorbid conditions (particularly cardiac conditions) and other chronic care demands. The high rate of obesity in the community is making patients more complex to treat and is increasing demand for obesity treatment and management, including bariatric surgery.
Strategic Priorities in Health Care Delivery to 2021

There is a lack of knowledge in the community about the benefits of hepatitis treatments. In 2013, it is expected that demand for treatment will increase when hepatitis therapies become available on the Pharmaceutical Benefit Scheme. There is inadequate capacity to meet anticipated demand for this treatment.

There are insufficient endoscopic facilities in the District, with work is undertaken in procedure rooms in operating theatre areas, limiting throughput. There are no funded standalone endoscopic facilities in the District to improve efficiency and throughput and meet demand.

Current staffing models are unable to meet demand and additional access to theatres/endoscopic suites, with associated technology and supports is required.

**Laboratory Services**

Demand for laboratory services is dependent on the availability and scope of clinical services provided across the District. Growth in inpatient and outpatient activity and changes to models of care will impact to varying degrees. At present, the main workload for laboratory services comes from the Cancer stream, with cancer incidence and prevalence projected to rise in line with population growth and ageing.

Some additional demand will be able to be managed through improved technology (particularly in relation to anatomical pathology). Ultimately however, additional laboratory space and appropriately trained technicians will be required.

**Medical Imaging**

Medical imaging services must be responsive to changing models of care and the changing medical technology environment (in diagnostics and treatment). EDs generate the highest volume of radiology referrals, with much of the demand out of hours. At present there is limited reporting and review capability out of hours and limited access to ultrasound (which could, if available, reduce the demand for CT services). All acute facilities require access to ultrasound and 24 hour real time reporting through a networked hub and spoke approach with additional consultations available on-site.

Whilst demand is increasing rapidly for CT, MRI and interventional radiology, this demand is currently being met at the expense of general x-ray services. Specialised paediatric services are limited.

Demand for interventional radiology is growing and is currently dependent on VMOs from SLHD. Interventional radiology requires the support of anaesthetic services and a bed base that includes recovery and critical care.

There is a need to upgrade and replace medical imaging technology such as general and mobile x-ray equipment, digital radiography, nuclear medicine and PET. PACS/RIS technology at all sites is also required as is exploration of the use of teleradiology and private services.

**Mental Health (shared IDA network across SWSLHD and SLHD to be split 2013-14)**

As noted previously, people with a mental health issue have a reduced life expectancy associated with general morbidity including health problems associated with respiratory disease, impacts of prescribed medications, poor oral health and delays in accessing medical services. Many people with a mental health issue also have comorbidities and behavioural problems associated with drug and alcohol use, intellectual disability or other chronic diseases. The complexity of mental and physical health problems results in the need for a holistic mental health service, which is better integrated with the whole health system and enables transition of services across the life cycle.
As many people with a mental health issue do not have a GP, hospitals or community based mental health services are often the main access points to the health system. For many, this results in a presentation to the ED (often after hours). A large proportion of these patients require one off consultations only, primarily in relation to intoxication, illicit drug use and behavioural disturbance (elderly people from residential aged care facilities). Limited services are available after hours and not all EDs are adequately positioned to respond to psychiatric emergencies (in a PECC unit) or people with a severe behavioural disturbance. Forensic patients in particular have unmet needs.

There is a significant lack of inpatient beds for all sub-groups (acute, sub-acute, adolescent and older people). Additional capacity is required to deliver electromagnetic therapies for neurostimulation in the treatment of mood disorders. Similarly, there are insufficient community supports to prevent acute episodes and provide assertive support after discharge. Linking with other community service providers is considered valuable; however there are limited opportunities to co-locate with the non-government/private sector.

**Surgical Specialties**

Demand is increasing in all surgical specialties, particularly in reconstructive surgery (post cancer), ophthalmology and trauma. There is insufficient theatre capacity to meet current demand and problems are experienced in delivering requisite training for surgeons due to this lack of theatre capacity.

Balancing emergency and elective surgery demands is problematic. The increasing trauma patient requirements (particularly at Liverpool Hospital) have the potential to further increase delays in treatment for elective cases. However, access to emergency surgery is also difficult in some cases. For example, there are currently long pre-operative stays (beyond treatment benchmarks) in relation to fractured neck of femur (NoF) and hand injury. There is a need to establish and support networked service arrangements.

Post operatively there is insufficient access to rehabilitation (particularly highly specialised services) and post acute care (which results in a longer than necessary length of stay). There are also limited outpatient services and multidisciplinary clinics (such as assessment and intervention for hand, orthopaedics, osteoporosis, falls and injury/trauma).

**Oral Health (shared IDA network across SWSLHD and SLHD to be split 2013-14)**

Access to public oral health services is limited to eligible people only (based on age and income). Changes to Australian Government funding programs have resulted in increased expectations without clear strategies to manage demand, particularly in the long term.

Within the District, there is a high burden of oral health disease, with certain communities showing a lower oral health status than others. The dentate population is also increasing, primarily as a result of population ageing. Many older people require complex dental care as a result of systemic conditions, polypharmacy and the presence of multiple comorbidities.

Public oral health services are unable to meet existing demand due to limited physical capacity (community and hospital) and issues with recruitment and retention (particularly high competition from the private sector and an associated likelihood of attracting primarily young/inexperienced graduates). Additionally, costs of providing care are increasing at a rate not matched by funding increases. As a result within SWSLHD, there is an increased use of the Oral Health Fee for Service Scheme, which increases the cost of each service.
**Paediatrics and Neonatology**

Paediatric services within SWSLHD are limited with complex and seriously ill patients transferred to the Children’s Hospital Network. Increasingly this is an issue as that network reaches capacity and some children are diverted back to SWSLHD services. This situation, combined with the anticipated growth in the paediatric population particularly in the South West Growth Centre development, will require a broader range and scope of paediatric services from within the District.

There is growing demand in children and adolescents with chronic/complex conditions requiring multiple service interventions, including children and adolescents with mental health problems, developmental disability, obesity, chronic pain, genetic conditions and allergies. There are also gaps in the ability to transition from paediatric to adult services for those with long term conditions. At present, the District is unable to thoroughly respond to this level and type of demand, at individual sites or via a coordinated District network.

EDs experience a high volume of paediatric presentations, without the range of supports required to locally treat many patients. For example, there are insufficient or inappropriate paediatric spaces within ED, limited staff expertise and limited options for transition out of ED, either inpatient or outpatient. All of these challenges impact on the way in which NEAT targets can be achieved.

Inpatient services require expansion, along with associated capacity in paediatric imaging and surgery. Some paediatric units are relatively small in bed capacity e.g. Fairfield Hospital. These units have difficulty in providing paediatric after-hours medical coverage and have limitations in the categories of patients they can provide care for.

Paediatric mental health services, ambulatory care services and prevention initiatives, including community based services also need to be developed. Paediatric ambulatory care services (with outreach back-up) can enable faster discharge from EDs and wards. Enhanced expertise in paediatric imaging is also required.

Paediatric surgery services require expansion to meet MoH policy and community expectations. Currently there are two specialist paediatric surgeons providing a limited volume of planned surgery at Liverpool and Campbelltown hospitals, however paediatric surgeons do not provide emergency surgery cover. Planned surgery is provided for children by specialist surgeons in ENT, Orthopaedics, Plastics and Urology. A review is currently underway of policies and guidelines for the management of emergency surgery in children.

Complex paediatric surgery and surgery on infants will need to continue through a tertiary children’s hospital, however, further progress is required to embed a model of local self-sufficiency in provision of non-tertiary surgery for children. This would include hospitals being supported to provide non-complicated surgery for children less than 12 years old. A longer term goal would be to provide an expert hub in paediatric surgery networked to all the paediatric inpatient units. This would require a significant increase in the critical mass of paediatric surgeons operating within the LHD.

A continued focus on child protection and the health needs of children in out of home care is also required.

Neonatal intensive care unit (NICU) services currently experience overcrowding and there is no paediatric high dependency service. There is currently a concerning number of hospital acquired infections in NICU. Upgrade and expansion is required.

**Population Health (shared IDA network across SWSLHD and SLHD to be split 2013-14)**

Population Health, along with direct clinical services, is experiencing challenges in meeting service expectations and demand as rising costs are unmatched by additional, recurrent funding.
The implementation of new legislation, as well as mandated state and national initiatives, often creates an increased workload and an inability to respond to local priorities. For example, through changes to the Public Health Act and Protection of the Environment Operations Act and increasing complexity of the Childhood Immunisation Schedule.

The changing profile of the population requires ongoing revision in the nature of services provided by Population Health and the initiatives undertaken. At present, key issues are population increase and demographic changes; tobacco consumption; overweight and obesity; hepatitis B; health effects of climate change; the development of Medicare Locals; urban development; health equity; and increasing numbers of refugees and asylum seekers. Monitoring infectious diseases, managing outbreaks and promoting immunisation are critical roles of the Public Health Unit. Services need to be responsive to changing immunisation regimes and be capable of targeting high risk populations. Responsiveness to new levels of detection and tracing is also required.

Population Health will increasingly focus on sustained collaboration with clinical and non-clinical services (such as the Planning Unit and Aboriginal Health) to design and implement health promotion and illness prevention initiatives. Evaluation of these initiatives, particularly in terms of reducing health impacts on the individual and the health system, is critical to the delivery of evidence based practice. Similarly, there is a need for Population Health to lead investigation into reducing health inequality.

**Women’s Health**

Demand for women’s health services is increasing due to the increasing fertility rate, demand for public infertility services (with associated genetics services) and uro-gynaecology. Facilities, services and policies are variable across the District and standardisation is required to ensure equity.

For maternity services, an immediate issue is the low rates of presentation for antenatal care prior to 14 and 20 weeks gestation. Encouraging greater attention to and providing additional services for delivery of timely antenatal care is a major priority. Having a broad range of maternity models is also important, to ensure women receive the level of care they need in the most appropriate setting. At present, there are insufficient services across the District to enable women to be triaged appropriately (for example to GP shared care or midwifery led models). An increasing number of high risk pregnancies, requiring complex care are also placing a strain on the system, including women with mental health issues, drug/alcohol issues, diabetes, obesity and/or women from particular cultural backgrounds. Continuity of care, from antenatal to postnatal, regardless of the model, is required.

In birthing, there is a need to focus attention on achieving a higher rate of vaginal deliveries, through providing more intensive resources to support first time mothers and women attempting vaginal births after caesareans. A range of day stay and outreach options need to be provided, with post delivery support provided at home if safe and appropriate. Opportunities to improve breast feeding rates must also be explored. Improvements to equipment and infrastructure are needed, along with facilities for foetal medicine.

Access to theatres and anaesthetic services are an issue to varying degrees across the District, with difficulties accessing timely pathology services a problem at some sites.
8. Service Development Directions

A diverse range of issues and challenges for healthcare service delivery in SWMLHD were identified in Section 7, arising from the wide ranging consultation process with communities, community partners and clinical services. Future healthcare service delivery in SWMLHD will be designed to meet these issues and challenges head on, responding effectively to growing community needs in a coherent and integrated manner. The response will reflect in practice the core elements of the SWMLHD vision, mission and principles outlined at Section 4, demonstrating a collaborative approach through teamwork and partnerships, an emphasis on leading care and innovation with new and enhanced models of care evidenced as best practice; and a prime focus on healthier communities through embedding quality improvement, excellence, translational research and a focus on holistic health in service delivery.

The Principles outlined at Section 4 will be prime drivers in the way services are developed, with growth and enhancement in service delivery being shaped by imperatives to ensure:

- Equity in access to services for all communities across all levels of disadvantage
- High quality
- Courtesy, dignity and respect for all
- Patient and family centred care
- Engaged communities make informed decisions with autonomy
- Focus on the health of communities through multifaceted Population Health strategies
- Integrated and networked services as centres of excellence
- Growth in teamwork and partnerships
- A well trained and consulted workforce
- Rapid uptake of emerging models of care evidenced as best practice
- Efficiency, effectiveness and sustainability of service delivery

From the diverse range of issues and challenges identified in Section 8, some prime considerations drive and shape service development directions in SWMLHD. Prime among these is the high rate of population growth (overall 20% increase in ten years to 2022) that is projected to accelerate as new housing developments come on stream in South West Sydney over the next twenty years. An aligned demographic impact is the rapid increase in older age groups, with around a 50% increase in those aged 70+ years projected over the ten years to 2022. Older age cohorts disproportionately consume healthcare resources e.g. in 2010-11, 36.1% of the acute hospital bed days provided for SWMLHD residents was for those aged 70+ years; by 2021 it is projected that this proportion will rise to 41.7% of overall bed days and the total bed days provided to those aged 70+years will have risen by >70% (data sourced from FLOWINFO V11.2 and AiM2010).

Unique factors driving the public healthcare development agenda in SWMLHD include:

- High and sustained population growth
- Very high population growth in older age cohorts
- Lifestyle behaviours negatively impacting on health
- Socioeconomic disadvantage impacts on health status
- Access issues for many CALD communities to services
- Insufficient Infrastructure for growing demands
- Low levels and gaps in private healthcare supply
- Attracting a skilled workforce from an aging pool
- Meeting national and state performance targets
- Long travel distances and inadequate public transport
Service development directions will also take account of the issues raised by the community and consumers on their experiences in using public healthcare and how they would like to see services develop in the future. These issues were identified in the consultation process summarised at Section 7.2.

The community identified characteristics of SWSLHD services that were valued and that should be built upon in service development. This included positive examples of attitudes, interpersonal and clinical skills by staff and of collaboration and teamwork at an individual, population and agency level.

The complexity of the health system was identified as daunting and a barrier to better health, indicating that a service development focus on improving access and navigation through services was important. Addressing service access and availability issues such as hours of service, cost of care, location of service, gaps in service availability and transport difficulties was seen as a particularly important focus in service development. Initiatives to improve the interface between general practice and SWSLHD services were also considered very important in service development.

Improving communication between all stakeholders in care and initiatives to expand a skilled workforce to meet current and projected healthcare needs were also seen as prime goals in service development.

Clinical Streams and Service Networks also identified common themes that required service development. Enhancing services to appropriately meet the growing, changing and emerging clinical care needs from population growth and ageing is seen as the prime driver for clinical service development. Increased rates of chronic disease and obesity will require more complex interventions within a multidisciplinary framework. Enhanced models of ambulatory, outpatient and community care will be required to meet performance targets, minimise inappropriate hospitalisation and provide more timely localised service provision.

Workforce planning, job design, administrative support and enhanced emphasis on research and education were also seen as important goals in service development.

To coherently address these issues, a comprehensive range of service development directions have been identified, traversing corporate and clinical practice. These directions are addressed in four themed areas:

- Corporate and organisational directions
- Model of care development for clinical streams and service networks
- Addressing the needs of priority population groups
- Enablers for clinical practice

The community, consumers and partner agencies identified several priority populations where service development should be emphasised, including:

- **Children** – community based therapy, ambulatory care, family centred practice, chronic care, transition to adult services, childhood obesity
- **Carers** – engagement into client care plan, flexible support services, advocacy, carer stress, respite, information and education
- **Cultural diversity** – health literacy, liaison services, bilingual practitioners, translation and interpretation
- **Mental health** issues – physical needs, coordination and case management, continuum of care, family centred practice, respite and inter-agency liaison.
- **Aboriginal people** – hospital liaison, health literacy and targeted services
8.1 Corporate and Organisational Directions

To complement and support the long term strategic direction in this Plan, Directions to Better Health - South Western Sydney Local Health District Corporate Plan 2013 – 2017, identifies District-wide corporate action required over the next five years. These actions are consolidated under eight Areas of Action, each reflecting an important corporate area where organisational values and vision can be included into the day to day operation of health services. These areas are interconnected and progress across all will be required to ensure that services meet the identified needs of local communities.

The Areas of Action are reflected in the Framework for Corporate Strategic Direction on the next page. The framework requires all corporate action to be underpinned by the shared core values and vision for the health of the communities of South Western Sydney. In turn these corporate actions will drive improvement and change.

The following summarises the directions proposed.

Corporate Action 1: Providing High Quality Health Services

The District will develop and deliver quality services at a District and local level. Through clinical governance and corporate structures and systems, quality will be monitored and new programs will be implemented to improve health service. Strategies to be implemented will:

- Develop the communication skills of staff and improve communication across the health system and with partners through effective systems
- Build the ability of staff to treat patients, community members and service providers with dignity, respect and in an ethical manner by implementing programs which consider end of life issues, the specific needs of Aboriginal people and people from other cultures and ethical practice
- Improve the quality and safety of health services through involvement in accreditation processes, implementation of infection control and other strategies focusing on specific aspects of care, and meeting NSW and Commonwealth targets for timeliness, activity and readmission
- Improve the patient experience by using information from patient surveys and complaints, and dedicated programs to improve patient care
- Strengthen early intervention and health promotion and illness prevention through multifaceted programs usually undertaken in collaboration with other agencies and the community. The programs will cover areas such as Families NSW, overweight and obesity, Aboriginal health, mental health promotion, falls, tobacco control, risk drinking, blood borne viruses and healthy environments; and increase vigilance and responsiveness to major disasters.

Areas for Corporate Action

1. Providing High Quality Health Services
2. Community Partnerships
3. Seamless Networks
4. Developing our Staff
5. Research and Innovation
6. Enhancing Assets and Resources
7. Supporting Business
8. Efficiency and Sustainability
Corporate Action 2: Community Partnerships

Communities have a significant role to play in health services - in service planning, in service provision through volunteering, in health research through active participation in clinical trials and other forms of research, in working with health services to meet patient needs or to provide support services, and in building physical capacity through donations and philanthropy. Different approaches will need to be developed to ensure that individuals, communities and business can contribute.

Integral to service development and delivery will be partnerships with patients, clients, carers and the community. Services will draw on the expertise, experience and diversity of community members. Health literacy will also play a key role in building effective partnerships with the community. Strategies to be implemented will:

- Engage and involve stakeholders in planning, service development and delivery using the SWSLHD Community Participation Framework, building the pool of consumers willing to participate in research, become a volunteer or provide expert consumer advise at a local and strategic level and build relationships with local Aboriginal health agencies to improve the health of Aboriginal people
- Increase fund-raising for health within the community and business sectors
- Raise the profile of the District locally through timely and accurate information associated with implementation of the SWSLHD Media and Communication Strategy
- Empower individuals and local communities to make informed health choices through use of a range of technologies which provide information to strengthen access and choices; and by implementing collaborative strategies to build health literacy.

Corporate Action 3: Seamless Networks

The health of individuals and communities depends on access to health services and also social determinants of health such as education and employment. Health improvement will require input from all health practitioners across public, private and primary health care settings and close collaboration and coordination with other government agencies and community based services. Strategies to be implemented will:

- Ensure active participation in regional and local forums to build capacity to respond to emerging needs, increase collaborative work with other agencies to address the social determinants of health and strengthen the partnership with the South Western Sydney Medicare Local
- Foster coordinated planning and service delivery in health care by developing models for integrated networks of care, strengthening access to state-wide and supra-District services and developing stronger service delivery partnerships with all health care providers
- Improve transfer of care and patient access to services within and between health facilities and with the community; improve information available about services; and work with Health and non-Health transport services to improve timely access to health services
- Strengthen access and support for high needs and vulnerable groups through the development and implementation of targeted plans and strategies. This includes initiatives such as implementing the Aboriginal Health Plan, continuing chronic disease programs, reviewing health interpreter services to better meet the needs of people from diverse communities, developing new Disability and Carers Plans informed by interagency initiatives, strengthening support for people with mental health problems and implementing stronger policies and procedures for children at risk.
Corporate Action 4: Developing Our Staff

The District will need to attract and retain skilled staff across all health professions and support services. It will also need to ensure that the skills and knowledge of existing staff are developed and that the workforce has the capacity and adaptability to adopt new practice, and skills needed to support innovation and change. Strategies to be implemented will:

- Develop a sustainable workforce that reflects and has the skills required to address community needs through implementing a workforce plan which focuses on using workforce information to guide decisions and education; further improvement of workforce development programs; a targeted approach to Aboriginal employment and collaborations with other education and workforce agencies
- Create an organisation that people want to work in by strengthening the programs required for a safe working environment and supporting personal and career choices
- Develop relationships with future employees by working collaboratively with universities, colleges of TAFE and high schools and building clinical training and traineeships.

Corporate Action 5: Research and Innovation

Health services and practices are evolving and changing with new evidence about better methods to respond to emerging needs and improve health care. Clinicians and health services will be encouraged to contribute to health improvement through innovation and research and use new health practice to improve health outcomes. Strategies to be implemented will:

- Foster an innovative culture and research capability through implementation of the District’s Research Strategy which focuses on building workforce capacity, incorporating research into new and existing health services, increasing clinical trials, building local leadership, further developing research facilities and providing additional support to the health research community
- Support innovation and best practice in prevention and clinical settings through strategies which recognise talent and showcase initiative, developing new models of care and focusing on clinical redesign and working collaboratively with other agencies to implement change.

Corporate Action 6: Enhancing Assets and Resources

The District will need to continue to identify and invest in capital infrastructure programs and new technology including information technology and ensure the efficient utilisation of existing resources. The District will also investigate and be open to new opportunities to develop health services for local communities. Strategies to be implemented will:

- Provide physical capacity to address emerging health needs and population increases by completing existing clinical and educational infrastructure projects, progressing planning for new projects across the District particularly development of mental health services, further developing information technology and actively pursuing new and innovative funding models. This includes progressing planning for priorities such as the Campbelltown Hospital Mental Health Redevelopment, redevelopment of Liverpool and Campbelltown Hospitals and the Bowral and District Hospital Redevelopment
- Respond to changes in the operating environment by regularly scanning the environment and identifying new clinical practices and changes in government priorities
- Ensure good stewardship of existing resources by developing an effective asset management, replacement and disposal plan informed by review of utilisation.
Corporate Action 7: Supporting Business

Clinicians and managers require access to appropriate and up-to-date information and data to support informed choices, monitor progress and develop new ways of care. New bedside technology and other applications will foster work practice innovation and business planning capabilities to ensure that existing and new services are viable. Strategies to be implemented will:

- Develop integrated and appropriate technology to meet the needs of clinicians, managers and patients through implementing an information management and technology plan, establishing single points of contact for services, using telehealth and related technologies to improve healthcare and participating in state-wide IT projects which foster integration. An important direction will be to further develop the electronic medical record to include capacity to support research, link with pathology services and enable access for general practitioners.
- Develop business intelligence and decision support capability through adoption of new ways of integrating data and information, supporting clinical services in their planning, linking performance to planning and activity and improving business planning capability in costs and benefits.

Corporate Action 8: Efficiency and Sustainability

Recent changes to funding models will drive change in how services are funded, provided, organised and measured. This will also create new risks which will need to be managed. Threats created by environmental change also require consideration. Strategies to be implemented will:

- Strengthen the financial sustainability of the District through a robust financial framework and processes, workforce development on activity based funding and financial management, improved recording of activity and coding, a efficiency and revenue plan, improved procurement strategies and a focus on meeting financial and activity targets.
- Minimise risk through strategies which strengthen governance, identify risks and focus on risk management including disaster recovery.
- Contribute to environmental sustainability through implementation of a District-wide sustainability plan, building sustainability into infrastructure maintenance and replacement and a focus on energy use reduction.
- Ensure efficiency of services through service review, reengineering and disinvestment. This includes planning for and increased appropriate use of subacute beds as an alternative to the inappropriate use of higher cost acute beds.
- Strengthen governance through targeted education for Board members, Executive, senior managers and clinicians, and other staff, with better governance processes and strengthened decision making and reporting, linking organisational performance requirements to the corporate and operational plans.

8.2 Model of Care Development for Clinical Streams and Service Networks

Consultation with the SWSLHD Clinical & Quality Council, Clinical Streams and District wide services identified the core service development directions to provide the framework for strengthening clinical networks, disseminating best practice models of care and addressing key clinical and other issues for the next ten years.

This process built on previous planning processes which had identified service development directions of continuing currency, some of which had been documented in formal Plans (Appendix A12). In other instances, clinical directions had been broadly defined by senior clinicians and progressively developed and implemented.

Collegiate debate occurred across streams and the use of C&QC as the mechanism for shaping coherent service development strategies and clinical network building across SWSLHD. It ensured that the matrix of
healthcare delivery proposed for the future reflected current and emerging clinical practice, government policy and an effective response to current and projected needs of local populations. For each clinical stream/district wide service, a service development profile was identified in three critical areas:

- model of care
- service development directions
- partners in service development

Appendix A18 provides detail of what was identified in these critical areas. There will be resourcing implications in moving to implement the models of care outlined. Further detailed business case planning will be required to clarify the full extent of these implications and whether funding sources can be identified to facilitate implementation. This would include enhanced and revised staffing profiles to enable the model of care to be effectively applied. These requirements would be the subject of detailed workforce and financial impact planning to occur progressively over the next decade and will not be addressed in detail in this Plan.

This Section focuses on the underlying themes in models of care development which will be applicable across most of the clinical streams and services networks over the coming decade. In particular three key overarching concepts are seen as important underlying constructs in model of care development:

- Optimising partnerships with external providers of care to improve access and choice for patients to care
- Supporting all services in achieving excellence in care provision
- Enhancing and strengthening clinical networks to improve timeliness in access to high quality care

**Partnerships with External Providers of Care**

The healthcare operating environment in NSW is now favourable to partnership development with the private sector to provide aspects of healthcare for public patients from within a private paradigm. The term Public Private Partnerships (PPP) has been used describe broad partnerships between private contractors and government, in which the common characteristics are that the public sector contracts (usually on a long term basis) with the private sector for the provision of a public service. They have normally been associated with infrastructure development such as in the Design, Build, Finance and Operate (DBFO) model with the private sector contracted to finance, rebuild or replace a public asset and maintain that asset for a concession period, usually between 20 to 30 years.

Models of private participation in healthcare are summarised in the adjacent information. In this Plan the term PPP is sometimes used to refer to a

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**Models for Private Participation in Healthcare**

Models for private (for and not for profit) participation in healthcare delivery, ranked from low to high private risk and responsibility include:

- **Service contracts** e.g. to provide radiology in a hospital or a health education program in the community
- **Management contracts** - to manage a public program either with full responsibility for service delivery (contracting out) or from within a public organisational structure (contracting in)
- **Lease** - private entities pay a fee to government to manage and use public healthcare facilities, accepting risk in exchange for a revenue stream
- **Concession arrangements** – private entities operate and maintain public healthcare facilities and assume responsibility for capital investment, usually under long term contract with eventual transfer back of assets e.g. build-operate-transfer (BOT) contracts
- **Divestiture** – transfer ownership of public healthcare facility to a private entity e.g. build-own-operate (BOO) contracts
- **Free entry** – private providers can freely enter and exit the healthcare market without a contractual relationship, but usually under regulatory oversight through licensing, certification and/or accreditation

**Source:** Marek et al 2003
broader range of arrangements with external providers of care, beyond infrastructure development to encompass integrated service delivery arrangements. For partnership arrangements, it would extend beyond the traditional “private” sector across tiers of government and with non-government and not for profit organisations.

Mixed public/private arrangements range across many aspects of healthcare provision. This includes infrastructure development, in full service procurement from the private sector for public patients, attracting private funding sources to support operating income, and in private operation of public assets. The box highlighted below provided additional information about options for private participation in hospitals86. Also partnerships with non-government organisations and not for profit entities in service provision are increasingly seen as opportunities for improved access and greater patient choice.

Nationally, there are a number of different PPP type arrangements in operation which could inform development of these models. This includes co-location of public and private hospitals; providing only a privately referred model in hospital outpatients; private services providing public care e.g. radiation oncology models in WA; privatised and not for profit services within public hospitals e.g. cardiac catheterisation laboratory models at RPAH, PoW and RNSH; purchasing treatment and care in the community e.g. TACP; Silver Chain in WA; and the not for profit operation of 3rd Schedule health services.

SWSLHD already has some arrangements with the private sector for the provision of services to public patients. This includes arrangements with the Sydney Southwest Private Hospital and the Southern Highlands Private Hospital. Partnerships with the not for profit sector are also in place through agreements with Affiliated Health Organisations and with non-government organisations to operate services from Health owned properties or using public Health funds. There is also a close partnership with the SWSML which extends to aspects of service provision, such as through the Connecting Care program and in joint planning exercises. These relationships will strengthen in time as further collaborative programs are developed, with a strong sustained relationship with general practice being required to implement IPCC models across SWSLHD.

Partnership arrangements across tiers of Government have also been utilised in infrastructure development e.g. the IIAMR building and in work with Councils. There are also State government inter-agency partnerships in service provision e.g. school health clinics and population health work with Housing NSW.

SWSLHD is being encouraged to be proactive in exploring further private and non-government partnership opportunities. However, this needs to be explored in the context of the current paucity of private healthcare provision in SWSLHD, in private hospital beds, in private specialists in practice, and in general practitioner and

Options for Private Participation in Hospitals

For hospital services, a range of options have been identified in the literature for the private sector to participate in the provision of care to public patients:

- Co-location of a private hospital/wing for private patients, which may also treat public patients under contract
- Outsourcing non-clinical support services e.g. cleaning, catering, laundry, security, maintenance
- Outsourcing clinical support services e.g. radiology and pathology
- Outsourcing specialized clinical services e.g. specific services such as ophthalmology, orthopaedics
- Private management of a public hospital under contract
- Private financing, construction and leaseback of new public hospital
- Private, financing, construction and operation of new public hospital
- Sale of public hospitals as going concern under contract
- Sale of a public hospital for alternative use

Source: Taylor et al, 2002
private allied health service availability in some regions. It also needs to be cognizant of the risks in entering into these partnership arrangements which revolve around issues such as:

- The need to build in profit margins to induce private sector involvement
- The impact of volume and income guarantees inhibiting longer term efficiency dividends that would be driven in a truly competitive arrangement
- Private sector reluctance to take on less profitable services or services where government health systems have an in-built competitive advantage e.g. frail aged, mental health, critical care services
- Private sector incentives to focus on episodic care with low complexity and high throughput to maximise profit return, even though these services could be profitable for public hospitals with efficient practice under ABF arrangements
- Service fragmentation with public healthcare required to provide a range of unfunded support services outside of the payment to the private sector for the episode of care
- Impact on the ability to maintain and enhance the workforce in the public system
- Ability to maintain oversight of performance against benchmarks in quality and effectiveness over the long haul and enforce rectification for non-compliance
- Flexibility to cope with unseen fluctuations in demand, the impact of evolving models of care and technological innovation and changing health needs and clinical demands of local populations
- Expertise to navigate complex legal, technical and financial transactions, in the context of lack of standardised processes and limited expertise in risk management and contract negotiations
- The impact on non-marketable aspects that underpin quality healthcare provision e.g. education and research
- Management and impact of labour costs, workforce award and entitlement issues and differentials between workplaces
- Maintaining political willingness and commitment to bring PPPs to implementation within an appropriate timeframe for optimising investment outcomes and avoiding penalty costs
- Appropriate sharing of risk e.g. in acquisition of technology and professional development

In addressing opportunities for further PPP type arrangements, a number of principles have been identified which SWSLHD would see as fundamental prerequisites for detailed negotiation with private proponents. These include:

- There is no detriment and preferably an enhancement to patient access and choice of service
- There is no detriment to the quality of services provided, with quality outcome indicators clearly delineated, monitored, reported and non-compliance rectified, within a quality improvement framework
- Avoiding establishment of a second tier service for public patients who cannot or choose not to receive care under a PPP arrangement
- Services where the LHD has the capacity and capability of providing efficiently as a profit line under ABF or other funding mechanism will not be considered for PPP provision, given the additional transaction and contract costs and higher risk profile
- Cost neutrality over the lifetime of the PPP arrangement, amortising transaction and set up costs over the lifecycle and appropriately accounting for the risk and opportunities from evolving healthcare practices
- There will be no detriment in equity for disadvantaged populations, not only in access by issues of geography, transport and out-of-pocket costs; but also in terms of the social determinants of health and issues of cultural and ethical appropriateness and community acceptance
Minimising the risk of market distortion in unintended systemic consequences in public health services e.g. increasing emergency department usage, raising demand for public provision of services in the community in services such as post-acute care, aged care, community nursing and mental health

Maintaining core model of care concepts within service provision including respecting patient dignity and empowering participation in care, providing integrated care, seamless transition between settings of care, multidisciplinary teamwork, active participation in networks of care and commitment to education and research to build excellence

There is no detriment and preferably an enhancement to the interconnectedness of care providers including shared access to core elements of the medical record

Incremental development of PPP arrangements, trialling and piloting, sharing the lessons learnt and building the base of expertise in PPP delivery mechanisms

There are a number of areas of healthcare where SWSLHD could consider service provision within a PPP paradigm. These include but are not restricted to developments such as:

- Diagnostic and interventional laboratories within public hospitals – cardiac catheterisation, interventional radiology, endovascular, cardiac and pulmonary diagnostics, etc.
- Medical specialty centres in the community providing a range of day procedures – day surgery, endoscopy, ambulatory cancer care, etc.
- Enhancing a PRNIP medical centre specialist model of care for ambulatory consultancy, diagnostic and minor procedural services
- Full service procurement in the private sector for high demand and projected high growth specialties where there are difficulties in meeting current demands e.g. orthopaedic surgery
- A private model of care within public hospitals with quarantined patient flow for elective high volume surgeries such as minimally invasive and endoscopic surgery
- Providing IPCC centres in the SWGC and establishing an IPCC model of care incorporating general practice within existing community health centres that have capacity to enhance service provision
- Chronic care services provided within the community strengthening existing links with the SWSML
- University ambulatory care clinics
- Medical imaging provided from SWSLHD hospital sites
- Privately referred outpatient clinics and the formal involvement of GPs in shared care arrangements, in providing health services and referring patients back to GPs for ongoing care

Section 9.7 provides further discussion of PPP opportunities in infrastructure development.

**Supporting services in achieving excellence**

All services within SWSLHD aspire to providing excellence in care. For some services, the pursuit of excellence has enabled development to a reputation as a “centre of excellence”. These services attract high quality staff, build expertise, utilise best practice models of care, have strong university affiliation, commit strongly to teaching, attract external funding and foster research that translates to clinical practice. They cover a diverse range of care types including:

- Trauma (Liverpool Hospital)
- Medical Emergency Teams (MET)
- Neurosurgery (Liverpool Hospital)
- Gastroenterology (Liverpool Hospital)
- Rheumatology (Liverpool Hospital)
• NSW Refugee Health Service
• Upper Gastrointestinal Surgery (Bankstown-Lidcombe Hospital)
• Cancer Services (across the District including Radiation Oncology, Medical Oncology and surgeries such as Adrenal Surgery)
• Brain Injury Service (Liverpool Hospital)
• Centre for Health Equity Training Research and Education (CHETRE) (social research focus)
• Gudaga Project (which aims to understand and improve the health of urban Aboriginal families)

Services developing as centres of excellence need a strong overarching brand that is neither facility nor profession specific, have in place sustained community engagement and develop a national (and sometimes international) reputation. Normally, a high volume of activity would be expected through a centre of excellence to provide the critical workload mass that enables high quality staffing, education and research. Centres of excellence have a strong leadership role for the District, enhancing the District’s reputation, confidence and the ability to attract highly qualified staff who expand District funding sources through enhancing grants, charitable donations and fund-raising. They are also potent attractors for young and enthusiastic junior staff and trainees with ambition to learn from the best.

Leadership from centres of excellence also extends to supporting less developed services to optimise their performance within their funding availability through example, support and identification of minimum standards of care to be applicable across the District.

Centres of excellence would normally take a prime role in a network of care extending across a broader region or the whole LHD. This could be as the hub of a hub and spoke model or as one centre of a binary or ternary arrangement of relatively equal partners.

Through their leadership within networks of care and high levels of expertise, education and research, Centres of excellence are prime drivers in achieving core aspects of the LHD’s vision for collaboration and innovation.

Clinical streams and services with potential to build on already high levels of excellence and enhance their status and reputation as centres of excellence include:

• Cancer services – a unique service with high quality research, well linked with Universities and IIAMR, providing strong leadership with high quality staff and a reputation that leads to referrals from outside the District
• Cardiology – high volume services in echocardiography and interventional cardiology, a reputable and desired site for training
• Trauma – a supra-District role with a large quantum of patients and well established research focus
• Education – through the new Simulation Centre with skills training across all disciplines and with the new Nursing Education Centre’s District wide focus

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- Mental Health – high demand and volumes of patients, projected to increase significantly
- Population Health – established expertise and reputation in equity and urban design and strong partnerships with councils, universities and the urban planning industry

**Strengthening Clinical Networks**

Continuing maturation of clinical networks is an important overarching construct informing model of care development. Clinical network in this context refers to an intra LHD operational network linking a clinical service across sites of service provision with integrated service provision. It does not refer to the broader concept of a clinical network such as the ACI clinical network model that aims to disseminate knowledge, protocols and guidelines on evidence based care, with a systemic focus on models of care and service redesign.

An important aim of clinical networks is to break through historical professional and institutional boundaries with effective processes of care that focus on patient outcomes and effective partnerships which ensure equitable provision of high quality clinically effective services. The focus is on best clinical practice rather than institutional autonomy.

Clinical networks move beyond sharing best practice and alignment of policies and strategies between institutions to engender new integrated service delivery structures. Clinical networks seek to address common issues faced by most services in optimising service delivery:

- Continuity of care involving different providers in different settings
- Using resources efficiently, managing growing demand, reducing unnecessary duplication of services
- Recruiting and retaining highly skilled staff and flexibly using their skills
- Addressing inequities in health outcomes
- Improving service access for disadvantaged populations and sustaining access in low-density and isolated communities
- Matching clinical expertise and skill, the viable caseloads to maintain those skills, and public expectation about the accessibility of services
- Disseminating evidence-based best practice and improving access to teaching and research

Clinical networks have been expanding across SWSLHD and the strengthening and enhancement of these networks is a prime focus of the Clinical Streams. There is however, some variability in the extent to which networks have been able to establish strong and sustainable networks. Services such as the emergency departments, aged care and rehabilitation, mental health, drug health, orthopaedic surgery, renal and cardiology (hub and spoke) have well established networking arrangements in place.
Liverpool Hospital, as the Principal Referral hospital for the District and with its enhanced capacity from the redevelopment, will continue to play the prime role in most clinical networks, supporting facilities operating at a lower level. It would normally assume the hub role in hub and spoke arrangements. Campbelltown Hospital as it develops towards Principal Referral hospital status will increasingly play a more senior role in clinical networks, serving as the hub for some networks or developing binary or ternary arrangements of equal status partnerships with other hospitals within the network. Bankstown-Lidcombe Hospital could also serve as the hub for some networks based on the centres of excellence that develop there and participate equally in some binary or ternary arrangements.

The imminent quinquennium clinical appointments round for VMO contracts and Department heads provides an opportunity to further energise the enhancement of clinical networks. Also, there is opportunity to re-engineer medical training arrangements such that trainee rotations for junior medical staff are increasingly intra-District rather than to external hospitals.

Defining “Model of Care”

Model of care as a concept is not definitively defined in the literature. It has been defined broadly as a “multidimensional concept that defines the way in which health care services are delivered” or “the structures of healthcare and the processes they deliver”. Normally a description of a model of care would address issues such as who delivers the care, where the care is delivered, when the care is delivered, the process for patients to get in and out of the service, etc. It should describe best practice care and services which “ensure people get the right care, at the right time, by the right team and in the right place”.

Models of care are constantly evolving in international, national, state and local healthcare systems. As background to the models of care discussions at the workshops of Clinical & Quality Council, published information on recent trends in clinical practice and emerging models of care within the clinical disciplines was made available to clinicians and managers. This information is included at Appendix A17 and was derived from contextual information included in the 2010 process to update the Ministry of Health’s inpatient projections methodology.

SWSLHD clinicians, managers and community representatives have also participated within ACI working groups refining models of care for application across NSW. These participants were able to bring their knowledge of progress in that process to the workshop discussions. From these discussions a number of overarching issues were identified as requiring consideration in the evolution of models of care into the future.
The WA Department of Health definition provides a useful way in identifying core model of care themes that SWSLHD will pursue into the future. In effect it provides a structure within which model of care development can be pursued identifying the core considerations requiring attention.

The core considerations in model of care development can be expressed as:

Providing the

*right services*

By the

*right team*

In the

*right place*

At the

*right time*

SWSLHD will systematically review current models of care and assess refinements and future developments in models of care against these criteria. This will be the prime responsibility of a high-level committee reporting to CQC who will on a rolling program across clinical disciplines scan emerging models of care and assess aspects of current models that require refinement to fully meet the criteria.

The consultations identified a range of model of care developments which will be explored within this schema. Diagrammatically these can be represented as follows.
## Core Elements in Models of Care Development

### Providing the right services
- Transitioning care provision to community settings (where this is appropriate)
- Boosting ambulatory care services
- Establishing centres and hubs of excellence
- Ambulatory assessment clinics
- Providing new treatment paradigms and technology that are based on evidence
- Rapid pathways in transitional research to the bedside
- Adopting new and validated models of care e.g. ACI models

### By the right team
- Multidisciplinary teemed care spanning settings
- Enhanced multidisciplinary outpatient clinics and ambulatory care
- Partnership links between service providers
- Integrated service provision in chronic care – single point of entry
- Community based models of care
- Embedding primary care within treatment teams
- Empowering general practice as the prime care coordinator e.g. chronic care, oncology follow-up
- Increasing use of nurse –led models

### In the right place
- Seamless service provision across the community – hospital spectrum
- Technology enabled transition of care to community settings and the home e.g. TeleHealth, NBN, PEACH model
- Providing services within RACFs
- Increased use of outpatient and ambulatory settings e.g. acute assessment, rapid discharge
- Using alternative settings to inpatient wards e.g. short stay ED, HITH, day hospital
- Managing higher dependency patients on home wards
- Enhancing ambulatory care e.g. infusion services, detoxification
- Transitioning surgery from main theatre blocks to day surgeries, from day surgeries to procedure spaces and ambulatory care, from hospital to community centres.

### At the right time
- Meeting benchmarks for waiting time to surgery
- Meeting benchmarks for ED waiting time to definitive care
- Ensuring diagnostic and treatment times for time-critical interventions are maintained within reasonable limits e.g. chemotherapy, radiology, radiotherapy, pathology
- Enhanced and flexible 24/7 work practices
- Enhancing after hours cover
- Optimising flow through inpatient acute assessment units
- Ambulatory acute assessment clinics
- 24 hour emergency response models under specialist teams
- Outreaching to vulnerable communities e.g. home visiting, community centres
- Real-time consultant diagnostic reporting
The principles underlying this classification and examples of model of care developments focussing on each of these aspects can be characterised as follows.

**Providing the right services**

The principle is that models of care are evidence based as efficacious, aiming to display best practice. It implies a review and evaluation framework where care is monitored and outcomes benchmarked. Models are adapted as evidence changes and where the evidence is unavailable or equivocal, participation is within the ethical framework of scientific enquiry – monitored, measured and evaluated. Where there is evidence of no or little benefit to patients, models are refined and changed to more effective ones. Through this process a focus on consistency and efficiency of care remains forefront.

As new models of care and clinical innovation emerge, strong research foundations ensure the testing of new ideas through clinical trials and clinical redesign. Resourcing is aligned to models that provide a positive impact on the patient journey at optimal cost-benefit.

At Appendix A18 a range of model of care developments are advanced which over time will see models of care evolving towards what the evidence base suggests are the **right services**, including:

- Emphasis on providing more and a greater range of care in the community - preventative care programs (through general practice, Medicare Local, community health centres, integrated primary health care centres), Compacks, community development
- Boosting and developing Ambulatory Care services so that they are involved in patient management and investigative workup, with enhanced use of Hospital in the Home services, expanded use of day hospitals and enhanced use of connecting care program
- Establishing new and building on existing Centres and Hubs of Excellence, including potentially in hepatology and hepatocellular cancer; Inflammatory Bowel Disease (IBD); pelvic oncology; head and neck cancer surgery; thyroid surgery; bariatric services; oesophageal surgery; hepatic surgery; complex colorectal surgery; gastric surgery; pancreatic surgery; paediatric surgery; hand surgery; oral health and dentistry; onco-plastic breast assessment and treatment; gynaecological oncology; melanoma management – all with robust multidisciplinary clinical services, interacting through MDTs and providing significant research activity and leadership, with specialist in hospital nursing for support & early post-operative discharge, improved coordination between GPs & discharge nurses for early post-op discharge and community nursing support. Centres of excellence will also extend to critical care services, particularly in EDs and ICUs
- Caring for the dying patient – widespread adoption of evidence-based end of life care planning and Advance Care Directives
- Integrated psychosocial care for patients across all facilities
- Increased and more effective use of electronic communication, scheduling and telehealth applications, wireless connectivity between primary and secondary providers
- Establishing Urgent Specialist Assessment Clinics - to review patients referred urgently from GPs or other specialists for management of acute conditions, especially where ED presentation is inappropriate
- Ensuring patients from south west Sydney have access to digital and robotic surgery
- Diffusing new treatment paradigms e.g. proteomics, theranostics (finding the right target for the right patient), immunohistochemistry and somatic genetics – all supported by comprehensive data bases, interlinked imaging and laboratory processes and a major focus on molecular based research
- Ensuring a rapid pathway between translational research and the bedside
- Ensuring a vibrant research environment that complements the clinical services provided
- Developing an osteoporosis case finding, investigation and management service led by for example a nurse coordinator (ACI fracture prevention model of care)
• Increasing collaboration through the redevelopment at Bowral Hospital to create a Critical Care “Hub” with HDU and ED.

By the right team

The principle is that models of care increasingly reflect multidisciplinary care practice, with formal and informal links between health professionals and across jurisdictions, within the framework of patient centred care involving patients, carers and family in care planning and decision making. This principle extends to models that focus on action with communities or populations. Training and education enhance the competencies of the team in providing care, including that of the patient in self management or the community in capacity building.

Clear delineation of team member roles clarifies leadership, governance, care and handover responsibilities. Job and system redesign ensures that care responsibilities lie at an appropriate and cost effective competency level.

Formal systems, infrastructure and support are required to facilitate linked up action, with streamlined referral pathways, joint sharing of protocols, guidelines, care plans and joint access to information technology that underpins quality care provision.

At Appendix A18 a range of model of care developments are advanced which, over time, will see models of care and supporting systems evolve to facilitate linked-up care by the right team, including:

• Development of multidisciplinary Ambulatory/Primary Care super centres as one stop shops that general practice can refer complex patients to, providing minor diagnostic and operative procedures including endoscopies and cataracts, intravenous infusions, specialist cardiac and respiratory nursing support, diabetes educators and allied health such as physiotherapy, occupational therapy, social work, speech pathology, podiatry and dietician. These could be at hospitals, community health centres or integrated primary and community care centres

• Development of better models of effective interaction between Medicare Locals and acute care providers, and increased support for evidence-based GP follow up across a range of chronic illnesses, including diabetes and cancer

• Effective use of discharge planning services, ambulatory care, community services and the connecting care program to help early discharge and prevent readmission

• Partnerships with key service providers in case management meetings and increased involvement in the planning processes of partner services e.g. Families NSW, acute facilities and the SWS Medicare Local

• Seamless management of patients with infections by the ID team through the ED, inpatient care, acute ambulatory care, and in the community through hospital-in-the-home and chronic disease management; facilitated through closer collaboration between the ID team, the general practitioner and the community nursing service.

• Nurse led models of care - advanced nursing roles in anaesthetics including nurse practitioners for minor sedation procedures; increased utilization of nurse practitioners and assistants; expansion of Midwifery-led models of care; and further development of cancer care coordination and nurse practitioner roles

• For diabetes care, enhancing multidisciplinary clinics e.g. diabetes in pregnancy (with obstetricians, midwives, renal/hypertension service), diabetes high risk foot clinic (with Infectious diseases, ambulatory care, vascular, orthopaedics); diabetes/renal/hypertension; neuroendocrine (with neurosurgery); thyroid (with nuclear medicine and head and neck surgery); complication screening; diabetes pre-admission to prepare poorly controlled patients with diabetes for elective surgery; Aboriginal diabetes/cardiovascular risk

• For management of obesity enhanced multidisciplinary care clinics for those with obesity, arthritis, diabetes and other complications of obesity; providing a comprehensive multidisciplinary service
• Establishing an integrated osteoporosis service - with rheumatology, orthopaedics, allied health, nursing, general practice
• Bringing together services that span hospitals and community with unified peer support, data sharing, safety and quality benchmarking etc; closer relationships with general practice, through electronic referrals and discharges, single point of contact etc; closer integration with community health services; close liaison with the SW Medicare Local to ensure integrated primary care occurs, supported by electronic systems to enable GPs and others to access the patient’s medical record post-discharge
• Increasing management of sicker patients in the community shared with the general practitioner, supported by drop-in hospital assessment clinics or hospital visits to GP assessment clinics;
• Availability of life-saving support for the critically ill in Emergency and Intensive Care Units, with clear protocols for the transfer of care back to inpatient specialty teams
• In care of frailer, old and chronic care patients, expanded partnerships in care provision, including in the falls prevention and management program and collaboration with SMHSOP services; developing new models of care in the ED for older people using an enhanced ASET model; prompt triage of chronic care patients seen in EDs, MAUs and Ambulatory Care Units to the appropriate service e.g. connecting care, HITH, aged care services, GPs; linking Connecting Care staff more closely with acute facilities especially EDs; development of a single point of contact for aged patients and patients with a chronic condition to a centralised service encompassing all aged care services, all community health services, HITH, connecting care, rehabilitation services etc.
• Strengthen the emphasis within MAUs on an assessment unit model, moving beyond an admission unit model, including the ability to take ambulance referrals direct from triage and ensuring early senior staff input at multiple times across the day
• In maternity, community based models of care for low risk pregnancies, including shared care models
• Developing peri-operative medicine to provide safer care for patients with multiple medical co-morbidities admitted under surgical teams – a joint initiative of aged care and general medicine (MAU)
• Developing a collaborative care model between ED, Toxicology, Drug Health and Mental Health to manage acute intoxication and behavioural disturbance
• Increased multidisciplinary care in paediatrics, chronic and complex care, post acute care and rehabilitation through enhanced dietetics, physiotherapy, occupational therapy, speech pathology and counselling services
• In cancer care, ensuring all MDT care plans are documented in clinical notes and used in determining outcome-driven service priorities; extending MDTs to areas such as melanoma and sarcoma; developing an integrated model of primary health care with GPs for cancer survivors & to manage symptom control, linking with chronic & complex care services; maintaining a support structure to encourage primary health care of cancer patients and reduce unnecessary specialist oncology follow-up; ensuring the Clinical Cancer Registry is maintained and up-to-date, to monitor and inform trends of care
• Establishing Cancer Wellness or survivorship centres and nurse practitioner led cancer survivorship support programs
• In allied health, establishing an Integrated Allied Health network sharing models of care across all facilities
• Developing Acute Surgical Unit (response teams) to ensure prompt, efficient management of surgical emergencies

In the right place

The principle is that models of care ensure that, where safety and quality can be assured, services are provided in the most cost-effective setting that optimises patient access. The systems, infrastructure and support that facilitate linked up action also enable more flexibility in providing care outside traditional high-density, high-cost, highly-congested and complex flow environments. Technological advances in connectivity ensure that the
diagnostic information to support care provision can be made available outside of traditional sites, no longer constrained by requirements of critical mass.

The complex nature of modern sub-specialty healthcare means that no one hospital is able to provide a total comprehensive service. However, District-wide networks allow hospitals regardless of size to develop centres of excellence and expertise in some sub-specialty services that accord with their strengths. Through this networking the communities of south west Sydney can be assured seamless access within the LHD to the full range of sub-specialty services regardless of the point of ingress, with the exception being some quaternary level services which the Ministry of Health plans on a State-wide basis.

Within the context of increasing demands from population growth and ageing, opportunities to take services to patients and communities, within a linked up model of care, can alleviate pressure at busy acute hospitals. In addition partnership arrangements can be pursued to improve access to care through alternative settings, such as through public private partnerships.

At Appendix A18, a range of models of care are identified which seek to change the setting of care to more cost effectively and with access benefits to patients and communities, safely provide appropriate modes of care in the right place, including:

- Seamless service provision across the spectrum of community and hospital care settings
- Increased provision of services in the community including via telehealth, to treat patient without the need for hospital presentation, with improved community based services providing disease management that is community focussed and patient centred
- Enhanced capability to provide services into RACFs, including nursing or nurse practitioner outreach visitation, enhanced education of staff in RACFs on care of patients with a chronic condition
- Building of day hospital/outpatient/home based therapy service capacity in all sectors to enable earlier discharge of patients, particularly from Aged Care and Rehabilitation wards
- Planning for and providing additional rehabilitation subacute beds across the District to ensure that patients are not treated inappropriately and inefficiently in acute beds
- In palliative care, widespread adoption of The Palliative Care Extended Aged Care at Home (PEACH) model, involving contracted services providing support for deaths at home.
- Development of community centre hubs, including within the SWGC, that could extend to providing infusion therapy for stable patients with chemotherapy and potentially radiotherapy delivery (subject to state-wide planning) and cancer survivorship clinics
- Providing services in patient’s homes including, post-discharge support services linked to specialist advice from the acute sector, home sleep studies and home CPAP titration
- Increasing the focus on outpatient and ambulatory settings e.g. acute assessment clinics, rapid discharge clinics; reducing hospital admissions and facilitating early discharge
- Increasing the focus on service provision in alternative settings to inpatient wards e.g. short stay ED, ambulatory care, hospital in the home, day hospital
- Outpatient specialist check-ups using telemedicine, involving general practice in a community setting
- Establishing integrated multi-functional Cardiology/Endovascular Interventional Suites at the major acute hospitals
- Establishing secure delirium units
- Establishing new services e.g. in Cancer Services – increased haematology services at Campbelltown Hospital and recommencement at Bowral and District Hospital; establishment of a multi-disciplinary melanoma service; establishment of a sarcoma service; establishment of cancer genetics clinics at Bankstown-Lidcombe and Campbelltown hospitals
• Increased use of transitional care settings for lower acuity patients where the only requirement is for nursing care from the start of the admission
• Respiratory wards with capability to manage higher dependency patients with respiratory failure requiring subacute non-invasive nasal ventilation
• Relocation of hospital based rehabilitation programs to community centres to provide better and quicker access for patients with a chronic condition, supporting an improved model of community care for COPD patients integrated with primary healthcare providers
• Hospital based diabetes services incorporate outreach community roles with hub and spoke models enabling services to be established at community health centres and/or integrated primary health care centres
• Enhanced ambulatory care infusion services – hospital ambulatory care, community centres and in the home.
• Co-location and integration of imaging services with the ED
• Enhanced ambulatory detoxification in a model of shared care with GPs
• Expanding ambulatory care models to expand into community based centres with consideration given to the inclusion of a Nurse Practitioner model
• Use of day only facilities for surgical procedures traditionally undertaken in hospitals e.g. cholecystectomy, breast surgery, hernia repair, gynaecology procedures such as large loop excision of the transformation zone (LLETZ); ophthalmology and many other procedures; facilitated by advances in technology
• Use of stand-alone or virtual stand-alone high volume/short stay procedural spaces within hospitals for day surgery previously provided within main theatre blocks or day surgeries, noting the continuing need to provide anaesthetic and perioperative support including recovery nursing
• Enhancements to mental health community teams, especially assertive community care teams
• Development of a comprehensive stand-alone Eye Centre providing clinical and consultation space
• Development of Surgical Ambulatory Care Units
• Development of stand-alone Endoscopy Units
• Development of a comprehensive SWSLHD Breast Cancer Assessment Unit.

At the right time

The principle is that models provide care expeditiously and efficiently, meeting benchmarks that optimise opportunity for high quality outcomes consistent with reasonable community and funder expectations. The focus is on ensuring appropriate waiting times to care reflecting patient acuity, streamlining referral pathways, fast tracking assessment and diagnosis through deployment of enhanced multidisciplinary clinical expertise and speedier access to imaging and laboratory support, with faster disposition to the appropriate setting for definitive care.

The ultimate aim is to minimise the time in each care phase to that within which patient benefit can be achieved, supported by seamless and efficient transfer of care between settings and partners in care.

Appendix A18 identifies a range of models of care which aim to extend and enhance the availability of care, to facilitate earlier and faster disposition to the team and setting that provides care at the right time, including:

• Streamlining services for patients with fractured neck of femur, ensuring access to a timely operation within benchmark waiting times
• Ensuring separation of predictable elective and non elective surgery to minimise disruption to patient flow
• Providing adequate emergency/trauma and scheduled emergency theatre access to minimise delays to treatment
- Enhanced and flexible work practices with 7 day week, extended hours coverage for social work to support patients/families with child protection, trauma, domestic violence, victims of crime, sudden unexpected death in infancy (SUDI) etc. issues
- Enhancing after-hours dedicated medical cover, including at the smaller hospitals a move to 24hr junior medical staff cover
- Ensuring that all patients presenting to hospital are reviewed by a senior doctor/consultant within 12-14 hours, noting that patients presenting after 1800 hours may need to be reviewed from 0800 hours the following morning
- Increasing hospital in the home and hospital in the RACF services, including an element providing 24/7 and after hours troubleshooting
- Widespread implementation of new therapies for stroke, including intravenous thrombolysis and neurointerventional radiology
- Facilitating effective use of the MAU/AAU through close liaison between MAU/AAU staff specialists and other specialties, to ensure that all patients in the Unit are assessed and managed expeditiously, with all patients in the AAU in the morning transferred on by 5.00 pm to provide beds for admissions during the evening and night

Further development of acute short stay medicine as a variant of general medicine, with MAU/AAU patients rapidly transferred to relevant medical specialties home wards within less than 48 hours from presentation

- Establishing MAU/AAU clinics for rapid assessment of patients referred from GP and community sources to prevent admission if possible and to allow early discharge of inpatients with review
- Implementing a 24 hour emergency response oncology model of care to avoid inappropriate ED presentations
- Establishing a Haematology step-down Unit to expedite earlier haematology discharge
- Further exploration of alternative care settings to deflect admissions e.g. short stay ED
- Extended hours and flexible service delivery e.g. flexibility in outreaching to vulnerable population groups – Home visiting programmes; paediatric outreach clinics; extended operating hours; use of community health centres on weekends
- Enhancing drug health hospital Consultation and Liaison services, with extended hours at Campbelltown and Liverpool hospitals
- Providing a real-time consultant imaging reporting model which includes after-hours access

8.3 Addressing the Needs of Priority Population Groups

The District will continue to have a strong, sustained and robust equity agenda to improve the health of people from disadvantaged and vulnerable groups and communities. Strategies will be implemented which:

**Medical and/or Acute Assessment Units (MAU & AAU)**

These units can improve patient flow, where they are:

- Co-located with EDs, not a separate acute ward
- Appropriately resourced, with adequate bed capacity
- Regularly provided with the strong medical governance of senior doctor rounds
- Staffed by those skilled in rapid assessment
- Supported by community follow-up to prevent readmission
• develop the capacity of individuals and communities to access and engage in health care and make informed choices regarding lifestyle and treatment options. A stronger focus on health literacy will support this direction

• include targeted programs for health conditions and high risk behaviours prevalent in communities

• increase staff knowledge and competencies in considering the holistic needs of patients, particularly those with complex problems, in developing care plans

• improve awareness and responsiveness to diversity

• strengthen collaborative partnerships to address the social determinants of health

• build on local success by incorporating evidence into District wide practice and care

• develop complementary services across primary, secondary and tertiary health care

• ensure planning and service development addresses the diverse needs of communities

The following are examples of directions that will be further developed. A number of these strategies have been included in Directions to Better Health - South Western Sydney Local Health District Corporate Plan 2013 – 2017.

Aboriginal People and Torres Strait Islanders

• Continue implementing relevant aspects of the SSWAHS Aboriginal Health Plan 2010-2014 including framework and corporate initiatives and actions in priority health areas of early years, children and young people; chronic diseases and ageing; drug health; mental health; infectious diseases and sexual health; and oral health. In 2013 -14, initiate a process to develop a SWSLHD Aboriginal Health Plan to apply from 2015

• Work with Tharawal Aboriginal Medical Service and Gandangara Land Council Medical Services to establish a framework for all SWSLHD services to review existing models of engagement, recruitment and care for Aboriginal patients, to ensure they remain a priority group for action

• Sustaining effort to meet the KPIs and targets in Aboriginal Health in the SWSLHD Performance Agreement and KPIs arising from the NSW Aboriginal Health Plan 2013 – 2023 and the National Aboriginal & Torres Strait Islander Health Plan (currently under development).

• Implementing the NSW Health Aboriginal Workforce Strategic Framework 2011 – 2015 through an Action Plan incorporating initiatives in recruitment and retention, education and training, and workforce assessment and planning; and developing a skilled Aboriginal workforce through the provision of traineeships, courses, mentorship and assistance supported by the Aboriginal Employment Coordinator.

• Delivering culturally appropriate care by training health professionals using the Respecting the Difference Aboriginal Cultural Training Framework

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Priority Population Groups Experiencing Disadvantage

Individuals and communities experiencing disadvantage requiring additional support include:

- Aboriginal people and Torres Strait Islanders
- People with chronic mental illness and their children
- People in contact with the criminal justice system and their families
- People in rural areas geographically isolated from health services
- People living in social housing with poor access to health and other services
- People with drug and alcohol issues
- People on low incomes, who are unemployed or have lower educational attainment
- People who are homeless or in insecure housing
- Children in care or from families with child protection issues
- People with a chronic illness and their carers
- Refugees and recently arrived migrants
- People with a disability
- Carers

Other important groups include babies, young people and older people.
Increasing Support

- Addressing Strengthening People

- Creating Strengthening People

Implementing Improving

- Ensuring Respite

- Undertaken Coordinating

Medical Health

- Facilitating Health Care

(Planning, Research, and Development) Services

- Complementary Health Service

- Community Health Health

- Child and Adolescent

- Mental Health and Development

- Alcohol and Other Substances

- Aboriginal Health

- Mental Health

- Service and System

- Indigenous Peoples

- Drug and Alcohol

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Working with Justice Health’s Community Integration Teams (CIT) to facilitate integrated on-going care for young ex-prisoners through specialist and generalist community services; and with Justice Health’s Nurse-led Model of Hepatitis Care to improve representation of people released from correctional facilities in community based clinic populations undergoing treatment for chronic hepatitis C (HCV)

Implementing assessment and treatment programs for people with alcohol addictions through a new Magistrates Early Referral Into Treatment (MERIT)

Maintaining the skills and abilities of staff to monitor the health and welling of children of people who have been in contact with the criminal justice system receiving drug health services

People living in rural areas geographically isolated from health services

- Enhancing and developing local services in the southern parts of the District e.g. establishment of Karitane at Camden, expansion of services across the continuum of care at Bowral and District, Campbelltown and Camden hospitals to provide paediatric and adult services closer to the homes of local residents. In addition, exploring use of new technology e.g. telehealth to bring health services to rural communities
- Upgrading existing facilities to improve local capacity e.g. Emergency Department and Operating theatres at Bowral and District Hospital and redevelopment of Campbelltown Hospital
- Updating Transport Access Guides (TAGs) for health facilities to help improve accessibility of services
- Providing state-wide specialist services such as brain injury and refugee health services to people living in other local health districts
- Working with local council and South Western Sydney Medicare Local (SWSML) to increase the level and range of primary health services in the Wollondilly LGA
- Providing outreach services to improve access to geographically isolated communities e.g. paediatric clinics
- Providing clinical placements for students undertaking health professional training in local universities and colleges e.g. Wollongong University students at Bowral Hospital to increase local knowledge and skills and develop a local workforce

People living in social housing with poor access to health and other services

- Working with the SWSML to improve access to after hours primary health care services
- Maintaining and developing outreach specialist health services to improve access to people in housing estates e.g. cardiovascular services at Millar and maternity services at Macquarie Fields
- Providing clinical placements for students undertaking health professional courses in local universities and colleges e.g. Macarthur Clinical School at UWS to increase local knowledge and skills and develop a local workforce
- Planning for new health services to meet the needs of residents within the South West Growth Sector
- Upgrading existing facilities to improve local capacity e.g. redevelopments of Liverpool and Campbelltown Hospitals and planning for further services
- Working collaboratively with the NSW Housing Department in community renewal projects to improve the health environment for people in public estates; and with Housing and other agencies to address the social determinants of health such as access to healthy food, access to employment, supporting education, etc.
People with drug and alcohol issues

- Creating awareness in the community of drug and alcohol issues – e.g. in partnership with Vietnamese Drug and Alcohol Professionals Association
- Supporting Community Drug Action Teams in identifying and addressing local issues which create drug and alcohol misuse
- Recognising the health and social causes and impacts of drugs and alcohol through the provision of court diversion programs
- Improving individual chances to successful treatment through the provision of case management services which address social issues such as employment and housing
- Improving staff health through the availability of a free Nicotine Replacement Therapy program for staff
- Expanding Needle and Syringe Programs and including dispensing machines and sharps disposal units in new developments; and strengthening access to primary health care for people who use illicit drugs
- Supporting people with mental health and drug health co morbidities by building collaborative approaches between mental health and drug health clinicians and GPs

People on low incomes, who are unemployed or have lower educational attainment

- In partnership with other agencies, implementing targeted programs and initiatives which address the social determinants of health including social and physical isolation and connectivity e.g. Housing NSW renewal projects, healthy food environments including improving access to low cost fresh food and advocacy through Food Alliances, addressing transport barriers and pathways to employment including trainee programs and social enterprise. Examples of current strategies are provided in Table 8.1
- Developing new approaches to health literacy in people with lower educational attainment, including refugees, people from non-English speaking backgrounds and Aboriginal people. This includes using new technology such as social media and traditional media including radio and newspapers

People who are homeless or in insecure housing

- Continuing implementation of the Regional Homelessness Action Plan 2010-14 Greater Western Sydney through interagency actions under the Greater Western Sydney Regional Committee. The four priority areas are access to long term affordable Housing; young people; permanent supported housing for people exiting institutions; and sustaining tenancies with a focus on Aboriginal tenants
- Actively engaging in implementation of the Housing and Mental Health Agreement of August 2011; the overarching framework for planning, coordinating and delivering mental health, accommodation support and social housing services for clients with mental health problems and disorders who are living in social housing or who are homeless or at risk of homelessness
- Enhancing service provision through the interagency and NGO partnered NSW Housing and Accommodation Support Initiative (HASI). This initiative enables more people with mental health problems to live in the community in stable and secure accommodation, with links to clinical mental health and rehabilitation services for people who require 16 or 24 hour support
- Implementing the draft NSW Ministry of Health policies NSW Health System – a policy for responding to homelessness 2011/12 – 2016/17 and Managing transfer of care for homeless people in the public health system, which address the National Partnership’s goal that there be no exits to homelessness from government services. These policies focus on improving support within health services.
- Improving use of health services by homeless young people through youth-specific strategies such as outreach to community-based settings, targeted health promotion programs, delineated medical and nursing clinics and priority access to oral health clinics for young people in out-of-home-care
Table 8.1 Examples of community development and related initiatives where SWSLHD services are a coordinating or partner agency

<table>
<thead>
<tr>
<th>Local Government Area</th>
<th>Community development and related initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bankstown</td>
<td>Community Gardens to enhance food security, reduce social isolation, build communities; Community kitchens to reduce social isolation, improve living skills and nutrition; Villawood Redevelopment Project – community renewal (One Place, One Plan); Community Drug Action Team</td>
</tr>
<tr>
<td>Campbelltown</td>
<td>Food Security Projects - Aboriginal and general community; Macquarie Fields Men’s Shed; Aboriginal Early Childhood Project - Gudaga and Gudaga Goes to School; Rosemeadow Ambarvale Community Interagency; Annual Youth Health and Safety Expo - Ambarvale/Claymore – nutrition; Claymore Community Renewal (One Place, One Plan); Love Bites - Ambarvale High School - domestic violence, sexual assault, healthy relationships</td>
</tr>
<tr>
<td>Fairfield</td>
<td>Community Gardens to enhance food security, reduce social isolation, build communities; Community kitchens to reduce social isolation, improve living skills and nutrition; Community Drug Action Team; Cabramatta Tobacco Project to increase awareness of the harmful effects of smoking</td>
</tr>
<tr>
<td>Liverpool</td>
<td>Community 2168 Project (Miller) – community renewal. Includes Well Women’s Clinic; Warwick Farm - Heart Smart, includes Heart Foundation Walking Group Project; Community Drug Action Team</td>
</tr>
<tr>
<td>Wollondilly</td>
<td>Wollondilly Men’s Shed</td>
</tr>
</tbody>
</table>

Children in care or from families with child protection issues

- Delivering timely care to children living in out of home care through the prioritization of these children to health assessment and treatment services
- Improving local responses to Ministry of Health guidelines, policies and procedures for the protection of Children and Young People. This includes improved identification and assessment of children at risk in EDs and paediatric services and continuing to implement NSW Government Keep Them Safe reforms
- Improving coordination and collaboration within health services by reviewing team management approaches to case discussion and care planning, incorporating child protection information into the electronic medical record and developing best practice guidance i.e. resources and tools about information exchange and sharing; and with other services by building relationships and addressing mutual problems

People with a chronic illness

- Improving health workforce and community awareness of chronic disease issues - establishing an Office of Preventative Health at Liverpool Hospital, providing information on SWSLHD website, participating in community based programs to improve health
- Delivering patient education on chronic disease self management
- Improving the early identification of changes in health status and improving responsiveness through delivery of the Coordinating Care program, including programs specifically targeted for Aboriginal people
- Enhancing the availability of coordinated, clinical services across the district for people with a chronic illness e.g. Bankstown-Lidcombe Hospital renal dialysis unit
- Developing comprehensive, coordinated, multidisciplinary services targeted at people with particular diseases or disease risks e.g. Camden Hospital BEAT It program for people with obesity
- Improving infrastructure to support patients with obesity e.g. purchasing additional bariatric beds, diagnostic equipment and lifters able to accommodate heavier people.
Refugees and recently arrived migrants

- Developing a SWSLHD Implementation Plan to ensure that the recommendations of the NSW Refugee Health Plan (2011-2016) provide equitable locally tailored strategies for refugee health
- Reviewing the structure of and access to the Health Interpreter Service
- Implementing the *NSW Health Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012–2016* to improve service delivery for people from diverse communities
- Reviewing orientation and mandatory training programs to ensure that multicultural policy requirements are incorporated
- Through the NSW Refugee Health Service, expanding nursing and other health services to refugee groups
- Implementing strategies to address health problems of higher prevalence in identified non-English speaking communities including: Hepatitis B and tuberculosis; risk factors that negatively affect people’s health such as smoking; improving access to screening programs such as cervical cancer; and increasing the health literacy of refugees and other non-English speaking people
- Developing strategies to increase participation of people from culturally and linguistically diverse (CALD) communities in health research and increasing health research in health conditions and lifestyle behaviours of higher prevalence in these communities

People with a disability

- Implementing District related actions from the *NSW National Disability Strategy (NDS) Implementation Plan 2012 – 2014*.
- Developing a SWSLHD Disability and Carers Action Plan incorporating NSW Government interagency initiatives and action on the SWSLHD Disability Guidelines
- Informing people with a disability of how health services can support their needs through the provision of a specific page on the SWSLHD website
- Implementing the SWSLHD Advocacy Policy to ensure that people with a disability have their needs met.
- Ensuring new capital infrastructure projects and renovations are informed by National and NSW Access and Building Codes and Standards
- Working collaboratively with agencies such as Ageing, Disability and Homecare and the Department of Health and Ageing to address the long term accommodation needs of younger people with disabilities

Dementia

- Developing a local Dementia Action Plan to ensure implementation of the *NSW Dementia Services Framework 2010 - 2015*
- Improving support for people with dementia along the continuum of care from diagnosis to end of life decisions and care. In particular, further defining and developing the role of local health services to support people with moderate and severe dementia, particularly those with behavioural disturbance
- Working in collaboration with other agencies to ensure that a full range of support services are available locally to people with dementia and their carers
- Rolling out the Top 5 Program to improve support to patients with dementia in hospitals

Babies and children

- Enhancing prevention and early intervention services through the delivery of universal home visiting and targeted sustained home visiting. In addition, trialling new initiatives to address key health issues e.g. Healthy Beginnings program addressing exercise, nutrition and television watching in disadvantaged areas
- Working with NSW Kids and Families, the NSW Children’s Hospital Network and other services to improve the surgical and medical care of children in local hospitals and continuing to improve access to secondary and tertiary services through initiatives such as the establishment of Karitane at Camden.

- Improving the care of critically ill babies through the NICU Nursing Intern Program to develop expertise in neonatal care; and the care of children in EDs through the development and implementation of a paediatric pain chart

- Supporting breastfeeding for employees through fostering a supportive environment including paid lactation breaks and flexible return to work options

- Improving care coordination for children with multiple, complex needs eg. Team Around the Child Program at Campbelltown and Bankstown

- Addressing obesity through the delivery of early childhood and school based prevention programs which improve nutrition and physical activity participation and through the development of treatment programs

- Delivering hearing screening programs in newborns and school based screening programs for vision.

**Young people**

- Continuing implementation of the *SWWAHS Youth Health Plan 2009 – 2013* and consider scoping of a new SWSLHD youth health planning process to be undertaken in 2013-14; planning to be informed by the *NSW Youth Health Policy 2011 – 2016 Healthy bodies, healthy minds, vibrant futures* and the *Youth Health Better Practice Framework (NSW CAAH 2005)*

- Creating awareness in young people of key health issues e.g. looking after your mates, alcohol and drugs, sexual and mental health, domestic violence, sexual assault and healthy relationships

- Delivering targeted services such as the Macarthur Young Adult Cancer Support Group

- Improving support for young people with complex health problems as they transition from paediatric and children’s health services to adult specialist services

- Implementing Mind Matters in local schools to promote and protect the mental health of young people

**Older people**

- Raising community awareness of key health issues and local health services for older people through participation in activities such as Seniors Week and via dedicated information on the SWSLHD website

- Increasing the number and range of specialist services delivered to the community through the creation of new services e.g. Bankstown Aged Care Day Hospital

- Improving care environments for people with dementia eg. redevelopment of Broughton House Dementia Day Care Centre at Camden in conjunction with the Department of Ageing, Disability and Homecare

- Reducing the likelihood and impact of falls in hospital through the Falls Champion Program initiative and within communities through development of multicultural falls prevention resources

- Reducing the need for people to access permanent residential aged care through the creation of a Residential Transitional Aged Care Unit at Bankstown in partnership with UnitingCare Ageing and improving support given to residential aged care facilities to reduce inappropriate admissions

- Improving end of life care by encouraging people to plan ahead and promoting Advanced Care Directives.

**Carers**

- Developing a SWSLHD Disability and Carers Action Plan incorporating NSW Government interagency initiatives and actions identified under the *Carer’s Recognition Act 2010* and *SWSLHD Carers Model of Care Framework*
- Improving carer awareness of health issues and services through a dedicated SWSLHD carer information web pages
- In the context of developing a new Workforce Plan, reviewing current arrangements for staff who are carers with the aim of developing information and support systems
- Working with carers of people with mental health issues to strengthen care networks and support carers
- Work collaboratively across streams with the Department of Education to implement strategies to support young carers

### 8.4 Enablers for Clinical Practice

A range of enablers support clinical services in operating effectively and efficiently across the District and the broader health system. These enablers include workforce (clinical and non-clinical), management and administration, finance, asset management and maintenance, engineering, security, food services, linen services, cleaning, childcare, transport, education and research.

Enablers will need to respond to changes in the operating environment such as the development of new facilities, redevelopment and expansion of existing facilities, consolidation of support services at a state level to drive efficiency, changing population and workforce characteristics and new models of care. Key Enabling Services in SWSLHD (listed in alphabetic order) and the directions proposed to 2021 follows. Many of the directions proposed for these services are articulated in greater detail in the *Directions to Better Health - South Western Sydney Local Health District Corporate Plan 2013 – 2017*.

#### Asset Management and Capital Works

Capital works in SWSLHD undertakes all stages of infrastructure development and project management from the finalisation of agreed clinical service and asset strategic plans to the commissioning of fully functional facilities. Asset management focuses on providing and maintaining the physical infrastructure such as hospital and community health facilities and equipment required for health care provision. Directions to 2021 include:

- Completing construction of the Subacute Mental Health Unit at Liverpool Hospital, the SWSLHD Nurses Education Centre at Liverpool and the redevelopment of Campbelltown Hospital
- Progressing mental health service infrastructure development including the Campbelltown Hospital Mental Health Redevelopment
- Completing Phases 2 & 3 of the Liverpool Hospital redevelopment
- Establishing Integrated Primary and Care Centres in the South West Growth Centre and develop a Community Health Infrastructure Renewal Strategy for established areas.
- Redeveloping Bowral and District Hospital and Bankstown-Lidcombe Hospital
- Progressing planning for the Fairfield/Braeside Hospitals
- Recruiting an in-house construction team.
- Developing, regularly updating and implementing the SWSLHD Asset Strategic Plan
- Developing and implementing an Asset Maintenance, Replacement and Disposal Program
- Working closely with Health infrastructure to progress capital developments and ensure new capital projects meet service requirements
- Participating in the state-wide development and implementation of TRIRIGA software to improve asset and space management
- Establishing a District-wide engineering structure to improve management of engineering and fire services
Biomedical Engineering

The Biomedical Engineering Service (BES) participate in the provision of highly complex acute care health services, particularly the implementation of new technologies and support for existing medical technology used in the hospital. It provides product evaluation, procurement and life cycle management; participation in clinical support and training; and supervision of support services supplied by external contractors. Directions to 2021 include:

- Grow internal biomedical capabilities and reduce reliance on contracted services
- Increasing the focus on preventative maintenance and safety inspections
- Enhancing capacity to manage increasing numbers and complexity of devices
- Increasing engagement in research and development projects (including research undertaken through the Ingham Institute of Applied Medical Research)
- Increasing engagement with the tertiary education sector (such as the universities of NSW and Sydney) to provide work experience for students in Biomedical Engineering field.

Clinical Library and Information Network

The Clinical Libraries and Information Network (CLIN) provide information and resources to staff and students for patient care, professional development and research. This includes the provision of high quality literature search services for patient care and systematic reviews for research, conducted by experienced librarians. In addition, CLIN libraries provide a physical environment for staff and students to work or study, with access to a range electronic and physical reference resources. Education on the use of various library and information resources is also provided. CLIN operates as a network to ensure that information resources from each library are available to all staff across the District. Directions to 2021 include:

- Expanding the CLIN network across SWSLHD, with increasing focus on a District-wide approach to allocation of resources for workforce and the purchase of access to databases
- Expanding electronic resources e.g. eBooks to enable greater access to information for staff 24 hours 7 days/week regardless of location
- Formalising the support and work of the information network in health research activities

Consumer and Community Participation

Community Participation is the involvement of consumers and carers in decisions about individual health care, and the involvement of consumers and communities in decisions about the provision of health care services across the District. Examples of how people participate include working with health staff in committees, working groups and projects; engaging with clinicians in care planning, conducting patient and carer interviews and surveys; attending forums to provide ideas and opinions; assisting in the training and orientation of health staff; sharing consumer stories to provide greater insight into the patient, carer and family member journey; joining an action group to work on specific issues and providing comments through social media or the formal feedback process. This commitment to participation leads to improved health care and health outcomes which are transparent, accountable and reliable.

SWSLHD is committed to consumer, carer and community involvement in the planning and operation of local health services and has a well established structure to support this participation. Each hospital has a Community Participation Network of individuals from the local community working with clinicians and non-clinical staff. There is also a peak consumer and community group at a senior strategic level to support and advises the SWSLHD Chief Executive and Board. Directions to 2021 include:

- Enhancing engagement with communities experiencing the greatest health disadvantage
Expanding representation on the Consumer and Community Council (CCC) and local networks to fully reflect the diversity of communities across SWSLHD

Developing new ways of consulting with the local community to achieve greater participation for example through social media and use of culturally appropriate methods

Expanding local community participation in research initiatives and building the skills of researchers to engage with consumers and patients

Increasing involvement and be proactive in strategic planning and advocate for changing community needs and concerns.

**Corporate Support Services**

SWSLHD support services include hotel services such as food services, cleaning, security, maintenance and engineering which are usually provided at a facility level and District wide services such as purchasing and procurement, finance, public relations, performance and health services planning.

For a number of these services, there is a close relationship with HealthShare NSW (previously Health Support Services) and joint responsibility for supporting patient and workforce requirements. HealthShare NSW focuses on health information technology systems, payroll and accounts payable functions, supporting patient care through food and linen services and assisting people with a disability to live and participate in the community. Directions to 2021 include:

- In food and nutrition management, upgrading food plating and delivery services across the District; participate in the development and implementation of the NSW-wide CBoard electronic food and nutrition ordering system; and implementing the NSW Health Nutrition Policy including localised best practice in nutrition, under the leadership of the District Nutrition Committee
- Implementing improved contract management initiatives, consistent with state-wide directions
- Collaborating and participating with HealthShare NSW in the development and successful implementation of NSW-wide initiatives and programs
- Strengthening the focus on safety and quality through participation in accreditation programs; implementation of NSW-wide clinical and service improvement programs; and using feedback from the patient experience and evidence to guide service improvement
- In finance, developing financial and reporting mechanisms, tools and training to support effective financial management; further developing capabilities in Activity Based Funding and meeting financial targets.
- Strengthening risk management through the development of a framework for managing risk and developing risk management systems.
- Progressing clinical service, population and corporate service planning to support achievement of the service directions articulated in this Plan and the Directions to Better Health - South Western Sydney Local Health District Corporate Plan 2013 – 2017.
- Strengthening governance through development of the knowledge and skills of the Board, Executive, General Managers and Clinical Directors in governance and management; strengthened systems and processes, and workforce education about responsibilities and accountabilities.
- Building an agenda of sustainability into all aspects of service development and delivery
- Improving performance through enhanced business intelligence and decision support; timely access to data and information; and stronger business planning which considers financial viability.
- Developing a longer term fund raising strategy to focus, prioritise and diversify fundraising activities to support development of clinical services
Disaster Planning and Preparedness

The NSW Ministry of Health and local health districts have an important role to play in managing the impact of disasters, including natural disasters, acts of terrorism and epidemics and pandemics. Directions to 2021 include:

- Participating in local and state exercises and events to ensure the currency of skills of clinicians and other staff to respond to disasters, including broader community participation events such as fun runs to ensure the readiness of services to respond to an outbreak of a disease outbreak or major incident
- Ensuring through regular audits of supplies, equipment, training and procedures that there is preparedness for disasters
- Ensuring that staff meet the NSW Health Hierarchy of Health Emergency Training Matrix and management role; and that workforce development programs meet identified needs
- Maintaining a volunteer register which identifies people who may be deployed overseas in the event of an emergency
- Undertaking a risk assessment of all major risks and threats of a public health nature e.g. a major pandemic, water problem or other health issue
- Upgrading technology which will assist in a faster response to emergencies and health problem outbreaks
- Working with Sydney Water, other government departments and local government in risk assessments for urban growth areas and new developments

Health Language Services

Health Language Services (HLS) is a 24 hour service providing interpreting and translation services to all public health facilities in this District. It also serves Sydney and South Eastern Sydney Local Health Districts, and Sydney Children’s and St Vincent’s hospitals.

Interpreting Services in over 75 languages including Auslan, are provided free of charge, as are translations directly related to patient care. Other translations are chargeable. The Service employs over 100 staff and engages approximately 350 contractors. Interpreters and translators are accredited by NAATI (National Accreditation Authority for Translators and Interpreters) and participate in an ongoing professional development program which includes medical terminology.

The service facilitates communication between health care providers and patients and clients of non-English speaking backgrounds and people with a hearing impairment. Services are provided on demand and are prioritised according to need. In 2010/11, it provided approximately 260,000 occasions of service. Directions to 2021 include:

- Improving and increasing video-conferencing facilities for the provision of interpreter services
- Monitoring, comparing and evaluating the use of interpreter services across various teams and departments
- Increasing promotion of Auslan interpreting services
- Conducting medical record audits to determine compliance with MOH “Standard Procedures for Use of Interpreters” policy
- Reviewing existing structures to improve access to services

Health Related Transport

Emergency patient transport is provided by the Ambulance Service of NSW. Non-emergency health related transport is provided by various agencies including SWSLHD Patient Transport Services, the Ambulance Service of NSW, Community Transport services, Aboriginal health services and the Department of Veterans’ Affairs.
SWSLHD Patient Transport Services provide intra and inter hospital transfers for inpatients, transport required for hospital admission or discharge, and outpatient transport to diagnostic consults and treatment (including day hospitals and cancer therapy centres). This transport is provided in SWSLHD vehicles or contracted to the Ambulance Service of NSW or local taxi services. Escorts are provided to patients subject to individual clinical management needs and medical status. Transport support is also provided through the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) to people who are very geographically isolated. Directions to 2021 include:

- Participating in the NSW Health Non-Emergency Patient Transport Reform Program to deliver an improve booking, scheduling and dispatching system for health fleet services, and standardised business processes and reporting
- Further enhancing the fleet to cater for bariatric patients
- Expanding non-emergency transport services for disadvantaged communities including rural people in partnership with community partners
- Undertaking an efficiency review of fleet utilisation
- Working with other transport providers to ensure that access to transport for those who require it is better coordinated

**Infection Control**

Infection Prevention and Control focuses on preventing patients from acquiring healthcare related infections and effectively managing infections when they occur. These include antimicrobial resistant bacterial infections such as methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant enterococcus (VRE), multi-resistant gram negative bacteria and *Clostridium difficile*, as well as highly transmissible viral and bacterial infections such as influenza, measles, Varicella zoster and gastroenteritis. These infections can be prevented through effective infection control measures, hand hygiene and appropriate use of antimicrobial agents.

The SWSLHD Infection Control Advisory Committee has been established to provide timely and comprehensive evidence-based advice to achieve optimum control of infection risk for inpatients and non-inpatients of the facilities of SWSLHD and to evaluate critically and objectively those measures. The Committee reports to the SWSLHD Clinical and Quality Council. Directions to 2021 include:

- Developing a District-wide coordinated, standardised and collaborative infection prevention strategy and service
- Developing an infection prevention workforce resourced to a level consistent with national guidelines to ensure that standards are met and outbreaks of pathogens are contained and managed appropriately
- Implementing an Antimicrobial Stewardship Program which includes a Computerised Decision Support System to optimize safe and appropriate use of antimicrobials and enhance clinical outcomes while minimizing unintended consequences of antimicrobial use
- Designing, implementing and evaluating quality improvement programs in Infection Prevention and Control aimed at reducing healthcare-associated infections and improving patient safety
- Strengthening monitoring, analysis and reporting of the epidemiology of healthcare related infection to improve identification of areas of concern and targeting of service provision
- Integrating evidence-based infection prevention and control practice into the operational policies, design and procurement processes for new capital and service developments

**Information Management and Technology Division (IM&TD)**

IM&TD supports SWSLHD management and health care professionals by improving information flows, enabling easier, quality communications, linking clinical information and providing a robust, secure technical
infrastructure. Services include the electronic medical record (eMR), WEB and collaboration services, client services, data centre, desk top and telecommunication services. Directions to 2021 include:

- Aligning services with eHealth, Pathology NSW and HealthShare NSW projects
- Enhancing functionality of existing technology such as email, internet and intranet
- Further developing and expanding eMR functionality to support clinical care e.g. Medication Management, SurgiNet, PowerChart Cardiology, PowerChart Maternity, Endoscopy, Community and Mental Health
- Developing a stronger focus and strategy around the use of technology platforms including technologies such as videoconferencing, telehealth and related technologies to improve access to high-quality multi-disciplinary care
- To support transfer of care, GP access to the electronic medical record including test results, discharge summaries, etc.
- Improving linkages with clinical leaders to develop and support the use of technology in clinical care
- Expanding the use of mobile technology, including remote application execution and access
- Continuing local system training and support development
- Improving storage capabilities and information technology security
- Investigating new models such as bring your own device (BYOD) and voice over internet protocols (VOIP)
- Developing asset management and replacement strategies for equipment such as desktop, servers and private automatic branch exchange (PABX) systems
- Supporting research capabilities
- Enabling use of social media to connect with the community
- Reviewing non IM&TD information and communication technology (ICT) System support groups within the District to maximise resources, minimise duplication and ensure compliance with relevant standards
- Improving help desk capabilities and responsiveness
- Managing telephone networks.

Pharmacy

Each Pharmacy department has responsibility for key aspects of medication management services to all inpatients and outpatients of the relevant hospitals and associated community health centres. This includes purchasing of pharmaceuticals and inventory management; dispensing and distribution services for all drugs in accordance with legislative requirements; clinical pharmacy services; quality management; participation in clinical drug trials; management of investigational drugs; and training and education. Priorities focus on enabling consumers to receive effective drug therapy as appropriate for the prevention or management of their disease process, whilst minimising adverse outcomes. Directions to 2021 include:

- Exploring innovative ways of medication management for the growing population of older patients and people with chronic complex conditions with increased medication needs.
- Advocating for improved access to Pharmacy services in line with Community expectations. Extended hours and weekend services may be implemented given adequate resources
- Incorporating information technology advances which would positively enhance the Pharmacy service or improve medication safety
- Strengthening pharmacy provision and business processes associated with research clinical trials
- Contributing to development of the Antimicrobial Stewardship Program within the District
- Further developing the Pharmacy workforce with a strong clinical focus
- Maintaining strong advocacy for patient medication safety
- Managing changes to pharmaceutical funding sought by the Australian and NSW Governments whilst maintaining a strong patient focus
Research

SWSLHD has an extensive health research program developed through the commitment of local clinicians and communities and in partnership with the tertiary educational sector including the University of New South Wales and the University of Western Sydney and with the Ingham Institute of Applied Medical Research at Liverpool. Research capacity and capability has developed from the platform of Bankstown-Lidcombe and Liverpool Hospital’s teaching hospital status. SWSLHD has a focus on applied research in a variety of health disciplines across medicine, nursing and allied health. The focus on health research across the District enables the delivery of enhanced clinical care and evidence based care, as well as acting as an attractor in establishing and maintaining a high quality, professional workforce. Directions to 2021 include:

- Implementing the Research Strategy for South Western Sydney Local Health District 2012 – 2021
- Developing a stronger research culture within the District. Key to this direction will be actions to build workforce capacity and capability to undertake and contribute to research. This includes a focus on those professions and facilities which do not have a strong research culture
- Incorporating research into new service developments and initiatives and expanding partnerships and collaborations with the tertiary education sector
- Increasing the number of Clinical Trials conducted in the District
- Expanding translational research and strengthen the application of evidence into care delivery
- Building community knowledge, interest and participation in health research with specific strategies focused on Aboriginal people and people from multicultural communities
- Strengthening governance and leaderships and developing the relationship with the Ingham Institute of Applied Medical Research
- Developing and optimising the use of infrastructure which supports research such as human resources, finance and information technology; and further developing the SWSLHD Research Office to support research and researchers and identify, report on and showcase research.

Volunteers, Auxiliary and Pastoral Care

Volunteers are involved in a wide range of activities including fundraising, welcoming and guiding patients, organising waiting rooms, participating in committees, operating gift stores and visiting patients throughout our hospitals and in the community. In addition, various local sporting teams, school students, choirs and other community members provide assistance to local facilities, patients and staff to improve the services provided to people in need. Pastoral carers from a variety of denominations also provide valued assistance to patients and their carers and families, particularly in times of crisis. Directions to 2021 include:

- Implementing the NSW Ministry of Health Framework for Engaging, Supporting and Managing Volunteers
- Improving the way in which services work with and support existing volunteers and the way individual volunteers and volunteers in general are recognised
- Developing the volunteer base supporting local health facilities and services.

Workforce

A capable, committed and professional workforce, large enough to meet the fluctuating levels of demand experienced by health services, is essential to the delivery of health care services in SWS now and in the future. Workforce requirements cover not only clinical staff, but also a range of support service staff without whom clinical staff are unable to effectively and efficiently provide direct care. These include technical, administration, management, food service and maintenance staff.

Growing and supporting the health workforce, to meet demand is one of the critical roles of the District. Understanding and meeting the needs of the workforce, as well as patients, will help ensure the provision of high quality services. A profile of the SWSLHD workforce is provided in Section 3. Directions to 2021 include:
- Developing and implementing a Workforce Plan for the District which positions the District to recruit and retain a strong, skilled and viable workforce, includes an effective workforce education program and ensures a safe working environment that people wish to work in
- Developing an understanding of the attractors the LHD can offer to staff and brand the LHD as an employer of choice
- Attracting more staff, particularly local residents
- Retaining existing, skilled and experienced staff and improve understanding of reasons behind staff turnover
- Undertaking workforce planning (including succession planning) to match workforce capabilities to the needs of the local community and the services provided by the LHD
- Reviewing performance management systems and link to organisational planning
- Reviewing positions across the District for equity in grading, remuneration and availability
- Further developing employment strategies aimed at Aboriginal people and disadvantaged groups within local communities. This includes implementing an Aboriginal Employment Strategy.

**Workforce Education and Development**

The Centre for Education and Workforce Development (CEWD) specialises in the education and training of the health workforce; offering a comprehensive range of clinical and professional skills development programs and qualifications for staff to ensure that the workforce has the knowledge, skills and behaviours necessary to provide high quality health services to their population. The Centre is the primary delivery site for NSW Health Registered Training Organisation (RTO), providing nationally recognised vocational training programs. The Centre also works in partnership with various universities, most notably the University of Tasmania, to deliver graduate certificates and masters programs.

Programs are available to all health occupation groups and include: Orientation - corporate, facility and nursing; Leadership and management; Vocational education and training including enrolled nursing, assistant and support roles; Postgraduate programs; Communication; Clinical redesign; Clinical quality and safety; workplace and administration skills; Occupational Health and Safety; Cultural diversity; Clinical skills – generic and specialty; and Mandatory Health Training. The various clinical schools operating within South Western Sydney (University of Sydney, University of NSW, University of Western Sydney) also offer extensive undergraduate and post graduate education and training, as well as clinical supervision and assessment.

In addition to CEWD learning programs, the Health Education and Training Institute (HETI) has developed a large number of learning resources including online training modules. Courses available include: Accreditation and Compliance; Carers; Communication; Child Protection; Clinical Supervision; Equity and Cultural Training; Education and Training; Finance; Health Promotion and Education; Medication and Prescribing; Mental Health; Orientation; Patient Assessment and Observation; Patient Care; Recruitment, Staff Management and Supervision; Safety; Systems and Applications Training. Module development is ongoing within the State Learning Management System (HETI Online). A number of HETI endorsed programs, resources and frameworks can assist in building the capacity of staff to deliver SWSLHD strategic priorities e.g. People Management Skills Framework, the People Management Skills Program, the Financial Managed Education Program and the NSW Health Leadership Framework. HETI is developing a state wide Education and Training Framework which will provide for ongoing collaboration with CEWD on continuous training and education.

Directions to 2021 include:

- Increasing accessibility and flexibility of education through elearning courses in clinical skills, general courses, leadership and management, maths in medication and occupational health and safety
- Further developing clinical teaching through simulation, including the development of a simulation facility at Campbelltown Hospital and the construction of the new District Nursing and Midwifery Education Support Centre
- Broadening the range of courses offered, in line with the recommendations from the Garling Review and other NSW Ministry of Health initiatives
- Developing new programs to attract local people into the health workforce through vocational education and training in schools
- Partnering with the Health Education and Training Institute (HETI), universities and other agencies to further develop the knowledge and skills of existing staff, including post graduate and doctorate qualifications.
9. Priority Strategic Directions in Service Development

Section 6 identifies very significant increases in healthcare demands for SWSLHD to 2021, arising from population growth and ageing. Although there is variation by service type, an overall increase of up to 40% in activity, services and beds is projected as necessary to meet increased healthcare demands by 2021. A significant expansion in physical capacity, workforce and recurrent budget to provide services will be required. A sustained and rolling program of service enhancement would be necessary, a significant call on a constrained State budget. Attempts to provide for this additional activity from within traditional structures and methods of public healthcare delivery are unlikely to be fundable and at threat of failure. New ways of providing services and new frameworks of operation will need to be explored to ensure the improved models of care outlined in this plan are provided for local communities.

Fundamental changes to organisational structures and service delivery frameworks will be required to secure the service developments required. The Vision of leading care, healthier communities requires a fundamental rethink of the way public health care is structured and organised. At the heart of innovation is making a change or doing something in a new way to improve outcomes. Collaboration also extends beyond organisations working together, it requires a focus on exchanging information, altering activities and sharing resources to achieve an overall benefit greater than the sum of individual effort.

Healthier communities where individuals, families and communities can enjoy the best health possible using evidence based programs, to prevent health problems and reduce disability; build the capacity of individuals and communities to improve their health and fully engage in health promoting activities; and create social and physical environments that are healthy and support healthy activities.

Health reform and changed strategic focus in health delivery from the Australian and State governments will also drive changes to the way service development proceeds over time. As Medicare Locals evolve they will increasingly influence through needs assessment and targeted project funding the way primary care services in the community (medical, nursing, allied and complementary) develop and how they integrate with LHD services, specialist and community health, provided in the community and at LHD facilities. The NSW Government has also changed emphasis in its service development focus, as outlined in the core planning documents - NSW 2021: A Plan To Make NSW Number One and NSW Government State Infrastructure Strategy December 2012. In particular, there is a firm Government agenda to consider collaboration with the private and not for profit sector in service development proposals. The changed government health policy environment dictates that new pathways to service development be explored to consolidate models of care that provide the right services by the right team in the right place at the right time.

Innovation and organisational change will need to be explored to ensure new and enhanced services and additional infrastructure can be funded and brought on line. This section outlines eight priority strategic directions that will underpin service developments, enhancing the way health care is delivered and organisations partner for better health in local communities:

- Build capacity to effectively service growing demands for health care
- Redesign of services bringing them closer to people and their communities
- Integrated action with the South Western Sydney Medicare Local
- Partnering with external providers to deliver public health care
- Enhancing service networks and growing centres of excellence
- Shared access to unified information for all the health care team
- An integrated focus on primary prevention for patients and communities
- Embedding education and research within service delivery
Multifaceted action will be required to make progress on these fundamental service development directions. High priority actions are identified under each direction to drive developments forward. Many of these actions require additional funding and a flexible approach will be required to identifying sources of funding and engaging with partners in collaborative service development to optimise benefit to communities.

9.1 Build capacity to effectively service growing demands for health care

The highest priority for SWSLHD over the coming decade is to build capacity to meet the growing demands for health care services from population growth and ageing. Capacity is broadly defined in this context, referring not only to buildings and equipment, but also activities; resources; technology; skills, knowledge and capability to take opportunities; leadership; learning and education; awareness, confidence, motivation and empowerment; and enabling policies and systems.

Building capacity must remain the prime response to managing the risk of being overwhelmed by healthcare demands. It needs to be a driving force across all aspects of the LHDs operations, including in:

- Physical infrastructure at hospitals, for community based services and for new models of integrated care provision
- Enhancement to the staffing levels available to provide patient care
- Skills enhancement to ensure that the highest quality of care is provided at all times
- More efficient and productive ways of operating through new models of care and clinical redesign
- Enhanced education and research to ensure the latest advances in treatment and care are available to local populations

The SWSLHD 2012 Asset Strategic Plan identifies infrastructure development priorities to consolidate an efficient and viable mix of services at the major hospital sites in the District so that the future models of care can be made available equitably to all SWSLHD residents, ensuring that the majority of the healthcare needs of local populations can be met by high quality services provided within local communities. The top five priorities are major cost hospital redevelopment projects and there is considerable risk that they may not be fundable through the State’s ten year Health CISP. Attempts to partially meet demand through dismantling of integrated development strategies into smaller projects would be at significant opportunity cost, neither providing an efficient return on investment, nor a sustainable or adequate response to future need. The five highest infrastructure priorities also do not extend to the urgent need to renew health infrastructure available in community settings. Therefore, although building infrastructure capacity remains a critical service development priority, other priorities identified within this section will need to be progressed at the same time, reflecting the inevitable risks and constraints in timely delivery of additional infrastructure.

The highest priority actions SWSLHD will pursue to build capacity are:

- Re-appraisal of the top five infrastructure development priorities (Section 9.1) for inclusion as priorities in the 2013 SWSLHD Asset Strategic Plan and subsequent iterations, noting the urgent need to address infrastructure development in community as well as hospital settings. A strengthened asset planning process is required for this re-appraisal with thorough consideration and economic appraisal of non-asset strategies and alternative service models, hospital avoidance strategies and private or not for profit sector involvement in responding to demand growth
- Providing additional, enhanced and new clinical services of greater sophistication and complexity across all SWSLHD hospitals, consistent with their expanding role in service networks, using contemporary models of care (Section 8.2), achieving the service development directions outlined at Appendix A19 and aiming for increased role delineation levels (sophistication and complexity of services provided) in greater than 40 clinical services (Appendix A3) provided across the SWSLHD hospital networks
- Develop a ten year SWSLHD Workforce Development Plan with a horizon scanning view, aligned to the NSW Health Professional Workforce Plan 2012-2022, to ensure that as services develop a high quality workforce is grown and supported to provide contemporary models of care, reflecting core attributes of right people, right skills and right place, fully recognising the value of generalist and specialist skills and the need for job redesign.
- Developing stronger more comprehensive educational services for all employees with flexible technology assisted learning opportunities facilitated through partnerships with the Health Education & Training Institute, Universities, TAFE NSW and professional colleges; utilising modern state of the art facilities including the HWA funded South Western Sydney Education Centre and the Ingham Institute’s Clinical Skills and Simulation Centre.
- Enhanced attention to patient-centred care, meeting the National Patient Safety and Quality Standards and National Health Performance Authority Indicators, fully implementing initiatives of the Clinical Excellence Commission and the Agency for Clinical Innovation.
- A systematic rolling program to plan for, implement and evaluate new models of care and undertake clinical redesign programs in priority areas, reviewing the efficiency and effectiveness of services and models of care and identifying strategies for reengineering and disinvestment.

### 9.2 Redesign of services bringing them closer to people and their communities

A constrained State budget means that the projected rapid growth in demand for health care across SWSLHD is unlikely to be met through a high cost hospital centred service development approach. Not only would this be unfundable, it would create inefficiencies and pressures at already crowded hospital campuses, an inappropriate response to community need, in contradiction to contemporary models of care which increasingly see the migration of acute ambulatory care and short stay hospital services to community settings. The establishment of Medicare Locals sees an increased focus on the integration of care pathways seamlessly across primary, secondary and tertiary care. The evolution of integrated primary and community care as the preferred health care delivery model for new housing developments such as the SWGC provides impetus for dissemination across the community health sector. At the same time the existing infrastructure capacity in community health struggles to meet existing demands with fragmentation arising from service relocations due to deteriorating building stock. A high priority for SWSLHD will be fundamental redesign to provide services closer to their homes and the communities in which they reside.

The highest priority actions SWSLHD will pursue to bring services closer to people and their communities are:

- Undertake a root and branch review of the range of services, models of care and service delivery mechanisms of Community Health Services, to identify which core clinical programs (e.g. early childhood; child protection; child, adolescent and family; community development; multicultural health; sexual health; women’s health; sexual assault, HIV/AIDS; community counselling; community nutrition; youth health; community nursing, community palliative care) should remain within the realm of public sector community health provision and those that might optimise community benefit through provision in partnership with the profit or not for profit sector. The review should identify service delivery arrangements that promote greater integration with primary care, increasing efficiency and productivity, managing with constrained funding and better outcomes for communities.
- Establish Regional IPCCs at Oran Park and Leppington by 2021, to provide a seamless and integrated continuum of services across prevention, primary care and ambulatory specialist care, within the local SWGC community. The preferred organisational model for providing these services is through an autonomous not for profit entity with active community participation in governance structures, a flat single line management structure, single shared service entry portal, shared medical record, providing multidisciplinary team care with clear delineation of clinical governance.
• Explore potential to consolidate the existing matrix of community health provision, from eleven major Community Health Centre sites and greater than 60 smaller outlets, into larger centres providing a greater range of services more efficiently, matched specifically to local health needs and readily accessible by local communities. From this process a Community Health Renewal Strategy will need to be included in the SWSLHD Asset Strategic Plan. This Renewal strategy will need to consider opportunities to establish “health care precincts” with clusters of related private and public health services, a key infrastructure development priority from the NSW Government State Infrastructure Strategy. The opportunity to provide general practitioner and other private primary care services under an IPCC model of care should be explored at consolidated Community Health Centre sites.

• Establish a rolling program for the increased migration of acute ambulatory care and day stay hospital services to community health centres, to enhance local access for communities and provide demand mitigation at highly congested hospital sites. The range of services that could potentially transfer include ophthalmology, day hospital, renal dialysis, ambulatory cancer care, infusion therapies, antenatal maternity care, less complex procedural activity, urgent care centres, ambulatory medical specialist activity etc.

9.3 Integrated action with the South Western Sydney Medicare Local

There is untapped potential for community benefit from establishing collaborative programs with the newly formed SWSML, enabling seamless continuity of care in communities. This can be facilitated through mechanisms of structural integration, which to date has not progressed beyond reciprocal Board membership. Formal structures for integrated action need to be established at other levels to provide a cohesive approach in addressing population need. This includes finalisation of the Collaboration Agreement which outlines how each organisation will work together to address agreed Common Health Priorities, to facilitate commitments outlined in the Statement of Intent signed in April 2013. The Collaboration Agreement emphasises a focus on working with significantly disadvantaged families and communities, including and particularly in Aboriginal communities and culturally and linguistically diverse communities.

Under the proposed structure in the Collaboration Agreement, joint funded Priority Issue Working Groups will be established to undertake time limited projects in areas of high need. These collaborative projects with shared funding will build on trail blazing projects such as the Connecting Care Program and Triple I (Intake, Information and Intervention) Hub. Already integrated planning activities are underway with SWSLHD tendering with SWSML to provide a Population Health Needs Assessment. Linked up structures will be required to sustain integrated action beyond this process in planning and in other areas where populations benefit from integrated actions across a continuum of care. One area where each organisation has identified significant potential benefit to patients, communities and the health system is in the development of care pathways which facilitate integrated action with NGOs and the health and non-health community sector.

The highest priority areas where SWSLHD will pursue Integrated action with the SWSML are in:

• Preventative Health – a core role of Medicare Locals is to form and sustain effective partnerships within the health sector and between the health sector and other sectors to ensure effective preventive health actions. A goal for the future would be to ensure an integrated preventative health strategy is working across all settings of care, involves all providers of care, all tiers and agencies of government and is embedded in community action. The potential to leverage benefit for local communities from location of the NSW Office of Preventative Health in south west Sydney will be pursued.

• Improving access to care providers in the community – a sustained collaboration to increase access to care providers in the community addressing the current sub-optimal allocation of resources, long waiting lists and, in particular lack of availability of after-hours care. A multilateral partnership approach is required,
aiming for extended hours availability across primary care, community health services and specialist services outreaching from hospitals, to avoid inappropriate hospital attendance due to lack of alternatives

- Interface with clinicians – an integrated clinical governance framework will be pursued, spanning across the LHD’s Clinical and Quality Council and the ML’s Primary Care Clinical Council
- Key performance Indicators – moving towards shared ownership by the LHD and ML of a core set of indicators to measure the impact of integrated action in improving health outcomes in targeted populations or areas of health need
- Community participation – developing a shared Consumer and Community Framework, growing the LHD’s hospital based community participation networks to facilitate consumer and community engagement on issues of primary care

9.4 Partnering with external providers to deliver public health care

Building of capacity in health infrastructure (capital, services and staff) has been identified as a priority across all regions of SWSLHD; however there is recognition that the required developments may not be fundable from the State budget. Government strongly supports the exploration of Public Private Partnerships (PPP) whereby the public sector contracts on a long term basis with the private sector for the provision of a public service. This is a core strategic priority identified in the NSW Government State Infrastructure Strategy. SWSLHD’s strategic planning adopts a broad remit in identifying PPP opportunities, to encompass integrated service delivery arrangements extending beyond the “private” sector across tiers of government and with non-government and not for profit organisations. Progress to date has essentially been reactive in consideration of PPP opportunities, responding to proposals from the private sector, including those made under the Government’s Unsolicited Proposals process. The strong view of Government is that proactive identification of PPP opportunities occur, across a broad spectrum of healthcare delivery. Priority areas where SWSLHD will explore partnering opportunities for the delivery of public health care include for:

- Diagnostic and interventional laboratories within public hospitals – cardiac catheterisation, interventional radiology, endovascular, cardiac and pulmonary diagnostics, etc.
- Medical specialty centres in the community providing a range of day procedures – day surgery, endoscopy, ambulatory cancer care, etc.
- Enhancing a PRNIP medical centre specialist model of care for ambulatory consultancy, diagnostic and minor procedural services
- Full service procurement in the private sector for high demand and projected high growth specialties where there are difficulties in meeting current demands e.g. some forms of elective surgery
- A private model of care within public hospitals with quarantined patient flow for elective high volume surgeries such as minimally invasive and endoscopic surgery
- University affiliated ambulatory care clinics
- Medical imaging provided from SWSLHD hospital sites
- Privately referred outpatient clinics and the formal involvement of GPs in shared care arrangements, in providing health services and referring patients back to GPs for ongoing care

Priority will also be given to developing a stronger organisational framework for collaboration with the charitable sector on fund raising.

At a systemic level, SWSLHD will strengthen its partnerships within the public health sector, including with the MoH Pillars (CEC, ACI, HETI, BHI & NSW Kids and Families) and locally with institutions such as the Ingham Institute for Applied Medical Research. It will also enhance partnerships with academic institutions leveraging the unique opportunity of intensive sustained collaboration with three major Universities – Sydney, NSW and Western Sydney.
SWSLHD’s planning has identified potential opportunity at all hospitals to explore the provision of additional capacity through a partnership arrangement with an external provider of care. For SWSLHD, the need to build capacity (beds, services and staff in hospitals and in the community) has been identified as a particular priority in mental health, aged care and paediatrics. SWSLHD will prioritise investigation in these clinical areas to explore whether sustained long term partnerships can be established for an external partner to manage the provision of public health care:

- maintaining and restoring mental health – exploring options for a partnership arrangement in provision of sub-acute mental health care
- aged care – given that a significant increase in sub-acute care capacity is projected for the Fairfield/Braeside hospitals campus, opportunities will be explored for a partnership with the Affiliated Health Organisation Hammondcare to develop and operate this additional capacity, which could be located on either of these adjacent hospital sites
- Enhancing capacity to meet the health care needs of children locally – in the context of the NSW Kids and Families statutory health corporation undertaking strategic planning and assessing the need for a new NSW Kids hospital providing tertiary & quaternary services, SWSLHD will actively explore options for developing a new Kids Hospital at the Campbelltown Hospital campus.

9.5 Enhancing service networks and growing centres of excellence

Strategic planning has identified fundamental overarching concepts to frame models of care development, emphasising the community benefit to be gained from stronger clinical networks and supporting all services in achieving excellence. Most clinical networks operate within SWSLHD boundaries, linking a clinical service across sites with integrated service provision; however, some also extend across other LHDs, particularly SLHD, often reflecting historical antecedent.

SWSLHD will prioritise the enhancement of clinical networks to optimise service delivery, facilitated through a focus on continuity of care, efficient resource management, flexibly deploying skilled staff, addressing inequities in health outcomes, improving patient access, ensuring evidence based best practice and enhancing teaching and research. Enhanced clinical networks will be a focus for all clinical streams and facilities in the District, growing consistent with the principles for clinical network development identified at section 8.2 of this plan and with clear identification of the benefits of the network for all stakeholders.

Recognising that maintaining effective networks of care requires leadership, SWSLHD will also prioritise growth in “centres of excellence” to further strengthen clinical networks. These centres of excellence will aim to attract a sufficient volume of patients to provide the critical workload mass that enables high quality staffing, education and research. The development of centres of excellence will be within a rigorous framework which clearly defines the characteristics of these centres, clarifies through research the expected health and operational outcomes and identifies services where development as a centre of excellence can optimise health benefit.

Distributional equity will be a priority focus in determining how service networks are enhanced and where centres of excellence are developed. The first principle will be that services are developed and resourced at the appropriate site, taking into account issues such as safety, the availability of required support services and the ability to attract and sustain workforce. The second principle will be that the value of networking is optimised, for all the network partners. As part of this process there will be a need to clearly enunciate and understand the role of smaller facilities in networks and to strongly support these facilities in achieving that role.

Planning has identified service developments which will allow networks of care to be expanded, creating potential for role delineation levels to increase for individual services at individual facilities. The priority focus
Sustained will be on strengthened networks that enable a range of sites to increase their role delineation level, rather than building up a hub of service provision at a prime site and not building the capacity to provide higher levels of care at spoke sites. Community benefit is optimised where all sites within the clinical network make advances in the level of care that they can provide.

The highest priority areas where SWSLHD will aim to enhance service networks and grow centres of excellence will be in:

- Strengthening of existing well performed service networks e.g. orthopaedics with the elective hub at the Whitlam Joint Replacement Centre Fairfield and orthopaedic trauma hub at Liverpool; Upper Gastrointestinal Surgery with hub at BLH; trauma, neurosurgery, gastroenterology, colorectal, rheumatology, interventional radiology hubs at Liverpool Hospital
- Establishing new service networks and centres of excellence in Surgical and Procedural Care e.g. High Volume Short Stay (HVSS) units at BLH and Campbelltown Hospital; stand alone endoscopy units at BLH, Campbelltown and Liverpool hospitals; hand surgery at Fairfield Hospital
- Establishing new centres of excellence e.g. a Pelvic Cancer Surgery unit at Liverpool Hospital and Breast Cancer Assessment Unit at Liverpool Hospital, with breast surgery disseminated across hospitals
- Sustained action to increase the role delineation (sophistication and complexity of care) of most clinical services provided at Campbelltown Hospital, including in diagnostic support; endovascular procedures; medical care such as neurology, renal, respiratory; surgical care such as thoracic, plastic, orthopaedics; and in maternity care
- Explore options for leading a State-wide network for the provision of lower volume highly specialised surgery such as for upper GIT malignancy and pancreatic procedures
- Establishing strong and sustainable SWSLHD specific networks and centres of excellence for services previously the subject of IDAs with SLHD, including in mental health, oral health, drug health, community paediatrics, population health etc. As these SWSLHD specific networks are embedded, there will need to be a strong focus on modes of operation and development strategies that meet the priority health needs of communities in south west Sydney and the Southern Highlands

9.6 Shared access to unified information for all the health care team

Information management issues were frequently raised as a fundamental concern in the strategic planning process, including from clinicians, consumer and community networks, government and non-Government health related agencies and primary care providers. All identified concern with the ability to efficiently transfer health information between providers of care to support seamless continuity of care. Most stakeholders identified problems with the flow of information, including in the coordination of discharge, transfer of care between units, transition from the ED to inpatient wards and in supporting ongoing management of care in the community.

These are long standing issues and have been addressed in previous information management strategies e.g. a prime objective in the SWSAHS IM&TD Strategy 2009 – 2012 was to enable more effective collaboration between clinicians and patients across care settings. The strategic approach adopted has been to extend the hospital based patient centred eMR to incorporate health information from stand alone clinical information systems maintained within the LHD. This centralised repository of health information could potentially be accessed by all of the LHD’s care provider team, including through remote wireless connectivity.

Whilst supportive of collaborative care across the LHD’s care teams, this approach fails to recognise that seamless continuity of care requires linked –up teams extending beyond LHD employ, including primary care providers in private practice and potentially other providers in the government, private and not for profit sectors. To support efficient and seamless continuity of care the priority service development direction in
information management should be to facilitate access by all healthcare team members to the LHD’s unified health record, irrespective of the provider’s employ. This requires a secure, accurate and robust communication system, meeting privacy obligations.

Strategic planning also identified concerns that the emphasis in information management to date, extending and enhancing the mainframe patient centred eMR, has for south west Sydney proceeded patchily, with varied implementation of different components across sites and less than optimal achievement of an integrated suite of critical health information. Whilst at the patient level, there has been the consolidation of health information to support clinical decision making, it was considered that the ability to extract an integrated suite of de-identified data to support the LHD’s goals in service planning, redesign, performance monitoring, efficiency auditing and research are underdeveloped.

The highest priority areas where SWSLHD will pursue the unification of health information, accessible by all the health team, meeting the information needs for patient care, service development and enterprise enhancement are in:

- Establishing a priority IT development agenda to provide all health professionals in the care team with access to the hospital eMR from remote locations e.g. general practice and other community based primary care providers, community health, outreach specialist services, other community services which work with patients and carers
- Developing a SWSLHD Enterprise Data Integration Model converting core de-identified clinical data into reporting modules to support decision making on Enterprise issues such as performance monitoring, efficiency auditing, clinical redesign and service development
- Expanding teleconferencing, telehealth, web based technologies and fibreoptic initiatives to improve the connectivity of all the health care team, including patients and carers, ensuring seamless continuity of care
- Supporting research and academic endeavours by developing research modules within the eMR and firewall traversal to universities and other research institutions
- Exploring innovative web and social media programs to provide a portal for all the community and service providers to access a unified service directory (health related government, non-government, not for profit and private agencies/providers) and access resources in health information, education and health literacy that support wellness and preventative health

9.7 An integrated focus on primary prevention for patients and communities

One of the prime ways SWSLHD can work for better health in local communities and seek to mitigate significant increases in demand for health care projected over the next decade, is through a concerted effort in primary prevention i.e. supporting communities to maintain or improve their health and avoid illness that will require health care services. Many factors combine together to affect the health of individuals and communities, including the social and economic environment, the physical environment, and a person’s individual characteristics and behaviours.

Primary prevention involves action on the determinants of health i.e. the range of behavioural, biological, socio-economic and environmental factors that influence the health status of individuals or populations. Potential areas of action include addressing health risk behaviours e.g. alcohol use, diet, sexual activity, sun exposure, tobacco use; environmental issues e.g. water and air quality; built environment, food safety; and/or socio-economic determinants e.g. social and support networks, health literacy; housing. Effective primary prevention approaches are generally characterised by the use of multiple strategies, the utilisation of different settings and the targeting of action to the diverse needs of individuals.

Community benefit from primary prevention is optimised by working in partnership with key agencies and groups across all tiers of government, the non-government and not for profit sector and with the private
sector. New and enhanced partnerships are required with emerging agencies such as Medicare Locals, which have been mandated to deliver health promotion and preventative health programs targeted to risk factors in their local communities.

A core area where primary prevention can generate return on investment is through focus on a small number of modifiable risk factors responsible for the burden of preventable chronic disease. These include behavioural risk factors of tobacco smoking, physical inactivity, alcohol misuse and poor nutrition, which also contribute to biomedical risk factors of obesity, high blood pressure and high blood cholesterol. Reducing these risk factors has benefits across a range of health problems, reducing health care demands from illnesses such as ischaemic heart disease, stroke, Type 2 diabetes, kidney disease, arthritis, osteoporosis, lung cancer, colorectal cancer, chronic obstructive pulmonary disease, asthma, depression and oral health.

Strategic planning identified prime service development directions in primary prevention as increasing the adoption of healthy lifestyles and the development of healthy environments. Service development in primary prevention will require increased investment in community-based programs that improve and maintain population health and reduce inequalities in health outcomes. To date, activities have focused on priority program areas of tobacco control, physical activity and nutrition, injury prevention and mental health promotion.

Future priorities identified for health promotion include closing the gap in Aboriginal life expectancy and health status (particular attention to overweight and obesity, smoking related harm, social and emotional health and injury), promoting healthy populations using both whole of population approaches and those targeted to disadvantaged and high needs groups (particular attention to healthy weight in children, overweight and obesity, smoking related harm, mental health and falls in older people); and Improving physical and social environments through design and development of healthy built environments, healthy food environments and reducing the health impact of disadvantage.

The focus on primary prevention will not be at the expense of continuing attention by SWSLHD to other levels of preventative health activity. This includes primal prevention (inhibiting long-term health consequences from gestational history), secondary prevention (reducing progression of disease through early detection, usually by screening at an asymptomatic stage, and early intervention), tertiary prevention (improving function and minimising the impact of established disease, and preventing or delaying complications) and quaternary prevention (inhibiting unnecessary health intervention).

The highest priority areas where SWSLHD will aim to increase investment and contribute to an integrated and multilateral focus on primary prevention will be in:

- Closing the gap in Aboriginal communities – programs developed in partnership with Aboriginal Land Councils and health organisations and collaborating with the SWSML, aiming in particular for reductions in overweight and obesity, smoking related harm and injury
- Providing children and youth with the best start in life – programs in partnership with all tiers of government, schools, early childhood education and care centres, youth services etc. including early childhood sustained home visiting in the first two years of life to vulnerable families and the promotion of healthy weight in children aged 0-18 years
- Reducing the burden of preventable chronic disease - consistent with the focus of the Australian National Preventative Health Agency and the NSW Office of Preventative Health reducing lifestyle related risk factors which lead to chronic disease through programs addressing smoking, obesity, healthy eating and drinking, food security, physical activity and falls prevention
- Reducing the health impact of disadvantage – targeting primary prevention programs in areas of locational disadvantage, multilateral action on community renewal and for people experiencing housing risk, ensuring programs address health inequity
Building and maintaining healthy environments – collaborating in the urban development process to influence healthy urban design, working with planning agencies to develop healthy urban environments that promote safety, encouraging social interaction, cohesion, connectivity and active transport; participating in community renewal activities; building healthy food environments.

Research and education to enhance the evidence base for primary prevention – collaborating with academic institutions in innovative programs and research in population health and with the NSW Office of Preventative Health in piloting State programs, action research to develop sustainable models for collaborative action with local agencies across all tiers of government and with non-government, not for profit and private organisations, to promote population health.

9.8 Embedding education and research within service delivery

Communities benefit significantly from having a vibrant teaching and research ethos in health care facilities. Although health care is the prime focus of SWSLHD’s services, a strong relationship with educational institutions and fostering of life-long learning and critical appraisal is essential in developing future health professionals and in strengthening research and evaluation.

Research is critical to bringing to the community the benefits associated with medical breakthroughs and improved understanding of health, wellbeing, disease, healing, health services and systems. Research fosters a spirit of critical enquiry and analysis and together with teaching, it provides a dynamic environment of collaborative exchange, new ideas, reflective discourse and a team approach where professionals learn from one another. These attributes are essential to improving quality, innovating and growing services; in developing new policies and care systems which are evidence based; and ensuring that health services and programs for the local community are efficiently and effectively provided.

An ongoing commitment to teaching and research is important in developing or attracting the most talented health professionals to lead in their fields of patient care, teach students and undertake research. The commitment of these highly qualified staff to service improvement and quality enhancement is integral to the pursuit of excellence.

With a growing and ageing population, South Western Sydney will need to develop or attract and retain a large and skilled workforce. Clinical teaching in South Western Sydney will increase students’ knowledge and understanding of the interplay between biological and social determinants of health; the importance of collaboration and communicating effectively with patients, carers, and clinicians and other service providers; and develop the skills required to provide high quality care. Community capacity and viability will also be increased by contributing to the health qualifications and skills of residents and by attracting and retaining high quality graduates who wish to undertake research and work with leading health professionals.

The highest priority areas SWSLHD will pursue to embed teaching and research into service delivery will be by:

- Creating a stronger research and teaching culture through enhanced leadership and direction at a Board, District, Clinical Stream and professional level, the greater recognition of research achievement and by attracting and retaining high quality academic clinicians in close collaboration with university partners and the Ingham Institute.
- Ensuring that University and TAFE curriculums and workforce development programs address local needs, service delivery and skill requirements and that clinical and non-clinical staff have the essential skills required to provide quality teaching and learning experiences for undergraduate and postgraduate students and the broader workforce.
- Leveraging off existing partnerships with universities and research centres, encouraging research that focuses on national, state and local priorities and service developments and builds collaboration across professions, specialties and facilities.
Growing and developing the research skills and capacity in clinical staff through stronger education, mentoring and support and by encouraging enrolment into postgraduate research courses. This includes building clinical trial capability by promoting the use of clinical trial methodologies in all aspects of clinical service practice, developing the governance and support structures required to enable quality research to be undertaken and streamlining business processes to improve efficiency and competitiveness.

Increasing the community’s willingness to participate in research and clinical teaching programs through a deeper knowledge and understanding of the importance of health research and teaching in creating a high quality skilled workforce and improving the health of the community.

Utilising the new Clinical Skills and Simulation Centres, South Western Sydney Education Centre and other local educational facilities, with effective intra-LHD linkages between facilities, to develop the clinical skills and techniques of health students and professionals, strengthen clinical leadership teamwork and communication, and translate research into practice in a safe and supported environment.
10. Implications for Infrastructure Development

Appendix A7 outlines a range of health infrastructure developments that have been achieved across the geography of SWSLHD in recent years. At Section 7.1 a range of contextual issues are identified that will impact on the ability of SWSLHD to address growing healthcare needs over the decade to 2021, driving the need for infrastructure renewal and development in LHD. These include increased healthcare capacity in the next ten years are rapid population growth, with a 20% increase projected overall and a 50% increase in those aged 70-84 and 85+ years. Lifestyle behaviours of local communities and socio-economic disadvantage will also have a continuing impact on healthcare demand.

As a result, SWSLHD will need to undertake a sustained and rolling program of service enhancement and infrastructure development to meet growing demands for healthcare. This will include increased capacity to provide:

- Inpatient, outpatient and ambulatory care services at hospital facilities
- Care in the community, from community health centres; through new models of integrated primary and community care which may be centre based or embedded in primary care practice; and through increasing transition of ambulatory care provision from hospital to community settings
- Preventative health, consultation, information and advice provided by health professionals to patients through technology enhanced communication mechanisms including social media and through virtual means, including NBN enabled technology to patient’s homes
- Connecting infrastructure to support teamed and linked up healthcare provision across continuums of care and practice settings

10.1 Current Infrastructure Development Priorities

The widespread range of models of care identified for progressive implementation across SWSLHD at Section 8 and Appendix A18 will substantially shape the future directions for infrastructure development across SWSLHD. This will build on current funded enhancements and the range of developments identified in the SWSLHD 2013 Asset Strategic Plan. The 2013 iteration of the LHD Asset Plan has been described as a work in progress (p.12 of ASP), in that it was prepared before finalisation of this Plan on strategic priorities in service delivery to 2021. Future ASPs will expand on asset needs, opportunities and solutions to implement the evolving and improved models of care that have been identified.

The SWSLHD 2013 Asset Strategic Plan has identified priorities for infrastructure development in SWSLHD. These priorities reflect the need to continue the program of infrastructure redevelopments commenced at Liverpool and Campbelltown Hospitals to meet current and projected patient demand. They also reflect the intention to consolidate an efficient and viable mix of services at the major hospital sites in the District so that the future models of care can be made available
equitably to all SWSLHD residents, ensuring that the majority of the healthcare needs of local populations can be met by high quality services provided within local communities. The rationale for identification of these priorities was as follows.

1. **Mental Health Stage 1 Campbelltown Hospital**

   Campbelltown mental health is the highest priority because current mental health bed capacity in SWSLHD is well below the benchmark level to the need revealed by the Ministry of Health’s endorsed *Mental Health Clinical Care and Prevention Model* (MHCCP Version 2010). The lack of bed capacity results in seriously disturbed and difficult to manage mental health patients spending extensive time in emergency departments whilst awaiting beds, consuming significant staff resources in observation and care, with implications for optimising patient flow, disruption to the ED environment and for the quality of care that can be provided in the acute phase of mental illness. A number of patients eventually require placement in facilities outside the LHD, including the Concord Centre for Mental Health. This access will become increasingly problematic as ABF funding is expanded to encompass mental health.

2. **Liverpool Hospital Stage 2 - Phases 2 & 3**

   The 2nd priority because the Stage 2 Phase 1 redevelopment currently under progressive commissioning addresses only the acute needs of the hospital for additional medical and surgical beds and operating/procedural room capacity. It does not provide additional capacity in aged care, rehabilitation and psychogeriatric care required to increase the significant aging of SWSLHD communities where those aged 70+ years are expected to grow by around 50% over the next ten years. Nor does it provide for additional capacity in maternity, neonatology, brain injury, emergency, allied health, community health, dental, support services such as pathology and food services, or for a redeveloped Cancer Care Centre to meet the projected 63% increase in prevalence of cancer in SWSLHD between 2007 and 2021, the highest of any LHD. All these services will require expansion to enable the campus to function operationally and cost effectively to meet projected patient demand. Without the expansion in aged care and rehabilitation capacity there will be significant impact on length of stay in the high cost environment of acute care with implications for financial viability under ABF and ability to meet NEAT targets.

3. **Macarthur Stage 2 (Acute) Campbelltown Hospital**

   The 3rd priority because the Stage 1 redevelopment currently underway will meet only around 40% of the additional capacity identified as required by 2021 in *A Clinical Services Plan for Macarthur to 2021*. The Stage 1 redevelopment does not address significant service expansions required to meet projected need such as the Cancer Therapy Centre which is already struggling to meet demand within current capacity, significant emergency department expansion required to meet the projected 40% increase in ED attendances projected in Macarthur by 2021, sufficient inpatient ward capacity or additional operating theatre capacity to enable Campbelltown to take its place as a Principal Referral Hospital surgical unit within the SWSLHD surgical network.

4. **Bowral & District Hospital (Masterplan Strategy)**

   The 4th priority because of the imminent need to address the poor quality of aging building fabric there and the need to provide additional medical and surgical beds in the hospital and expand ambulatory care and ED capacity. The aging of the Wingecarribee population indicates that additional dedicated aged care, rehabilitation and palliative care beds will be required within the next decade. Community Health also needs redevelopment.

5. **Bankstown-Lidcombe Hospital (Clinical Services Development Plan strategy)**

   The 5th priority because of the need to expand the hospital in niche areas of service provision and to consolidate its role within the networks of care developing in SWSLHD, particularly in surgical care. This will
enable BLH to further develop contemporary and emerging models of care such as in High Volume Short Stay (HVSS) surgery, a dedicated stand alone endoscopy unit, endovascular interventional unit and further development of centres of excellence in gastroenterology, upper gastrointestinal tract surgery and potentially other surgeries such as pancreatic, colorectal etc. These developments will be very important in enabling cost effective and revenue optimising activity under ABF funding. Additional capacity in ED, cardiology, mental health and cancer care are also required at BLH.

10.2 Infrastructure Development Directions for the NSW Health System

The NSW Government has announced a program of new hospital works to start in 2012 and 2013. The Campbelltown Hospital (Acute) Stage 1 redevelopment is part of that program and will provide an additional 90 beds to be available from 2015-16. The NSW Government is considering projects from the SWSLHD 2012 Asset Strategic Plans for inclusion on the MoH ten year Capital Investment Strategic Plan (CISP). As reported in Infrastructure NSW’s 20 year State Infrastructure Strategy (p.167), Infrastructure NSW, the Ministry of Health and NSW Treasury are reviewing these capital plans for the 2013-14 Budget.

Infrastructure NSW have recommended to Government service development directions for Health infrastructure over the next twenty years at Section 13 of their State Infrastructure Strategy (SIS) report, released October 2012. This report has been informed by documentation from the MoH and will inform the Government’s view as to the health infrastructure proposals to be supported within the CISP. The SIS report asserts that NSW is already well serviced with large full-service general hospitals (SIS p.171). It contends that contemporary models of care will lower demand for high-cost hospital services over time and significantly change the portfolio of health assets needed into the future (SIS p. 168).

The MoH advice reflected in the SIS report is that growth across the state of 1.5% p.a. in the number of hospital beds will be required over the next ten years, lower than growth in demand because as models of care change, bed numbers decrease in relevance as more services are provided out of hospital (SIS p.165). In this context, the SIS report makes a number of recommendations about service development directions with a view to a reformatting of the portfolio of health assets needed into the future, including:

- Reducing the high proportion of private hospital patients in public hospitals, freeing up hospital capacity for public patients, reducing the need for new capital expenditure (SIS p.166-167)
- Repurposing community and family health centres to deliver new models of care with a mixture of general practice, public health and private services (such as diagnostics), through partnership models with private and not-for-profit organisations, providing a convenient local access point to health services that facilitate integrated care (SIS p.169)
- Development of purpose built specialist standalone facilities (mini specialist hospitals) providing a limited range of medical treatments such as dialysis, ambulatory cancer treatment, cardiology diagnostics and day surgery, as an alternative to expanding existing hospitals. Alternatively, it suggests that these services be purchased from the private sector, potentially through a model similar to Independent Sector TreatmentCentres in the UK (SIS p.169)
- Outsourcing through full service procurement to increase the private sector’s proportion of supply of public health services, a buy rather than build strategy, with in the short term use of excess capacity in the private sector (SIS p.170)
- Establishing centres of excellence in pro-actively planned health care precincts with clusters of related health services delivered by government and non-government providers, optimising the benefits of agglomeration, specialisation and networking (SIS p.171)
• Exiting clinical support services at existing sites (imaging, pathology, pharmacy etc) and non-clinical support such as car parking where the private sector can provide these services at an efficient price, with recycling of capital to provide other services such as beds (SIS p.171)

The Government’s response to Infrastructure NSW’s SIS, the NSW Government State Infrastructure Strategy 2012 \(^31\) identifies service development directions for health infrastructure as highlighted.

The SIS report’s emphasis on integrated primary and community care centres, purpose built stand alone facilities, centres of excellence and optimisation of opportunities for private and not-for-profit partnership accord substantially with the model of care development directions identified at Section 8.2. The models of care proposed are essentially consistent. As they are adopted within SWSLHD close attention will be given to the opportunities for procurement and delivery of these models of care through the settings envisaged under the SIS.

It is important to note that South Western Sydney has high levels of social disadvantage and lower levels of private health insurance. As a result the level of private patients within public hospitals is significantly less than in more affluent LHDs and there has not been significant provision of private hospital beds (Attachment A10 identifies only 256 private beds across the whole of SWSLHD). Therefore the opportunities for a substantial impact from SIS initiatives such as freeing up of capacity through reconfiguring private patients to private hospitals or using excess private hospital capacity for public patients are severely constrained. Nevertheless, opportunities that are available will be pursued.

### 10.3 Inpatient Care at Hospital Sites

As identified at Section 6.2, to meet the projected additional demand for public healthcare provision over the next decade SWSLHD will need to provide additional resources approaching 900 beds or bed equivalents in service provision. This is across the spectrum of day only and overnight acute and sub-acute hospital beds, mental health beds, chairs for infusion therapy, emergency department treatment spaces and for some components of ambulatory care provision such as HITH.

Resourcing this additional 900 beds or bed equivalents represents only what is required to address the projected increased demand at the MoH benchmark occupancy levels. It does not address any deficits that may exist in the capability of LHD to meet current demand at these benchmark occupancy levels. It is noted from Infrastructure NSW’s SIS report that SWSLHD had for June 2011 the highest occupancy level of any LHD, well above the benchmark of 85% and approaching 100% (SIS p. 166). The extent to which this deficit exists is illustrated at Appendix A19 which outlines the current services profile of facilities, their average available beds

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**Service Development Directions in Health Infrastructure**

The NSW Government’s strategic priorities focus on developing “health care precincts”, demand management strategies and supporting the delivery of health services and facilities by a range of public and private providers. Specifically:

- Establish “health care precincts” with clusters of related private and public health services
- Identify opportunities for non-government provision of non-clinical support services; and reconfiguration or divestment of assets
- Develop an overall integrated service delivery model to deliver a range of services at multipurpose facilities
- Investigate expanding the provision of new public hospital capacity by the private sector in the short term and implement solutions to better meet demand
- Upgrade and build new healthcare facilities to meet demand; whilst implementing demand management strategies in response to growth, including clinical services redesign, integrated care models, out-of-hospital care and telehealth.

Source: NSW Government State Infrastructure Strategy December 2012 (pp’s 20-21)
over 2011-12, their activity in 2010-11 and the notional bed allocation that would be required to provide for that 2010-11 activity at the MoH benchmark occupancy levels.

The following table brings together this data from Appendix A19, which uses the MoH endorsed projection methodologies to provide a “supply” projection of how increased demand would be serviced across current facilities, assuming that the clinical profile and flow patterns of patients were maintained into the future. It takes no account of changed flow patterns that would be expected from the introduction of new services at a facility. SWSLHD would expect that new services would have a net impact of attracting some SWSLHD resident patients who currently receive care outside the LHD. Also some residents of adjoining LHDs residing close to borders may be attracted to new and enhanced SWSLHD services where they are geographically closer (natural flows). Appendix A8 identifies the current outflows of SWSLHD resident public patients to other LHDs and inflows from outside the LHD to SWSLHD facilities. Section 3 identifies some outflows that would be expected to be substantially turned around with establishment of new services in SWSLHD.

The table also assumes the current flow pattern to private hospitals remains with SWSLHD residents exercising their option to use a private hospital at current rates. If SIS recommendations for realignment of private patients from public to private hospitals are supported by Government and can be realised within the capacity of private hospital beds in SWSLHD, there may be scope to provide for some of the additional public demand into beds currently occupied by private patients. Full service procurement to purchase public beds from the private sector would also alleviate the impact on public hospital capacity but not change the population demand profile. The impact of other SIS initiatives to offset the increased demand on public hospital beds would likewise have an impact reflect on the setting of care and not on the overall demand profile e.g. some beds could be provided in specialist stand-alone facilities and HITH, being admitted activity, is included within the acute inpatient projections. Therefore, the increased beds or bed equivalents, whilst allocated to individual hospitals are best viewed as provided for hospital catchments i.e. on-site or in the community.

**Table 10.1 Additional inpatient beds required in 2021 at benchmark levels of provision**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Acute beds</th>
<th>Sub-acute beds</th>
<th>Mental Health beds</th>
<th>Other beds</th>
<th>Total beds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Avail. Beds</td>
<td>Req’d @ b’mark</td>
<td>Addit. to 11-12</td>
<td>Avail. Beds</td>
<td>Req’d @ b’mark</td>
</tr>
<tr>
<td>Liverpool</td>
<td>547 720 175</td>
<td>24 43 19</td>
<td>69 111 42</td>
<td>158 197 39</td>
<td>798 1,071 273</td>
</tr>
<tr>
<td>BtH</td>
<td>293 380 87</td>
<td>43 47 4</td>
<td>30 34 4</td>
<td>78 95 17</td>
<td>444 556 112</td>
</tr>
<tr>
<td>C’town</td>
<td>274 407 133</td>
<td>0 13 13</td>
<td>66 151 85</td>
<td>101 168 67</td>
<td>441 739 298</td>
</tr>
<tr>
<td>Camden</td>
<td>40 56 16</td>
<td>31 69 38</td>
<td>0 0 0</td>
<td>6 8 2</td>
<td>77 133 56</td>
</tr>
<tr>
<td>Fairfield</td>
<td>156 189 33</td>
<td>30 40 10</td>
<td>0 0 0</td>
<td>61 78 17</td>
<td>247 307 60</td>
</tr>
<tr>
<td>Braeside</td>
<td>0 0 0</td>
<td>72 120 48</td>
<td>0 16 16</td>
<td>0 0 0</td>
<td>72 136 64</td>
</tr>
<tr>
<td>Bowral</td>
<td>66 89 23</td>
<td>0 10 10</td>
<td>2 2 0</td>
<td>26 34 8</td>
<td>94 135 41</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,376 1,841 465</td>
<td>200 342 142</td>
<td>167 314 147</td>
<td>430 580 150</td>
<td>2,173 3,077 904</td>
</tr>
</tbody>
</table>

Overall, the “supply” projections at Attachment A20 are consistent with the demand projections presented at Section 6.2, with around an additional 900 beds required by 2021 at benchmark levels of provision to cater for the growth in demand for public healthcare.

All facilities across SWSLHD will require a significant expansion in capacity across all bed types:

- Acute – an additional 465 beds, with expansion mainly applying at Liverpool, Campbelltown/Camden and Bankstown-Lidcombe hospitals
- Sub-acute – an additional 142 beds, with expansion mainly applying at Braeside/Fairfield hospitals campus, at Camden Hospital and also at Liverpool Hospital
Mental health – an additional 147 beds, with expansion mainly applying at Campbelltown Hospital and Liverpool hospital, but also at Braeside

Other beds (ED, renal dialysis, perinatology and delivery) – an additional 150 beds mainly applying at Campbelltown Hospital and Liverpool Hospital.

### 10.4 Outpatient and Ambulatory Care at Hospital Sites

As identified at Section 6.2 and Appendix A15.9, demand for healthcare provided on an outpatient and ambulatory care basis is expected to increase significantly over the coming decade. This reflects evolving models of care for increased activity to be provided on an ambulatory basis at hospitals sites and in the community, including at domiciliary sites. The impact will be most evident in procedural medicine and in providing care for the significant increase in patients with chronic disease expected as demographic changes in population growth and ageing and the impact of lifestyle related preconditions for illness impact.

An overall increase in demand of 30% is projected and provision of an additional 750,000 NAPPOOS is estimated as necessary to meet that increased demand. Infrastructure development at hospital and community sites will be required to provide additional treatment spaces for this additional outpatient and ambulatory care service.

### 10.5 Staging of Hospital Infrastructure Development

The facility profiles at Appendix A19 identify that on the 2010-11 activity data, an additional 123 beds to the average available bed base in 2011-12 would have been required for SWSLHD facilities to provide the 2010-11 volume of care at MoH benchmark occupancy levels. Infrastructure development has been underway in SWSLHD to provide additional capacity to meet current and imminent forecasted demand. Infrastructure development to increase bed capacity is funded through the MoH CISP. The infrastructure developments currently funded by MoH on the CISP include:

- Liverpool Hospital Phase 1 stage 1, which with full commissioning will provide capacity for an additional 110 beds to the baseline average available beds in 2011-12 (additional theatre, procedural room and ambulatory care capacity is also provided). Full commissioning is subject to MoH funding and currently scheduled for 2013-14
- Liverpool Hospital Sub-acute Mental Health Redevelopment, a COAG funded initiative which will provide capacity for a net additional 11 sub-acute mental health patients at the Liverpool Hospital campus (25 bed unit, with decanting of 14 existing sub-acute mental health beds within the unit’s bed base). Full commissioning is currently scheduled for 2013-14
- Macarthur Stage 1 (Acute Hospital Services) Campbelltown Hospital Redevelopment which will provide capacity for an additional 90 beds to the baseline average available beds in 2011-12 (some additional ED,
pathology, outpatient and ambulatory care capacity is also provided). Full commissioning is currently scheduled for 2016-17.

In addition, detailed services planning has been undertaken to identify the infrastructure enhancements required at most hospital sites in SWSLHD to provide for projected demands in 2021. These requirements are detailed in reports:

- **A Clinical Services Plan for Macarthur to 2021 (SSWAHS 2010)**
- **Liverpool Hospital Phase 2 Development Business Case** (Capital Insight for Health Infrastructure NSW 2010)
- **Bowral and District Hospital Masterplan Strategy** (Capital Insight 2009)

NSW Health has recently advised that acute care is more costly and that sub-acute care is less costly than previously predicted. It will therefore be critical for the District to ensure that additional subacute beds are available therefore to improve the operating efficiency required by the National Health Reform and to meet patient rehabilitation needs.

The infrastructure developments identified in these documents, although scoped, remain unfunded. The hospital sites in SWSLHD where detailed planning for infrastructure development has not taken place is at the adjoining campuses of Fairfield and Braeside hospitals.

The relative contribution of funded projects; scoped but unfunded projects; and projects yet to be scoped in meeting the additional bed requirements at 2021 using MoH benchmarks is outlined in the following tables.

**Table 10.2  Liverpool Hospital – Infrastructure build to meet 2021 bed capacity benchmarks**

<table>
<thead>
<tr>
<th>Build Status</th>
<th>Infrastructure Development Phase</th>
<th>Beds Supplied</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Acute</td>
</tr>
<tr>
<td>Funded</td>
<td>Baseline - average available 2011-12</td>
<td>547</td>
</tr>
<tr>
<td></td>
<td>Full commission Liverpool Stage 2 Phase 1&lt;sup&gt;1&lt;/sup&gt;</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>COAG Sub-acute mental health&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Unfunded</td>
<td>Liverpool Stage 2 Phase 2&lt;sup&gt;3&lt;/sup&gt;</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>Liverpool Stage 2 Phase 3&lt;sup&gt;4&lt;/sup&gt;</td>
<td>70</td>
</tr>
<tr>
<td>Total Planned Stage 2 Phases 1-3 Liverpool Hospital</td>
<td></td>
<td>761</td>
</tr>
<tr>
<td>Total Required 2021 at MoH benchmarks</td>
<td></td>
<td>720</td>
</tr>
</tbody>
</table>

<sup>1</sup> capacity expansion to 899 available beds (852 reported 2012 ASP + ED + Delivery - Chemotherapy)

<sup>2</sup> includes 20 sub-acute palliative care and capacity to expand to 40 ICU/HDU (subject to NSW MoH funding)

<sup>3</sup> 110 = + 20 ICU/HDU + 7 maternity + 36 acute aged care/rehab + 14 SCN/NICU + 1 delivery + 20 SMHOP + 10 adolescent MH + 2 PECC

<sup>4</sup> to provide capacity towards 2026 demand. 110 = 77 acute (+ 30 cancer care + 30 medical +10 day med/surg) + 13 sub-acute (brain injury) + 27 other (+20 ED + 7 renal dialysis)

At Liverpool Hospital there is scope for some of the Stage 2 Phases 2-3 additional bed requirements to be provided off-site e.g. day medical/surgical beds, renal dialysis, ambulatory cancer care. It should be noted that the Liverpool Hospital Phase 2 Development Business Case identified as part of the stage 2 Phase 3 work that a Liverpool Clinic be developed off-site to accommodate four operating theatres, short-stay surgical beds and ambulatory care clinics including dermatology, ophthalmology and satellite dialysis. Enhancement of HITH activity may also alleviate the necessity to provide some of this additional capacity on-site.
Table 10.3 Macarthur Hospitals – Infrastructure build to meet 2021 bed capacity benchmarks
(Campbelltown and Camden hospitals under an integrated management structure)

<table>
<thead>
<tr>
<th>Build Status</th>
<th>Infrastructure Development Phase</th>
<th>Acute</th>
<th>Sub-acute</th>
<th>Mental Health</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funded</td>
<td>Baseline - average available 2011-12</td>
<td>314</td>
<td>31</td>
<td>66</td>
<td>107</td>
<td>518</td>
</tr>
<tr>
<td></td>
<td>Macarthur Stage 1 (Acute) Campbelltown(^1)</td>
<td>80</td>
<td>10</td>
<td></td>
<td>11</td>
<td>101</td>
</tr>
<tr>
<td>Unfunded</td>
<td>Mental Health Stage 1 Campbelltown(^2)</td>
<td></td>
<td></td>
<td>72</td>
<td></td>
<td>72</td>
</tr>
<tr>
<td></td>
<td>Macarthur Stage 2/3 (Acute) Campbelltown(^3)</td>
<td>90</td>
<td>20</td>
<td>48</td>
<td></td>
<td>158</td>
</tr>
<tr>
<td></td>
<td>Macarthur Stage 2 (Sub-acute) Camden(^4)</td>
<td>20</td>
<td></td>
<td>2</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td><strong>Total Planned Stages 1-3 Macarthur Hospitals</strong></td>
<td><strong>484</strong></td>
<td><strong>81</strong></td>
<td><strong>138</strong></td>
<td><strong>168</strong></td>
<td></td>
<td><strong>871</strong></td>
</tr>
<tr>
<td><strong>Total Required 2021 at MoH benchmarks</strong></td>
<td><strong>463</strong></td>
<td><strong>82</strong></td>
<td><strong>151</strong></td>
<td><strong>176</strong></td>
<td></td>
<td><strong>872</strong></td>
</tr>
</tbody>
</table>

\(^1\) +90 beds with 80 acute (+30 surgical & +30 medical inc. assessment units, +20 aged care) and 10 sub-acute (palliative care)
\(^2\) +72 includes +30 non-acute adult, +20 SMSHOP, +10 acute adult +2 acute adolescent and +10 intensive care (not covered in MHCCP methodology)
\(^3\) Indicative based on CSPM +90 acute inc. medical, surgical, acute aged care, maternity and paediatrics, +20 sub-acute (rehabilitation & GEM), +48 Other (+11 ED, +17 renal dialysis, +6 SCN, +10 bassinets, +4 delivery)
\(^4\) Indicative based on CSPM, assumes all acute inpatient activity decanted to Campbelltown, build of additional sub-acute rehabilitation and palliative care capacity and +2 ED spaces

At the Macarthur hospitals (Campbelltown and Camden) there is scope for some of the Macarthur Stage 2 (Acute) Campbelltown additional bed requirements to be provided off-site e.g. day medical/surgical beds, renal dialysis, ambulatory cancer care. Enhancement of HITH activity may also alleviate the necessity to provide some of this additional capacity on-site. Note that the Macarthur hospitals already have long established and comprehensive HITH services in operation.

Table 10.4 Bankstown-Lidcombe Hospital – Infrastructure build to meet 2021 bed capacity benchmarks

<table>
<thead>
<tr>
<th>Build Status</th>
<th>Infrastructure Development Phase</th>
<th>Acute</th>
<th>Sub-acute</th>
<th>Mental Health</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funded</td>
<td>Baseline - average available 2011-12</td>
<td>293</td>
<td>43</td>
<td>30</td>
<td>78</td>
<td>444</td>
</tr>
<tr>
<td>Unfunded</td>
<td>BLH Clinical Services Development Plan(^1)</td>
<td>102</td>
<td></td>
<td>8</td>
<td>3</td>
<td>113</td>
</tr>
<tr>
<td><strong>Total Planned Bankstown-Lidcombe Redevelopment</strong></td>
<td><strong>395</strong></td>
<td><strong>43</strong></td>
<td><strong>38</strong></td>
<td><strong>81</strong></td>
<td></td>
<td><strong>557</strong></td>
</tr>
<tr>
<td><strong>Total Required 2021 at MoH benchmarks</strong></td>
<td><strong>380</strong></td>
<td><strong>47</strong></td>
<td><strong>34</strong></td>
<td><strong>95</strong></td>
<td></td>
<td><strong>556</strong></td>
</tr>
</tbody>
</table>

\(^1\) Indicative based on BLHCSDP 2012 = 102 acute (45 medical inc. assessment units and ambulatory care, + 35 surgical, + 16 cardiology, + 6 ICU/HDU), +8 mental health (+4 IP, +4 PECC), +3 Other (+2 ED, +1 delivery)

At Bankstown-Lidcombe Hospital there is scope for some of the Clinical Services Development Plan additional bed requirements to be provided off-site e.g. day medical/surgical beds, renal dialysis, ambulatory cancer care. Enhancement of HITH activity may also alleviate the necessity to provide some of this additional capacity on-site. Note that there are private hospital proponents with an interest in establishing services in Bankstown LGA. If these proponents are successful in establishing services the viability of full service procurement for some of the additional beds identified above could be explored.
Table 10.5 Bowral and District Hospital – Infrastructure build to meet 2021 bed capacity benchmarks

<table>
<thead>
<tr>
<th>Build Status</th>
<th>Infrastructure Development Phase</th>
<th>Beds Supplied</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Acute</td>
</tr>
<tr>
<td>Funded</td>
<td>Baseline - average available 2011-12</td>
<td>66</td>
</tr>
<tr>
<td>Unfunded</td>
<td>BDH Masterplan Strategy(^1)</td>
<td>22</td>
</tr>
<tr>
<td>Total Planned BDHMS</td>
<td></td>
<td>88</td>
</tr>
<tr>
<td>Total Required 2021 at MoH benchmarks</td>
<td></td>
<td>89</td>
</tr>
</tbody>
</table>

\(^1\) Indicative based on BDHMS (planning horizon 2016) = + 22 acute (+16 surgical and medical short stay
+ 4 medical longer stay +2 high dependency + 2 paediatrics and -2 maternity)
+ 13 sub-acute (rehab and palliative care) + 3 other (+4 ED and -1 renal dialysis)

Note that the Bowral and District Hospital Masterplanning was based on a 2016 planning horizon and will need to be recast to a 2021 planning horizon. However, at MoH benchmarks for 2021 there is only a small deficit to the projected bed capacity required. BDH is co-located with the Southern Highlands Private Hospital (SHPH), where ambulatory cancer care services are already provided for public patients. Therefore, there is scope to explore arrangements for some of the other Masterplan Strategy additional bed requirements to be provided at SHPH e.g. additional surgical activity. This could be through full service procurement or other like arrangements.

Table 10.6 Fairfield and Braeside hospitals – Infrastructure build to meet 2021 bed capacity benchmarks

<table>
<thead>
<tr>
<th>Build Status</th>
<th>Infrastructure Development Phase</th>
<th>Beds Supplied</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Acute</td>
</tr>
<tr>
<td>Funded</td>
<td>Baseline - average available 2011-12</td>
<td>156</td>
</tr>
<tr>
<td>Unfunded</td>
<td>No Plan - difference to 2021 benchmark(^1)</td>
<td>33</td>
</tr>
<tr>
<td>Total Required 2021 at MoH benchmarks</td>
<td></td>
<td>189</td>
</tr>
</tbody>
</table>

\(^1\) across the two campuses there is a significant increase in sub-acute bed capacity projected (+58)
with a lesser proportionate increase in acute bed capacity (+33) and other beds (+17).
16 SMHSOP beds are recognised as MH.

At the Fairfield and Braeside hospitals campus, most of the additional bed requirements identified above are in sub-acute care. It is not considered likely that a significant proportion of these beds could be provided off-site or as bed equivalents through HITH.

In summary, the total impact across all SWSLHD hospitals is a projected increase in bed or bed equivalent capacity of around 40% in the decade to 2021 to attain benchmark levels of service provision. The potential to provide some of this bed capacity off hospital sites will be explored, which may include through stand-alone SWSLHD run specialty centres; full service procurement from private hospital providers; blended arrangements with private primary care and specialist providers and potentially non-government providers; and/or alignment with integrated primary and community care models to operate in the community.

Whilst acute bed capacity is projected as increasing slightly above 30% to attain benchmark, the impact of population aging is reflected in a projected increase in sub-acute bed capacity of around 70%. The potential to provide sub-acute care off hospital sites is considered more limited however enhanced HITH services may have a role in ameliorating the additional capacity that is projected as required at public hospitals.

An increase in ED treatment space capacity to benchmark is projected at 37%. Enhanced preventative care and partnerships with primary care practitioners may have the potential to ameliorate some of this additional capacity requirement. It is noted that some private proponents are considering the establishment of an urgent care centre practice model within SWSLHD. Limited adoption of this model is unlikely to have any discernable impact on enhanced ED treatment space capacity requirements.
10.6 Healthcare Services in the Community

As discussed at Section 6.2, evolving models of care will see increased demand for services to be provided in the community. This includes services traditionally provided through Community Health Centres such as in Child and Family Health assessments and interventions in nursing, allied health and health promotion. Specialist areas of community health are also likely to face increased demands e.g. multicultural health, sexual health, women’s health, sexual assault, HIV/AIDS, nutrition, community development and youth health. Significant increased demands are also expected for community health nursing including post-acute care, general nursing and palliative care nursing.

Other specialist clinical services which provide care in community settings will also experience increased demands as their target populations and their health needs grow, including oral health, drug health, mental health, aged care and rehabilitation, respiratory and cardiovascular. It is expected that an increasing proportion of ambulatory and day care services previously provided on hospital sites will increasingly migrate to being provided at community sites, with access and convenience benefits for patients.

SWSLHD has over 60 sites including early childhood and other centres from which community health services are delivered. Eleven of these are major community health centres. A service development strategy identified at Appendix A19 is for development of a Community Health Infrastructure Renewal Strategy to match infrastructure requirements to emerging models of care; potential outreach of ambulatory hospital services; fibre optic enabled practice; and changed and evolving population growth patterns.

Surgical Services planning in SWSLHD has identified as a core development strategy that less complex surgical procedures and most endoscopic services be undertaken outside of the main theatre blocks with separate delineated patient flow and quarantined access to procedural spaces to optimise workflow efficiencies. Whilst this would often be achieved within hospital confines through procedure rooms and ambulatory care spaces, there is potential for some day procedural activity to be provided in community settings, some of which may be through co-location at community health centres. In addition, there is significant scope for ambulatory medical specialist activity to be migrated from hospital sites to a community setting, again potentially co-located in community health centres. Lack of spare capacity at community health centres precludes these options being explored from within the current building stock. The Community Health Infrastructure Renewal Strategy will need to explore in detail the options for expanding the capacity of the community health infrastructure inventory to undertake these new roles.

New models of care such as IPCC will also have infrastructure implications. In the SWGC, it will be towards the end of the coming decade before sufficient catchment population has moved in to justify economic investment in infrastructure for IPCC provision. It is expected that only the major RIPCCCs would come within scope of funding under the MoH CISP. Initial planning has occurred to identify RIPCCC within master planning at both Leppington and Oran Park town centres in the SWGC. Indicative estimates of internal space at 10,000 sq. metres for Leppington and >4,000 sq. metres at Oran Park suggest quite major infrastructure development implications. For Leppington, a 1.6 hectare site has been identified on the final indicative Layout Plan (ILP) and town centre masterplan.

In exploration of options for expanding the capacity of the community health infrastructure in existing settled areas, consideration should also be given to the feasibility of accommodating an IPCC model of care within any expanded community health infrastructure.

10.7 Opportunities to Grow Infrastructure in Partnership

As foreshadowed in Sections 9.3-9.6, there are significant potential opportunities for a PPP model to be explored as the delivery mechanism for the expanded infrastructure projected earlier as required to meet population need. Expanded health infrastructure will be required in all regions of SWSLHD and potentially PPP
arrangements could provide a delivery mechanism for some of the additional infrastructure required in each region. The following outlines possibilities in each region.

In the SWGC, RIPCCCs are planned at Leppington town centre and Oran Park, with construction envisaged within the ten year timeframe of this Plan. Eventually a third RIPCCC will be needed in the western portion of the SWGC as population grows in that region. There is significant potential for RIPCCCs to provide a range of services for public patients that have traditionally been provided from public hospital campuses including ambulatory procedural care and infusion therapies e.g. chemotherapy, renal dialysis; and also day surgery. RIPCCCs could be developed in accord with the model envisaged in the SIS of “specialist medical facilities (mini specialist hospitals) which provide a limited range of medical treatments such as dialysis, cancer treatment centres, cardiology diagnostics, sleep disorder therapy and day surgery” (p.169).

However, RIPCCCs would go beyond this SIS model of a specialist medical facility by also providing a range of primary care services on-site (general practice and community health) through an integrated model of practice. As such they would also accord with other SIS service development directions e.g. “Community health centres with a mix of GP, public health and private services (such as diagnostics) have potential to provide a convenient local access point to health services that facilitate integrated care” (p.169). The RIPCCC infrastructure could be procured under a PPP arrangement, which could be structured as a DBFO, BOO, BOOT or BOLB model as identified above or a hybrid model derived from these.

In Liverpool, the Liverpool Hospital Stage 2 - Phases 2 & 3 redevelopment builds on the enhanced acute capacity provided by the Phase 1 redevelopment, with the scope of work envisaged in the Liverpool Hospital Phase 2 Development Business Case addressing the need to expand capacity in women’s health (maternity, neonatology and paediatrics), cancer care, aged care and rehabilitation, brain injury, mental health, pathology, allied health, clinic spaces and supporting services such as food services and administration. Consideration needs to be given as to whether any of this infrastructure could be delivered through a PPP arrangement. It is noted that the Business Case prepared late in 2010 eliminated PPPs as a viable capital procurement strategy given the status of project definition and uncertainty over the market for private financing.

Some discrete service units envisaged for Liverpool Hospital may be suitable for management within a private partnership model that meets the broader definition of a PPP arrangement. This includes procedural units such as the Surgical Ambulatory Care Unit (SACU) and Special Endoscopy Unit (SEU) which are to be located within Phase 1 built infrastructure.

Some aspects of the master plan development strategy for Liverpool Hospital are referenced but not within the scope of work identified in the Liverpool Hospital Phase 2 Development Business Case. This includes the development of a new “Liverpool Clinic” off-campus but within the vicinity of Liverpool hospital, providing four day surgery theatres, associated day beds and ambulatory clinic capacity for units such as ophthalmology and dermatology. This development
would be eminently suitable for procurement through a PPP arrangement using one of the models identified above or a hybrid model.

In addition, the redevelopment of community health facilities in Liverpool is identified in the master plan development strategy but not scoped within the Business Case. One option would be to package together the “Liverpool Clinic” and Community Health development requirements within an integrated development that could be procured through a PPP arrangement. If this were to be progressed there would be the opportunity to embed an integrated primary and community care model of practice, including the provision of general practice services. The Liverpool Clinic could then develop as an IPCC centre, similar in concept to that proposed for the SWGC. Like the SWGC IPPCS, the Liverpool Clinic could also reflect the model envisaged in the SIS of specialist medical facilities (mini specialist hospitals), by providing ambulatory day stay services such as infusion therapy (including chemotherapy and renal dialysis) and day hospital type activities.

In Macarthur, the as yet unfunded Mental Health Stage 1 Campbelltown, Macarthur Stage 2 (Acute) Campbelltown and Macarthur Stage 2 (sub-acute) Camden proposals entail a significant enhancement to hospital capacity. The potential to procure some of this capacity through PPP arrangements requires exploration. The sub-acute capacity expansion at Camden hospital is considered unlikely to be viable for procurement under a PPP arrangement. Some aspects of the acute capacity expansion at Campbelltown Hospital may be able to be addressed through a PPP model of procurement, as could management arrangements for provision of new services to be provided in the funded Macarthur Stage 1 infrastructure, such as cardiac catheterisation.

A significant issue in Macarthur is the fragmentation of infrastructure available in the community from which community health services can be delivered. Some infrastructure is leased, some is vacant due to condition issues, some is aged requiring redevelopment and some is in localities distanced from urban centres and not easily accessible by public transport. Like Liverpool and consistent with what is proposed for the SWGC, there is potential to package up some services proposed for enhancement in the Macarthur Stage 2 (Acute) development (day surgery, infusion therapy, ambulatory procedural care, day hospital etc.) with community health services within an integrated development that could be procured through a PPP arrangement. As identified in Liverpool, if this were to be progressed there would be the opportunity to embed an integrated primary and community care model of practice, including the provision of general practice services.

In Bankstown, the opportunity to expand infrastructure at Bankstown-Lidcombe Hospital is constrained by the landlocked nature of a cramped, crowded hospital campus. Significant addition to infrastructure is envisaged under the BLHCSDP, with new services to be introduced and enhancement to existing services. Some of the major enhancements identified are the establishment of an Interventional Endovascular Unit incorporating cardiac catheterisation; development of a High Volume Short Stay Surgical (HVSS) centre; and provision of a stand-alone or virtual stand-alone endoscopy service, which could be provided within the HVSS model, provided there was separate delineation of patient flow. There may be potential to consider establishment of the Interventional Endovascular Unit under some form of PPP arrangement, as a contracted-in service.

It is understood that there are private hospital proponents seeking to establish private health infrastructure in Bankstown LGA that extends to the provision of surgical services. Therefore it may be possible to establish a HVSS service under a PPP model of full service procurement as a contracted-out service. This could include endoscopic services. This might be restricted to day surgical procedures depending upon the capability of the private facilities that are developed. Cancer care services will also require expansion in Bankstown and the issue of Bankstown residents having to travel outside of their local community for radiotherapy will require addressing as demand grows. If private capacity is developed in Bankstown and this extends to the capability to provide components of cancer care, a full service procurement PPP model may also be possible to improve local access to components of cancer care as a contracted-out service.
In Fairfield, most of the infrastructure enhancement required is in sub-acute care and it is not considered that this could viably be procured under a PPP with the private sector. However under the broader definition of PPP adopted in this plan a partnership with the not for profit affiliated health organisation at Braeside Hospital would be considered to provide for this capacity. Braeside and Fairfield hospitals have adjacent campuses. If infrastructure development was undertaken on the Braeside site, services would be provided as a PPP contracted out service, as currently occurs. Alternatively, infrastructure development could take place at Fairfield Hospital and the service could be managed by Braeside as a PPP contracted-in service.

In Wingecarribee, the location of Bowral Hospital adjacent to the Southern Highlands Private Hospital provides opportunities for PPP arrangements to provide the additional infrastructure and services identified as necessary over the next ten years. One service development direction identified is for the provision of ENT and urology services locally for public patients. This could be provided at the private hospital under a PPP contracted-out model. The new and upgraded infrastructure required at Bowral Hospital could also be considered for provision under a PPP arrangement, which could be structured as a DBFO, BOO or BOOT arrangement or hybrid version of these models.

The Bowral and District Hospital Masterplan Strategy also identifies a need for upgraded community health infrastructure which could be included in any PPP arrangement identified for the hospital redevelopment. Alternatively, the capital procurement, as in Liverpool and Campbelltown, could be structured as a separate PPP, with the opportunity to again embed an integrated primary and community care model of practice, including the provision of general practice services.

The range of PPP opportunities identified above, across the LHD, would require detailed business planning and intensive negotiation before consideration of adoption. PPPs would only proceed after due consideration of the fundamental prerequisites for negotiation identified at Section 8.2.
11. Next Steps

This Plan charts the course for healthcare service development in SWSLHD over the decade to 2021. Based on the best available projection models, endorsed for use by the MoH and evidence based from practice in other health jurisdictions where a MoH methodology is unavailable, it identifies a requirement for a significant expansion in healthcare capacity for public patients and communities in general. The Plan has been developed under sustained oversight of the SWSLHD corporate governance entities, including the Steering Committee, Clinical and Quality Council (CQC) and with input from Board members.

There was extensive community consultation undertaken in 2012 as part of the fact finding and needs assessment phases of planning, through the established Community Participation Networks of SWSLHD, through contact with community advocacy and consumer groups and through survey of government and non-government agencies which partner with SWSLHD aiming to improve the health of local communities. Drafts of the strategic and corporate plans were made available in May-June 2013 for all community members and SWSLHD staff to comment on whether the proposed service development directions met their needs, expectations and preferences for healthcare delivery. A Summary for Consultation paper was prepared to assist in this process and opportunities for comment made available through on-line survey, email, written submissions and attendance at consultation forums.

Following the community and staff consultation process, an amended strategic healthcare services delivery plan and corporate plan was provided to CQC and then the Board for ratification. Following their endorsement, implementation of service development can now proceed subject to funding availability and within the framework of service developments, targets and KPIs identified in the SWSLHD Annual Strategic Priorities and Performance Agreement. Implementation will be progressed, monitored and reviewed through a number of processes under the oversight of SWSLHD governance committees.

The Board has expressed its strong desire that the framework of the strategic and corporate plans flow through to facility, clinical stream, service and business planning.

Implementation of corporate service development directions will proceed under the umbrella of the Corporate Plan, which identifies for each strategy an Executive Sponsor and Manager responsible for implementation. The SWSLHD Executive Management Team will annually review progress, drawing in part from the performance reports prepared for the SWSLHD Annual Strategic Priorities and Performance Agreement with the NSW MoH. An annual report on implementation will be sought from the Executive Sponsor and Responsible Manager for strategies not covered by the current performance agreement. The Corporate Plan will also provide guidance on local priorities that may be suitable for inclusion in the Annual SWSLHD Strategic Priorities and Performance Agreement for subsequent financial years. The Executive Management Team annual review will also consider new and emerging NSW Government priorities and whether they are adequately reflected within the Corporate Plan.

The eight Corporate Areas of Action from the Framework for Corporate Strategic Actions for SWSLHD will provide the scaffold on which facility, service and business plans are built. This will ensure that at all organisational levels, drilling down to business and operational plans, there is a clear indication of how a service/unit will contribute to achieving the eight organisational goals of high quality care, seamless networks, community partnerships, efficiency and sustainability, developing staff, enhancing assets & resources, research and innovation and supporting business. Templates will be developed so that consistency in the planning approach and outputs can be achieved across all levels of the organisation.
Implementation of service development directions in Infrastructure will proceed under the umbrella of the SWSLHD Asset Strategic Plan (ASP). The 2013 ASP submitted to the MoH reflects the future services profile identified in this strategic (healthcare services) plan and detailed investigation of the functionality and opportunities of the existing asset base. ASPs also consider non-asset strategies, asset disposal opportunities and the potential for delivery of an expanded asset base through PPP style arrangements.

Developments in clinical models of care will be progressed under the oversight of CQC. As identified earlier, consideration will be given to establishing a standing committee of CQC to systematically review current models of care and assess refinements and future developments in models of care against the criteria identified in Section 8.2, within the construct of right services, right team, right place and right time. This could be undertaken as a rolling program across clinical disciplines, scanning emerging models of care and assessing aspects of current models that require refinement to fully meet the criteria.
Appendices

A1. Background to Health Reform

Significant reform of the Australian and state health system has been on the agenda for a number of years, as a result of a lack of public confidence (or a perceived lack of confidence) in the quality and safety of health care services, inequity in service provision across regions and population groups and changing clinical and community expectations and needs.

In 2011, the Council of Australian Governments (COAG) signed the National Health Reform Agreement. It outlines a shared intention by all states/territories and the Australian Government to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system. The reform aims to achieve improved access to services, greater local accountability and transparency, enhanced responsiveness to local communities and additional Commonwealth funding to strengthen the financial basis of the health system.

The direction of the reform agenda has primarily been informed by the National Health and Hospitals Report 2009. Key recommendations from this report actioned through the reform agenda include:

- The establishment of a single national health system
- The staged introduction of an activity based funding (ABF) model, from July 2012
- The introduction of national performance targets in relation to elective surgery waiting times, emergency department waiting times and the availability of sub-acute beds
- The establishment of Medicare Locals as regionally based organisations with responsibility for the coordination of primary health care services
- The transfer of responsibility for non-acute / non-inpatient aged care services from the state to the Commonwealth
- Creation of a National Health Performance Authority (NHPA) to produce reports on performance of hospitals and primary care services
- Establishment of an Independent Hospital Pricing Authority (IHPA) to set the efficient price for services provided by public hospitals under the ABF model
- Initiatives to improve access and equity of health systems for all Australians, through addressing Aboriginal health, mental health, rural and regional health, dental health, and improving the quality of care in public hospitals (bed availability and waiting times)
- Strengthened processes for community engagement
- Improved systems for data collection and reporting and the use of information technology
- A stronger focus on education and training.

As a result of this reform, new performance and monitoring frameworks have been established for hospitals and health care services across the country, including:

- A 4 hour target for emergency waiting times to reduce long waiting times in public hospital emergency departments, by aiming to have patients assessed, treated and discharged, or admitted within four hours, where clinically appropriate
- A 95% elective surgery target aimed at ensuring 95% of all patients waiting for elective surgery are treated within clinically recommended times
A National Access Guarantee to ensure that no Australian experiences extremely long waits for elective surgery

In NSW, national reforms were consistent with the findings of the *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (the Garling Report). This inquiry was the most significant review of acute health services undertaken in NSW. It noted that although the NSW health system was amongst the best in the world, there was a need to refocus on patient care.

Consistent with the findings and recommendations of the Garling Report and the National Health Reform Agreement, the NSW Government has made a commitment to Health services across NSW having a renewed focus on the patient through improving access to timely, quality healthcare across the state. Preventative healthcare, better management of people with chronic disease and a strengthening of the public health system have been emphasised.

In early 2011, Area Health Services in NSW were dissolved and fifteen new Local Health Districts (LHDs) were created. These Local Health Districts are responsible for providing health services in a wide range of settings, from primary care in the remote areas to metropolitan tertiary health centres. In addition, two specialist networks: Children’s and Paediatric Services, and Justice Health and Forensic Mental Health, were established together with a third network of Sydney facilities operated by St Vincent’s Health. Locally, two new entities, South Western Sydney Local Health District and Sydney Local Health District were created when Sydney South West Area Health Service (SWSAHS) was dissolved. The organisational structure of the NSW Health system is reflected in Figure A1.1 following.

The establishment of smaller, localised Districts has been designed to enhance local decision making and community involvement in healthcare service delivery and to deliver most clinical care within the NSW health system. They will deliver care in accordance with a Service Agreement and within an agreed budget, with the inclusion of activity-based funding.

The model for service reform implemented in NSW included the creation of a NSW Ministry of Health (replacing the NSW Department of Health), supporting the executive and statutory roles of the NSW Minister for Health and Medical Research and monitoring the performance of the NSW Health system. The vision identified for the Ministry is that everyone in NSW Health to work together to achieve "Healthy People - now and in the future" with goals to:

- keep people healthy
- provide the health care that people need
- deliver high quality services and
- manage health services well.

NSW health reform also included creation (or enhancement) of “pillars” or clinical support agencies including:

- The [NSW Agency for Clinical Innovation](https://www.health.nsw.gov.au/acil) (ACI) established in 2010 to drive continuous improvement in the way care is provided to patients in the NSW Health system
- The [Bureau of Health Information](https://www.health.nsw.gov.au/bohi) established in 2009 to be the leading source of information on the performance of the NSW public health system
- The [Health Education and Training Institute](https://www.health.nsw.gov.au/hetti) (HETI) established in 2010 has leadership responsibility for the education and training of clinicians and clinical support staff in NSW Health, including nursing and allied health staff
The **Clinical Excellence Commission** (CEC) established in 2004 to build confidence in healthcare in NSW, by making it demonstrably better and safer for patients and a more rewarding workplace.

**NSW Kids and Families** established in 2012 will champion the health interests of children and young people whether they are at home, in the community or in or out of hospital.

The Ministry of Health and clinical support agencies support Districts and Networks through state-wide planning, purchasing and performance monitoring, delivering public health functions (disease surveillance, control and prevention) and through regulatory functions. The way in which the relationships between each entity is formalised is reflected in Figure A1.2.
Figure A1.1
Map of NSW Health System

Minister For Medical Research
Minister For Mental Health
Minister For Healthy Lifestyles

Director - General

Health Administration Corporation (HAC)

Other NSW Health Bodies
- Cancer Institute NSW
- NSW Mental Health Commission
- NSW Institute of Psychiatry

The Ministry of Health
- Governance, Workforce & Corporate
- Population and Public Health
- System Functioning and Performance
- Strategy and Resources
- Office for Health & Medical Research
- Audit

Public Health Support Division
- HealthShare NSW
- eHealth NSW
- Health Infrastructure
- NSW Health Pathology

Public Health Organisations
- Ambulance Service of NSW

Statutory Health Corporations
- The Pillars
  - Agency for Clinical Innovation
  - Bureau of Health Information
  - Clinical Excellence Commission
  - Health Education & Training Institute
  - NSW Kids & Families
  - Justice & Forensic Mental Health Network
  - Sydney Children’s Hospitals Network

Local Health Districts (LHDs)
- Metropolitan NSW
  - Central Coast
  - Illawarra Shoalhaven
  - Nepean Blue Mountains
  - Northern Sydney
  - South Eastern Sydney
  - South Western Sydney
  - Sydney
  - Western Sydney
- Rural & Regional NSW
  - Far West
  - Hunter New England
  - Mid North Coast
  - Murrumbidgee
  - Northern NSW
  - Southern NSW
  - Western NSW

Affiliated Health Organisation (2nd Schedule)
- Benevolent Society of NSW
- Carntag wen Centennial Care Ltd
- Calvary Health Care (Newcastle) Ltd
- Calvary Health Care Sydney Ltd
- Catholic Healthcare Ltd
- HammondCare Health and Hospitals Ltd
- Kantane
- Mercy Care Centre, Yning
- Mercy Health Service Albury Ltd
- NSW STARTS
- Royal Rehabilitation Centre Sydney
- Royal Society for the Welfare of Mothers & Babes (Tresillian)
- Stewart House
- St Vincent’s Hospital Sydney Ltd
- The College of Nursing
- Uniting Church in Australia

Source: Adapted from a diagram within the NSW Infrastructure + Health Infrastructure Baseline Report, 2012 (PWC) + updated Oct 2014
National and State policy context

Although generally autonomous, national and state health legislation, policies and programs guide the way in which the District plans and delivers services. Compliance with legislation and policies enables the delivery of equitable health care services to all Australians, regardless of their location, age, ethnicity or health requirements.

National policies include:

**Closing the Gap**

The National Indigenous Reform agenda (Closing the Gap) has been agreed by COAG and articulates the need for government to respond to indigenous disadvantage in the related areas of early childhood, schooling, health, economic participation, healthy homes, safe communities and government and leadership. Specific targets of greatest relevance to health services relate to infant mortality (children under 5) and also overall life expectancy.

**Building a 21st Century Primary Health Care System: National Primary Health Care Strategy**

This strategy is the first of its kind in Australia and aims to provide citizens with a responsive and integrated primary health care system for the 21st century. It identifies 4 priority directions for change: improving access and reducing inequity, better management of chronic conditions, increasing the focus on prevention and improving quality, safety, performance and accountability. Five building blocks have been identified to address these issues: regional integration, information technology (including eHealth), skilled workforce, infrastructure and financing and system performance.

**Australian Commission on Safety and Quality in Health Care (ACSQHC)**

The new National Safety and Quality Health Service Standards released covering:
Governance for Safety and Quality in Health Service Organisations
- Partnering with Consumers
- Preventing and Controlling Healthcare Associated Infections
- Medication Safety
- Patient Identification and Procedure Matching
- Clinical Handover
- Blood and Blood Products
- Preventing and Managing Pressure Injuries
- Recognising and Responding to Clinical Deterioration in Acute Health Care
- Preventing Falls and Harm from Falls

Full implementation of the Standards commenced January 2013.

The Commission has developed Australian Safety and Quality Goals for Health Care. In August 2012, Australian Health Ministers agreed to three goals:

1. Safety of care: That people receive health care without experiencing preventable harm
2. Appropriateness of care: That people receive appropriate, evidence-based care
3. Partnering with consumers: That there are effective partnerships between consumers and healthcare providers and organisations at levels of healthcare provision, planning and evaluation.

State policies include:

**NSW State Plan NSW 2021: A Plan to Make NSW Number 1**

The plan articulates one of the goals of the NSW government as to restore confidence in the public health system by rebuilding hospitals and health infrastructure, re-engaging clinicians, and giving communities and health care providers a strong and direct voice in improved local patient care.

It states that by focusing on illness prevention, (including a strong focus on mental health) reductions can be made in the burden of chronic disease on the health system and communities can be made active and healthy.

Specific goals are to:

- Keep people healthy and out of hospital
- Provide world class clinical services with timely access and effective infrastructure

Targets have been developed around reducing smoking rates, reducing overweight and obesity rates, reducing risk drinking, closing the gap in Aboriginal infant mortality, improving outcomes in mental health, reducing potentially preventable hospital admissions, reducing hospital waiting times for planned surgery and emergency department treatment, improving transfer of patients from emergency departments to wards, reducing unplanned readmissions, decreasing healthcare associated bloodstream infections, ensuring all publicly provided health services meet national patient safety and quality standards and increasing patient satisfaction. Every Health District will contribute to meeting these targets through their individual activities.

**NSW Health Statewide Services Plans**

The Ministry of Health (MoH) has developed various state-wide services plans for highly specialised/low volume acute services. These plans identify Liverpool Hospital as a centre for state-wide services in trauma
(adult), radiotherapy and blood and marrow transplantation (with the commencement of allogeneic transplantation in 2012).

**NSW Trauma Services Plan 2009**

This Plan\(^98\) seeks to reconfigure and further develop the NSW trauma services and identifies Liverpool Hospital as a Major Trauma Service (MTS) for adults through capacity to provide the full spectrum of care for major and moderately injured patients, from initial resuscitation through to rehabilitation and discharge. Liverpool is the only designated trauma service in the District.

**Radiotherapy Services in NSW Strategic Plan to 2016**

The Plan\(^99\) identifies the geographic areas for new and expanded radiotherapy services in NSW. Beyond the 4 radiotherapy machines approved for the new Liverpool Hospital Cancer Therapy Centre, no additional machines have been identified for this District to 2016.

**Selected Specialty and Statewide Service Plan for Spinal Cord Injury 2010**

The Plan\(^100\) provides direction for coordination of spinal cord injury planning and services delivery. No role has been proposed for south western Sydney with patients requiring specialised services to be transferred to Prince of Wales Hospital (acute and sub-acute), Royal North Shore Hospital (acute) or the Royal Rehabilitation Centre Sydney (sub-acute).

**Selected Specialty and Statewide Service Plan for Blood and Marrow Transplantation 2010**

The Plan\(^101\) focuses on blood and marrow transplantation services and identifies a role for Liverpool Hospital Blood and Marrow Transplantation (BMT) unit commencing an allogeneic BMT service to complement the existing autologous service by 2016, subject to achievement of identified staffing and quality criteria. Progression to delivery on related allogeneic BMT is possible beyond 2016.

**Surgery Futures: A Plan for Greater Sydney 2011**

The Plan\(^102\) recognises the need to plan for the significant growth in populations in the South West and North West Sydney corridors. It identifies specialisation of surgical roles at a number of hospitals in the District.
A2. South Western Sydney Local Health District Organisational Chart

SWSLHD Organisational Structure

- **Director Medical Services**
  - Disaster Management
  - Investigations & Compliance

- **Director Allied Health**
  - Carers Program

- **Director Clinical Governance**
  - Patient Safety
  - Complaints
  - Clinical Audit & Incident Management
  - Quality
  - Redesign
  - Clinical Excellence Commission Liaison / Program Co-ordination

- **Director of Nursing and Midwifery**
  - Clinical Practice & Innovation
  - Workforce
  - Essentials of Care
  - Centre for Applied Nursing Research
  - Clinical Placement

- **Director Finance**
  - Management
  - Accounting & Efficiency
    - Salary Packaging
  - Financial Accounting
    - Accounts Payable
    - Revenue
    - Special Purpose & Trust (SPRT)

- **Director of Operations**
  - Facilities & Services
  - Clinical Management
  - Clinical & Business Support
  - Capital Works
  - Risk Management
  - OH & S
  - Work Compensation
  - Government Information Public Access Act (GIPAA) Compliance
  - Performance
  - Legal
  - Human Resources
  - Shared & Corporate Services
    - Fleet & Travel
    - Engineering
    - Supply Services

- **SWSLHD Board**

- **Chief Executive**

- **Sub Committees of the Board**
  - Research & Teaching
  - Health Care Quality & Safety
  - Finance
  - Audit & Risk
  - Consumer & Community Council
A3. Current and Potential Role Delineation of SWSLHD Hospitals and Community Health Services

This table provides an overview of the approved role delineation levels for all clinical services across SWSLHD (January 2012). Where service development directions identified in this Plan are able to be implemented, the role delineation level of some specialty services will increase in a number of facilities across the District. Those specialties which will potentially increase their role delineation level are highlighted in blue.

<table>
<thead>
<tr>
<th>Service</th>
<th>Bankstown-Lidcombe</th>
<th>Fairfield</th>
<th>Liverpool</th>
<th>Campbell-town</th>
<th>Camden</th>
<th>Bowral</th>
<th>Braeside</th>
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</tbody>
</table>

2 **Campbelltown.** Anaesthetic, Cardiology, Child/Adolescent Mental Inpatients, Coronary Care, Dermatology, Drug and Alcohol Services, Endocrinology, Gastroenterology, Immunology, Infectious Diseases, Neurology, Neurosurgery, Oncology – Medical, Oncology – Radiation, Orthopaedics, Paediatric Medicine, Respiratory Medicine and Rheumatology services at Campbelltown Hospital all require access to various higher level support services. These support services are Diagnostic Imaging, Nuclear Medicine, Rehabilitation and Intensive Care. For these services, Campbelltown Hospital is closely networked with Liverpool Hospital for level 6 services. Campbelltown is also networked with Braeside Hospital for level 6 rehabilitation services.

3 **Camden.** Geriatrics, Palliative Care, Rehabilitation services at Camden Hospital are supported by higher level support services (Intensive Care Unit; Pathology; Coronary Care Unit; Diagnostics Imaging; Anaesthetics; and Pharmacy) via close networking arrangements with Campbelltown and Liverpool hospitals. Camden no longer has surgical services on site as these have been consolidated at the Campbelltown Hospital

4 **Bowral.** The following core services: Burns; Cardiology; Dermatology; Drug and Alcohol; Emergency; Endocrinology; Gastroenterology; General Medicine; General Surgery; Geriatrics; Gynaecology; Haematology – Clinical; Intensive Care; Immunology; Infectious Diseases; Neurology; Oncology – Medical; Ophthalmology; Orthopaedics; Paediatric Medicine; Renal Medicine; Respiratory Medicine; Rheumatology; Sexual Health Services are provided at Bowral and District Hospital at role levels requiring higher levels of: Pharmacy, Diagnostic Imaging, Anaesthetics and Coronary Care Unit services. For these support services Bowral and District Hospital is closely networked with Campbelltown and Liverpool hospitals to provide higher levels of these services.

5 **Braeside.** Some Support Services (Pathology and Pharmacy) are provided at a basic level on site with access to Support Services at a higher level and the remaining Support Services (Nuclear Medicine, Diagnostic Imaging and Intensive Care) provided at Fairfield and Liverpool Hospitals.

6 **Pathology.** All smaller labs within SWSLHD are linked with the pathology hub at Liverpool Hospital, a level 6 laboratory that provides a 24/7 courier service to other laboratories such as Campbelltown.
<table>
<thead>
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<sup>7</sup> Bankstown-Lidcombe Endocrinology. Supported by a networked arrangement across SWSLHD for pathology and pharmacy
<sup>8</sup> Bankstown-Lidcombe Gastroenterology and General Surgery. Supported by a networked arrangement across SWSLHD for pathology.
<sup>9</sup> Campbelltown Haematology has a specialist Haematologist with links to Palliative Care
<sup>10</sup> Bankstown Lidcombe Medical Oncology has research and 24 hour onsite medical cover
<sup>11</sup> Fairfield Neurology. Networking arrangements are in place with Liverpool Hospital for geriatric services
<sup>12</sup> Bankstown – Lidcombe Respiratory. Supported by a networked arrangement with Liverpool Hospital for cardiothoracic surgery services
### MATERNAL AND CHILD HEALTH

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### INTEGRATED COMMUNITY AND HOSPITAL

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¹³ Fairfield. There is no planned Vascular Surgical service at Fairfield.

¹⁴ Fairfield Paediatric Medicine. Networking arrangements are in place with Liverpool Hospital for level 6 Nuclear Medicine services.

¹⁵ Campbelltown Paediatric Surgery meets level 4 support needs and performs minor and moderate and selected major procedures.

¹⁶ Family and Child Health. The service is provided at a level 4 where paediatric inpatient services are available. At other sites a level 3 service is provided.

¹⁷ Adolescent Health. A level 3 service is provided across most of SWSLHD. Level 4 services are available at Campbelltown.

¹⁸ Bankstown-Lidcombe Older Adult Mental Health (IP). Although the service is provided at a role level of 2, the service includes many features of a service provided at a role level of 5.

¹⁹ Braeside Older Adult Mental Health Inpatient Care. Although the service is provided at a role level of 2 with gazetted beds, it includes most features of a Level 3, 4, 5 or 6 service. The following features are not provided: emergency mental health care service (Level 3); Resident Medical Officer on site 24 hours (Level 3); access to a consultant physician in geriatric medicine on site; expectation to provide telepsychiatry (Level 4); Psychiatric Registrar on call after hours (Level 5); a supra-LHD referral service (Level 6); a range of teaching and research function; and telepsychiatry (Level 6). The service also has access to a CNC and CNS specialising in psychogeriatrics rather than a CNC and CNS specialising in ageing.

²⁰ Braeside Adult Mental Health Outpatients. Although the service is provided at level 2, it includes some of the features of a service provided at a role level 3, 4, 5 or 6. The following features are not provided: additional extended hours coverage via on-call arrangements and consultation-liaison to emergency department and general inpatient service of local hospital. The service is also not an Authorised Health Care Agency and there is no formal program to provide education and training for other lower level services in the Area mental health service.

²¹ Campbelltown PANOC does not have social work after hours coverage hence a Level 3 service.

²² Fairfield Drug and Alcohol. Networking arrangements are in place with Liverpool Hospital for level 6 Nuclear Medicine, Diagnostic Imaging, Pharmacy and Pathology services.

²³ Bankstown – Lidcombe Geriatrics. Supported by a networked arrangement across SWSLHD for Pathology and Pharmacy services.
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²¹Liverpool Palliative Care while it meets some aspects of a level 6 service there are no designated beds managed by the Palliative Care Specialist and no allied health within the Palliative Care Team.

²²Camden Palliative care has support services which are provided through the group Campbelltown Hospital

²³Braeside Palliative Care A level 6 service is provided with inpatient (hospital) and consultancy liaison to Fairfield Hospital. Features include a registrar in palliative medicine, as well as a CNC and allied health staff. The community service component is a level 5 community consultative service. Staff include a palliative care physician and allied health. Links include oncology, radiotherapy, anaesthetics, psychiatry, multidisciplinary pain clinic, rehabilitation and surgical services. Community nursing for this service is located under community health.

²⁷Aboriginal Health. A level 5 service is provided across SWSLHD

²⁸Community Health – General. A level 5 service is provided across SWSLHD. Some services within community health such as palliative care provide level 6 services.

³⁹Community Nursing. A level 5 service is provided across SWSLHD.

³⁰Multicultural Health. A level 3 service is provided across SWSLHD.

³¹Oral Health Services. Oral Health Services in SWSLHD are provided at a range of community health centre locations. Residents of SWSLHD are able to access these services at centres either located on hospital sites or in the community. The oral health role delineation levels that are indicated for each hospital facility reflects the level of service that is available in the local government area in which the hospital is located.

³²Sexual Health. A level 4 service is provided at Liverpool and a Level 3 service at Campbelltown. Other hospitals provide level 1 services.

³³Women’s Health. A level 4 service across SWSLHD
A4. Clinical Streams and Networks

**Aged Care and Rehabilitation**
Specialties and departments include: Geriatric Medicine; Rehabilitation Medicine; Transitional Care; Brain Injury Unit; Aged Care Community Services; Carer Respite; and Cognitive & Behavioural Disorder of the Elderly (liaison with Mental Health).

**Allied Health**
Departments and services include: Nutrition and Dietetics; Occupational Therapy; Orthoptics; Orthotics; Physiotherapy; Podiatry, Psychology, Speech Pathology; and Social Work.

**Cancer**
Specialties and departments include: Medical Oncology; Gynaecological Oncology (liaison with Women’s Health); Radiation Oncology; Melanoma Unit; Clinical Haematology; Palliative Care; Dermatology; Urology; Head and Neck Surgery; Breast Cancer Surgery; Endocrine Surgery; and Bone & Soft Tissue Tumour Service.

**Cardiovascular**
Specialties and departments include: Cardiology; Cardio-thoracic Surgery; Vascular Surgery; Vascular Diagnostics; Renal Medicine; Cardiac Rehabilitation; Heart Failure Services; Hypertension Unit; and Renal Transplantation.

**Complex Care and Internal Medicine**
Specialties and departments include: Neurology / Stroke; Neurophysiology; General Medicine; General Practice; Endocrinology including Diabetes (liaison with Cardiovascular); Infectious Diseases; Clinical Immunology and Allergy / HIV Medicine; Clinical Genetics; Respiratory Medicine / Sleep Disorders; Rheumatology; Andrology; Oral Medicine; and Medical Ambulatory Care Services.

**Community Health Services**
Services include: Early Childhood Health Services; Child Adolescent and Family Health Services; Child Protection; Sexual Health Clinical Services; Sexual Health Promotion; Women’s Health Services; Sexual Assault Services; Youth Services; Community Health Nursing; Counselling Services; Nutrition Services; Palliative Care Nursing; and Health Care Interpreter Services.

**Critical Care**
Specialties and departments include: Emergency Departments; ICU; HDU; Anaesthetics; Pain Medicine; Burns; and Clinical Toxicology.

**Drug Health**
Specialties and departments include: Opioid Treatment Program; Inpatient and Outpatient Detoxification; Residential Rehabilitation; Perinatal and Family Drug Health; Hospital Consultation and Liaison; Harm Minimisation Programs; Medical Outpatient Clinics; Court Diversion Programs; and Counselling.

**Gastroenterology and Liver**
Specialties and departments include: Gastroenterology; Endoscopy; Hepatology / Liver Unit; Upper GIT Surgery; Colorectal Surgery; Hepatobiliary Surgery; Transplantation Unit; and General Surgery.
Laboratory Services
Specialties and departments include: Anatomical Pathology (including Cytopathology); Microbiology; Molecular Diagnosis; Forensic Pathology; Serology; Immunopathology; Clinical Chemistry; Laboratory Genetics; Laboratory Haematology (including Blood Bank); and Clinical Pathology (including Endocrinology & Toxicology).

Medical Imaging
Specialties and departments include: Radiology; PET; General Ultrasound; Nuclear Medicine; and Interventional Imaging.

Mental Health
Specialties and departments include: Child and Adolescent Mental Health; Youth Mental Health; Perinatal Mental Health; Adult Mental Health; Specialist Mental Health Services for Older People; Speciality Programs; and Psychogeriatrics.

Oral Health
Specialties and departments include Preventive Dentistry/Community Dental Services; Prosthodontics including Implant Dentistry; Periodontics; Conservative Dentistry including Endodontics; Paediatric Dentistry; Oral and Maxillo-Facial Surgery (liaison with Surgery); Orthodontics; Special Needs Dentistry; Diagnostic Imaging (Dentistry); Dental Prosthetic Laboratory Services; Forensic Dentistry; School Dental Assessments; and Oral Health Promotion.

Paediatrics and Neonatology
Specialties and departments include: In-patient Paediatrics; Neonatology; Paediatric Ambulatory Care; Paediatric Surgery; Adolescent Medicine; and Child & Adolescent Developmental Services.

Population Health
Services include: Public Health Unit; Health Promotion Service; Multicultural HIV/AIDS and Hepatitis Service; HIV & Related Programs; Centre for Research, Evidence Management and Surveillance; Centre for Health Equity Training, Research and Evaluation; NSW Refugee Health Service; and the Directorate.

Surgical Specialties
Specialties and departments include: Neurosurgery; ENT Surgery; Ophthalmology; Orthopaedic Surgery; Hand Surgery; Plastic and Reconstructive Surgery; Trauma Surgery; and Oromaxillary Facial Surgery.

Women’s Health
Specialties and departments include: Obstetrics & Midwifery Services; Gynaecology; Foetal Medicine; Reproductive Endocrinology & Infertility; and Reproductive Imaging.
### A5. Facility Workforce Profile

Headcount of People working in SWSLHD by facility at 01/07/2012

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<td>-</td>
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<td>775</td>
<td>348</td>
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<td>175</td>
<td>11,984</td>
</tr>
</tbody>
</table>

* Number of Oral Health employees who work in South Western Sydney

Source: SWSLHD Payroll
### A6. Health Service Activity for District Facilities 2011/12

| Activity Indicators | SWSLHD | Campbelltown-Lakemba | Bankstown-Lidcombe | Bowral Braeside | Camden Campbelltown Fairfield Karitane Fairfield | Liverpool | Karitane | Community Mental Drug Other Oral Health Services Activity |
|---------------------|--------|----------------------|-------------------|---------------|-----------------------------------------------|---------|---------|-----------------|----------------|
| **Emergency Activity** |        |                      |                   |               |                                               |         |         |                 |                 |
| Emergency Admissions | 233,678| 45,584               | 18,103            | 0             | 12,444                                        | 56,698  | 33,884  | 65,775          | 63,735          |
| Emergency Admissions to Ward | 73,181 | 17,222               | 4,937             | 0             | 3,963                                        | 16,969  | 8,817   | 26,840          | 44,360          |
| Emergency Admissions 1 | 64,974 | 14,314               | 2,972             | 0             | 70                                           | 15,201  | 6,665   | 25,047          | 24,292          |
| **Inpatient Activity** |        |                      |                   |               |                                               |         |         |                 |                 |
| Inpatient Number of Beds 1 | 2,330  | 43,987               | 8,916             | 0             | 2,137                                        | 40,724  | 26,699  | 67,528          | 16,608          |
| Planned Separations 2 | 12,413 | 31,722               | 6,722             | 0             | 4,694                                        | 26,818  | 41,416  | 41,600          | 16,625          |
| Unplanned Separations 3 | 7,113  | 12,127               | 2,627             | 0             | 2,966                                        | 13,356  | 25,421  | 29,757          | 0              |
| Same Day Separations | 85,672 | 19,983               | 3,947             | 0             | 1,075                                        | 15,313  | 15,029  | 24,908          | 30              |
| Overnight Bed Days | 371,937 | 18,385               | 23,306            | 0             | 19,938                                      | 126,757 | 64,947  | 241,998         | 5,303           |
| Occupied Bed Days | 272,926 | 18,385               | 19,322            | 0             | 21,360                                      | 123,096 | 76,959  | 275,666         | 5,295           |
| Births | 30,107 | 2,124                | 467               | 0             | 0                                           | 918     | 3,385   | 5,439           | 0              |
| Elective Operations | 26,553 | 9,203                | 2,698             | 0             | 0                                           | 5,398   | 10,063  | 7,246           | 0              |
| Emergency Operations | 15,435 | 3,145                | 585               | 0             | 0                                           | 3,725   | 1,132   | 6,758           | 0              |
| **Outpatient Activity** |        |                      |                   |               |                                               |         |         |                 |                 |
| NAPOOS 1 | 2,416,724 | 275,380              | 55,125            | 4,463         | 114,802                                      | 365,085 | 190,234 | 696,154         | 33,700          |

1. June 2011 average number of beds
2. The number of beds for other includes Carrington NH (94)
3. The Other outpatient activity relates to SCARBA
A7. Recent achievements in services and infrastructure

Key developments over the past five years in governance structures and clinical services provided to the local community include:

District-wide achievements

- Enhanced clinical governance through the establishment of clinical streams to provide clinicians with a stronger voice in service direction
- Expanding clinical service availability through supportive clinical networks
- Establishment of an Local Health District Board to facilitate involvement of providers, consumers of health services and other members of the local community, in the development of policies, plans and future initiatives
- The SWSLHD Community Participation Framework was developed to guide the progress in partnerships between health services and communities, including involving consumers, carers and community members in decision-making and service evaluation
- Annual patient surveys, which involve in-depth interviews with patients and carers about their experience and satisfaction with the health services to better understand patient and carers needs
- An Executive & Divisions of General Practice Liaison Committee was established to identify opportunities for improving communication and patient and community health. Relationships under development with the new South Western Sydney Medicare Local include representation on governance structures.
- Community renewal and place management activities in areas such as Bonnyrigg, Miller, Canterbury-Bankstown, Cabramatta, Macquarie Fields and Airds ensured an integrated approach to planning and implementation in disadvantaged communities
- A Partnership agreement was signed with Tharawal Aboriginal Medical Service to ensure conjoint planning, partnered health improvement approaches and complementary service developments
- Advice was provided into the development of subregional plans for Sydney’s south west to ensure that health concerns and strategies are included in state-wide plans
- Local Disability Guidelines were developed to ensure that staff had the capacity to support people with disabilities and carers.

Facility-Specific Achievements

- The Liverpool Hospital Stage 2 Redevelopment was initiated, incorporating expanded acute beds, ambulatory care, operating theatres and cancer therapy services. The first $390m phase and a new 800 staff car park were completed in 2012. Later phases are yet to be funded by Government. The Liverpool Hospital Mental Health Unit and Emergency Department redevelopment also occurred.
- Additional beds were added in Sydney South West, including over 80 additional beds at Liverpool and over 60 additional beds at Campbelltown hospitals.
- The new Macarthur Stage 1 (Acute Hospital Services) - Campbelltown Hospital Redevelopment commenced. At Camden Hospital, University Medical Clinics have been established, including in sleep and respiratory failure, asthma, arthritis, immunology and allergy, and the new Karitane Residential Family Care Unit opened.
- At Bankstown-Lidcombe Hospital, an Emergency Medical Unit (EMU) was established in 2011.
• At Bowral and District Hospital, major renovations of the Children’s Ward and the Special Care Nursery were undertaken, the Short Stay ward relocated and renovated, minor renovations of the Emergency Department, Theatres and the High Dependence Unit completed and the hospital grounds landscaped. General Medicine Junior Medical Officer Rotations, Advanced Paediatrics Trainees and Medical Students from University of Wollongong commenced.

• The transfer of Queen Victoria Memorial Home to RSL Lifecare was completed

Clinical Service Achievements

• In cardiology services, an additional cardiac catheterisation laboratory and interventional radiology at Liverpool Hospital and a new echocardiography service at Campbelltown Hospital were established.

• In cancer services, a second linear accelerator was opened at Campbelltown Hospital and at Bankstown-Lidcombe Hospital, oncology was refurbished and haematology services expanded. A palliative care day hospital was also opened at Camden Hospital. A fourth linear accelerator was installed at Liverpool Hospital. This is a new technology called Tomotherapy and is the first of this type to be installed in NSW. Chemotherapy delivery was enhanced at Liverpool and Bankstown-Lidcombe Hospitals and Palliative Care services enhanced at Liverpool and Bankstown-Lidcombe. A Haematology service recommenced at Campbelltown and haematology services were enhanced at Liverpool hospitals, including the opening of the Allogeneic Bone Marrow Transplant Service. Greater fundraising links with community groups have occurred for Cancer Services and consumer engagement has been increased. Cancer Services has also developed a Research Strategic Plan and attracted additional grant funding including $1.7M from the NSW Cancer Institute to establish a Translational Cancer Research Unit.

• In mental health, a new 50 bed mental health unit at Liverpool Hospital and new mental health facilities at Campbelltown Hospital including a Psychiatric Emergency Care Centre were opened.

• In renal services, a new 12-chair renal dialysis unit was established at Fairfield Hospital, a new one chair satellite service at Bowral Hospital and expansion of renal services at Bankstown-Lidcombe Hospital

• In radiology, new 64 slice CT scanners were developed at each of Campbelltown and Fairfield Hospitals, an MRI and two new CT scanners were provided at Bankstown-Lidcombe Hospital, one with SPECT-continuous fluoroscopy capabilities, and an MRI and new ultrasound was added at Campbelltown Hospital. A new MRI and PET-CT was purchased and a linear accelerator replaced at Liverpool Hospital. Picture Archiving and Communication System (PACS) was also implemented at Bankstown-Lidcombe Hospital, enhancing the delivery of filmless medical images. At Liverpool Hospital, new mobile and fixed x-ray infrastructure.

• In pathology, ongoing upgrades to equipment

• In paediatrics and neonatology, the Sydney Children’s Hospital Macarthur Paediatric Unit opened at Campbelltown Hospital, paediatric facilities at Bowral Hospital were refurbished and Karitane opened a new service at Camden Hospital providing care and advice for families with infants and young children.

• In surgery, new ultrasound equipment including a digital endoscopic ultrasound for use in upper GI surgery was purchased together with a state-of-the-art digital operating theatre at Bankstown-Lidcombe Hospital, Fairfield Hospital operating theatres were refurbished and additional surgical beds opened at Campbelltown. New heart-lung bypass equipment, digital imaging and interventional equipment was commissioned for the operating theatres and an academic unit for colo-rectal surgery was established at Liverpool Hospital.

• In aged care and rehabilitation, a new day hospital was built and commenced operation at Bankstown-Lidcombe Hospital, new beds were opened at Fairfield Hospital, a dementia day care centre completed at
Camden Hospital and a new aged care day hospital established at Liverpool and Bowral hospitals. District-wide Aged Care Triage (ACT) services were established.

- In emergency and critical care, the ED at Liverpool Hospital was expanded, a new fast-track and new short stay unit developed at Fairfield Hospital, a new short stay unit and refurbished triage area completed at Bowral Hospital, and refurbished triage and cubicle area at Campbelltown Hospital completed (with both hospitals including safe assessment rooms).

- In maternity services, the Campbelltown Midwifery Group Practice was established. In neonatology, advances in technology have enabled significantly improved survival and outcomes for small babies, supported by strong and effective intra-District and Statewide networks.

- In surgical specialties, the Whitlam Joint Replacement Centre at Fairfield was completed.

- In oral health, a new and expanded 6 chair oral health clinic at Ingleburn was established, digital radiography was expanded across the District, the Early Childhood Oral Health (ECOH) Program was implemented, student rotations commenced in most clinics and a collaborative research program was established with the Centre for Applied Nursing Research.

- In community health, implementation of sustained nurse home visiting for Aboriginal teenage mothers (Fairfield and Liverpool) extended to Aboriginal families (Bankstown, Liverpool, Fairfield and Campbelltown) and vulnerable families with multiple risk factors (Liverpool and Fairfield) and supported by research collaborations with Centre for Health Equity Training Research & Evaluation (CHETRE). The Strong Fathers, Strong Families, part of New Directions Home Visiting Program, assisted dads in parenting their children. Models of care for high risk populations (young people, Aboriginal people and people from culturally and linguistically diverse communities have been reoriented to intersectoral partnerships, health promotion and community development. A new clinic for young refugees and a new model for transdisciplinary developmental assessment were established. Centralised intake for Child and Family Health Nursing referrals commenced in 2010, supported by an electronic medical record. In collaboration with local hospitals, implementation of the NSW Health Safe Start Guidelines via new Perinatal Psychosocial Guidelines. An expanded car park at Hoxton Park Community Health Centre.

- In population health, a partnership between the NSW government departments of Health and Housing was established in 2007 to improve the health and wellbeing of people in social housing communities through joint planning and project work. The NSW Healthy Urban Development Checklist was developed locally and launched in 2009, assisting health workers to suggest health promoting improvements to policies and plans for the built environment. Health Promotion Services developed Transport Access Guides (TAGs) for each hospital; implemented a community-based and multi-strategic Arabic Tobacco project which reduced self-reported smoking and increased smoke-free homes; and completed the Healthy Beginnings project, an early childhood obesity prevention program for children up to 2 years, demonstrating that home-based early intervention delivered by trained community nurses significantly reduced mean BMI and TV viewing time and improved vegetable intake for children at age 2 years. A Community HIV Team providing community-based care to people living with HIV was established.

- In allied health, better practice projects were successful in supporting hidden carers particularly carers from emerging CALD communities.

- Planning was undertaken for the further development of mental health facilities at Campbelltown Hospital, new integrated primary care centres and community health centres in the South West Growth Centre (SWGC) and services at Bankstown-Lidcombe Hospital.
Non-Clinical and Corporate Support Achievements

- In biomedical engineering, changes to systems to improve safety for equipment users; equipment purchased to assist with heavy lifting; and automation of systems to improve quality and safety.
- In Corporate Support Services, redevelopment of systems through mergers into Health Support Services, separation of services previously provided across the former SSWAHS and also formalising network arrangements with SLHD.
- In the Clinical Library and Information Network, an upgrading of the existing Library Management System to enable external access to the Library Catalogue; redesign of the CLIN libraries intranet/internet sites to include interactive request forms, and links to relevant resources; and expansion of the suite of journals available electronically and establishment of internal and external access to electronic journals 24/7.
- In community participation, the development and launch of the SWSLHD Community Participation Framework; annual conferences on health related topics for the members and community; and involvement in the development of the first Community Engagement Policy and Volunteers Guidelines for the NSW Health system.
- In disaster management, implementation of a public health response to the H1M1 influenza pandemic; and full assessment of the water quality, food safety and communicable diseases at the Jambrero.
- In Health Language Services, developed a new and improved orientation program and package for all newly engaged contract interpreters; promoted the service through corporate orientation and facility and team specific sessions and received very positive feedback from a customer satisfaction survey.
- In Health Support Services, standardised pay cycles, accounting and financial management systems; achieved substantial savings through centralised purchasing and procurement; implemented linen usage minimisation strategies; made efficiency gains in food production and process improvements; and consolidated warehousing and distribution.
- In infection control, the Liverpool Hospital Staphylococcus aureus bacteraemia (LivSAB) project was recognised as a finalist for the Harry Collins award in the 2012 New South Wales Health Awards; and substantial progress was made in improving rates of hand hygiene compliance across the entire District, meeting the NSW average and exceeding the national average.
- In Information Management and Technology, the rollout of the eMR continued; implementation of PACS/RIS technology commenced at Liverpool, Fairfield, and Bankstown-Lidcombe; there was data and Voice Network / system implementation at Liverpool Hospital; implementation of activity based funding initiatives commenced; there was consolidation of data centres and an upgrade of existing technology including networks, internet, email, security, desktops and servers.
- In pharmacy, a major redevelopment of the Liverpool Hospital Pharmacy Department for improved access to services including an upgraded facility for the preparation of aseptically prepared products; improved services for supporting intravenous therapy in the home or via Ambulatory care services; expansion of chemotherapy services provided at Campbelltown hospital; establishment of pharmacy service to renal and dialysis patients at peripheral hospitals; and improved management of the provision of biologics in the treatment of patients with chronic conditions such as multiple sclerosis, Crohn’s disease, psoriasis and rheumatoid arthritis.
- In research, establishment of the Ingham Institute for Applied Medical Research to facilitate cutting-edge health research on a range of disease areas affecting the local community; development of the Ingham Institute Building, a Clinical Skills and Simulation Centre and the Research Radiation Oncology Bunker with only the second in the world MRI complex linear accelerator; appointment of Research Directors for SWSLHD and the Ingham Institute providing leadership and direction to the research effort in SWSLHD; and appointment of a Director of Clinical Trials funded through the Ingham Institute to increase capabilities in the conduct of clinical trials for the District; expansion of research design and analysis.
capacity through the appointment of a bio-statistical team; and development of a new Research Strategy to guide research direction in the District

- In health related transport, purchase of additional, more appropriate vehicles; increased capacity to transport bariatric patients; centralised all transport bookings and reviewed transport routes and times; and provided additional transport for outpatients/ambulatory patients. In addition Transport Access Guides (TAG) were produced for all SWSLHD hospitals.

- In workforce management, the Aboriginal Traineeship Program successfully recruited over 50 trainees, many of whom have been retained in permanent positions; workforce management was strengthened through improved reporting systems, including the new Payroll system “Staff Link” which will assist in workforce management and monitoring staff establishments; and a Workforce Committee was established to strategically plan for workforce related initiatives.

- In workforce education, over 300 training programs were provided through CEWD, with over 115,000 occasions of training service provided in the last year; collaboration with the University of Western Sydney Clinical School; and a simulation centre at Rozelle was established offering clinical training with an emphasis on inter-professional and multidisciplinary learning.

- In undergraduate and graduate education, worked with NSW, national and international universities to register 805 clinical placements at 491 sites and covering 14 disciplines. In addition, placements were provided to students attending NSW Colleges of Technical and Further Education.
### A8. Patient Flows

#### A8.1 Flow of SWSLHD Residents to Hospital, Overnight Separations 2010-11

<table>
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<th>Hospital</th>
<th>Local Government Area</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
<th>No.</th>
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<td>18,132</td>
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<td>940</td>
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<td>70</td>
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<td>162</td>
<td>0.7%</td>
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<td>69</td>
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<td>102</td>
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**Note:** The table includes patient flows for various hospitals within the SWSLHD area, categorized by local government area and hospital type, covering the years 2010-11.
<table>
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<th>No. %</th>
<th>No. %</th>
<th>No. %</th>
<th>No. %</th>
<th>No. %</th>
<th>No. %</th>
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### A9. Health Funded Non-Government Organisations

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<tr>
<th>NSW Health Non-Government Organisation (NGO) Program</th>
<th>Program Area</th>
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<td>Bankstown Community Transport Inc.</td>
<td>Transport</td>
</tr>
<tr>
<td>Bankstown Women's Health Centre</td>
<td>Women's Health</td>
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<tr>
<td>Benevolent Society of NSW</td>
<td>Women's Health</td>
</tr>
<tr>
<td>Cabramatta Community Centre</td>
<td>Drug &amp; Alcohol</td>
</tr>
<tr>
<td>CatholicCare Sydney</td>
<td>Women's Health</td>
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<tr>
<td>GROW Community</td>
<td>Drug &amp; Alcohol</td>
</tr>
<tr>
<td>GROW Community</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Headway Adult Development Program</td>
<td>Aged &amp; Disability</td>
</tr>
<tr>
<td>Illawarra Disability Trust</td>
<td>Mental Health</td>
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<tr>
<td>Immigrant Women's Health Service</td>
<td>Women's Health</td>
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<tr>
<td>Lifeline Macarthur</td>
<td>Community Services/MH</td>
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<td>Liverpool Older Womens Network</td>
<td>Women's Health</td>
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<td>Liverpool Women's Health Centre</td>
<td>Women's Health</td>
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<tr>
<td>Mission Australia LTD - South West Youth Services</td>
<td>Drug &amp; Alcohol</td>
</tr>
<tr>
<td>New Horizons - Supported Accommodation</td>
<td>Mental Health</td>
</tr>
<tr>
<td>New Horizons - Living Fair Café</td>
<td>Mental Health</td>
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<tr>
<td>Odyssey House McGrath Foundation</td>
<td>Drug &amp; Alcohol</td>
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<tr>
<td>Quest for Life Foundation</td>
<td>Community Services</td>
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<td>Southern Highlands Bereavement Care Service</td>
<td>Community Services</td>
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<tr>
<td>St Vincent De Paul Society</td>
<td>Drug &amp; Alcohol</td>
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<tr>
<td>WILMA Women's Health Centre</td>
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<tr>
<td>Youth Solutions</td>
<td>Drug &amp; Alcohol</td>
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<table>
<thead>
<tr>
<th>NSW Health Housing and Accommodation Support Initiative (HASI) Program</th>
<th>Program Area</th>
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<td>NEAMI</td>
<td>Mental Health</td>
</tr>
<tr>
<td>New Horizons</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Disability Trust</td>
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Source: SWSLHD NGO Coordinator, May 2012 and SWSLHD Mental Health Services, June 2012
## A10. Private Hospitals and Day Procedure Centres

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<th>Suburb</th>
<th>LGA</th>
<th>Classes</th>
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<td><strong>Private Hospitals</strong></td>
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</tr>
<tr>
<td>Campbelltown Private Hospital - 92 beds</td>
<td>Campbelltown</td>
<td>Campbelltown</td>
<td>Anaesthesia Medical Mental Health Paediatric Rehabilitation Surgical</td>
</tr>
<tr>
<td>Southern Highlands Private Hospital - 71 beds</td>
<td>Bowral</td>
<td>Wingecarribee</td>
<td>Anaesthesia Gastrointestinal Endoscopy Medical Paediatric Rehabilitation Surgical</td>
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<td>Sydney Southwest Private Hospital - 93 beds</td>
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<td>Liverpool</td>
<td>Anaesthesia Maternity Medical Mental Health Surgical</td>
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<td><strong>Private Day Procedure Centres</strong></td>
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<td></td>
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<tr>
<td>Bankstown Primary Health Care Day Surgery</td>
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<td>Anaesthesia Gastrointestinal Endoscopy Surgical</td>
</tr>
<tr>
<td>Bouleverde Day Surgical Centre</td>
<td>Fairfield Heights</td>
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<td>Anaesthesia Gastrointestinal Endoscopy Paediatric Surgical</td>
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<td>Liverpool</td>
<td>Liverpool</td>
<td>Anaesthesia Surgical</td>
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<tr>
<td>Liverpool Day Surgery</td>
<td>Moorebank</td>
<td>Liverpool</td>
<td>Anaesthesia Gastrointestinal Endoscopy Paediatric Surgical</td>
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<tr>
<td>Liverpool Eye Surgery</td>
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<td>Anaesthesia Paediatric Surgical</td>
</tr>
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<td>South Western Endoscopy Centre</td>
<td>Liverpool</td>
<td>Liverpool</td>
<td>Anaesthesia Gastrointestinal Endoscopy</td>
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<td>Southern Highlands Private Hospital Specialist Centre</td>
<td>Bowral</td>
<td>Wingecarribee</td>
<td>Chemotherapy</td>
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Source: NSW Ministry of Health, March 2012
## A11. Residential Aged Care Facilities (RACFs)

### A11.1 Residential Aged Care Facilities in South Western Sydney 2012

<table>
<thead>
<tr>
<th>Name of Facility</th>
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<th>LGA</th>
<th>High Care Beds</th>
<th>Low Care Places</th>
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<td>Chester Hill</td>
<td>Bankstown</td>
<td>72</td>
<td>1 28</td>
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<tr>
<td>Advantaged Care Georges Manor</td>
<td>Georges Hall</td>
<td>Bankstown</td>
<td>105</td>
<td>22 45</td>
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<td>Bankstown Aged Care Facility</td>
<td>Greenacre</td>
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<td>63</td>
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<td>Bass Hill Aged Care</td>
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<td>Revesby</td>
<td>Bankstown</td>
<td>70</td>
<td>26 40</td>
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<tr>
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</tr>
<tr>
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<td>Fairfield</td>
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<td><strong>Subtotal - Fairfield LGA</strong></td>
<td></td>
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<tr>
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<table>
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<th>Suburb</th>
<th>LGA</th>
<th>Name of Facility</th>
<th>High Care Beds</th>
<th>Low Care Places</th>
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<tr>
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<td>Nyora Gardens</td>
<td>90</td>
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<td></td>
</tr>
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<td>Rosary Village</td>
<td>140</td>
<td>5 12</td>
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<td></td>
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<td>106</td>
<td>42 16</td>
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<tr>
<td></td>
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<td>SWIA Village</td>
<td>53</td>
<td>1 12</td>
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<td><strong>Subtotal - Liverpool LGA</strong></td>
<td>794</td>
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<tr>
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<td>Bernard Austin Lodge</td>
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<td>Blue Hills Manor</td>
<td>67</td>
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<td>100</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Elizabeth House</td>
<td>40</td>
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<td></td>
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<td>Emmas Retirement Village</td>
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<tr>
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<td>Hammondcare Bond House</td>
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<td>1 57</td>
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<td>Hammondcare Southwood</td>
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<td></td>
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<td>Hammondcare The Meadows</td>
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<td><strong>Subtotal - Liverpool LGA</strong></td>
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### Residential Aged Care Facilities Continued

<table>
<thead>
<tr>
<th>Name of Facility</th>
<th>Suburb</th>
<th>LGA</th>
<th>High Care Beds</th>
<th>Low Care Places</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total Beds</td>
<td>Inc. respite</td>
<td>Inc. Secure Dementia</td>
</tr>
<tr>
<td>A11.2 Number of Residential Aged Care Facilities in South Western Sydney 2012 compared to the National 2011 target</td>
<td></td>
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</table>

The Australian Government target for 2011 for residential aged care is 113 places per 1,000 people aged 70 years and over 88 RACF places (44 high care and 44 low care) and 25 community places (4 high care and 21 low care). Overall SWSLHD has a similar number of places to the RACF target (87.1 compared to 88 places) however it has fewer community places (20.3). Distribution across the District is not even with the total number of RACF places substantially higher than the National target in Camden and Campbelltown and in community places in Campbelltown, Liverpool and Wingecarribee.

<table>
<thead>
<tr>
<th>Name of Facility</th>
<th>Suburb</th>
<th>LGA</th>
<th>High Care Beds</th>
<th>Low Care Places</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total Beds</td>
<td>Inc. respite</td>
<td>Inc. Secure Dementia</td>
</tr>
</tbody>
</table>

Source: Compiled by PHIDU using data from the Department of Health and Ageing, June 2010; and ABS Estimated Resident Population, 30 June 2010
A12. Health Plans Relevant to Local Communities

A range of local health plans were developed under the previous Area Health Service to improve the health of the community and address specific health problems. These plans identify service development directions which remain relevant and serve as a baseline for future planning. The following summarises the intent of these plans, including current plans, those that have recent expired timeframes, draft plans and plans under review for continuing relevance. Completed plans endorsed by the previous Area Health Service are available at [http://www.swshd.nsw.gov.au/publications.html](http://www.swshd.nsw.gov.au/publications.html).

The SSWAHS *Youth Health Plan 2009-2013* takes a population health approach in considering the needs of younger people aged 12 – 24 years. Strategies include:

- Improving prevention and early intervention - focusing on mental health, drug health, tobacco, injury, nutrition, physical activity and sexual health.
- Improving service access, referral pathways and the quality of care for people with chronic illness, who are Aboriginal, from CALD backgrounds, homeless or in Out-of-Home Care.
- Strengthening primary health and continuing care, focussing on mental health, drug health, oral health and services for young parents.
- Building partnerships with local government, non-government organisations and General Practice.
- Amalgamating Youth Health Services into a single service and management structure and ensuring equity based on need.
- Building capacity in the entire workforce.
- Ensuring services reflect population growth and promoting new service models and/or sources of funding.

The SSWAHS *Aboriginal Health Plan 2010-2014* includes framework initiatives to support capacity building, community renewal, health promotion and partnership arrangements with Aboriginal communities and service providers. It is founded on principles of holistic health, relationship building, partnerships, integrated responses, community empowerment and service provision complementary, supportive and non-duplicative to that provided by Aboriginal Medical Services. It includes a range of strategies on corporate issues (workforce development, cultural safety, access, social support, data collection) and strategies targeting:

- The early years, children and young people
- Chronic diseases and ageing
- Drug health
- Mental health
- Infectious diseases and sexual health
- Oral health

The SSWAHS *Overweight and Obesity Prevention and Management Plan 2008-2012* focuses on four areas: prevention in children aged 12 years and under; child and adolescent overweight and obesity treatment and management, adult overweight and obesity treatment and management, and to a limited degree adolescent and adult prevention. It recognises the need to work in collaboration with community organisations, schools and preschools and the important role that all health professionals should have in early identification and referral. The plan focuses on behaviour, capacity building, environment, quality improvement, advocacy and management. Key strategies include:

- Implementing healthy eating and exercise programs for young children
- Resources and tools to ensure that health workers can identify patients with overweight problems
- Developing and running groups for children with overweight and obesity problems
- Establishing a bariatric surgery service for adults who are overweight and obese
Ensuring a culture that is respectful of children, adolescents and adults with overweight and obesity problems

Building infrastructure and systems (including governance structures) to support effective practice and programs

The SWSLHD Sexual Health Strategy for Sexual Transmissible Infections (2013-2018) outlines broad directions of:

- Continue implementing the Best Practice Model in SWSLHD including undertaking clinical audit, research, GP education and targeting gay and men who have sex with men (MSM) as a priority population
- Further developing the Rosemeadow Campbelltown Sexual Health Clinic (RCSHC) and developing the priority population and outreach focus of the Liverpool Sexual Health Clinic
- Increasing GP education and partnership with the South Western Sydney Medicare Local
- Increase the focus on Aboriginal populations through:
  - Strengthening the partnership with Aboriginal Community Controlled Organisations in SWSLHD
  - Increase outreach testing at Aboriginal community events
  - Undertaking Aboriginal Health Impact Statements

The SSWAHS Strategic Framework for HIV/AIDS and Related Programs (HARP) Funded Services 2008-2012 includes strategies relating to:

- Capacity and infrastructure
- Collaboration and partnerships
- Support of innovation
- People living with HIV and AIDS
- Gay and other homosexually active men
- Aboriginal people
- People from priority CALD backgrounds
- People who inject drugs
- Sex workers
- Young people
- Heterosexuals with recent partner change
- HIV negative people in sero-discordant relationships
- People in correctional facilities
- People with an intellectual disability

The SSWAHS report Strategies to address the health burden of Chronic Viral hepatitis in the communities of Inner West and South West Sydney and supporting Background Report highlights that Chronic Viral Hepatitis (CVH, both HBV and HCV) and its sequelae - cirrhosis of the liver and hepatocellular cancer (HCC) - are increasing significantly in our community. HCC incidence is increasing at a faster rate than any other solid tumour malignancy. The report includes strategies across the spectrum of:

- Prevention - increase access to sterile injecting equipment, increase hepatitis B immunisation rates in adults, eliminate the risk of iatrogenic transmission of HBV and HCV, expand access to community based and peer based education on hepatitis, strengthen partnerships and collaboration to work with identified target groups with multiple health issues.
- Early intervention - improve diagnosis rates through targeted HBV and HCV screening programs for priority populations, ensure that women who screen positive for HBV antenatally are seen by the
appropriately local clinic to manage their condition, establish a region wide screening and surveillance program to enhance screening rates and follow-up in community settings.

- **Treatment and Care** - Increase treatment uptake and post treatment support of people with HBV/HCV, improve the capacity of clinics to manage patients with cirrhosis, advanced liver disease, liver cancer and comorbidities, increase referrals of children with hepatitis infection to specialist clinics
- **Community Engagement** – respond to unique needs of each priority population group with targeted health promotion programs, improve access to services by strengthening partnerships with General Practice.
- **Organisational Capacity and Infrastructure** - formal governance structures and delivery processes, staffing models, staff knowledge and expertise in CVH care, organisational capacity to respond to increased demand, data collection and reporting.

The SSWAHS *Disability Action Plan 2008-2011* seeks to achieve “justice and dignity for all” by focusing on seven action areas: physical access; accessible information; improving health care for people with disabilities; positive community attitudes; staff training; employment; and complaints and feedback procedures. Strategies include:

- Clinical guidelines focused on the main points of access to health services to support staff in caring for people with disabilities
- A flexible education strategy which focuses on knowledge and skills of staff
- Ensuring that new capital developments comply with BCA Disability Standards and legislation

The SSWAHS *Carers Action Plan 2007-2012* has five priorities for action which are fundamental to improving the quality of life for carers and the people they care for:

- Carers are recognised, respected and valued;
- Hidden carers are identified and supported;
- Services for carers and the people they care for are improved;
- Carers are partners in care;
- Carers are supported to combine caring and work.

Key initiatives include the development and implementation of a generic carer friendly model of care to help clinical services become carer friendly, the development of carer information panels to provide carers with practical advice in all facilities and surveying staff who are carers about their needs to develop a supportive work culture.

The SSWAHS *Transport for Health Plan 2007-2012* focuses on non-emergency health related transport. This includes transport of patients between health facilities and also access to health services by patients who are unable to reasonably gain access to local health services by either public or private transport. This includes people who are frailer, people with disabilities, people who are socio-economically disadvantaged and people from rural and remote areas. Key initiatives include the development of a single transport unit and a single contact number to improve coordination and access to transport services for patients, carers and staff, the development of transport access guides (TAG) to ensure that patients and carers are aware of public transport services and routes to facilities, incorporating patient and carer accommodation into hospital redevelopments, and working with other transport providers to improve access to facilities.

The SSWAHS *Aged Care and Rehabilitation Clinical Services Plan 2007-2012* considers the needs of two groups: older people who require a comprehensive multi-disciplinary approach due to acute or chronic illness, particular physical or mental disabilities, issues with care, accommodation and support, multiple medical or polypharmacy problems, dementia, or history or risk of falling; and adults requiring rehabilitation with
particular attention to the needs of people who have had a stroke, have a chronic disease, an intellectual
disability, brain injury, spinal cord injury or severe burns. The Plan includes strategies such as:

- A single point of contact to improve access to range of services
- Expanding day hospital, outpatient and home based therapy services
- Development of new models of care for older people presenting to ED
- Broader systemic approaches such as workforce development to enable all health services to be
  responsive to the needs of these groups.

The SSWAHS Community Health Strategic Plan 2007-2012 focuses on the range of community based
prevention, early intervention, assessment, treatment, health maintenance and continuing care services
designed to improve or maintain the health and wellbeing of individuals and communities. The plan includes
strategies to expand the range of preventative health programs; increase service responsiveness, flexibility and
coordination; reduce avoidable hospital admission; work with other services; workforce development; and
infrastructure development.

The SSWAHS Maternity Services Plan 2009-2013 provides a framework for maternity services to promote
continuity of care and increase birthing choices for women. It also aims to deliver the appropriate level of care
commensurate with the degree of risk to the mother and baby during the antenatal, birthing and postnatal
period so that desirable health outcomes are achieved. It includes a range of strategies:

- Maintaining birthing services at Liverpool, Bankstown-Lidcombe, Campbelltown, Fairfield and Bowral and
  District hospitals and continuing with the Midwifery Group Practice at Camden with birthing at
  Campbelltown Hospital; with tertiary level services centred at Liverpool
- Enhancing choice for women by expanding the range of maternity care options;
- Increasing participation in GP Antenatal Shared Care programs
- Increasing the availability of midwifery-led models such as midwifery group practice
- Increasing the number of community based antenatal clinics
- Rolling out programs specific to Aboriginal women and babies consistent with the Aboriginal Maternal and
  Infant Health Strategy
- Implementing policies promoting breastfeeding
- Developing a workforce plan for maternity and related services.
## A13. Demographic profile of South Western Sydney Communities

<table>
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<tr>
<th>Total persons (ERP)</th>
<th>Aboriginal people and Torres Strait Islanders</th>
<th>Persons born overseas</th>
<th>Language spoken at home - English proficiency</th>
<th>Education: Completed Year 12 or equivalent</th>
<th>Carers: Unpaid assistance to a person with a disability</th>
<th>Disability need for assistance with core activities</th>
<th>Education: Completed Year 10 or below equivalent</th>
<th>Education: Completed Year 9 or below equivalent</th>
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<tbody>
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<td>190,637</td>
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<td>9.5%</td>
<td>21.2%</td>
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<td>Strategic &amp; Healthcare Services Plan</td>
<td>Strategic Priorities in Health Care Delivery to 2021</td>
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<td>Barakulah</td>
<td>Bankstown</td>
<td>Camden</td>
<td>Campbelltown</td>
<td>Fairfield</td>
<td>Liverpool</td>
<td>Wingecarribee</td>
<td>Wollondilly</td>
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<td>81,895</td>
<td>6.7%</td>
<td>1.1%</td>
<td>11.7%</td>
<td>22.5%</td>
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<td>134,742</td>
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<td>1.8%</td>
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<td>387,392</td>
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<td>31.3%</td>
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<td>1.6%</td>
<td>1.6%</td>
<td>3.8%</td>
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<td>583,384</td>
<td>11.1%</td>
<td>1.0%</td>
<td>34.4%</td>
<td>35.8%</td>
<td>5.1%</td>
<td>5.1%</td>
<td>4.1%</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

### Education

- **Total persons 15 years and over, no longer attending primary or secondary school**: 115,880
- **Education: Completed Year 12 or equivalent**: 135,880
- **Education: Completed Year 10 or below equivalent**: 51,696

### Carers: Unpaid assistance to a person with a disability

- **Carers: Unpaid assistance to a person with a disability**: 28,859
- **Disabled need for assistance with core activities**: 23,781
- **Carers: Unpaid assistance to a person with a disability**: 19,632
### Demographic Profile Continued

<table>
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<tr>
<th>Population Characteristics</th>
<th>Bankstown</th>
<th>Camden</th>
<th>Campbell-town</th>
<th>Fairfield</th>
<th>Liverpool</th>
<th>Winge-carrabbe</th>
<th>Wollondilly</th>
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<td>Total labour force</td>
<td>75,608</td>
<td>29,969</td>
<td>70,235</td>
<td>75,950</td>
<td>80,189</td>
<td>20,106</td>
<td>22,224</td>
<td>374,280</td>
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<td>Employed full time</td>
<td>44,906</td>
<td>19,295</td>
<td>43,968</td>
<td>44,617</td>
<td>50,804</td>
<td>11,367</td>
<td>13,886</td>
<td>228,853</td>
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<td>Unemployed</td>
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<td>1,209</td>
<td>5,182</td>
<td>7,341</td>
<td>5,620</td>
<td>846</td>
<td>936</td>
<td>26,873</td>
<td>196,526</td>
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<td>Income: Median individual ($/weekly)</td>
<td>428</td>
<td>690</td>
<td>549</td>
<td>369</td>
<td>510</td>
<td>548</td>
<td>617</td>
<td>N.A.</td>
<td>561</td>
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<tr>
<td>Income: Median household ($/weekly)</td>
<td>1,091</td>
<td>1,727</td>
<td>1,251</td>
<td>1,022</td>
<td>2,199</td>
<td>1,094</td>
<td>1,478</td>
<td>N.A.</td>
<td>1,237</td>
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<td>Families</td>
<td>47,029</td>
<td>15,462</td>
<td>39,123</td>
<td>49,714</td>
<td>46,563</td>
<td>12,271</td>
<td>11,877</td>
<td>222,039</td>
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<tr>
<td>Couple families with children</td>
<td>24,715</td>
<td>8,494</td>
<td>19,016</td>
<td>25,853</td>
<td>26,421</td>
<td>4,777</td>
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<td>4,635</td>
<td>10,769</td>
<td>11,569</td>
<td>11,058</td>
<td>5,539</td>
<td>3,906</td>
<td>59,887</td>
<td>669,019</td>
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<td>One parent families</td>
<td>9,069</td>
<td>2,182</td>
<td>8,718</td>
<td>11,227</td>
<td>8,478</td>
<td>1,832</td>
<td>1,613</td>
<td>43,119</td>
<td>297,904</td>
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<tr>
<td>Other families</td>
<td>834</td>
<td>151</td>
<td>620</td>
<td>1,065</td>
<td>606</td>
<td>123</td>
<td>111</td>
<td>3,510</td>
<td>30,780</td>
</tr>
<tr>
<td>Household composition: private dwellings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Households</td>
<td>57,238</td>
<td>17,875</td>
<td>47,286</td>
<td>55,835</td>
<td>53,595</td>
<td>16,694</td>
<td>13,953</td>
<td>262,476</td>
<td>2,471,296</td>
</tr>
<tr>
<td>Family household</td>
<td>44,620</td>
<td>14,963</td>
<td>37,380</td>
<td>45,959</td>
<td>44,019</td>
<td>12,053</td>
<td>11,472</td>
<td>210,466</td>
<td>1,777,398</td>
</tr>
<tr>
<td>Lone person household</td>
<td>11,454</td>
<td>2,589</td>
<td>8,854</td>
<td>8,737</td>
<td>8,596</td>
<td>4,324</td>
<td>2,245</td>
<td>46,799</td>
<td>599,148</td>
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<tr>
<td>Other households</td>
<td>1,164</td>
<td>323</td>
<td>1,052</td>
<td>1,139</td>
<td>980</td>
<td>317</td>
<td>236</td>
<td>5,211</td>
<td>94,750</td>
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<tr>
<td></td>
<td>2.0%</td>
<td>1.8%</td>
<td>2.2%</td>
<td>2.0%</td>
<td>1.8%</td>
<td>1.9%</td>
<td>1.7%</td>
<td>2.0%</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

SWLHD Strategic & Healthcare Services Plan
Strategic Priorities in Health Care Delivery to 2021.
Demographic Profile Continued

<table>
<thead>
<tr>
<th>Dwelling characteristics</th>
<th>Bankstown</th>
<th>Camden</th>
<th>Campbelltown</th>
<th>Fairfield</th>
<th>Liverpool</th>
<th>Winge-carribee</th>
<th>Wollondilly</th>
<th>SWSLHD</th>
<th>NSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total private dwellings</td>
<td>60,236</td>
<td>18,806</td>
<td>49,486</td>
<td>58,369</td>
<td>55,958</td>
<td>19,656</td>
<td>15,038</td>
<td>277,549</td>
<td>2,736,637</td>
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<tr>
<td>Median rent ($/weekly) (occupied private)</td>
<td>310</td>
<td>360</td>
<td>260</td>
<td>280</td>
<td>295</td>
<td>260</td>
<td>270</td>
<td>N.A.</td>
<td>300</td>
</tr>
<tr>
<td>Median loan repayment ($/monthly) - occupied</td>
<td>2,002</td>
<td>2,167</td>
<td>1,800</td>
<td>1,800</td>
<td>2,167</td>
<td>1,873</td>
<td>2,167</td>
<td>N.A.</td>
<td>1,993</td>
</tr>
<tr>
<td>Occupied private dwellings - fullyowned</td>
<td>19,467</td>
<td>4,648</td>
<td>11,435</td>
<td>18,139</td>
<td>12,908</td>
<td>6,945</td>
<td>4,298</td>
<td>77,840</td>
<td>820,006</td>
</tr>
<tr>
<td>Occupied private dwellings - rented including rent-free</td>
<td>32.3%</td>
<td>24.7%</td>
<td>23.1%</td>
<td>31.1%</td>
<td>23.1%</td>
<td>35.3%</td>
<td>28.6%</td>
<td>28.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Occupied private dwellings - rented</td>
<td>16,549</td>
<td>3,347</td>
<td>14,373</td>
<td>17,181</td>
<td>16,301</td>
<td>3,564</td>
<td>2,276</td>
<td>73,591</td>
<td>743,050</td>
</tr>
<tr>
<td>Occupied private dwellings - rent-free</td>
<td>27.5%</td>
<td>17.8%</td>
<td>29.0%</td>
<td>29.4%</td>
<td>29.1%</td>
<td>18.1%</td>
<td>15.1%</td>
<td>26.5%</td>
<td>27.2%</td>
</tr>
</tbody>
</table>

Source: Total persons data from ABS Estimated Resident Population (ERP) (ABS 3218.0 Regional Population Growth, Australia - released 31 July 2012) - includes an allowance for census net undercount and estimated number of Australian residents temporarily overseas at the time of the 2011 census.

The other data is from the Australian Bureau of Statistics 2011 Census of Population and Housing; percentages apply to census count data, not ERP data.
### A14. Detailed Population Projections

#### A14.1 Population Growth Rates per annum 2006 – 2036

<table>
<thead>
<tr>
<th>Year</th>
<th>Bankstown</th>
<th>Camden</th>
<th>Campbelltown</th>
<th>Fairfield</th>
<th>Liverpool</th>
<th>Wingecarribee</th>
<th>Wollondilly</th>
<th>SWSLHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>176,857</td>
<td>50,940</td>
<td>147,440</td>
<td>187,263</td>
<td>41,127</td>
<td>41,127</td>
<td>44,374</td>
<td>819,030</td>
</tr>
<tr>
<td>2011</td>
<td>185,762</td>
<td>1.01%</td>
<td>67,441</td>
<td>192,166</td>
<td>47,425</td>
<td>45,109</td>
<td>47,425</td>
<td>879,674</td>
</tr>
<tr>
<td>2016</td>
<td>193,114</td>
<td>0.79%</td>
<td>96,917</td>
<td>197,421</td>
<td>50,629</td>
<td>50,629</td>
<td>50,629</td>
<td>958,397</td>
</tr>
<tr>
<td>2021</td>
<td>201,440</td>
<td>0.86%</td>
<td>125,970</td>
<td>197,421</td>
<td>50,629</td>
<td>50,629</td>
<td>50,629</td>
<td>1,038,021</td>
</tr>
<tr>
<td>2026</td>
<td>209,069</td>
<td>0.76%</td>
<td>154,327</td>
<td>203,925</td>
<td>56,660</td>
<td>56,660</td>
<td>56,660</td>
<td>1,108,521</td>
</tr>
<tr>
<td>2031</td>
<td>218,565</td>
<td>0.91%</td>
<td>182,844</td>
<td>219,798</td>
<td>62,932</td>
<td>62,932</td>
<td>62,932</td>
<td>1,179,030</td>
</tr>
<tr>
<td>2036</td>
<td>228,475</td>
<td>0.91%</td>
<td>233,332</td>
<td>239,301</td>
<td>67,879</td>
<td>67,879</td>
<td>67,879</td>
<td>1,249,540</td>
</tr>
</tbody>
</table>

#### Population Growth Projections per annum 2006 – 2036

<table>
<thead>
<tr>
<th>Year</th>
<th>Bankstown</th>
<th>Camden</th>
<th>Campbelltown</th>
<th>Fairfield</th>
<th>Liverpool</th>
<th>Wingecarribee</th>
<th>Wollondilly</th>
<th>SWSLHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>176,857</td>
<td>50,940</td>
<td>147,440</td>
<td>187,263</td>
<td>41,127</td>
<td>41,127</td>
<td>44,374</td>
<td>819,030</td>
</tr>
<tr>
<td>2011</td>
<td>185,762</td>
<td>1.01%</td>
<td>67,441</td>
<td>192,166</td>
<td>47,425</td>
<td>45,109</td>
<td>47,425</td>
<td>879,674</td>
</tr>
<tr>
<td>2016</td>
<td>193,114</td>
<td>0.79%</td>
<td>96,917</td>
<td>197,421</td>
<td>50,629</td>
<td>50,629</td>
<td>50,629</td>
<td>958,397</td>
</tr>
<tr>
<td>2021</td>
<td>201,440</td>
<td>0.86%</td>
<td>125,970</td>
<td>197,421</td>
<td>50,629</td>
<td>50,629</td>
<td>50,629</td>
<td>1,038,021</td>
</tr>
<tr>
<td>2026</td>
<td>209,069</td>
<td>0.76%</td>
<td>154,327</td>
<td>203,925</td>
<td>56,660</td>
<td>56,660</td>
<td>56,660</td>
<td>1,108,521</td>
</tr>
<tr>
<td>2031</td>
<td>218,565</td>
<td>0.91%</td>
<td>182,844</td>
<td>219,798</td>
<td>62,932</td>
<td>62,932</td>
<td>62,932</td>
<td>1,179,030</td>
</tr>
<tr>
<td>2036</td>
<td>228,475</td>
<td>0.91%</td>
<td>233,332</td>
<td>239,301</td>
<td>67,879</td>
<td>67,879</td>
<td>67,879</td>
<td>1,249,540</td>
</tr>
</tbody>
</table>
### A14.2 Population Age Cohorts 2011 and 2021

#### 2011

<table>
<thead>
<tr>
<th>LGA</th>
<th>0-14</th>
<th>% of Pop</th>
<th>15-44</th>
<th>% of Pop</th>
<th>45-69</th>
<th>% of Pop</th>
<th>70-84</th>
<th>% of Pop</th>
<th>85+</th>
<th>% of Pop</th>
<th>Total Pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bankstown</td>
<td>40,921</td>
<td>22.03%</td>
<td>77,844</td>
<td>41.91%</td>
<td>48,843</td>
<td>26.29%</td>
<td>14,312</td>
<td>7.70%</td>
<td>3,843</td>
<td>2.07%</td>
<td>185,762</td>
</tr>
<tr>
<td>Camden</td>
<td>16,396</td>
<td>24.31%</td>
<td>30,162</td>
<td>44.72%</td>
<td>16,715</td>
<td>24.78%</td>
<td>3,314</td>
<td>4.91%</td>
<td>854</td>
<td>1.27%</td>
<td>67,441</td>
</tr>
<tr>
<td>Campbelltown</td>
<td>34,786</td>
<td>22.46%</td>
<td>68,305</td>
<td>44.11%</td>
<td>43,324</td>
<td>27.98%</td>
<td>7,070</td>
<td>4.57%</td>
<td>1,379</td>
<td>0.89%</td>
<td>154,864</td>
</tr>
<tr>
<td>Fairfield</td>
<td>39,672</td>
<td>20.64%</td>
<td>82,234</td>
<td>42.79%</td>
<td>54,353</td>
<td>28.28%</td>
<td>13,320</td>
<td>6.93%</td>
<td>2,587</td>
<td>1.35%</td>
<td>192,166</td>
</tr>
<tr>
<td>Liverpool</td>
<td>44,479</td>
<td>23.80%</td>
<td>84,026</td>
<td>44.96%</td>
<td>47,258</td>
<td>25.28%</td>
<td>9,462</td>
<td>5.06%</td>
<td>1,683</td>
<td>0.90%</td>
<td>186,908</td>
</tr>
<tr>
<td>Wingecarribee</td>
<td>8,994</td>
<td>18.96%</td>
<td>15,088</td>
<td>31.82%</td>
<td>16,791</td>
<td>35.41%</td>
<td>5,381</td>
<td>11.35%</td>
<td>1,171</td>
<td>2.47%</td>
<td>47,425</td>
</tr>
<tr>
<td>Wollondilly</td>
<td>10,479</td>
<td>23.23%</td>
<td>18,820</td>
<td>41.72%</td>
<td>16,791</td>
<td>35.41%</td>
<td>5,381</td>
<td>11.35%</td>
<td>1,171</td>
<td>2.47%</td>
<td>47,425</td>
</tr>
<tr>
<td><strong>Total SWSLHD</strong></td>
<td><strong>195,727</strong></td>
<td><strong>22.25%</strong></td>
<td><strong>376,481</strong></td>
<td><strong>42.80%</strong></td>
<td><strong>240,300</strong></td>
<td><strong>27.32%</strong></td>
<td><strong>55,169</strong></td>
<td><strong>6.27%</strong></td>
<td><strong>11,998</strong></td>
<td><strong>1.36%</strong></td>
<td><strong>879,674</strong></td>
</tr>
<tr>
<td>NSW</td>
<td>1,376,717</td>
<td>19.10%</td>
<td>2,977,617</td>
<td>41.31%</td>
<td>2,123,179</td>
<td>29.46%</td>
<td>584,873</td>
<td>8.11%</td>
<td>145,256</td>
<td>2.02%</td>
<td>7,207,641</td>
</tr>
</tbody>
</table>

#### 2021

<table>
<thead>
<tr>
<th>LGA</th>
<th>0-14</th>
<th>% of Pop</th>
<th>15-44</th>
<th>% of Pop</th>
<th>45-69</th>
<th>% of Pop</th>
<th>70-84</th>
<th>% of Pop</th>
<th>85+</th>
<th>% of Pop</th>
<th>Total Pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bankstown</td>
<td>45,203</td>
<td>22.44%</td>
<td>83,516</td>
<td>41.46%</td>
<td>51,933</td>
<td>25.78%</td>
<td>16,401</td>
<td>8.14%</td>
<td>4,388</td>
<td>2.18%</td>
<td>201,440</td>
</tr>
<tr>
<td>Camden</td>
<td>29,874</td>
<td>23.71%</td>
<td>51,601</td>
<td>40.96%</td>
<td>33,722</td>
<td>26.77%</td>
<td>8,111</td>
<td>6.99%</td>
<td>1,962</td>
<td>1.56%</td>
<td>125,970</td>
</tr>
<tr>
<td>Campbelltown</td>
<td>42,083</td>
<td>22.60%</td>
<td>78,868</td>
<td>42.35%</td>
<td>49,557</td>
<td>26.61%</td>
<td>13,551</td>
<td>7.28%</td>
<td>2,167</td>
<td>1.16%</td>
<td>186,225</td>
</tr>
<tr>
<td>Fairfield</td>
<td>42,076</td>
<td>20.59%</td>
<td>84,533</td>
<td>41.36%</td>
<td>56,726</td>
<td>27.76%</td>
<td>17,177</td>
<td>8.40%</td>
<td>3,854</td>
<td>1.89%</td>
<td>204,366</td>
</tr>
<tr>
<td>Liverpool</td>
<td>55,071</td>
<td>23.63%</td>
<td>99,913</td>
<td>42.88%</td>
<td>60,584</td>
<td>26.00%</td>
<td>14,581</td>
<td>6.26%</td>
<td>2,860</td>
<td>1.23%</td>
<td>233,009</td>
</tr>
<tr>
<td>Wingecarribee</td>
<td>9,546</td>
<td>17.77%</td>
<td>15,151</td>
<td>28.20%</td>
<td>18,690</td>
<td>34.79%</td>
<td>8,558</td>
<td>15.93%</td>
<td>1,781</td>
<td>3.32%</td>
<td>53,727</td>
</tr>
<tr>
<td>Wollondilly</td>
<td>12,195</td>
<td>22.79%</td>
<td>21,630</td>
<td>40.43%</td>
<td>15,161</td>
<td>28.34%</td>
<td>3,817</td>
<td>7.13%</td>
<td>697</td>
<td>1.30%</td>
<td>53,501</td>
</tr>
<tr>
<td><strong>Total SWSLHD</strong></td>
<td><strong>236,048</strong></td>
<td><strong>22.31%</strong></td>
<td><strong>435,212</strong></td>
<td><strong>41.13%</strong></td>
<td><strong>286,374</strong></td>
<td><strong>27.06%</strong></td>
<td><strong>82,895</strong></td>
<td><strong>7.83%</strong></td>
<td><strong>17,709</strong></td>
<td><strong>1.67%</strong></td>
<td><strong>1,058,238</strong></td>
</tr>
<tr>
<td>NSW</td>
<td>1,518,850</td>
<td>18.97%</td>
<td>3,150,158</td>
<td>39.34%</td>
<td>2,344,965</td>
<td>29.28%</td>
<td>804,762</td>
<td>10.05%</td>
<td>189,565</td>
<td>2.37%</td>
<td>8,008,299</td>
</tr>
</tbody>
</table>

Source: Department of Planning & Statewide Services Development Branch, NSW Health 2009
## A15. Projected Healthcare Demand from SWSLHD Residents to 2021

### A15.1 Acute day only separations by age & clinical category - 2011 and 2021

<table>
<thead>
<tr>
<th>Age</th>
<th>Clinical Category</th>
<th>Separations</th>
<th>Cost Weighted Separations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Planned &amp; Other</td>
<td>Unplanned</td>
</tr>
<tr>
<td></td>
<td>10/11</td>
<td>20-21</td>
<td>Diff.</td>
</tr>
<tr>
<td>0-14</td>
<td>Medical</td>
<td>2,081</td>
<td>2,074</td>
</tr>
<tr>
<td></td>
<td>Surg/Proc</td>
<td>1,941</td>
<td>2,780</td>
</tr>
<tr>
<td></td>
<td>Tot 0-14</td>
<td>4,022</td>
<td>4,854</td>
</tr>
<tr>
<td>15-64</td>
<td>Medical</td>
<td>5,963</td>
<td>6,877</td>
</tr>
<tr>
<td></td>
<td>Surg/Proc</td>
<td>14,699</td>
<td>18,347</td>
</tr>
<tr>
<td></td>
<td>Maternity³</td>
<td>2,268</td>
<td>2,781</td>
</tr>
<tr>
<td></td>
<td>Tot 15-64</td>
<td>22,930</td>
<td>28,005</td>
</tr>
<tr>
<td>70-84</td>
<td>Medical</td>
<td>2,199</td>
<td>3,313</td>
</tr>
<tr>
<td></td>
<td>Surg/Proc</td>
<td>3,909</td>
<td>7,691</td>
</tr>
<tr>
<td></td>
<td>Tot 70-84</td>
<td>6,108</td>
<td>11,004</td>
</tr>
<tr>
<td>85+</td>
<td>Medical</td>
<td>513</td>
<td>722</td>
</tr>
<tr>
<td></td>
<td>Surg/Proc</td>
<td>418</td>
<td>968</td>
</tr>
<tr>
<td></td>
<td>Tot 85+</td>
<td>931</td>
<td>1,690</td>
</tr>
<tr>
<td>Total all ages</td>
<td>33,991</td>
<td>45,553</td>
<td>11,562</td>
</tr>
</tbody>
</table>

1 Excludes qualified & unqualified babies, perinatology, chemotherapy and renal dialysis
2 Excludes separated and discharged within emergency department
3 Includes vaginal delivery, caesarean delivery, ante-natal admission and post-natal admission
### A15.2 Acute overnight separations by age & clinical category - 2011 and 2021

<table>
<thead>
<tr>
<th>Age</th>
<th>Clinical Category</th>
<th>Separations&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Cost Weighted Separations&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Planned &amp; Other</td>
<td>Unplanned</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10/11 20-21 Diff. % A</td>
<td>10/11 20-21 Diff. % A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Planned &amp; Other</td>
<td>Unplanned</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10/11 20-21 Diff. % A</td>
<td>10/11 20-21 Diff. % A</td>
</tr>
<tr>
<td>0-14</td>
<td>Medical</td>
<td>880 1,837 957 108.8%</td>
<td>8,645 9,804 1,159 13.4%</td>
</tr>
<tr>
<td></td>
<td>Surg/Proc</td>
<td>1,283 1,695 412 32.1%</td>
<td>810 914 104 12.8%</td>
</tr>
<tr>
<td></td>
<td>Tot0-14</td>
<td>2,163 3,532 1,369 63.3%</td>
<td>9,455 10,718 1,263 13.4%</td>
</tr>
<tr>
<td>15-64</td>
<td>Medical</td>
<td>3,067 3,869 802 26.1%</td>
<td>20,682 19,729 -953 -4.6%</td>
</tr>
<tr>
<td></td>
<td>Surg/Proc</td>
<td>9,840 10,434 594 6.0%</td>
<td>6,964 7,066 102 1.5%</td>
</tr>
<tr>
<td></td>
<td>Maternity</td>
<td>11,783 13,836 2,053 17.4%</td>
<td>814 870 56 6.9%</td>
</tr>
<tr>
<td></td>
<td>Tot15-64</td>
<td>24,690 28,139 3,449 14.0%</td>
<td>28,460 27,665 -795 -2.8%</td>
</tr>
<tr>
<td>70-84</td>
<td>Medical</td>
<td>1,127 2,143 1,016 90.2%</td>
<td>11,496 16,193 4,697 40.9%</td>
</tr>
<tr>
<td></td>
<td>Surg/Proc</td>
<td>3,276 4,806 1,530 46.7%</td>
<td>2,159 3,156 997 46.2%</td>
</tr>
<tr>
<td></td>
<td>Tot75-84</td>
<td>4,403 6,949 2,546 57.8%</td>
<td>13,655 19,349 5,694 41.7%</td>
</tr>
<tr>
<td>85+</td>
<td>Medical</td>
<td>307 721 414 134.9%</td>
<td>5,411 7,814 2,403 44.4%</td>
</tr>
<tr>
<td></td>
<td>Surg/Proc</td>
<td>443 683 240 54.2%</td>
<td>736 1,003 267 36.3%</td>
</tr>
<tr>
<td></td>
<td>Tot85+</td>
<td>750 1,404 654 87.2%</td>
<td>6,147 8,817 2,670 43.4%</td>
</tr>
<tr>
<td>Total all ages</td>
<td></td>
<td>32,006 40,024 8,018 25.1%</td>
<td>57,717 66,549 8,832 15.3%</td>
</tr>
</tbody>
</table>

<sup>1</sup> Excludes qualified & unqualified babies, perinatology, chemotherapy and renal dialysis

<sup>2</sup> Excludes separated and discharged within emergency department

<sup>3</sup> Includes vaginal delivery, caesarean delivery, ante-natal admission and post-natal admission
### A15.3 Acute overnight bed days & average length of stay by age & clinical category - 2011 and 2021

<table>
<thead>
<tr>
<th>Age</th>
<th>Clinical Category</th>
<th>Planned &amp; Other</th>
<th>Unplanned</th>
<th>Planned &amp; Other</th>
<th>Unplanned</th>
<th>Planned &amp; Other</th>
<th>Unplanned</th>
<th>Planned &amp; Other</th>
<th>Unplanned</th>
<th>Planned &amp; Other</th>
<th>Unplanned</th>
<th>Planned &amp; Other</th>
<th>Unplanned</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>10/11</td>
<td>20-21</td>
<td>Diff.</td>
<td>% Δ</td>
<td>10/11</td>
<td>20-21</td>
<td>Diff.</td>
<td>% Δ</td>
<td>10/11</td>
<td>20-21</td>
<td>Diff.</td>
<td>% Δ</td>
</tr>
<tr>
<td>0-14</td>
<td>Medical</td>
<td>3,683</td>
<td>6,544</td>
<td>2,861</td>
<td>77.7%</td>
<td>20,362</td>
<td>22,358</td>
<td>1,996</td>
<td>9.8%</td>
<td>4.19</td>
<td>3.56</td>
<td>-0.62</td>
<td>-14.9%</td>
</tr>
<tr>
<td></td>
<td>Surg/Proc</td>
<td>4,777</td>
<td>5,210</td>
<td>433</td>
<td>9.1%</td>
<td>4,603</td>
<td>4,259</td>
<td>-344</td>
<td>-7.5%</td>
<td>3.72</td>
<td>3.07</td>
<td>-0.65</td>
<td>-17.4%</td>
</tr>
<tr>
<td></td>
<td>Tot 0-14</td>
<td>8,460</td>
<td>11,754</td>
<td>3,294</td>
<td>38.9%</td>
<td>24,965</td>
<td>26,617</td>
<td>1,652</td>
<td>6.6%</td>
<td>3.91</td>
<td>3.33</td>
<td>-0.58</td>
<td>-14.9%</td>
</tr>
<tr>
<td>15-69</td>
<td>Medical</td>
<td>18,838</td>
<td>24,955</td>
<td>6,117</td>
<td>32.5%</td>
<td>88,208</td>
<td>91,929</td>
<td>3,721</td>
<td>4.2%</td>
<td>6.14</td>
<td>6.45</td>
<td>0.31</td>
<td>5.0%</td>
</tr>
<tr>
<td></td>
<td>Surg/Proc</td>
<td>38,029</td>
<td>39,232</td>
<td>1,203</td>
<td>3.2%</td>
<td>49,497</td>
<td>48,460</td>
<td>-1,037</td>
<td>-2.1%</td>
<td>3.86</td>
<td>3.76</td>
<td>-0.10</td>
<td>-2.7%</td>
</tr>
<tr>
<td></td>
<td>Maternity</td>
<td>36,128</td>
<td>41,708</td>
<td>5,580</td>
<td>15.4%</td>
<td>364,178</td>
<td>41,708</td>
<td>5,580</td>
<td>15.4%</td>
<td>3.07</td>
<td>3.01</td>
<td>-0.05</td>
<td>-1.7%</td>
</tr>
<tr>
<td></td>
<td>Tot 15-64</td>
<td>92,995</td>
<td>105,895</td>
<td>12,900</td>
<td>13.9%</td>
<td>140,325</td>
<td>143,233</td>
<td>2,908</td>
<td>2.1%</td>
<td>3.77</td>
<td>3.76</td>
<td>0.00</td>
<td>-0.1%</td>
</tr>
<tr>
<td>70-84</td>
<td>Medical</td>
<td>8,364</td>
<td>17,037</td>
<td>8,673</td>
<td>103.7%</td>
<td>76,158</td>
<td>116,509</td>
<td>40,351</td>
<td>53.0%</td>
<td>7.42</td>
<td>7.95</td>
<td>0.53</td>
<td>7.1%</td>
</tr>
<tr>
<td></td>
<td>Surg/Proc</td>
<td>18,778</td>
<td>28,112</td>
<td>9,334</td>
<td>49.7%</td>
<td>28,671</td>
<td>37,096</td>
<td>8,425</td>
<td>29.4%</td>
<td>5.73</td>
<td>5.85</td>
<td>0.12</td>
<td>2.0%</td>
</tr>
<tr>
<td></td>
<td>Tot 75-84</td>
<td>27,142</td>
<td>45,149</td>
<td>18,007</td>
<td>66.3%</td>
<td>104,829</td>
<td>153,605</td>
<td>48,776</td>
<td>46.5%</td>
<td>6.16</td>
<td>6.50</td>
<td>0.33</td>
<td>5.4%</td>
</tr>
<tr>
<td>85+</td>
<td>Medical</td>
<td>3,145</td>
<td>6,787</td>
<td>3,642</td>
<td>115.8%</td>
<td>40,407</td>
<td>63,761</td>
<td>23,354</td>
<td>57.8%</td>
<td>10.24</td>
<td>9.41</td>
<td>-0.83</td>
<td>-8.1%</td>
</tr>
<tr>
<td></td>
<td>Surg/Proc</td>
<td>3,029</td>
<td>4,810</td>
<td>1,781</td>
<td>58.8%</td>
<td>10,863</td>
<td>13,812</td>
<td>2,949</td>
<td>27.1%</td>
<td>6.84</td>
<td>7.04</td>
<td>0.20</td>
<td>3.0%</td>
</tr>
<tr>
<td></td>
<td>Tot 85+</td>
<td>6,174</td>
<td>11,597</td>
<td>5,423</td>
<td>87.8%</td>
<td>51,270</td>
<td>77,573</td>
<td>26,303</td>
<td>51.3%</td>
<td>8.23</td>
<td>8.26</td>
<td>0.03</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total all ages</td>
<td></td>
<td>134,771</td>
<td>174,395</td>
<td>39,624</td>
<td>29.4%</td>
<td>321,389</td>
<td>401,028</td>
<td>79,639</td>
<td>24.8%</td>
<td>4.21</td>
<td>4.36</td>
<td>0.15</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

1 Excludes qualified & unqualified babies, perinatology, chemotherapy and renal dialysis
2 Excludes separted and discharged within emergency department
3 Includes vaginal delivery, caesarean delivery, ante-natal admission and post-natal admission
## A15.4 Sub-acute overnight bed days & average length of stay by age & clinical category - 2011 and 2021

<table>
<thead>
<tr>
<th>Age</th>
<th>Clinical Category</th>
<th>Separations</th>
<th>Bed days</th>
<th>Average Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-69</td>
<td>Rehabilitation</td>
<td>811</td>
<td>1,507</td>
<td>696</td>
</tr>
<tr>
<td></td>
<td>Palliative Care</td>
<td>391</td>
<td>464</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>Psychogeriatric</td>
<td>7</td>
<td>32</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Maintenance</td>
<td>68</td>
<td>78</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>1,277</strong></td>
<td><strong>2,081</strong></td>
<td><strong>804</strong></td>
</tr>
<tr>
<td>70-84</td>
<td>Rehabilitation</td>
<td>1,261</td>
<td>2,605</td>
<td>1,344</td>
</tr>
<tr>
<td></td>
<td>Palliative Care</td>
<td>336</td>
<td>583</td>
<td>247</td>
</tr>
<tr>
<td></td>
<td>Psychogeriatric</td>
<td>52</td>
<td>153</td>
<td>101</td>
</tr>
<tr>
<td></td>
<td>Maintenance</td>
<td>226</td>
<td>375</td>
<td>149</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>1,875</strong></td>
<td><strong>3,716</strong></td>
<td><strong>1,841</strong></td>
</tr>
<tr>
<td>85+</td>
<td>Rehabilitation</td>
<td>707</td>
<td>1,481</td>
<td>774</td>
</tr>
<tr>
<td></td>
<td>Palliative Care</td>
<td>113</td>
<td>233</td>
<td>120</td>
</tr>
<tr>
<td></td>
<td>Psychogeriatric</td>
<td>16</td>
<td>28</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Maintenance</td>
<td>231</td>
<td>334</td>
<td>103</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>1,067</strong></td>
<td><strong>2,076</strong></td>
<td><strong>1,009</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Total all ages</strong></td>
<td><strong>4,219</strong></td>
<td><strong>7,873</strong></td>
<td><strong>3,654</strong></td>
</tr>
</tbody>
</table>
A15.5 Mental Health beds by age category and bed type – 2012 actual, 2011 & 2021 modelled MHCCP

15.5.1 Mental Health projections (MH_CCP 1.11)

<table>
<thead>
<tr>
<th>Bed Type</th>
<th>2012 Actual</th>
<th>2012 MHCCP</th>
<th>2021 MHCCP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012 Actual</td>
<td>@80%</td>
<td>Δ to 2012</td>
</tr>
<tr>
<td>Acute</td>
<td>10</td>
<td>8.4</td>
<td>1.6</td>
</tr>
<tr>
<td>Non-acute</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>8.4</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Adults aged 18-64 years

<table>
<thead>
<tr>
<th>Bed Type</th>
<th>2012 Actual</th>
<th>2012 MHCCP</th>
<th>2021 MHCCP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012 Actual</td>
<td>@80%</td>
<td>Δ to 2012</td>
</tr>
<tr>
<td>Acute</td>
<td>130</td>
<td>119</td>
<td>11</td>
</tr>
<tr>
<td>Non-acute</td>
<td>16</td>
<td>82</td>
<td>-66</td>
</tr>
<tr>
<td>PECC</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>156</td>
<td>201</td>
<td>-55</td>
</tr>
</tbody>
</table>

Adults aged 65+ years

<table>
<thead>
<tr>
<th>Bed Type</th>
<th>2012 Actual</th>
<th>2012 MHCCP</th>
<th>2021 MHCCP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012 Actual</td>
<td>@80%</td>
<td>Δ to 2012</td>
</tr>
<tr>
<td>Acute</td>
<td>0</td>
<td>21</td>
<td>-21</td>
</tr>
<tr>
<td>Non-acute</td>
<td>16</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>28</td>
<td>-12</td>
</tr>
</tbody>
</table>

All ages

<table>
<thead>
<tr>
<th>Bed Type</th>
<th>2012 Actual</th>
<th>2012 MHCCP</th>
<th>2021 MHCCP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012 Actual</td>
<td>@80%</td>
<td>Δ to 2012</td>
</tr>
<tr>
<td>Acute</td>
<td>140</td>
<td>148.4</td>
<td>-8.4</td>
</tr>
<tr>
<td>Non-acute</td>
<td>32</td>
<td>89</td>
<td>-57</td>
</tr>
<tr>
<td>PECC</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>182</td>
<td>237.4</td>
<td>-65.4</td>
</tr>
</tbody>
</table>

1. Acute child and adolescent beds (2012) are a statewide service
2. Subacute beds (2012) for people aged 65+ years are not funded through the Mental Health program
3. PECC beds identified separately as they are not included in the MH-CCP 1.11 model
15.5.2 Mental Health projections (MH_CCP 2010)

<table>
<thead>
<tr>
<th>Children and Adolescents aged &lt;18 years</th>
<th>2012 MHCCP</th>
<th>2021 MHCCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Type</td>
<td>@80%</td>
<td>Δ to 2013</td>
</tr>
<tr>
<td>Acute</td>
<td>10</td>
<td>10.4</td>
</tr>
<tr>
<td>Non-acute</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>18.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adults aged 18-64 years</th>
<th>2012 MHCCP</th>
<th>2021 MHCCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Type</td>
<td>@80%</td>
<td>Δ to 2013</td>
</tr>
<tr>
<td>Acute</td>
<td>140</td>
<td>135.2</td>
</tr>
<tr>
<td>Non-acute</td>
<td>16</td>
<td>23.2</td>
</tr>
<tr>
<td>Total</td>
<td>156</td>
<td>158.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adults aged 65+ years</th>
<th>2012 MHCCP</th>
<th>2021 MHCCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Type</td>
<td>@80%</td>
<td>Δ to 2013</td>
</tr>
<tr>
<td>Acute</td>
<td>0</td>
<td>23.2</td>
</tr>
<tr>
<td>Non-acute</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>35.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All ages</th>
<th>2012 MHCCP</th>
<th>2021 MHCCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Type</td>
<td>@80%</td>
<td>Δ to 2013</td>
</tr>
<tr>
<td>Acute</td>
<td>150</td>
<td>168.8</td>
</tr>
<tr>
<td>Non-acute</td>
<td>32</td>
<td>43.2</td>
</tr>
<tr>
<td>Total</td>
<td>182</td>
<td>212</td>
</tr>
</tbody>
</table>

1. PECC incorporated into 2012 Acute Adult beds to reflect MHCCP 2010 modeling requirements for Acute Adult Services
A15.6 Emergency Department bed capacity – 2012 actual, 2011 & 2021 modelled

15.6.1 Liverpool Hospital

<table>
<thead>
<tr>
<th>Age Cohort</th>
<th>Population Liverpool LGA</th>
<th>Attends</th>
<th>ED Spaces Indicated</th>
<th>Per Head of Pop</th>
<th>Population Liverpool LGA</th>
<th>Attends @ 2011 rate</th>
<th>ED Spaces Indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>16,041</td>
<td>6,274</td>
<td>4.30</td>
<td>0.3911</td>
<td>19,506</td>
<td>7,630</td>
<td>5.23</td>
</tr>
<tr>
<td>5-14</td>
<td>28,439</td>
<td>4,689</td>
<td>3.21</td>
<td>0.1649</td>
<td>35,564</td>
<td>5,864</td>
<td>4.02</td>
</tr>
<tr>
<td>15-24</td>
<td>28,606</td>
<td>8,607</td>
<td>5.90</td>
<td>0.3009</td>
<td>33,714</td>
<td>10,144</td>
<td>6.95</td>
</tr>
<tr>
<td>25-34</td>
<td>27,708</td>
<td>8,501</td>
<td>5.82</td>
<td>0.3068</td>
<td>34,661</td>
<td>10,634</td>
<td>7.28</td>
</tr>
<tr>
<td>35-44</td>
<td>27,712</td>
<td>7,711</td>
<td>5.28</td>
<td>0.2783</td>
<td>31,539</td>
<td>8,776</td>
<td>6.01</td>
</tr>
<tr>
<td>45-54</td>
<td>24,722</td>
<td>7,197</td>
<td>4.93</td>
<td>0.2911</td>
<td>29,114</td>
<td>8,476</td>
<td>5.81</td>
</tr>
<tr>
<td>55-64</td>
<td>16,956</td>
<td>6,187</td>
<td>4.24</td>
<td>0.3649</td>
<td>23,245</td>
<td>8,482</td>
<td>5.81</td>
</tr>
<tr>
<td>65-74</td>
<td>9,767</td>
<td>5,418</td>
<td>3.71</td>
<td>0.5547</td>
<td>15,062</td>
<td>8,355</td>
<td>5.72</td>
</tr>
<tr>
<td>75-84</td>
<td>5,275</td>
<td>5,096</td>
<td>3.49</td>
<td>0.9661</td>
<td>7,744</td>
<td>7,481</td>
<td>5.12</td>
</tr>
<tr>
<td>85+</td>
<td>1,683</td>
<td>2,536</td>
<td>1.74</td>
<td>1.5068</td>
<td>2,860</td>
<td>4,310</td>
<td>2.95</td>
</tr>
<tr>
<td>Total</td>
<td>186,909</td>
<td>62,216</td>
<td>42.61</td>
<td>0.3329</td>
<td>233,011</td>
<td>80,151</td>
<td>54.90</td>
</tr>
</tbody>
</table>

2012 capacity = 50 (exclude 4 PECC) comprising 24 acute, 10 short stay, 8 sub acute, 4 paediatric, 4 resuscitation

15.6.2 Bankstown-Lidcombe Hospital

<table>
<thead>
<tr>
<th>Age Cohort</th>
<th>Population Bankstown LGA</th>
<th>Attends</th>
<th>ED Spaces Indicated</th>
<th>Per Head of Pop</th>
<th>Population Bankstown LGA</th>
<th>Attends @ 2011 rate</th>
<th>ED Spaces Indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>14,859</td>
<td>4,898</td>
<td>3.35</td>
<td>0.3296</td>
<td>15,600</td>
<td>5,142</td>
<td>3.52</td>
</tr>
<tr>
<td>5-14</td>
<td>26,061</td>
<td>3,257</td>
<td>2.23</td>
<td>0.1250</td>
<td>29,602</td>
<td>3,700</td>
<td>2.53</td>
</tr>
<tr>
<td>15-24</td>
<td>27,226</td>
<td>5,773</td>
<td>3.95</td>
<td>0.2120</td>
<td>28,768</td>
<td>6,100</td>
<td>4.18</td>
</tr>
<tr>
<td>25-34</td>
<td>25,788</td>
<td>5,788</td>
<td>3.96</td>
<td>0.2244</td>
<td>28,747</td>
<td>6,452</td>
<td>4.42</td>
</tr>
<tr>
<td>35-44</td>
<td>24,830</td>
<td>4,493</td>
<td>3.08</td>
<td>0.1810</td>
<td>26,001</td>
<td>4,705</td>
<td>3.22</td>
</tr>
<tr>
<td>45-54</td>
<td>23,613</td>
<td>4,542</td>
<td>3.11</td>
<td>0.1924</td>
<td>23,635</td>
<td>4,546</td>
<td>3.11</td>
</tr>
<tr>
<td>55-64</td>
<td>18,518</td>
<td>3,973</td>
<td>2.72</td>
<td>0.2145</td>
<td>20,231</td>
<td>4,341</td>
<td>2.97</td>
</tr>
<tr>
<td>65-74</td>
<td>12,191</td>
<td>3,746</td>
<td>2.57</td>
<td>0.3073</td>
<td>15,264</td>
<td>4,690</td>
<td>3.21</td>
</tr>
<tr>
<td>75-84</td>
<td>8,834</td>
<td>4,675</td>
<td>3.20</td>
<td>0.5292</td>
<td>9,203</td>
<td>4,870</td>
<td>3.34</td>
</tr>
<tr>
<td>85+</td>
<td>3,843</td>
<td>3,282</td>
<td>2.25</td>
<td>0.8540</td>
<td>4,388</td>
<td>3,747</td>
<td>2.57</td>
</tr>
<tr>
<td>Total</td>
<td>185,763</td>
<td>44,427</td>
<td>30.43</td>
<td>0.2392</td>
<td>201,439</td>
<td>48,294</td>
<td>33.08</td>
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</tbody>
</table>

2012 capacity = 27 comprising 19 emergency department and 8 EMU
### A15.6.3 Macarthur Hospitals (Campbelltown and Camden)

<table>
<thead>
<tr>
<th>Age Cohort</th>
<th>2011 Pop Macarthur</th>
<th>2010-11 Attend</th>
<th>ED Spaces Indicated</th>
<th>Per Head of Pop</th>
<th>2021 Population Macarthur</th>
<th>Attends @ 2011 rate</th>
<th>ED Spaces Indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Campbell’tn</td>
<td>Camden</td>
<td>Campbell’tn + Camden</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td>21,522</td>
<td>7,964</td>
<td>1,724</td>
<td>9,688</td>
<td>6.64</td>
<td>0.4501</td>
<td>28,599</td>
</tr>
<tr>
<td>5-14</td>
<td>40,139</td>
<td>5,881</td>
<td>2,118</td>
<td>7,999</td>
<td>5.48</td>
<td>0.1993</td>
<td>55,552</td>
</tr>
<tr>
<td>15-24</td>
<td>42,504</td>
<td>8,728</td>
<td>2,109</td>
<td>10,837</td>
<td>7.42</td>
<td>0.2550</td>
<td>52,305</td>
</tr>
<tr>
<td>25-34</td>
<td>37,160</td>
<td>7,215</td>
<td>1,372</td>
<td>8,587</td>
<td>5.88</td>
<td>0.2311</td>
<td>50,753</td>
</tr>
<tr>
<td>35-44</td>
<td>37,625</td>
<td>6,081</td>
<td>1,447</td>
<td>7,528</td>
<td>5.16</td>
<td>0.2001</td>
<td>49,041</td>
</tr>
<tr>
<td>45-54</td>
<td>35,797</td>
<td>5,068</td>
<td>1,065</td>
<td>6,133</td>
<td>4.20</td>
<td>0.1713</td>
<td>43,962</td>
</tr>
<tr>
<td>55-64</td>
<td>28,684</td>
<td>4,745</td>
<td>871</td>
<td>5,616</td>
<td>3.85</td>
<td>0.1958</td>
<td>38,717</td>
</tr>
<tr>
<td>65-74</td>
<td>14,373</td>
<td>3,291</td>
<td>604</td>
<td>3,895</td>
<td>2.67</td>
<td>0.2710</td>
<td>28,155</td>
</tr>
<tr>
<td>75-84</td>
<td>6,895</td>
<td>3,194</td>
<td>372</td>
<td>3,566</td>
<td>2.44</td>
<td>0.5172</td>
<td>13,286</td>
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<tr>
<td>85+</td>
<td>2,714</td>
<td>2,214</td>
<td>196</td>
<td>2,410</td>
<td>1.65</td>
<td>0.8880</td>
<td>4,826</td>
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<tr>
<td>Total</td>
<td>267,413</td>
<td>54,381</td>
<td>11,878</td>
<td>66,259</td>
<td>45.38</td>
<td>0.2478</td>
<td>365,696</td>
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</table>

2012 capacity = 38 (excluding 6 PECC Campbelltown) comprising 32 Campbelltown and 6 Camden

### A15.6.4 Fairfield Hospital

<table>
<thead>
<tr>
<th>Age Cohort</th>
<th>2011 Population Fairfield LGA</th>
<th>2011 Attend</th>
<th>ED Spaces Indicated</th>
<th>Per Head of Pop</th>
<th>2021 Population Fairfield LGA</th>
<th>Attends @ 2011 rate</th>
<th>ED Spaces Indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td>13,975</td>
<td>4,315</td>
<td>2.96</td>
<td>0.3088</td>
<td>14,140</td>
<td>4,366</td>
<td>2.99</td>
</tr>
<tr>
<td>5-14</td>
<td>25,697</td>
<td>2,904</td>
<td>1.99</td>
<td>0.1130</td>
<td>27,937</td>
<td>3,157</td>
<td>2.16</td>
</tr>
<tr>
<td>15-24</td>
<td>29,862</td>
<td>4,472</td>
<td>3.06</td>
<td>0.1498</td>
<td>29,183</td>
<td>4,370</td>
<td>2.99</td>
</tr>
<tr>
<td>25-34</td>
<td>26,476</td>
<td>4,160</td>
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<td>0.1571</td>
<td>29,015</td>
<td>4,559</td>
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<tr>
<td>35-44</td>
<td>25,896</td>
<td>3,403</td>
<td>2.33</td>
<td>0.1314</td>
<td>26,334</td>
<td>3,461</td>
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</tr>
<tr>
<td>45-54</td>
<td>26,597</td>
<td>3,302</td>
<td>2.26</td>
<td>0.1241</td>
<td>24,851</td>
<td>3,085</td>
<td>2.11</td>
</tr>
<tr>
<td>55-64</td>
<td>20,892</td>
<td>3,027</td>
<td>2.07</td>
<td>0.1449</td>
<td>22,530</td>
<td>3,264</td>
<td>2.24</td>
</tr>
<tr>
<td>65-74</td>
<td>12,458</td>
<td>2,519</td>
<td>1.73</td>
<td>0.2022</td>
<td>17,192</td>
<td>3,476</td>
<td>2.38</td>
</tr>
<tr>
<td>75-84</td>
<td>7,725</td>
<td>2,725</td>
<td>1.87</td>
<td>0.3528</td>
<td>9,329</td>
<td>3,291</td>
<td>2.25</td>
</tr>
<tr>
<td>85+</td>
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<td>1,210</td>
<td>0.83</td>
<td>0.4677</td>
<td>3,854</td>
<td>1,803</td>
<td>1.23</td>
</tr>
<tr>
<td>Total</td>
<td>192,165</td>
<td>32,037</td>
<td>21.94</td>
<td>0.1667</td>
<td>204,365</td>
<td>34,832</td>
<td>23.86</td>
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</table>

2012 capacity = 14
**A15.6.5 Bowral and District Hospital**

<table>
<thead>
<tr>
<th>Age Cohort</th>
<th>Population Wingecarribe LGA</th>
<th>ED Spaces Indicated</th>
<th>Per Head of Pop</th>
<th>Population Wingecarribe LGA</th>
<th>Attends @ 2011 rate</th>
<th>ED Spaces Indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>2,805</td>
<td>2,189</td>
<td>1.36</td>
<td>3,006</td>
<td>2,132</td>
<td>1.46</td>
</tr>
<tr>
<td>5-14</td>
<td>6,189</td>
<td>2,007</td>
<td>1.37</td>
<td>6,541</td>
<td>2,121</td>
<td>1.45</td>
</tr>
<tr>
<td>15-24</td>
<td>5,270</td>
<td>2,555</td>
<td>1.75</td>
<td>5,098</td>
<td>2,472</td>
<td>1.69</td>
</tr>
<tr>
<td>25-34</td>
<td>4,022</td>
<td>1,544</td>
<td>1.06</td>
<td>4,424</td>
<td>1,698</td>
<td>1.16</td>
</tr>
<tr>
<td>35-44</td>
<td>5,797</td>
<td>1,876</td>
<td>1.28</td>
<td>5,629</td>
<td>1,822</td>
<td>1.25</td>
</tr>
<tr>
<td>45-54</td>
<td>6,742</td>
<td>1,812</td>
<td>1.24</td>
<td>6,615</td>
<td>1,778</td>
<td>1.22</td>
</tr>
<tr>
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<td>6,857</td>
<td>1,869</td>
<td>1.28</td>
<td>8,040</td>
<td>2,191</td>
<td>1.50</td>
</tr>
<tr>
<td>65-74</td>
<td>5,634</td>
<td>1,881</td>
<td>1.29</td>
<td>7,936</td>
<td>2,650</td>
<td>1.81</td>
</tr>
<tr>
<td>75-84</td>
<td>2,938</td>
<td>1,651</td>
<td>1.13</td>
<td>4,657</td>
<td>2,617</td>
<td>1.79</td>
</tr>
<tr>
<td>85+</td>
<td>1,171</td>
<td>1,009</td>
<td>0.69</td>
<td>1,781</td>
<td>1,535</td>
<td>1.05</td>
</tr>
<tr>
<td>Total</td>
<td>47,425</td>
<td>18,193</td>
<td>12.46</td>
<td>53,727</td>
<td>21,015</td>
<td>14.39</td>
</tr>
</tbody>
</table>

2012 capacity = 10

**A15.7 Demand for Chemotherapy and Radiotherapy - SWSLHD residents 2011 – 2021**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>2011</th>
<th>2016</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total new cases of cancer SWSLHD1</td>
<td>3,810</td>
<td>4,477</td>
<td>5,298</td>
</tr>
<tr>
<td><strong>Chemotherapy Demand Projections</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total chemo courses of treatment demand2</td>
<td>1,905</td>
<td>2,239</td>
<td>2,649</td>
</tr>
<tr>
<td>Total PCVs supplied3</td>
<td>19,050</td>
<td>22,385</td>
<td>26,490</td>
</tr>
<tr>
<td>Total Chairs required4</td>
<td>67</td>
<td>79</td>
<td>93</td>
</tr>
<tr>
<td>With additional capacity for non-chemo uses5</td>
<td>74</td>
<td>86</td>
<td>102</td>
</tr>
<tr>
<td><strong>Radiotherapy Machine Demand Projections</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New cases of cancer requiring radiotherapy6</td>
<td>2,286</td>
<td>2,686</td>
<td>3,179</td>
</tr>
<tr>
<td>Radiotherapy attendances7</td>
<td>43,434</td>
<td>51,038</td>
<td>60,397</td>
</tr>
<tr>
<td>Radiotherapy machine demand8</td>
<td>5.52</td>
<td>6.48</td>
<td>7.67</td>
</tr>
</tbody>
</table>

1 *Cancer incidence and mortality: projections 2011 to 2021*
2 Cancer Institute NSW, Sydney: May 2011. p.18
3 40% of new cases of cancer plus 25% re-treatment = 50% overall
4 10 PCVs per course of treatment
5 10% increased capacity
6 National planning parameter of 52.3% of new cases requiring radiotherapy and 25% of these retreatment = 60%
7 National planning parameter of 19 attendances per course of treatment.
8 National planning parameter - 4.1 attendances per hour, 8 operating hours per day,
240 working days per year = 7,872 attendances per machine p.a.
## A15.8 Demand for Renal Dialysis - SWSLHD residents 2011 – 2021

### A15.8.1 2011 projected prevalence, 2012 supply at 90% and 2012 chairs available in SWSLHD

<table>
<thead>
<tr>
<th>Parameter 2011</th>
<th>Age Grouping</th>
<th>Total</th>
<th>Chairs reqd for prev.</th>
<th>Chairs Supply @ 90%</th>
<th>SWSLHD Chairs 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-4</td>
<td>5-14</td>
<td>15-24</td>
<td>25-34</td>
<td>35-44</td>
</tr>
<tr>
<td>NSW Population</td>
<td>476,936</td>
<td>899,781</td>
<td>972,786</td>
<td>995,240</td>
<td>1,009,592</td>
</tr>
<tr>
<td>NSW Prevalence</td>
<td>1</td>
<td>10</td>
<td>54</td>
<td>121</td>
<td>280</td>
</tr>
<tr>
<td>NSW Prevalence rate</td>
<td>0.021</td>
<td>0.111</td>
<td>0.555</td>
<td>1.216</td>
<td>2.773</td>
</tr>
<tr>
<td>SW Prevalence rate</td>
<td>0.032</td>
<td>0.172</td>
<td>0.860</td>
<td>1.884</td>
<td>4.299</td>
</tr>
<tr>
<td>Macarthur Pop</td>
<td>21,521</td>
<td>40,139</td>
<td>42,504</td>
<td>37,161</td>
<td>37,626</td>
</tr>
<tr>
<td>Liverpool Pop</td>
<td>16,041</td>
<td>28,439</td>
<td>28,605</td>
<td>27,708</td>
<td>27,712</td>
</tr>
<tr>
<td>Fairfield Pop</td>
<td>13,975</td>
<td>25,697</td>
<td>29,862</td>
<td>26,476</td>
<td>25,896</td>
</tr>
<tr>
<td>Bankstown Pop</td>
<td>14,859</td>
<td>26,061</td>
<td>27,226</td>
<td>25,787</td>
<td>24,830</td>
</tr>
<tr>
<td>Wingecarribee Pop</td>
<td>2,805</td>
<td>6,189</td>
<td>5,270</td>
<td>4,021</td>
<td>5,796</td>
</tr>
<tr>
<td>Macarthur Prevalence</td>
<td>0.07</td>
<td>0.69</td>
<td>3.66</td>
<td>7.00</td>
<td>16.17</td>
</tr>
<tr>
<td>Liverpool Prevalence</td>
<td>0.05</td>
<td>0.49</td>
<td>2.46</td>
<td>5.22</td>
<td>11.91</td>
</tr>
<tr>
<td>Fairfield Prevalence</td>
<td>0.05</td>
<td>0.44</td>
<td>2.57</td>
<td>4.99</td>
<td>11.13</td>
</tr>
<tr>
<td>Bankstown Prevalence</td>
<td>0.05</td>
<td>0.45</td>
<td>2.34</td>
<td>4.86</td>
<td>10.67</td>
</tr>
<tr>
<td>Wingecarribee Prevalence</td>
<td>0.01</td>
<td>0.11</td>
<td>0.45</td>
<td>0.76</td>
<td>2.49</td>
</tr>
<tr>
<td>Total Prevalence</td>
<td>0.22</td>
<td>2.18</td>
<td>11.48</td>
<td>22.83</td>
<td>52.38</td>
</tr>
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</table>
### 2021 projected prevalence and 2012 supply at 90%

<table>
<thead>
<tr>
<th>Parameter</th>
<th>2021</th>
<th>2012 Supply</th>
<th>90% Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW Population</td>
<td>515,870</td>
<td>998,097</td>
<td>894,865</td>
</tr>
<tr>
<td>NSW Prevalence rate</td>
<td>0.019</td>
<td>0.070</td>
<td>0.062</td>
</tr>
<tr>
<td>NSW Prevalence (%)</td>
<td>1.76</td>
<td>7.41</td>
<td>6.82</td>
</tr>
<tr>
<td>SW Prevalence rate</td>
<td>0.029</td>
<td>0.104</td>
<td>0.094</td>
</tr>
<tr>
<td>SW Prevalence (%)</td>
<td>2.60</td>
<td>10.82</td>
<td>9.84</td>
</tr>
<tr>
<td>Macarthur Pop</td>
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## Strategic Priorities in Health Care Delivery to 2021

### SWSLHD Strategic & Healthcare Services Plan

### Strategic Priorities

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**Total**

| | | | |
| | | 294,989 | 44,976 | 339,965 | 1,173 | 387,776 |

### Strategic Priorities

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## Strategic & Healthcare Services Plan

### SWSLHD Strategic & Healthcare Services Plan

#### Allied Medical Aged Care

- **Camden Group**
  - **Aged Care & Rehab**
    - Aged Care Assessment Programme 500150
    - A.C.A.R.S. - H.A.C.C. 500152
    - A.C.A.R.S Resident Placement Officer 500154
    - Admin Transport for Therapy/Clinic Services 500154
    - Dementia Advisory Service-H.A.C.C. 500155
    - Dementia Day Centre – H.A.C.C. 500156
    - Physical Disability Outreach-H.A.C.C. 500158
    - Medical Officers - Amputee & Prosthet Clinics 500160
    - Medical Officers - Geriatrics Clinic 500160
    - Medical Officers – Rehab Clinic 500160
    - Medical Officers - Spina Bifida Clinic 500160
    - Respite A Hrs/Weekend Service - N.R.C.P. 500161
    - Day Care Centre (Picton) 500164
    - Macarthur Respite Service - H.A.C.C. 500166
    - Dementia Monitoring Service - H.A.C.C. 500168
    - Reslink - N.R.C.P. 500170
    - Occupational Therapy Department - H.A.C.C. 500171
    - Medical Officers - Orthotics Clinic 500160
    - Transcultural Respite Programme - N.R.C.P. 500169
  - **Allied Health**
    - Macarthur Podiatry (High Risk Foot Clinic) 497568
    - Macarthur Podiatry - 497569
    - Macarthur Podiatry - H.A.C.C. 497569
    - Dietetics Department 500250
    - O.T.(Palliative Care Outpatient Clinic) 500252
    - Occupational Therapy Department 500252
    - Physiotherapy Dept (Rehabilitation Clinic) 500253
    - Physiotherapy Department 500253
    - Social Work Department 500254
    - Palliative Day Therapy Centre 500091
  - **Cardiovascular**
    - University Medical Clinics (Cardiac Rehab) 500124
    - University Medical Clinics (Cardiology Clinic) 500124
  - **Critical Care**
    - Emergency Department 500100
    - University Medical Clinics (Pre-Admission) 500124
  - **Complex Care**
    - Macarthur (Diabetes Educator) 497428
    - University Medical Clinics (Asthma Clinic) 500124
    - University Medical Clinics (Chronic Synovitis) 500124
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    - University Medical Clinics (Diabetes Clinic) 500124
    - Early Arthritis & Connective Tissues Disease 500124
    - University Med Clinic (Endocrinology Clinic) 500124
    - University Medical Clinics (Genetics Clinic) 500124
    - University Medical Clinics (Hypertension) 500124
    - University Medical Clinics (Immunology) 500124
    - University Medical Clinics (Sleep & Resp Failure) 500124
    - University Medical Clinics (Thyroid Clinic) 500124
    - Metabolic Rehab Service (Arthritis Clinic) 500125
    - Metabolic Rehab Service (Diabetes Clinic) 500125
    - Metabolic Rehab Service (Fatty Liver Clinic) 500125
    - Metabolic Rehab Service OAS/Diabetes Clinic 500125
    - Ambulatory Care Unit (M.A.C.S.) 500126
  - **Medical Imaging**
    - Radiology Department 500300

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### Strategic Priorities in Health Care Delivery to 2021

#### Mental Health
- **Uni Med Clinics (Intellectual Disability Psychiatric)**
  - 2011/12: 6,606,660,76.00, 1,166

#### Surgical Spec
- **University Medical Clinics (Fracture Clinic)**
  - 2011/12: 61,868,929,36.30, 1,266

#### Pathology
- **Pathology 500310**
  - 2011/12: 14,295,13,14,308,36.80, 19,573

#### Paediatrics
- **Antenatal Services (Paediatric Clinic)**
  - 2011/12: 32,32,36.50, 44

#### Womens Health
- **Birthig Midwife Group Practice Antenatal**
  - 2011/12: 1,937,1,937,36.70, 2,648

#### Facility Services
- **Patient Transport 497022**
  - 2011/12: 4,964,4,964,36.80, 6,791

### Project -ions Group Name Cost Centre Name

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#### Group Name

- **Campbelltown**

#### Allied Health
- **Disability Services 497481**
  - 2011/12: 898,898,1,093, 1,807

#### Allied Health
- **Dietetics Department (Oncology Clinic) 497563**
  - 2011/12: 596,596,1,192

#### Allied Health
- **O. T. Department (Lymphodema Clinic) 497564**
  - 2011/12: 1,544,1,544,3,088

#### Allied Health
- **O. T. Department (Oncology Clinic) 497564**
  - 2011/12: 111,111,1,023

#### Allied Health
- **Dietetics Department (Paediatric General Clinic) 497563**
  - 2011/12: 701,701,36.50, 957

#### Allied Health
- **Dietetics Department (Paediatric Immunology Clinic) 497563**
  - 2011/12: 31,31,36.50, 42

#### Allied Health
- **Dietetics Department (Predialysis Clinic) 497563**
  - 2011/12: 506,506,1,018

#### Allied Health
- **O. T. Department (Paediatric General Clinic) 497564**
  - 2011/12: 2,662,2,662,3,333

#### Allied Health
- **Occupational Therapy Department 497564**
  - 2011/12: 60,60,1,018

#### Allied Health
- **Physiotherapy Department (Paeds General Clinic) 497565**
  - 2011/12: 2,831,2,831,3,864

#### Allied Health
- **Physiotherapy Department (Plaster Clinic) 497565**
  - 2011/12: 558,558,1,116

#### Allied Health
- **Physiotherapy Department (Women’s Health Clinic) 497565**
  - 2011/12: 178,178,358

#### Allied Health
- **Physiotherapy Department 497565**
  - 2011/12: 5,020,5,020,10,040

#### Allied Health
- **Social Work Department 497566**
  - 2011/12: 7,498,7,498,15,086

#### Allied Health
- **Speech Pathology Department 497567**
  - 2011/12: 3,513,3,513,7,026

#### Cancer
- **C.N.C. McGrath Foundation Breast Care Nurse 497007**
  - 2011/12: 3,875,3,875,5,386

#### Cancer
- **C.N.C. McGrath Foundation Breast Surgery Pre-Admission Clinic**
  - 2011/12: 18,18,36.00, 25

#### Cancer
- **Cancer Therapy Centre – Medical Oncology 497250**
  - 2011/12: 212,14,423,14,635,39.00, 20,343

#### Cancer
- **Cancer Therapy Centre – Radiation Oncology 497252**
  - 2011/12: 2,499,13,952,16,451,39.00, 22,867

#### Cancer
- **Cancer Therapy – Admin (Clinical Psychologist) 497255**
  - 2011/12: 348,348,39.00, 484

#### Cancer
- **General Outpatient Clinic (Haematology) 497434**
  - 2011/12: 6,6,39.00, 8
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### Fairfield

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## Karitane

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## SWSLHD Strategic Healthcare Services Plan

### Strategic Priorities in Health Care Delivery to 2021

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Strategic Priorities in Health Care Delivery to 2021

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### Strategic Priorities in Health Care Delivery to 2021

<table>
<thead>
<tr>
<th>Group Name</th>
<th>Cost Centre Name</th>
<th>2011/12</th>
<th>Growth Factor %</th>
<th>2021 Projections</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>Equiv NAPOOS Private ly Referred Total</td>
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<td></td>
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<table>
<thead>
<tr>
<th>Group Name</th>
<th>Cost Centre Name</th>
<th>2011/12</th>
<th>Growth Factor %</th>
<th>2021 Projections</th>
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<td></td>
<td>Equiv NAPOOS Private ly Referred Total</td>
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<td></td>
<td></td>
</tr>
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<td>Oral Health Services</td>
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<tr>
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## A16. Health status indicators by LGA

### A16.1 Reported Health Status and Behaviours in Adults

<table>
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<th>Indicator (Actual Estimates)</th>
<th>Bankstown</th>
<th>Camden</th>
<th>Campbelltown</th>
<th>Fairfield</th>
<th>Liverpool</th>
<th>Wingecarribee</th>
<th>Wollondilly</th>
<th>SWSLHD</th>
<th>NSW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reported Health Status and Behaviours, Adults 16 years and over</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>High or very high levels of psychological distress, 2008-10</td>
<td>13.8%</td>
<td>9.5%</td>
<td>15.9%</td>
<td>13.2%</td>
<td>15.4%</td>
<td>7.7%</td>
<td>8.3%</td>
<td>13.2%</td>
<td>11.1%</td>
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<tr>
<td>Consumes 2+ standard drinks a day when drinking alcohol, 2008-10</td>
<td>20.4%</td>
<td>36.5%</td>
<td>32.7%</td>
<td>16.5%</td>
<td>21.8%</td>
<td>23.0%</td>
<td>33.0%</td>
<td>23.8%</td>
<td>30.4%</td>
</tr>
<tr>
<td>Current smoking, 2008-10</td>
<td>15.9%</td>
<td>17.6%</td>
<td>25.3%</td>
<td>17.3%</td>
<td>22.3%</td>
<td>14.8%</td>
<td>17.3%</td>
<td>19.2%</td>
<td>17.1%</td>
</tr>
<tr>
<td>Recommended fruit consumption, 2008-10</td>
<td>54.4%</td>
<td>50.8%</td>
<td>50.7%</td>
<td>59.1%</td>
<td>56.0%</td>
<td>58.9%</td>
<td>49.7%</td>
<td>54.9%</td>
<td>56.6%</td>
</tr>
<tr>
<td>Recommended vegetable consumption, 2008-10</td>
<td>8.3%</td>
<td>7.7%</td>
<td>5.4%</td>
<td>4.9%</td>
<td>4.1%</td>
<td>20.9%</td>
<td>10.6%</td>
<td>7.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Adequate physical activity, 2008-10</td>
<td>46.8%</td>
<td>50.9%</td>
<td>49.9%</td>
<td>42.8%</td>
<td>21.9%</td>
<td>23.0%</td>
<td>33.0%</td>
<td>23.8%</td>
<td>30.4%</td>
</tr>
<tr>
<td>Overweight, 2008-10</td>
<td>15.9%</td>
<td>17.6%</td>
<td>25.3%</td>
<td>17.3%</td>
<td>22.3%</td>
<td>14.8%</td>
<td>17.3%</td>
<td>19.2%</td>
<td>17.1%</td>
</tr>
<tr>
<td>Obese, 2008-10</td>
<td>20.4%</td>
<td>17.6%</td>
<td>25.3%</td>
<td>17.3%</td>
<td>22.3%</td>
<td>14.8%</td>
<td>17.3%</td>
<td>19.2%</td>
<td>17.1%</td>
</tr>
<tr>
<td>Excellent, very good or good self rated health status, 2008-10</td>
<td>74.8%</td>
<td>77.8%</td>
<td>76.6%</td>
<td>73.3%</td>
<td>79.8%</td>
<td>81.3%</td>
<td>76.9%</td>
<td>80.2%</td>
<td>10.8%</td>
</tr>
<tr>
<td>Current asthma, 2008-10 *</td>
<td>11.4%</td>
<td>6.1%</td>
<td>11.9%</td>
<td>11.8%</td>
<td>6.3%</td>
<td>7.4%</td>
<td>12.7%</td>
<td>9.1%</td>
<td>10.8%</td>
</tr>
<tr>
<td>Diabetes or high blood glucose, 2008-10 *</td>
<td>11.1%</td>
<td>2.7%</td>
<td>9.4%</td>
<td>6.6%</td>
<td>6.1%</td>
<td>11.6%</td>
<td>10.1%</td>
<td>7.8%</td>
<td>7.7%</td>
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<tr>
<td>Visited a dental professional in last 12 months, 2008-10</td>
<td>60.1%</td>
<td>52.6%</td>
<td>51.3%</td>
<td>55.9%</td>
<td>51.5%</td>
<td>62.8%</td>
<td>64.1%</td>
<td>56.8%</td>
<td>58.9%</td>
</tr>
<tr>
<td>Has private health insurance for dental expenses, 2008-10 *</td>
<td>50.4%</td>
<td>60.5%</td>
<td>42.7%</td>
<td>33.1%</td>
<td>39.4%</td>
<td>52.9%</td>
<td>60.4%</td>
<td>44.6%</td>
<td>50.6%</td>
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<td></td>
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<tr>
<td>Influenza immunisations, adults aged 65 and over, 2008-10 *</td>
<td>80.3%</td>
<td>73.9%</td>
<td>69.2%</td>
<td>76.5%</td>
<td>63.7%</td>
<td>71.8%</td>
<td>73.4%</td>
<td>72.1%</td>
<td>72.4%</td>
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<tr>
<td>Pneumococcal immunisations, adults aged 65 and over, 2008-10 *</td>
<td>59.6%</td>
<td>51.7%</td>
<td>52.2%</td>
<td>45.7%</td>
<td>44.4%</td>
<td>61.4%</td>
<td>53.3%</td>
<td>52.5%</td>
<td>56.3%</td>
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<tr>
<td><strong>Reported Health Status and Behaviours, Women</strong></td>
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<td></td>
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</tr>
<tr>
<td>Pap test in the last 2 years, females aged 20-69, 2008 &amp; 2010 *</td>
<td>56.9%</td>
<td>79.8%</td>
<td>62.8%</td>
<td>61.3%</td>
<td>70.0%</td>
<td>82.2%</td>
<td>63.2%</td>
<td>64.9%</td>
<td>71.0%</td>
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<tr>
<td>Hysterectomy, females aged 20-69, 2008 &amp; 2010 *</td>
<td>9.5%</td>
<td>12.8%</td>
<td>10.3%</td>
<td>9.4%</td>
<td>10.8%</td>
<td>12.7%</td>
<td>11.2%</td>
<td>10.5%</td>
<td>11.6%</td>
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<tr>
<td>Screening mammogram in the last 2 years, females aged 50-69, 2008-10</td>
<td>70.0%</td>
<td>68.0%</td>
<td>50.6%</td>
<td>54.3%</td>
<td>80.0%</td>
<td>75.5%</td>
<td>84.3%</td>
<td>67.0%</td>
<td>76.3%</td>
</tr>
</tbody>
</table>

Source: NSW Adult Population Health Survey (SaPHaRI); Centre for Epidemiology and Evidence, NSW.

* Figures may not be truly representative of the population due to the small number of respondents.
## A16.2 Health Conditions

<table>
<thead>
<tr>
<th>Indicator</th>
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<th>Camden</th>
<th>Campbelltown</th>
<th>Fairfield</th>
<th>Liverpool</th>
<th>Wingecarribee</th>
<th>Wollondilly</th>
<th>SWSLHD</th>
<th>NSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalisations 2009-10 to 2010-11, smoothed number of separations per year (smoothed estimate of Standardised Separation Ratio - seSSR)</td>
<td>65,895 (98.5)## 18,270 (92.9)## 58,156 (103.8)* 59,179 (89.4)## 58,010 (99.9)## 18,560 (94.9)## 13,943 (96.5)## 284,213</td>
<td>2,645,561 (100)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Potentially preventable hospitalisations 2009-10 to 2010-11, smoothed number of hospitalisations per year (seSSR)</td>
<td>5,009 (103.4)## 1,318 (95.1)## 3,850 (115.8)## 914 (73.4)## 916 (82.3)## 29 (87.5)## 229 (82.7)## 18,560 (94.9)## 4,792 (n.a.)</td>
<td>48,814 (100)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol attributable hospitalisations, 2009-10 to 2010-11, smoothed number of hospitalisations per year (seSSR)</td>
<td>1,000 (82.2)## 262 (69.7)## 797 (84.9)## 914 (73.4)## 916 (82.3)## 29 (87.5)## 229 (82.7)## 18,560 (94.9)## 4,792 (n.a.)</td>
<td>48,814 (100)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking attributable hospitalisations, 2009-10 to 2010-11, smoothed number of hospitalisations per year (seSSR)</td>
<td>1,049 (94.5)## 278 (93.3)## 84 (114.7)## 1,082 (100.2)## 865 (99.1)## 340 (93.4)## 169 (66.1)## 18,560 (94.9)## 4,792 (n.a.)</td>
<td>44,786 (100)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High body mass index attributable hospitalisations, smoothed number of separations per year 2009-10 to 2010-11 (seSSR)</td>
<td>952 (100)## 263 (102.1)## 806 (121.7)## 889 (92.3)## 775 (101.7)## 117 (101.7)## 216 (103.8)## 4,218 (n.a.)</td>
<td>40,015 (100)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Coronary heart disease hospitalisations 2009-10 to 2010-11 smoothed number of hospitalisations per year (seSSR)</td>
<td>1,111 (95.7)## 327 (106.3)## 908 (112.6)## 1,012 (87.1)## 821 (91.2)## 354 (83.8)## 263 (106.6)## 4,806 (n.a.)</td>
<td>49,935 (100)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD hospitalisations, persons aged over 65, 2008-09 to 2009-10, smoothed number of hospitalisations per year (seSSR)</td>
<td>372 (96.1)## 74 (101.5)## 252 (145.2)## 382 (115.6)## 287 (128.9)## 108 (82.5)## 58 (97.8)## 1,533 (n.a.)</td>
<td>15,052 (100)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes hospitalisations, 2009-10 to 2010-11, smoothed number of separations per year (seSSR)</td>
<td>550 (114.9)## 121 (91.3)## 424 (130.9)## 477 (101.6)## 515 (132.1)## 89 (89.4)## 2,293 (n.a.)</td>
<td>19,193 (100)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and over, 2008-09 to 2009-2010 combined, smoothed number of hospitalisations per year (seSSR)</td>
<td>833 (101.8)## 163 (108.7)## 369 (110.7)## 588 (93.8)## 437 (105.5)## 169 (66.1)## 100 (90.2)## 2,659 (n.a.)</td>
<td>30,864 (100)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
### A16.2 Health Conditions (continued)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Bankstown</th>
<th>Camden</th>
<th>Campbelltown</th>
<th>Fairfield</th>
<th>Liverpool</th>
<th>Wingecarribee</th>
<th>Wollondilly</th>
<th>NSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potentially avoidable deaths from causes amenable to health care, persons aged under 75 years, 2006 to 2007 combined, smoothed number of deaths per year (sSMR)^2</td>
<td>2006-2007</td>
<td>2007</td>
<td>2007</td>
<td>2007</td>
<td>2007</td>
<td>2007</td>
<td>2007</td>
<td>2007</td>
</tr>
</tbody>
</table>


1. NSW Admitted Patient Data Collection and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence. NSW Ministry of Health.
3. Cancer Institute NSW Registry 2011 accessed 20/06/2012

Note: Data asterixed with ** shows a statistically significant poorer health outcome than the NSW rate. Data asterixed with ## shows a significantly better health outcome than the NSW rate.
## A16.3 Maternal Indicators

<table>
<thead>
<tr>
<th>Maternal Indicator</th>
<th>Bankstown</th>
<th>Camden</th>
<th>Campbelltown</th>
<th>Fairfield</th>
<th>Liverpool</th>
<th>Wingeearibee</th>
<th>Wollondilly</th>
<th>SWSLHD</th>
<th>NSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual births 2010 (^1)</td>
<td>2,954</td>
<td>843</td>
<td>2,458</td>
<td>2,665</td>
<td>3,097</td>
<td>458</td>
<td>553</td>
<td>13,028</td>
<td>99,054</td>
</tr>
<tr>
<td>Total fertility rate 2010 (^1)</td>
<td>2.2</td>
<td>2.0</td>
<td>2.1</td>
<td>1.8</td>
<td>2.1</td>
<td>2.2</td>
<td>2.1</td>
<td>n.a.</td>
<td>1.9</td>
</tr>
<tr>
<td>Smoking during pregnancy, 2008 to 2010 combined, number of mothers who smoked per year, smoothed estimate of standardised prevalence ratio (^2)</td>
<td>394 (112.3)**</td>
<td>125 (123.1)**</td>
<td>628 (118.8)**</td>
<td>346 (111.7)**</td>
<td>445 (124)**</td>
<td>83 (143.4)**</td>
<td>110 (155.6)**</td>
<td>2,131 (n.a.)</td>
<td>11,235 (100)</td>
</tr>
<tr>
<td>First antenatal visit before 14 weeks of gestation, 2008 to 2010 combined, smoothed percent of pregnancies, smoothed standardised prevalence ratio (^3)</td>
<td>57% (70.7)**</td>
<td>68% (85.4)**</td>
<td>59% (73.9)**</td>
<td>49% (61.8)**</td>
<td>76% (95.5)**</td>
<td>78% (97)**</td>
<td>72% (90.3)**</td>
<td>7,986 (n.a.)</td>
<td>79.3% (100) (2010 data)</td>
</tr>
</tbody>
</table>

3. Note: Data asterisked with ** shows a statistically significant poorer health outcome than the NSW rate. Data asterisked with ## shows a significantly better health outcome than the NSW rate.
## A16.4 Mortality and Life Expectancy

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Bankstown</th>
<th>Camden</th>
<th>Campbelltown</th>
<th>Fairfield</th>
<th>Liverpool</th>
<th>Wingecarribee</th>
<th>Wollondilly</th>
<th>SWSLHD</th>
<th>NSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaths from all causes 2003-2006, Standardised Mortality Ratio (SMR)</td>
<td>101.1</td>
<td>102.0</td>
<td>107.4</td>
<td>100.1</td>
<td>105.8</td>
<td>94.0</td>
<td>91.2</td>
<td>n.a.</td>
<td>100.0</td>
</tr>
<tr>
<td>Deaths from all causes 2005-2007, Standardised Mortality Ratio (SMR)</td>
<td>99.0</td>
<td>101.8</td>
<td>106.8</td>
<td>100.0</td>
<td>107.3</td>
<td>93.9</td>
<td>88.3</td>
<td>100.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Life expectancy at birth and by gender 2002-2006</td>
<td>Males: 78.8</td>
<td>Females: 84.8</td>
<td>Males: 79.4</td>
<td>Females: 82.9</td>
<td>Males: 80</td>
<td>Females: 84.3</td>
<td>Males: 79.5</td>
<td>Females: 83.4</td>
<td>Males: 80.6</td>
</tr>
</tbody>
</table>

Source: SSWAHS Centre for Research, Evidence Management and Surveillance, NSW Health Centre for Epidemiology and Research and the NSW Chief Health Officer’s Report 2010

1. Source of SWSLHD data: ABS mortality data and population estimates (HOIST), Centre for Epidemiology and Research, NSW Department of Health

2. Data for NSW is derived from 2006/07 data only

* ABS mortality data and population estimates (SAPHRRI), Centre for Epidemiology and Evidence, NSW Ministry of Health
### A16.5 Blood Borne and Sexual Transmitted Communicable Diseases  2004 - 2011

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Bankstown</th>
<th>Camden</th>
<th>Campbelltown</th>
<th>Fairfield</th>
<th>Liverpool</th>
<th>Wingecarribee</th>
<th>Wollondilly</th>
<th>SWSLHD</th>
<th>NSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B - number and rate per 100,000 population</td>
<td>1,132 (78)</td>
<td>58 (13.6)</td>
<td>404 (33.9)</td>
<td>2,470 (161.8)</td>
<td>716 (50.7)</td>
<td>21 (5.8)</td>
<td>30 (8.9)</td>
<td>4,831 (72.1)</td>
<td>2,0867 (376)</td>
</tr>
<tr>
<td>Hepatitis C - number and rate per 100,000 population</td>
<td>777 (53.5)</td>
<td>98 (22.9)</td>
<td>931 (78.1)</td>
<td>1,348 (88.3)</td>
<td>773 (54.8)</td>
<td>157 (43.7)</td>
<td>86 (25.5)</td>
<td>4,170 (62.2)</td>
<td>3,1775 (572)</td>
</tr>
<tr>
<td>Infectious Sphihis - number and rate per 100,000 population</td>
<td>30 (2.1)</td>
<td>-</td>
<td>20 (1.7)</td>
<td>33 (2.2)</td>
<td>27 (1.9)</td>
<td>&lt; (n.a.)</td>
<td>&lt; (n.a.)</td>
<td>115 (1.7)</td>
<td>2999 (5.4)</td>
</tr>
<tr>
<td>Gonorrhea - number and rate per 100,000 population</td>
<td>259 (17.8)</td>
<td>47 (11)</td>
<td>196 (16.4)</td>
<td>305 (20)</td>
<td>235 (16.6)</td>
<td>29 (8.1)</td>
<td>25 (7.4)</td>
<td>1,096 (16.3)</td>
<td>14,272 (25.7)</td>
</tr>
<tr>
<td>Chlamydia - number and rate per 100,000 population</td>
<td>1,674 (115.4)</td>
<td>431 (100.9)</td>
<td>1,870 (156.9)</td>
<td>1,917 (125.6)</td>
<td>1,951 (138.2)</td>
<td>564 (156.8)</td>
<td>347(102.9)</td>
<td>8,754 (130.6)</td>
<td>113,312 (203.9)</td>
</tr>
</tbody>
</table>

Source: NSW Hoist 2004-2011
## A16.6 Key Health Priority Indicators – Data for South Western Sydney and NSW

<table>
<thead>
<tr>
<th>Indicator</th>
<th>SWSLHD</th>
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<th></th>
<th>NSW</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Rate per 100,000</td>
<td>No.</td>
<td>Rate per 100,000</td>
<td></td>
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</tr>
<tr>
<td>Potentially preventable hospitalisations 2010-11**</td>
<td>20,025</td>
<td>2,342.3</td>
<td>183,372</td>
<td>2,379.3</td>
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<tr>
<td>Alcohol attributable hospitalisations 2010-11**</td>
<td>4,545</td>
<td>536.0</td>
<td>49,409</td>
<td>564.8</td>
<td></td>
<td></td>
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<tr>
<td>Alcohol attributable hospitalisations for Aboriginal people 2010-11**</td>
<td>95</td>
<td>344.5</td>
<td>2,180</td>
<td>1,677.3</td>
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<td></td>
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<tr>
<td>Alcohol attributable injury hospitalisations 2010-11**</td>
<td>2,555</td>
<td>301.6</td>
<td>24,451</td>
<td>317.9</td>
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</tr>
<tr>
<td>Smoking attributable hospitalisations 2010-11**</td>
<td>4,607</td>
<td>547.6</td>
<td>44,632</td>
<td>558.0</td>
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<tr>
<td>Smoking attributable lung cancer hospitalisations 2010-11**</td>
<td>566</td>
<td>68.5</td>
<td>4,839</td>
<td>59.5</td>
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<tr>
<td>High body mass attributable hospitalisations 2010-11**</td>
<td>3,870</td>
<td>464.2</td>
<td>36,354</td>
<td>454.6</td>
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<tr>
<td>Coronary heart disease hospitalisations, all ages, 2010-11**</td>
<td>4,763</td>
<td>578.3</td>
<td>49,426</td>
<td>608.7</td>
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<tr>
<td>Coronary revascularisation procedure hospitalisations 2009-2010**</td>
<td>1,771</td>
<td>217.4</td>
<td>15,066</td>
<td>191.1</td>
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<tr>
<td>Stroke hospitalisations, people aged 75+, 2010-11**</td>
<td>864</td>
<td>1,923.2</td>
<td>10,188</td>
<td>2,011.8</td>
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<tr>
<td>Stroke hospitalisations, all ages, 2010-11**</td>
<td>1,962</td>
<td>241.7</td>
<td>19,513</td>
<td>234.4</td>
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<tr>
<td>Diabetes related hospitalisations, 2010-11**</td>
<td>1,293</td>
<td>154.1</td>
<td>10,999</td>
<td>144.7</td>
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<td></td>
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<tr>
<td>Fall related injury hospitalisations, persons aged over 65, 2010-11**</td>
<td>3,310</td>
<td>3,363.9</td>
<td>34,828</td>
<td>3,129.2</td>
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<tr>
<td>Intentional self harm hospitalisations, all ages, 2010-11**</td>
<td>1,019</td>
<td>117.7</td>
<td>8,975</td>
<td>127.7</td>
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<tr>
<td>Total replacement procedures of hip and knee, hospitalisations 2010-11**</td>
<td>10,106</td>
<td>1,241.4</td>
<td>104,450</td>
<td>1,280.5</td>
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<tr>
<td>Asthma hospitalisations, persons aged 5-34, 2010-11**</td>
<td>521</td>
<td>137.0</td>
<td>3,726</td>
<td>133.6</td>
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<tr>
<td>Asthma hospitalisations, all ages, 2010-11**</td>
<td>1,621</td>
<td>173.2</td>
<td>11,999</td>
<td>169.5</td>
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<tr>
<td>COPD hospitalisations, persons aged over 65 years, 2010-11**</td>
<td>1,436</td>
<td>1,498.4</td>
<td>15,256</td>
<td>1,470.4</td>
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<tr>
<td>COPD hospitalisations, all ages, 2010-11**</td>
<td>1,841</td>
<td>231.5</td>
<td>19,766</td>
<td>239.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking attributable COPD hospitalisations, 2010-11**</td>
<td>1,420</td>
<td>178.4</td>
<td>15,415</td>
<td>185.9</td>
<td></td>
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</tr>
<tr>
<td>Influenza and pneumonia hospitalisations, all ages, 2009-10**</td>
<td>2,133</td>
<td>255.1</td>
<td>21,956</td>
<td>283.5</td>
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<tr>
<td>Influenza and pneumonia hospitalisations, persons aged 0-4, 2009-10**</td>
<td>437</td>
<td>677.9</td>
<td>2,623</td>
<td>569.4</td>
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<td></td>
</tr>
<tr>
<td>Influenza and pneumonia hospitalisations, people aged 65+, 2009-10**</td>
<td>865</td>
<td>919.4</td>
<td>11,471</td>
<td>1,092.7</td>
<td></td>
<td></td>
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<tr>
<td>Deaths from all causes, number per year, 2006-2007*</td>
<td>4,270</td>
<td>605.7</td>
<td>46,172</td>
<td>596.6</td>
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<tr>
<td>Potentially avoidable deaths, people aged under 75, 2006-2007**</td>
<td>1,114</td>
<td>154.8</td>
<td>10,372</td>
<td>154.4</td>
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<tr>
<td>Potentially avoidable deaths from causes amenable to health care, people aged under 75, 2006-2007**</td>
<td>443</td>
<td>61.6</td>
<td>4,248</td>
<td>63.1</td>
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<td></td>
</tr>
<tr>
<td>Potentially avoidable deaths from preventable causes , people aged under 75, 2006-2007*</td>
<td>671</td>
<td>92.1</td>
<td>6,124</td>
<td>91.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol attributable deaths 2007*</td>
<td>113</td>
<td>14.6</td>
<td>1,224</td>
<td>16.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular disease deaths, persons aged 25-74, 2006-2007*</td>
<td>373</td>
<td>83.9</td>
<td>3,401</td>
<td>79.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke deaths, people aged 75+, 2006-2007*</td>
<td>266</td>
<td>693.0</td>
<td>3,533</td>
<td>753.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke deaths, all ages, 2006-2007*</td>
<td>341</td>
<td>50.1</td>
<td>4,194</td>
<td>52.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes related deaths, 2007*</td>
<td>1,092</td>
<td>154.2</td>
<td>11,157</td>
<td>142.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury and poisoning deaths, 2006-2007*</td>
<td>247</td>
<td>32.0</td>
<td>2,322</td>
<td>32.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicides 2007*</td>
<td>56</td>
<td>7.0</td>
<td>541</td>
<td>7.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia notifications 2009-2010****</td>
<td>1,367</td>
<td>152.1</td>
<td>16,514</td>
<td>234.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Cervical cancer screening, women aged 20-69, 2009 to 2010               | 126,336 | 52.1          | 1,126,213 | 56.5   |
| Breast cancer screening, women aged 50-69, 2009 to 2010                | 42,273  | 48.3          | 419,143   | 52.7   |
| Smoking in pregnancy all women, 2010***                                 | 1,917   | 15.3          | 10,685    | 11.2   |
| Smoking in pregnancy Aboriginal women 2010***                           | 80      | 45.5          | 1,481     | 47.9   |
| Smoking in pregnancy non-Aboriginal women 2010***                       | 1,831   | 14.8          | 9,178     | 10.0   |
| Antenatal care before 14 weeks gestation, 2010**                        | 6,770   | 53.9          | 75,317    | 79.3   |
| Antenatal care before 20 weeks gestation, 2010**                        | 9,930   | 79.1          | 87,157    | 91.7   |
| Antenatal care before 14 weeks gestation, Aboriginal women, 2010***     | 95      | 54.0          | 2,204     | 71.3   |
| Antenatal care before 20 weeks gestation, Aboriginal women, 2010***     | 124     | 70.5          | 2,600     | 84.1   |
| Preterm births , Aboriginal women, 2009-2010***                         | 19      | 10.8          | 338       | 11.1   |
| Preterm births, non-Aboriginal women, 2009-2010***                      | 569     | 6.7           | 6,716     | 7.2    |
| Low birth weight, 2010***                                               | 932     | 7.4           | 5,900     | 6.1    |

*Source: ABS Mortality Data and Population Estimates (SaPHaRI); Centre for Epidemiology and Evidence, NSW Ministry of Health accessed 28/09/2012 and 29/09/2012
** Source: NSW Admitted Patient Data Collection and ABS Population Estimates (SaPHaRI); Centre for Epidemiology and Evidence, NSW Ministry of Health
*** Source: NSW Perinatal Data Collection (SaPHaRI); Centre for Epidemiology and Evidence, NSW Ministry of Health
**** Source: NSW Notifiable Conditions Information Management System (NCIMS) and ABS Population Estimates (SaPHaRI). Centre for Health Protection and Centre for Epidemiology and Evidence, NSW Ministry of Health.
### A16.7 Use of Medicare benefits Schedule Items by residents of SWSLHD compared to the NSW Rate

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Bankstown</th>
<th>Camden</th>
<th>Campbelltown</th>
<th>Fairfield</th>
<th>Liverpool</th>
<th>Wingecarribee</th>
<th>Wollondilly</th>
<th>NSW</th>
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<tbody>
<tr>
<td>Total GP services (MBS and DVA)</td>
<td>136</td>
<td>117</td>
<td>137</td>
<td>145</td>
<td>134</td>
<td>90</td>
<td>110</td>
<td>100</td>
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<tr>
<td>45 Year Old Health Checks by GPs, persons aged 45 to 49 years</td>
<td>101</td>
<td>119</td>
<td>106</td>
<td>53</td>
<td>105</td>
<td>89</td>
<td>107</td>
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<tr>
<td>Annual health assessments by GPs, persons aged 75 years and over</td>
<td>85</td>
<td>133</td>
<td>62</td>
<td>73</td>
<td>63</td>
<td>83</td>
<td>127</td>
<td>100</td>
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<tr>
<td>Total services by GPs for Enhanced Primary Care items</td>
<td>81</td>
<td>116</td>
<td>87</td>
<td>70</td>
<td>89</td>
<td>88</td>
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<td>Practice Nurse services under the MBS</td>
<td>34</td>
<td>81</td>
<td>79</td>
<td>35</td>
<td>74</td>
<td>105</td>
<td>118</td>
<td>100</td>
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<tr>
<td>Better Access Program: Preparation of Mental Health Care Plan by GPs</td>
<td>82</td>
<td>101</td>
<td>125</td>
<td>68</td>
<td>80</td>
<td>137</td>
<td>90</td>
<td>100</td>
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<tr>
<td>Better Access Program: Psychiatrists</td>
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<td>83</td>
<td>77</td>
<td>104</td>
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<tr>
<td>Better Access Program: Psychologists</td>
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<td>95</td>
<td>67</td>
<td>77</td>
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<td>Better Access Program: General Psychologists</td>
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<td>Better Access Program: Social Workers</td>
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<td>Better Access Program: Occupational Therapists</td>
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<td>56</td>
<td>90</td>
<td>13</td>
<td>23</td>
<td>n.a.</td>
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Source: Medicare Benefits Schedule Data sourced from the Public Health Information Development Unit 2012
A17. Recent Trends in Models of Care and Clinical Innovation

Extensive consultation was undertaken with clinical specialties during 2010 as part of stakeholder consultations to inform the development of the AIM2010 inpatient projection methodology. These consultations focussed on the recent trends in clinical practice and emerging models of care within the clinical disciplines. In summary, the key system-wide influences identified for clinical practice were:

- Ageing of the population, with most diseases/procedures relating to older persons expected to increase e.g. heart failure, renal failure, dementia and other chronic diseases. Increased complications and co-morbidities (e.g. hypertension, diabetes) are expected in these older age groups, in turn impacting on their length of stay in hospital.
- Increased survival of children with congenital/childhood diseases, with children that would have been expected to die young from, for example, problems associated with low birth weight, spina bifida, cystic fibrosis and brain/spinal injury, now surviving into adulthood. As a result, there is a growing cohort of patients surviving into adulthood dependent on the health system and for whom the children’s hospitals are no longer in a position to maintain responsibility for. There is a higher use of acute inpatient beds by this group due to a lack of alternatives, including early intervention strategies.
- Increased survival rates generally, with increasing multiple co-morbidities and risk of complications in patients. There is also increased demand for revision procedures e.g. hip and knee replacements, as survival extends beyond the lifespan of the prosthetic device. Trends towards day only or outpatient care, aided by minimally invasive surgical techniques and improved drugs, although overnight admissions may remain appropriate for the elderly and/or those with multiple complications and co-morbidities.
- Expansion of community acute and post acute services, including hospital in the home, post acute care, acute post acute care, ambulatory care in the community and acute care at home programs.

The key clinical development trends identified from the consultation with clinicians by specialty included:

- Cardiology and cardiothoracic surgery:
  - Increasing numbers of PCIs over CABGs, and both procedures increasingly being performed on older people
  - Better diagnosis of conditions, such as non-ST elevation myocardial infarction (NSTEMI) and chest pain, leading to increasing numbers of presentations of patients with these conditions.
  - Introduction of percutaneous aortic valve replacement
  - Less invasive cardiothoracic surgical/procedural techniques, incl. off-pump CABG, minimally invasive CABG, endoscopic CABG, hybrid revascularisation and transmyocardial revascularisation
  - Newer model stents which may decrease risk of thrombosis
  - Biodegradable stents
  - Radiofrequency ablation for the treatment of cardiac arrhythmias
  - Percutaneous closure of patent foramen ovale (“hole in the heart”) for the prevention of cerebral embolic stroke.
  - Multidetector computed tomography (MDCT) imaging to evaluate patients with chest pain in the emergency department
  - Implantable cardioverter defibrillator (although may be hazardous)
  - Remote monitoring devices

- Endovascular Surgery is expanding, with the ratio of endovascular to vascular approaches now 50:50 and expected to be 75:25 in the next five years. Conditions now being treated using this approach include aneurysms, arteriovenous malformations, carotid cavernous sinus fistulae, vascular tumours, arterial
stenosis (in place of carotid endarterectomy), cerebral revascularisation after clotting, stent grafting, peripheral vascular disorders, percutaneous valves.

- Renal - interventional procedures are now performed by nephrologists and interventional radiologists rather than surgeons e.g. insertion of vascath, angiography and peritoneal dialysis catheters.
- Critical Care - older people are now being ventilated who historically would not have been considered suitable for intervention. Also, smaller and younger babies now survive due to innovations in clinical practice, technology and retrieval practices, and are driving further demand for neonatal intensive care.
- Paediatrics - children with conditions/diseases that would have previously resulted in death (e.g. spina bifida, cystic fibrosis, spinal cord injuries) now surviving into adulthood, and some have babies (leading to very complicated pregnancies). Also increasing incidence of some chronic illnesses (e.g. type 1 and type 2 diabetes)
- Obstetrics - pregnancies are becoming increasingly high risk due to higher incidence & prevalence of diabetes, obesity and older mothers, leading to longer length of stay
- Bone Marrow Transplants (BMT) - developments in laboratory, pharmaceutical and clinical practice leading to increased admissions and ability to treat potentially life threatening complications
- Urology - increased diagnosis of urological cancers such as prostrate and bladder and treatments are becoming increasingly non-admitted e.g. by using flexible cystoscopy. Brachytherapy treatment for prostate cancer may potentially reduce radical prostatectomy
- Neurology - improved imaging, increasing use of minimally invasive surgery and greater inter-disciplinary cross-over
- Respiratory Medicine - respiratory infections increasing, lung cancer is falling but metastatic disease is increasing
- Geriatric medicine – longer survival means more complicated conditions that require more innovative management to reduce costs and improve quality of life.
- Diabetes - on the increase, especially Type II. Also more children and adolescents with Type I diabetes, and women with gestational diabetes. Renal and other complications (such as CVD) are also increasing
- Endocrinology - under and over nutrition contribute to many disease conditions e.g. diabetes, obesity, malnutrition, wound healing and conditions affecting a person’s ability to consume food (e.g. dysphagia from stroke, gastro-oesophageal disease in children and cerebral palsy).
- Orthopaedics - vitamin D deficiency across all age groups is leads to fragility, obesity leads to increased osteoarthritis requiring joint replacement surgery. Revision joint replacements increasing due to people living longer
- Cancer - increases in cancer incidence and survival from cancer requiring increased treatments, increased follow up care for survivors, and increased monitoring for relapse
- Nuclear Medicine - PET/CT and to a lesser extent SPECT/CT results may change patient management from surgical to radiotherapy/chemotherapy, or in the worst case, palliative treatment only.
- Gynaecological Oncology - interventional radiology applications and the possibility of an increase in the administration of intraperitoneal (IP) chemotherapy
- Colorectal Cancer - increasingly minimally invasive surgery
- Upper GIT surgery - neoadjuvant and adjuvant therapies will increase the rates of admission for all gastrointestinal tumours for both complications of therapies, commencement of more aggressive therapies and specialised investigations e.g. PET Scans, EUS, confocal endomicroscopy
- Bariatric Surgery - currently limited in the public system, however increased metabolic clinics will increase demands
- Infectious Diseases - antimicrobial stewardship programs for managing infection
Radiology - increased use of interventional radiology

Detailed observations on contemporary and emerging models of care made in consultations with individual specialties included the following.

Cardiology/cardiothoracic surgery

- Reduction of risk factors (smoking, obesity, high blood pressure, high cholesterol)
- Early detection of disease
- PCI increasingly being used over CABG as a less invasive means of treating coronary heart disease (PCIs have more than doubled in the last decade)
- PCI increasingly being performed on a day basis. This may not show in inpatient data as many will be performed on a non-admitted basis. A 50:50 admitted/non-admitted split should be used as a rule of thumb.
- Some patients will have a „staged PCI“ where a number of stents will be inserted on separate occasions
- Stenting has also allowed treatment of patients considered unsuitable for CABG
- In the USA, studies indicate that younger people (<60 years) have a better long term health outcomes by undergoing a coronary artery bypass surgery early rather than stenting and/or re-stenting, although the average length of stay may drift up. The length of stay could also reduce to 4 days for younger patients undergoing bypass surgery
- Percutaneous aortic valve replacement (PAVR) - potential to reduce the LOS for patients requiring surgical valve replacement compared to traditional surgery (which involves sternotomy and several days in ICU)
- The flattening of the total separations in the future for coronary artery bypass (ESRG 421) maybe generous, as it may continue to drop with new technology
- Less invasive cardiothoracic surgical/procedural techniques, incl. off-pump CABG, minimally invasive CABG, endoscopic CABG, hybrid revascularisation and transmyocardial revascularisation
- Newer model stents which may decrease risk of thrombosis
- Biodegradable stents (not currently available in Australia)
- Radiofrequency ablation for the treatment of cardiac arrhythmias (early stages – alternative energy sources such as cryoablation and microwave ablation are currently under investigation)
- Percutaneous closure of patent foramen ovale ("hole in the heart") for the prevention of cerebral embolic stroke
- Multidetector computed tomography (MDCT) imaging, a technological advance over traditional CT, to evaluate patients with chest pain in the emergency department Implantable cardioverter defibrillator (although may be hazardous)
- Remote monitoring devices

Endovascular surgery

- Now commonplace for Vascular surgeons, Neurologists/neurosurgeons, Cardiologists, Cardiac surgeons, Renal physicians, Radiologists
- Conditions treated using endovascular approach – Aneurysms, Arteriovenous malformations, Carotid cavernous sinus fistulae, Vascular tumours, Arterial stenosis (e.g. in place of carotid endarterectomy), Cerebral revascularisation after clotting, Stent grafting, Peripheral vascular disorders, Percutaneous valves
- Approach will lead to shorter LOS for some procedures, for example, day only aortic aneurysm repair is already happening in the USA
- Ratio of vascular to endovascular approach is now 50:50 and is expected to be 75:25 in the next five years
Currently the ALOS for some procedures does not reflect decreased LOS possible with an increased endovascular approach

Day only rate likely to increase in 539 Other Vascular Surgery Procedures due to more patients coming in for e.g. angiograms

**Renal**

- Early detection and prevention of CKD (chronic kidney disease) may reduce incidence of end stage renal failure
- Emphasis on home-based modalities but more patients having dialysis so hospital/satellite numbers increase anyway
- Renal interventional procedures performed by nephrologists and interventional radiologists rather than surgeons e.g. insertion of VasCath, angiography and PD catheters
- Greater emphasis on palliative care
- Primary nursing and case management enables early identification of issues and reduced hospitalisation
- VRE (Vancomycin-Resistant Enterococci) rates are expected to increase as all renal patients have this
- Expanding ambulatory care for renal patients in place of admissions

**Critical care**

- USA – chronic ventilation centres
- Palliative care now being done in ICU for relevant patients
- Non-invasive ventilation is becoming increasingly common e.g. for respiratory disorders
- Tracheotomies are undertaken earlier in admission rather than later, e.g. at 3 days rather than at 10 days
- High flow oxygen therapy in special care nurseries/NICUs reduces acuity but may not reduce length of stay

**Paediatrics**

- Trend toward treating children on an ambulatory basis (e.g. Paediatric Ambulatory Care Service at Hornsby Ku-ring-gai - may reduce the rates of paediatric admission
- Treatment of the family as a whole – not just the child, leads to earlier discharge and ambulatory rather than admitted treatment on an ongoing basis
- Models for children with chronic illnesses including:
  - Spina Bifida Adult Resource Team (commencing Aug 2009) to provide transition care across the state
  - Kogarah disability model – support of developmentally disabled children into adulthood and over lifespan
  - Transition clinics e.g. for diabetes, CF at various hospitals e.g. Westmead, Ballina, RNS, Nepean
  - Shared care
  - Multidisciplinary pain teams, which can decrease ALOS of paediatric patients for some conditions
- Introduction of rotavirus vaccine in 2009 to the childhood immunisation schedule has resulted in a small decrease in admissions in paediatric wards for gastro
- Implementation of the Baby Friendly Hospital initiative and extended lactation support has led to an increase in exclusive breastfeeding rates, which in turn may impact on reduced admission rates to paediatric wards within first two years of life

**Obstetrics**

- Day assessment units may reduce admissions
- Early pregnancy assessment units may reduce admissions
- Fetal medicine units
- Subspecialisation in maternal fetal medicine
- Antenatal diagnosis and antenatal triaging to the appropriate place for delivery leads to better management of LOS of complicated cases
- Concern about increasing trend of having neonatal beds without adequate maternity beds
- Case management/team midwifery leads to better outcomes (e.g. birth weight) and lowers levels of interventions and operative deliveries
- Caseload midwifery/woman centred care can reduce LOS, in fact allowing women to go home a few hours after giving birth. Women are then followed up at home by their caseload midwife
- Implementation of EDD (expected date of discharge) on admission
- Bubble CPAP in Level 4 facilities has allowed retention of babies that previously would have been transferred to a higher level unit
- Keeping mothers in hospital longer with their qualified babies whenever possible has led to shorter LOS for baby
- Accommodation of fathers on postnatal wards has reduced LOS due to increased confidence of mother in caring for baby
- NSW Health “Towards Normal Birth” initiative aims to reduce the caesarean section rate

**Bone Marrow Transplants**
- Supported early discharge leads to reduced LOS
- Establishment of rural support pre and post transplant care has reduced LOS and ongoing visits to super-specialty units
- Weekend outpatient service enables earlier discharge and reduced LOS

**Urology**
- Brachytherapy treatment for prostate cancer enables reduced admissions for radical prostatectomy for which ALOS is 7-10 days
- Flexible cystoscopies on an outpatient basis reduce admissions
- Laser surgery may be better for TURP patients with anticoagulation therapies, but business case yet to be developed

**Neurosurgery**
- Insufficient rehab beds lead to increased LOS
- Reduction in specialist nurses leads to increased LOS
- Lack of state-wide electronic imaging capabilities leads to increased LOS

**Respiratory medicine**
- Particularly for chronic, progressive diseases such as COPD, there is a move from reactive hospital management to anticipatory strategies, e.g. home monitoring and early detection - community-based interventions are required. In absence of a new model, increased admissions are expected

**Aged Care/geriatric medicine**
- Medical assessment units/ aged care assessment units
- Behavioural units
- Falls rooms
- Transitional care
- Cellulitis/PE/DVT outpatient protocols (cellulitis increasingly being treated on hospital in the home basis)
- HITH/CAPAC/Improved links between hospital and GP/ community
- Recognition and uptake of "Orthogeriatric model", i.e. that elderly person should be admitted under a geriatrician for their care, regardless of their specific problem at the particular time (e.g. renal). The geriatrician can provide more holistic care to the patient.
- Multidisciplinary care e.g. Acute Care of the Elderly “ACE" model
- Outpatient clinics – general, memory, Parkinson’s, wound, continence etc., (but lack of specialised units in community)
- Advanced care directives in aged care facilities
- Chronic care management (self management, education, rehabilitation)
- “Flying squads” to assess patients prior to acute deterioration
- Better diagnosis of specific problems (e.g. “Delirium Project”)

**Diabetes**

- Glycaemic control units – improved control can reduce length of stay where diabetes is a secondary diagnosis, needs to be targeted & timely
- Outpatient clinics, especially those aimed at high-risk patients lead to improved glycaemic control and reduce admission/re-admission
- Partnership arrangements with GPs/Medicare Locals (esp. in rural areas)

**Other endocrinology**

- Improved Home Enteral Nutrition discharge planning and access to services in the community aims to reduce length of stay and readmission with tube feeding and nutrition related complications
- GMCT is working to improve nutrition in hospitals by addressing areas such as food and nutrition policy and standards, nutrition screening, and strategies to promote patient feeding
- GMCT is developing a statewide Home Enteral Nutrition service model aims to manage and treat Home Enteral Nutrition in the community and prevent avoidable presentations to acute hospital care with tube feeding and poor nutrition related complications

**Orthopaedics/musculoskeletal**

- Secondary fractures – data from RCTs indicate that appropriate prevention initiatives can reduce fractures, therefore reduce admissions and associated long length of stay
- Self-management – effective in management of all musculoskeletal conditions
- Fractured NOF, distal radial fractures and osteoporotic fractures best treated by open reduction and internal fixation
- Anti-osteoporotic medication in patients at risk of fractures can prevent some fractures, but not currently widely used
- Expect rates of hip replacement to remain flat in the public sector
- Model of rehab for post operative orthopaedics – gaining access to rehab services for major orthopaedic surgery clients at an earlier period post operatively – patients being identified as requiring rehab from pre-operative clinics
- Shift to outpatient care for some orthopaedic procedures
Medical oncology/chemotherapy/nuclear medicine

- The most relevant and important advancement to impact significantly on patient management is PET/CT and to a lesser extent SPECT/CT. The results from these procedures can change patient management from surgical, to radiotherapy/chemotherapy or in the worst case palliative treatment only. This impacts on both hospital admission rates, and time in hospital.
- The newer radionuclide therapies for cancer treatment, currently not available, are a day treatment as opposed to chemo, which require multiple admissions over a period of months. More treatment rooms will need to be made available to cater for these.
- Cancer care is increasingly being provided on a non-admitted basis with only very ill patients, with multiple co-morbidities, being admitted. Therefore, while the per cent of cancer patients needing admission will fall, the ALOS of those admitted may increase.
- The increased incidence of cancer and follow up care will increase the usage of diagnostic services. The diagnostic work up for cancer patients is now increasingly complex, e.g. need for PET/CT; sub specialised diagnostic services in endoscopy and radiology. These services are now offering a therapeutic as well as diagnostic service e.g. oesophageal stenting, interventional procedures for liver tumours – radiofrequency ablation etc.
- Outreach oncology nurses could assist with reducing admission to hospital for patients with chemotherapy induced febrile neutropenia.
- More aggressive chemotherapies available together with improved supportive measures
- Demethylating agents mean that treatment is available for more haematological malignancies
- Markedly increased survival and more novel (and expensive agents) that have increased the overall volume of malignant haematology
- Changing migration patterns mean an increase in the overall community burden of haemoglobinopathies
- Non-ablative stem cell transplantation is becoming suitable for older patients with broader uptake
- Transfer of more activity to a day only facility will mean that most of the inpatient admissions are longer. More intensive inpatient therapies mean that more patients develop fungal infections and require more intensive supportive care

Plastics

- Skin grafts and lower limb procedures are now predominantly day only
- Most reconstructions for breast tumours are now done at time of breast surgery

Gynaecological oncology

- Interventional radiology is likely to impact on gynaecological oncology in the near future
- There is the possibility of an increase in the administration of intraperitoneal (IP) chemotherapy. At the moment this is not standard treatment, however it is part of clinical trials. Patients require overnight admission for this treatment
- Most gynaecological oncology chemotherapy is administered in the outpatient department. However, sometimes women are admitted for chemotherapy as they are on protocols that cannot be administered on an outpatient basis
- Rates of day admissions are increasing
- Fast tracking of patients means reduced LOS
- PACC model used for follow up e.g. antibiotics, wound care, clexane
- Improved outpatient imaging techniques enable more accurate delineation of the extent of disease, therefore enabling more accurate planning of surgery and ideally fewer “wasted” inpatient days gathering this information and defining a treatment plan.

**Gastroenterology**

- Growth of numbers of colonoscopies appears small. Federal bowel cancer screening program may increase numbers. However, many are being done on non-admitted basis, and therefore, numbers shown as admitted only present part of the picture Colonoscopy surgery

**Colorectal surgery**

- The trend in management of colorectal cancer is increasingly directed towards minimally invasive surgery.
- This will lead to an increase demand for specialised operating theatre facilities, and LOS may decrease.

**Upper GI surgery**

- More aggressive therapies will prolong length of stay in oncology surgery. These therapies lead to more aggressive surgery with longer in hospital recovery rates and higher complication rates. Examples of this will include vascular resection for pancreatic cancers and more extensive lymph node resections for pancreatic and other upper GI tumours.
- More aggressive therapies particularly neoadjuvant chemoradiation increases the morbidity of the subsequent surgery with anastomotic breakdown and other complications. This may be as high as 400 per cent based on overseas data Evidence would also show a prolonged recovery period.
- The increasing trend in adenocarcinoma of the cardio-oesophageal junction and lower oesophagus may not change the overall incidence of tumours of the stomach and oesophagus which remains stable, but the change in distribution increases the complexity of surgery and length of stay.
- Improvements in laparoscopic surgery does hold some promise for decreased length of stay but in upper GI oncology surgery, overseas and local data does not indicate that procedures performed laparoscopically offer any benefit in terms of length of stay. This is true of gastric, oesophageal and pancreatic tumours. The only exception to this would be in the surgical treatment of GIST tumours where lesser resections are able to be performed which can be done laparoscopically and also laparoscopic resection of liver tumours.
- With benign surgery, there is a potential of decreased length of stay in laparoscopic cholecystectomies as the majority of these may be performed as day cases rather than the current EDO/23hr model.
- Outcomes in upper GI oncology are directly related to volume of work. UK and European data indicates that not only are outcomes improved with increased volumes but also more patients are offered curative treatment and palliative interventions improving. This means that centres of excellence need to develop and for efficiency should be spread as a network within different campuses. This is consistent with the NSW Cancer institute plan and is consistent with the development we have seen previously in transplant services, and peritonectomy.
- For pancreatic cancer there has been a gradual concentration of cases to 2 centres with Bankstown-Lidcombe Hospital and RNS Hospital between them now performing 2/3 of the pancreatic resections in NSW. This creation of centres of excellence should be allowed to continue in its gradual evolutionary form. This trend will continue and the reality is that should only be 3 resectional units in Sydney. Based on current workloads and outcomes they should be Bankstown-Lidcombe, RNS and Westmead.
- Similarly for oesophageal and gastric cancers we see concentration in the teaching hospitals and it is unlikely that this major surgery will be performed in major metropolitan hospitals in the future. Again data indicates improved outcomes and increased curative and palliative interventions. This is particularly true as neoadjuvant and adjuvant therapies become available and the creation of MDTC will only increase this trend.
This does not mean that all services should be concentrated in a few "super Hospitals". A networked system will permit designated hospitals to perform at a tertiary or quaternary level for some things and district level for others. This means that a smaller facility may become an elective oncology unit in gastric tumours with other cancers operated on elsewhere. We already see this for elective orthopaedics and it should develop for elective predictable oncology.

Bariatric surgery will become more common and should be as part of a comprehensive program through a metabolic clinic. The Statewide obesity plan as outlined by GMTT and as illustrated by SSWAHS Overweight and Obesity plan indicates the model for this and outlines how this should be concentrated in a few centres, not necessarily teaching hospitals.

**Injury**

- Clinical redesign initiatives and models of care that potentially would reduce rates of admission and length of stay are available but are not resourced appropriately to achieve changes in clinical practice when implemented. Examples: 1. managing acute mental health issues and/or drug and alcohol concerns in people with brain injury in public hospitals and preventing readmissions by accessing these Services when living in the community, working with D & A services. 2 Models of care for managing challenging behaviour after a brain injury would length of stay and prevent readmission if resourced and implemented statewide as an education and training initiative to achieve meaningful changes in clinical practices.
- Promotion of earlier referral to rehabilitation improves outcomes but requires additional beds and staff to respond to demand. Referral and acceptance criteria manages access to limited resources.
- The introduction of online x-ray reporting has decreased length of stay by decreasing the incidence of lost films and reporting delays.
- Spinal cord injury – greater emphasis on transition to non-inpatient care with in-reach support to patients admitted to non-specialised hospitals.
- Development of the Acute Transfer Guidelines for Spinal Cord Injury - this recommends that all acute traumatic spinal cord injuries are transferred to the spinal specialty units within 24 hours following injury.

**Infectious diseases**

- Antimicrobial stewardship programs currently being introduced in many hospitals around Australia, should impact positively on the quality of patient care and potentially reduced length of stay and cost of inpatient care associated with managing infection.
- These programs are designed to reign in the expanding and frequently indiscriminate use of antimicrobials which are associated with adverse effects, particularly the development of antimicrobial resistant organisms, necessitating prolonged, more expensive inpatient treatment for increasing numbers.
- Antimicrobial stewardship has been shown to be effective in reducing these adverse effects in addition to less drug reactions, less intravenous cannulations with concomitant complications. DOH support for these programs should have measurable positive impact.

**Sexual health**

- Clinical redesign to focus on priority population groups within SWSLHD should improve service delivery, health promotion, collaboration, research and evaluation; which will aim to reduce the transmission of sexually transmissible infections (STIs) including HIV and Viral Hepatitis and reduce the negative impact of STIs on health status, personal and social well-being.
**Stroke**

- Increased levels of thrombolysis in NSW compared with other states. For example, at John Hunter Hospital, approx. 24 per cent of patients are thrombolysed, when in other states it is about 1 per cent.
- TIA patients increasingly being admitted for diagnostic testing, as often they may have had a stroke rather than TIA.
- As a result of Stroke Services NSW (SSNSW) initiatives 21 metropolitan stroke units (plus 2 unfunded) and 9 rural stroke services have been established.
- Stroke Services NSW have active programs that focus on service delivery (and equity of access) from the pre hospital phase (primary prevention, GPs, and Ambulance), including TIA management protocols, through hyper acute phase (liaison with emergency departments and imaging services, development of thrombolytic services) to the acute phase with integration with sub-acute and post-acute services (most notably in rehabilitation and aged care programs) at inpatient and community levels, including secondary prevention and maintenance. Programs have been established to maximise and demonstrate improved efficiencies and outcomes of stroke patients as a result of these developments and interventions, for example the nurse initiated outpatient stroke clinic. SSNSW carried out a review of stroke rehabilitation programmes in NSW in 2010.
- NSF and NSRI/GMCT audit indicates increased access to CT or MRI scan (within 12hrs of arrival at hospital) for stroke patients.

**Burns**

- Trend towards managing patients in an ambulatory care setting and this continues to increase and impacts on the need to admit patients overnight.
- LOS continues to be improved by efficient and effective dressing protocols.
- Effective multi-disciplinary involvement in a timely manner.
- Effective outpatient management team and support structure.
- Time to theatre for grafting.
- Infection control.
- Rural patients have increased lengths of acute stay due to lack of step down facilities and possibly lack of services locally.
- The photographic email sites (e.g. "kidsburns") at the three burn units promotes effective assessment and subsequent treatment of outpatients often negating the need for admission.
- Burns nursing structure revision including (at CHW) CNC appointment to provide optimal care. Daily multi-disciplinary team meetings to co-ordinate care.
- Enhanced rehabilitation facilities for burns patients.
- Setting up of satellite paediatric ambulatory care burns clinics (GWACHN initiative) will promote efficiency in selective outpatient review.
- Burns Ambulatory Care clinics are co-located and run by the same staff that run the inpatient admitted acute burn units, therefore, better outpatient management of burns leads to reduced admission/re-admission.

**Drug and alcohol**

- More patients are being treated for alcohol withdrawal in primary and community care or in residential settings rather than on an admitted basis. (Research indicates that for most withdrawals, inpatient treatment is not required.)
- Evaluated D&A consultation liaison models for EDs and other hospital units.
- Improved clinical management of mental health patients with D&A problems may reduce LOS in acute MH units
- Funding to NGOs and provision of specialist medical and nursing consultation (including provision of medication) leads to a reduction in acute LOS in a hospital bed

**Radiology**

- Improved Decision Support, using eMR, so that referrers can have some guidance on appropriate investigations, appropriate rate of repetition of investigations
- Better integration between public and private diagnostic service providers to reduce the rate of unnecessary repetition of tests, and to improve access to test images & results across both areas of clinical practice - will require a state-wide or nationwide approach to informatics integration
- Increased availability and improvement in central venous access devices is allowing patients to be treated in the community by PACC

**Nursing**

- Models leading to decreased LOS include models for managing chronic care, Community Transitional Care, Compacks, Hospital in the Home, clinical pathways
- Focus on prevention of falls and pressure sores, thus preventing avoidable increases in LOS
A18. Future Clinical Stream and Service Network Models of Care

For each clinical stream/district wide service, a future profile is identified in three critical areas:

- model of care
- service development directions
- partners in service development

**Aged Care and Rehabilitation**

Service developments in Aged Care and Rehabilitation (AC&R) will build on the planning undertaken under the previous administration - *SSWAHS Aged Care and Rehabilitation Clinical Services Plan 2007-2012* [103]. The AC&R clinical stream also covers the Liverpool Hospital Brain Injury Rehabilitation Unit (BIRU), a Statewide service where planning, service development directions and funding are primarily the responsibility of the Ministry of Health. Advice from BIRU on service development directions are included below.

**Models of Care for the future**

Developments in the model of care for the future across SWSLHD include:

- Improved and streamlined entry points for people seeking admission to Aged Care, Rehabilitation, Community Nursing and Chronic Care services.
- More rapid and consistently applied strategies and implementation for early rehabilitation/mobilisation of all hospitalised patients minimising hospital acquired debility.
- Seamless service provision across the spectrum of community and hospital care settings.
- Increased provision of services in community and RACF settings including via telehealth, to treat patient without the need for hospital presentation.
- Enhanced preventative care services in the community.
- Enhanced community and home based services to meet growing demands from the increased numbers of aged and disabled in the community.
- Maintaining the spectrum of current services with better coordination.
- Streamlining of services for patients with fractured neck of femur, ensuring access to a timely operation within benchmark waiting times.
- Expansion and development of the community and hospital based dementia teams.
- Expansion of Compacks services across SWSLHD.
- Improved linkages with other service providers.
- Upgrading of IM&T and data systems.
- Improved patient transport systems to facilitate access to services.
- Strengthen the capacity to undertake research and enhance education capabilities through academic links.
- Continuing review models of care in liaison with ED and MAU clinicians.

Model of care developments specific to services provided within the Bankstown-Lidcombe Hospital catchment include:

- Further development of the Day Hospital as a tertiary referral centre, including a Professorial Memory Clinic as a tertiary referral service for SWSLHD and telemedicine resource for rural NSW; providing diagnostic assistance in difficult to diagnose cases, such as younger onset dementia and also multi-
disciplinary input in managing the day-to-day difficulties encountered by dementing patients and their carers

- Establishing a multi-disciplinary “educating the fallers” Professorial clinic to educate patients on reduction of behaviours reflecting lack of judgement which may put them at unnecessary risk of falls; this clinic could take referrals from a range of services where risk of falling is a significant issue

Model of care developments specific to services provided within the Liverpool Hospital catchment include:

- Expansion of acute and subacute geriatric units in line with population growth
- Co-location of outlier patients into a functional home ward enabling multidisciplinary care provision
- Develop/redevelop physical infrastructure to effectively address the care needs of inpatients with dementia/delirium
- Co-location of disabled patients requiring acute rehabilitation in a medical environment
- Enhance Aged Care Assessment Teams (ACAT), developing a rapid response service for Community Aged Care
- Developing new models of care in the ED for older people; an enhanced ASET model requires consideration
- Expansion of outpatient Geriatric clinic services
- Expanded capacity of the aged care inpatient consultative service
- Enhancement of home therapy and day hospital services through COAG funding.
- Enhancement of the Dementia Advisory Service (DAS) program
- Expanded partnerships in care provision, including in the falls prevention and management program and collaboration with SMHSOP services
- Enhanced availability of specialist allied health services

Model of care developments specific to the Liverpool Hospital BIRU address increasing demand pressures on services with clients admitted to inpatient services with extremely severe impediments requiring intensive therapy and longer lengths of stay, and more severely impaired clients being discharged from acute settings directly to BIRU community services. Service developments to address this increased demand and acuity include:

- Establishment of a Day Program to facilitate client transition from inpatient services to the community and for patients residing in the community, enabling continuing access to intensive rehabilitation programs encompassing social, physical, cognitive, communication and functional retraining – requires additional staffing, treatment areas and equipment
- Development of multidisciplinary group programs so that multiple clients receive therapy at the same time, to manage increased workloads and provide optimal interventions for clients
- Enhancement to specialist clinics, increasing the scope and range of specialty services, to efficiently assess and manage clients
- Development of a high care transitional Living Unit (TLU) within the BIRU inpatient service, facilitating transitioning of clients with high care needs to community care – enabling carer/family training, development and trial of home therapy and maintenance programs and trial of recreation and leisure programs
- Increased use of technology to support clients in planning and completing therapy sessions, structuring and completing everyday activities, developing new skills and providing recreational opportunities
Service Development Directions

In Aged Care and Rehabilitation, there is a range of critical service development directions required over the next decade, including for SWSLHD as a whole:

- Building of day hospital/outpatient/home based therapy service capacity in all sectors to enable earlier discharge of patients from Aged Care and Rehabilitation wards e.g. providing a Geriatrician and Orthopaedic surgeon consultative service on the same day to patients who have falls and fractures
- Planning for and developing additional sub-acute beds to ensure that patients are treated in the most appropriate and efficient settings where they can access required treatment and therapies
- Improved falls education/prevention programmes to prevent ED re-presentation of fallers, as well as hospital admission avoidance.
- For older people presenting to EDs, enhanced identification of elderly patients at high risk for poor outcomes with early intervention by skilled staff to decrease re-presentations, admissions and poor outcomes (data on elderly patients attending EDs indicate that 68% of presentations require admission; the frail elderly with impairment of premorbid function are twice as likely to present with syndromes such as delirium; and following ED discharge - 45% report a change in their ability to care for themselves, 30% of 75 year olds re-present to ED within 14 days, hospitalisation occurs in 24% and death or institutionalisation occurs in 10%)

Critical service developments required to meet the growing and ageing population of Macarthur include establishing at Campbelltown Hospital:

- Acute aged care unit
- Rehabilitation unit
- Secure unit for patients with Behavioural and Psychological Symptoms of Dementia

Macarthur also requires the development of a Day Hospital Service and an overall expansion of the Specialist Aged Care and Rehabilitation Team including Home Based Therapy Services.

For the Liverpool Hospital catchment, service developments identified include:

- Adjustment to acute aged care bed numbers based on performance and bed occupancy; this would include an additional 24 - 30 bed acute aged care ward (noting that currently in the Liverpool/Fairfield sector on average 50-55 patients are managed by acute geriatrics as inpatients at Liverpool Hospital)
- Development of Acute Rehabilitation Services at Liverpool
- Expansion of the Aged Service Emergency Team (ASET service) and ED Falls Service
- Enhanced capability to provide services into RACFs
- Establishment of a secure 10 bed delirium unit (noting that prevalence rates of delirium on admission to hospital are 10% - 24%; delirium develops in up to 56% of older people in hospital (climbing to 61% post operatively); rates of morbidity, mortality and length of hospital stay are much greater in this population, with length of stay 4 times longer in this population; and longer length of stay may be able to be reduced via rapid recognition and management in a purpose built or modified unit)
- Creation of a precinct for Aged Care and Rehabilitation including the Day Hospital
- Enhancement to community Aged Care and Rehabilitation services including ACAT, Specialist Aged Care and Rehabilitation Community Service and TACP - this includes chronic care initiatives, collaborative work with GPs and post discharge follow up services
- Development of Acute Aged Care Psychiatry beds; the option of combining with the delirium unit should be explored
At Fairfield Hospital critical service developments include:

- Development of specialised Geriatric Services (currently there are no acute admissions under Geriatrics, although a number of acute geriatric patients are managed by general physicians)
- Staffing enhancement of a Geriatrician/registrar/RMO
- Consideration of establishing a 24 bed acute geriatric and rehabilitation ward (noting that in the short term management of elderly patients by the general physicians with geriatrician consultation can continue, however outcomes would be improved by direct admission to an acute geriatric unit)

At Bowral Hospital critical service developments include:

- Enhancement to geriatric and rehabilitation specialist services
- Enhanced community Aged Care service

For the Liverpool Hospital BIRU critical service developments include:

- Development and utilisation of group, day hospital and clinic services to facilitate rehabilitation and care for TBI clients
- Upgrading of existing physical facilities, particularly the Transitional living Unit (TLU), Community Living Unit (CLU) and Head2work facilities
- Additional inpatient beds as outlined in the Liverpool Hospital Stage 2 Phase 2 redevelopment plan
- Additional physical facilities to enable model of care enhancements including day hospital, group therapy space and additional specialty clinics
- Appropriate levels of staffing to manage existing services and to facilitate future development of the service, this includes Research fellow and Research Assistant positions to build on the increasing profile of BIRU as an active participant with partners in clinical research

Partners in Service Development

For aged care and rehabilitation the partnerships which need to be forged and strengthened to facilitate models of care and service developments in the future include:

- Continued close liaison and co-location in partnership with the HammondCare Health and Hospitals
- Consolidating professional and clinical governance relationships of community AC&R services with Allied Health, Community Health and Mental Health Clinical streams.
- Continued liaison of both in-patient and community AC&R services with the SW Medicare Local and local RACFs.
- On-going linkages with NGOs, including the sharing of patients/clients; case conferencing to improve co-ordination of care; Aged Care and Disability Forums; the Packaged Care Providers Meeting
- Multilateral linkages through the Aged Care Advisory Committee, with SWSLHD community, health, mental health and allied health streams and outside NGO, Medicare Local and consumer representation.
- Enhanced delivery of brokered models of care where both community and residential services are purchased from NGOs and for profit organisations.
- Expanded partnership models of Care e.g. Telehealth initiatives
- Greater involvement with the SWSLHD Planning Process
- Improved co-ordinated care of patients – better communications
- Integrated IT systems
For the BIRU partnerships which need continuing attention to facilitate models of care and service developments include:

- continuing close relationships with acute specialty teams to facilitate appropriate transitioning of clients
- Aging, Disability and Homecare (ADHC) services to provide supported/group housing, attendant care/support and community/group facilities
- Department of Housing to ensure housing needs are met within reasonable timeframes
- Lifetime care and Support scheme (LTCSS) to fund treatment, rehabilitation and attendant care services to people severely injured in motor vehicle accidents (40-50% of BIRU clients)
- Insurance companies for BIRU clients with Workers Compensation and third party motor vehicle insurance claims
- Carer agencies to facilitate effective discharge, ongoing community-based rehabilitation and maintenance of clients in their own environment
- Private rehabilitation providers for ongoing therapy to support BIRU case management and medical services
- Research entities, including organisations such as the Reabilitiation Studies Unit, the George Institute for Global Health, the Motor Accidents Authority of NSW, the Agency for Clinical Innovation and the Lifetime Care & Support Authority

**Allied Health**

Allied Health Services have adopted an LHD wide organisational structure to ensure healthcare delivery is guided by clinical guidelines that are consistent, effective, monitored and measured.

**Models of Care for the future**

The proposed model of care emphasises close collaboration with medical specialties and subspecialties in multidisciplinary care delivery for inpatients and in ambulatory care settings. Work is prioritised to targeted vulnerable population groups, including where:

- there is a mandated responsibility e.g. suicide counselling, child protection work, domestic violence, victims of crime etc.
- delays in assessment/treatment will result in an adverse outcome
- supportive activities decrease the length of stay or readmission
- the greater health impact can be achieved e.g. prevention or maintenance activities such as falls prevention
- no alternative service is available and the absence of a service would have a negative health/ development impact

Enablers for allied health provision include consistent staffing levels; timely access to interpreters to ensure that people from CALD communities are able to fully participate in their care and decisions regarding their health needs; a strong research capability and also effective clinical governance. Core aspects of the model of care for implementation in the future include:

- Patient/Family centred multidisciplinary care available in all LGAs with waiting times within expected timeframes (both inpatient and non-inpatient) that utilises evidence based practice
- Specific services designated to support at risk families
- Enhanced weekend services for all allied health in hospitals and after hours services for social work and physiotherapy
- A strong research and education focus with conjoint academic positions
- Specific funded services to provide community development and prevention of preventable conditions
- Integrated models of care ensuring that gaps in services are not created by different/ changing funding models (e.g. changes in eligibility criteria of federally funded services resulting in gaps in services for rehabilitation).

Service Development Directions

The core service development directions for allied health include:

- Increased multidisciplinary care in paediatrics, chronic and complex care, post-acute care and rehabilitation through enhanced allied health across acute, sub-acute and community settings
- Upgraded data systems to make better use of ABF funding opportunities and management of services
- Development of a strong research and teaching culture through support of junior staff and emerging researchers; and development of dedicated research positions with conjoint appointments with local university partners to oversee the enhancement of a research and teaching framework for allied health
- Consolidated relationships with universities to enhance recruitment opportunities
- Enhanced and flexible work practices with 7 day week, extended hours coverage for social work to support patients/families with child protection, trauma, domestic violence, victims of crime, sudden unexpected death in infancy (SUDI) etc. issues
- Enhanced and flexible physiotherapy services within Emergency Departments to support appropriate triage and rapid responses
- Flexible employment practices to support permanent staff to ensure continuity of care
- Administrative and business support to free up clinical staff to make more efficient use of time
- Development of sustainable chronic care programs across the continuum of care
- Integration of Allied Health into outpatient medical specialist clinics to improve clinical planning, handover and teamwork
- Improved ability to share information and resources
- Enhance Community Development services
- Enhanced inpatient services for with appropriate follow up and post-acute services.

Partners in Service Development

To implement this model of care and service developments Allied Health services will work with a range of core partners including:

- Information Management and Technology Division (IM&TD) on IT infrastructure and support
- Academic Institutions on research and teaching e.g. collaboration with CHETRE, Centre for Applied Nursing Research (CANR), Ingham Institute for Applied Medical Research (IIAMR) and universities
- Other Government and NGO services- collaboration to continue to improve continuity of care and cohesion in terms of eligibility and reduction of gaps and overlaps (including GP’s Medicare Locals etc.)
- A range of services internal to SWSLHD with continued work to ensure integrated care
- Families and communities to promote early identification and ongoing enrichment of children’s lives and their environments
- Consumers to improve interaction and to learn from patient experiences.
Cancer

Models of Care for the future

The model of care in Cancer will build on current arrangements whereby services are provided in a multidisciplinary team (MDT) framework within tumour specific programs, with regular scheduled meetings of medical and allied health professionals lead by a Tumour Program Leader. Patients will have access to specialist nurse care co-ordinators and psychosocial screening and support.

It is noted that under current organisational arrangements the Cancer clinical stream does not have direct responsibility for mammography services, which are provided through the joint Commonwealth/State funded program BreastScreen NSW. This program has been engaged in the planning process and provided an indication of service development directions, which are included below.

By 2021 this model of care will have been consolidated and enhanced, with:

- All MDT care plans documented in clinical notes and used in determining outcome-driven service priorities.
- End of life care planning implemented in all hospitals and across all streams
- Development of nurse-led Acute Assessment Units in all SWLHD cancer centres, specifically to evaluate cancer patients that previously would present to ED for evaluation and management (i.e. ED avoidance pathway)
- Widespread use of Advance Care Directives
- The Palliative Care Extended Aged Care at Home (PEACH) model adopted widely, involving contracted services providing support for deaths at home.
- Involvement in NSW carers program with Allied Health involvement in the planning and implementation phases.
- Specialty models of care that address specific needs for paediatric patients, adolescent and young adults, CALD and Aboriginal populations
- Integrated model of primary health care with GPs for cancer survivors & to manage symptom control, linking with chronic & complex care services
- Availability of a telephone and web-based support program for cancer patients.
- Integrated psychosocial care for patients across all facilities
- Integrated Allied Health network sharing models of care across all facilities
- Standardisation of LHD policies on medication formularies and medication access for patients at home
- Maximise utilisation of EMR, providing access to patient records across all care settings by all clinicians including GPs and RACFs
- Website update, providing web tools that increase exposure of available services, providing referral pathways for GPs and patient information regarding services, treatments and cancer types
- Single point of referral for all cancer services
- Community Palliative care – increase in vehicle access to enable timely home visits
- Establishment of cancer survivors centres (Wellness Centres) for non-acute cancer therapy
- Development of community centre hubs, including within the SWGC, that could extend to providing infusion therapy for stable patients with chemotherapy and potentially radiotherapy delivery (subject to State-wide planning) and cancer survivorship clinics
- Resourcing of cancer care co-ordinators from 2014 within LHD budgets in recognition that current funding through the NSW Cancer Institute will no longer be available
Service Development Directions

- Infrastructure redevelopment of the Liverpool, Bankstown-Lidcombe & Macarthur cancer treatment centres to manage current and projected demands, including requisite staffing enhancements
- Expansion of services in line with cancer projections, for Haematology (Bowral, Bankstown and Macarthur) and Medical Oncology & Radiation Oncology (Liverpool and Macarthur) with requisite staffing and consumable (drugs) enhancements
- Develop Cancer Genetics services accessible at Bankstown, Macarthur and Bowral
- Establishment of a SWSLHD service for patients at genetically high-risk of developing cancer, including access to appropriate screening and diagnostic tools e.g. breast cancer imaging including MRI and mammography available on-site
- Development of a public hospital mammography service
- Development of a prostate brachytherapy service at Liverpool
- Enhancement to Urology services at Liverpool & Fairfield hospitals, with requisite enhancement to theatre time and surgical staffing; enhancement to outpatient continence services
- Palliative care 20 bed inpatient ward operational at Liverpool; development of palliative care inpatient units at Bankstown and Macarthur; and infrastructure redevelopment of the Braeside Hospital day unit including requisite staffing enhancements
- 30 bed inpatient Haematology unit and Oncology inpatient unit operational at Liverpool Hospital
- Development of Cancer Acute Assessment units in all SWSLHD Cancer centres
- Establishment of a Haematology Step-down Unit in the Liverpool Cancer Therapy Centre
- Provision of enhanced Haematology services at Campbelltown, Bankstown and Bowral
- Continued provision of Allogeneic Bone Marrow Transplants at Liverpool Hospital
- Radiation oncology research bunker operational at Liverpool Hospital from 2012
- Installation of a planning MRI scanner at Liverpool Hospital
- Upgrading of radiation oncology machinery e.g. linear accelerator replacements at Campbelltown and Liverpool will be needed in the next ten years
- Development of a Cancer Care Centre in Bowral, noting Federal funded day oncology unit at Southern Highlands Private Hospital
- Increased access to Allied Health staff for community palliative care clients
- Within an Integrated Primary and Community Care Centre in the SWGC, provide chemotherapy and potentially radiotherapy delivery (subject to state-wide planning) and cancer survivorship clinics for the newly settled population of the South West Growth Centre
- Establishing Wellness centres, initially at Liverpool and Camden and potentially at Bowral and Campbelltown, to enhance survivorship care pathways
- Establishing a melanoma clinic at Liverpool Hospital with requisite enhancement to staff specialist and support staff and infrastructure for clinics, pathology services and treatments
- Establishing a sarcoma clinic with requisite enhancement to staff specialist and support staff and infrastructure for clinics, pathology services and treatments
- Establishing paediatric oncology services at Campbelltown Hospital, in response to growth in paediatric populations
- Additional fixed screening sites for BreastScreen NSW within SWSLHD (noting that a business case is under preparation for a fixed site in Fairfield)
- Enhanced access to cancer-specific allied health services, both in hospital and in the community
- Enhanced capabilities to provide community nursing support for cancer patients, including blood-taking, symptom control etc.
- Enhanced access to radiographer support for BreastScreen NSW through joint appointments with SWSLHD hospital radiographers
- Develop oncology, palliative care and haematology nurse practitioner roles
- Increased SWSLHD commitment to research development in partnership with the Ingham Translational Cancer Research Centre, boosting clinical trials, laboratory research, MRI linac and Health Services research.
- Developing a training centre for undergraduates and also carers, to provide education programs on palliative care, and provide information on patient care options.
- Expansion of palliative care inpatient beds, consultancy and palliative care services in community settings
- Enhancement and strengthening of the SWSLHD Cancer Genetics service.
- Enhancement and strengthening of dermatology services across SWSLHD, including a redevelopment of the Dermatology clinic area at Liverpool Hospital and incorporation within the Cancer precinct
- Explore potential to lead or partner in supra-regional provision of low volume cancer surgery e.g. pancreatic.

**Partners in Service Development**

To implement this model of care and service developments Cancer services will work with a range of core partners including:

- Consumers, providing feedback on priority service developments including through representation on the Cancer Services Council, participation in research and development of care plans
- General Practice, through electronic notification of patient care plans to maximise involvement in models of care, developing survivorship care plans and enhancing primary healthcare provider access to oncology electronic records
- Private Health facilities, in the reporting of cancer diagnostic and treatment information to the clinical registry
- Cancer Institute NSW, on implementation of State-wide initiatives; for grants funding, data collection and KPI reporting; and participation in CanRefer, the cancer services directory for GPs and patients
- Cancer Council patient resource centres for patient information, volunteer and carer support
- BreastScreen NSW to effectively link screening, assessment and specialist care and treatment when required
- Community fund raising for equipment and services
- Ingham Institute for Applied Medical Research in research projects such as “Healthy me” on patient initiated records for psychosocial supportive care; and inclusion in the Annual research output report
- National Health and Medical Research Council (NHMRC) for research grants funding
- Universities (UWS, UNSW, UoQ, UoW) for conjoint appointments, training and higher degrees for clinical staff and research collaboration
- Professional Colleges for professional development and reporting of patient outcomes
- Clinical Oncological Society of Australia (COSA) through Innovation conferences
- Pharmaceutical companies for Phase 1 and Pharmaceutical Clinical Trials
- Medicare Locals and Integrated Primary and Community Care (IPCC) collaboration with primary care to optimise patient care and outcomes
- NSW Palliative Care and the Australian Department of Health and Ageing assisting in purchase of high cost equipment to enable patients to transition home
- Oral health on referral pathways, treatment and information
Diagnostic services for palliative care access to on-line results
Equipment loan pools for devices to support patients at home
Community respite for carers of palliative care patients
Interpreters in all settings
State-wide Centre for Improvement of Palliative Care (SCIP), Palliative Care NSW and Palliative Care Australia for program and policy development and funding opportunities

**Cardiovascular**

**Models of Care for the future**

Increasingly Cardiovascular Services will develop in a hub and spoke model, which is already well-developed for both Renal and Cardiology services. In both Cardi tho thoracic and Vascular services, this will be facilitated by the funded and further proposed enhancements at Campbelltown Hospital and the proposed development of Interventional Endovascular (cardiology/vascular) units at Bankstown and Campbelltown hospitals. To support this model there will increasingly be LHD-wide and cross hospital appointments of medical, sonographer, allied health and nursing positions. Within this hub and spoke framework emerging models of care will be explored including:

- The development of public-private partnerships, for Cardiology/Endovascular Interventional units and potentially Diagnostic Services within the Cardiology and Vascular Service
- Emerging technologies in surgical practice widening the scope of interventions, increasing the demand for overnight beds across all clinical services within the Stream
- Continuing focus within the renal service on optimising home training and self-management within the home environment where safe and practicable, with an outreach service for renal patients to support them through home therapy modalities
- Development of early discharge processes within relevant services to support patients at home, including allied health
- Disease prevention and disease management services that are easily accessible for patients under a risk management stratification
- Improved links with the SW Medicare Local to facilitate care management plans that are integrated and patient centred
- Enhanced community based services to facilitate integrated care across care settings
- Enhancement to cardiology services through development of a Cardiology on call roster for Bowral and Fairfield hospitals
- Improved access to rehabilitation and palliative care services to optimise patient outcomes

**Service Development Directions**

Immediate priorities for service development within Cardiovascular Services include:

- The commissioning of cardiac step-down beds at Liverpool Hospital
- Ensuring adequate resources for thoracic and cardiac surgery across the District, including cardiothoracic theatre sessions at Liverpool Hospital
- Establishing a Cardiology roster for the HDU at Fairfield Hospital
- Increase access to Vascular Surgical theatre list at Liverpool and Bankstown hospitals
- Increased access to ICU/HDU beds at Liverpool hospital for cardiothoracic and vascular surgery patients commensurate with increased theatre sessions
• Continuing refurbishment of renal dialysis units and staged implementation of dialysis chair enhancements consistent with high demand growth

In the medium term priorities for service development within Cardiovascular Services include:

• Ensuring Cardiology/Endovascular Interventional Suites are fully resourced and operational at Campbelltown and Bankstown
• Ensure the development of a comprehensive vascular surgery service at Campbelltown Hospital
• Establishment of a Cardiology roster for the HDU at Bowral
• Increasing the bed base across the Cardiovascular Stream to meet demand from population growth and ageing
• Continuing staged implementation of dialysis chair enhancements consistent with high demand growth
• Establishing after-hours dedicated medical cover at Liverpool Hospital
• The development of PPP arrangements for Cardiology/Endovascular Interventional Suites
• Development of a Centre of Excellence for Cardiology and Renal Services, which would include an Academic Chair in Cardiology
• Improved community based services to improve disease management that is community focussed and patient centred to assist with hospital avoidance, including allied health
• Post-discharge support services readily accessible from patient residences and linked to specialist advice from the acute sector, to support patients at home and prevent re-admission
• Enhance the Interventional component of the renal service,
• Enhanced education focus through increased learning modules and supporting the implementation of patient education services for primary and tertiary prevention
• Development of an Asset register and management plan. This should include not only equipment but also a database for service contracts and tender renewals with access to the relevant personnel
• Improved access to anaesthetic support for non-theatre sessions within each clinical group

Partners in Service Development

To implement this model of care and service developments Cardiovascular Services will work with a range of core partners including:

• Collaboration with ACI / CEC to increase the awareness of current initiatives
• Increased involvement & participation with national and international professional bodies with conference planning, patient education, and accreditatation
• Improved links to community partners to ensure enhancement of services to support disease prevention and disease management concepts
• NSW Ambulance Service on the State Cardiac Reperfusion Strategy (SCRS)
• Increased involvement and participation with professional and research institutions
• Increased involvement with consumers and patient participation in the development of education material, care planning, and community outreach.
• Measuring patient satisfaction
• Ambulatory Services in terms of Medical governance
• Cardiac ambulatory services to broaden the scope of services to incorporate other clinical specialties such as vascular paths as well.
• SWS Medicare Local – improving GP access to management plans, supporting seamless care across the continuum
Complex Care and Internal Medicine

The Complex Care and Internal Medicine clinical stream provides care across a wide range of medical disciplines and settings. The identification of future models of care and service development directions is provided under the main departments included within the stream.

Models of Care for the future

In **general medicine**, current models of care vary across the hospitals providing this service (Bowral, Campbelltown and Fairfield), increased standardisation of the model of care will develop in the future, with key elements including:

- Development of acute short stay medicine as a variant of general medicine with a view to discharge or transfer to specialty teams within 48 hours
- Increasing focus on service provision in alternative settings to inpatient wards e.g. short stay ED, ambulatory care, hospital in the home, day hospital
- Increased use of transitional care settings for lower acuity patients where the only requirement is for nursing care from the start of the admission
- Increasing focus on outpatient and ambulatory settings e.g. acute assessment clinics, rapid discharge clinics; reducing hospital admissions and facilitating early discharge
- Increasing use of endoscopic diagnostic investigation
- Potential for outreach visitation to RACF, this could be nursing or nurse practitioner led
- At the smaller hospitals a move to 24hr junior medical staff cover

In **ambulatory care** significant change to the current model of care is not expected, with focus to be on enhancement and refinement, including:

- Increased and more effective use of electronic communication, scheduling and telehealth applications, wireless connectivity between primary and secondary providers
- Continued close relationships with medical inpatient services, particularly MAU
- Closer relationships with general practice, through electronic referrals and discharges, single point of contact etc.; and closer integration with community health services
- Increasing hospital in the home and hospital in the RACF services – this could include a hospital element providing 24/7 and after hours troubleshooting and potentially a day hospital; with community hubs that could extend to providing infusion therapy for stable patients
- Increased participation in chronic disease management and prevention, particularly in secondary prevention of conditions frequently presenting to hospital e.g. falls, chronic airways disease, chronic heart failure
- Development of multidisciplinary Ambulatory/Primary Care super centres as one stop shops that general practice can refer complex patients to, providing minor procedures, intravenous infusions, specialist cardiac and respiratory nursing support, diabetes educators and allied health such as physiotherapy, occupational therapy, social work, speech pathology, podiatry and dietician – these could be at hospital sites, community health centres or integrated primary and community care centres
- Bringing together services that span the hospital/community divide with unified peer support, data sharing, safety and quality benchmarking etc.

In **respiratory medicine**, models of care are not expected to vary significantly to that provided currently with key aspects of focus including:

- Development of respiratory home wards with capability to manage higher dependency patients with respiratory failure requiring subacute non-invasive nasal ventilation
- Increasing outpatient and ambulatory care provision enabling patients to be reviewed earlier at home or in clinics, closely linked with chronic care teams
- Increasing management of sicker patients in the community shared with the general practitioner, supported by drop-in hospital assessment clinics or hospital visits to GP assessment clinics
- Outpatient specialist check-ups using telemedicine, involving general practice in a community setting
- Cohorting of respiratory patients with patients of like needs from other specialties e.g. cardiology and non-trauma cardiothoracic
- Scope for some respiratory services to be concentrated at one or two hospitals across the SWSLHD network e.g. pleural procedures, tuberculosis, pulmonary hypertension
- Increasing development of specialised clinics in sleep medicine and lung cancer, along with acute assessment clinics and multidisciplinary sleep clinics involving neurology, psychology, ENT, dental and psychiatry
- Advancing technology in sleep studies enabling home sleep studies and home CPAP titration
- Increasing interventional pulmonology with interventional bronchoscopy, endobronchial ultrasound and pleural ultrasound
- More advanced lung function testing including forced oscillation technique (FOT) and exhaled nitric oxide (ENO)
- Improved model of community care for COPD patients including improved access to pulmonary rehabilitation and improved integration with primary healthcare providers

In **neurology/stroke**, the model of care has developed such that most cases are now managed on an outpatient basis and this is expected to continue into the future. Further expansion of outpatient clinics will be required, to meet expanding demands and as an important strategy to reduce preventable admissions. Key aspects of the model of care development for the future include:

- Improved access to allied health services in outpatient settings – social work, physiotherapy, occupational therapy, speech therapy, dietetics, clinical psychology, neuropsychology
- New therapies for stroke – intravenous thrombolysis and neurointerventional radiology – interventional services need to grow at Liverpool and commence at Campbelltown
- Stroke admissions will increase significantly with ageing and increased obesity in south west communities
- Increased interaction with general practice, community health, allied health, connecting care program and ambulatory care services to support patients in the community with chronic neurology conditions and to manage cardiovascular risk factors
- Enhancement of neurointerventional radiology at Liverpool Hospital including anaesthetic cover, enhanced neuro-audiology services and provision of on-site rehabilitation beds
- Establishment of interventional neuroradiology at Campbelltown and a neurosurgical service, with enhancement of neurophysiology services (nerve conduction EMG and EEG) and the neurology department there able to manage complex neurological patients and operating as a centre for excellence in neurological research, with a full electrophysiology laboratory
- Enhancement of services at Bankstown – inpatient capacity, thrombolysis service, outpatients and neurophysiology
- Maintaining the general medical model of care for neurology and stroke patients at Fairfield and Bowral with increased stroke bed capacity and services at each site and establishment of a nurse specialist led stroke thrombolysis service at Bowral

For **Medical Assessment Units (MAU)**, the model of care which has developed for acute management of medical admissions through the ED with multidisciplinary assessment within 48 hours is expected to continue and expand into the future. In the future MAUs are likely to be referred to as Acute Assessment Units (AAU). Key aspects of the model of care development for the future include:
The majority of stable patients admitted from the ED will transit through the MAU/AAU or equivalent, and will have any complex work up done there rather than in the ED.

There will be an increasing emphasis on suitable patients bypassing the ED direct to the MAU/AAU; supported by a stronger relationship of the MAU/AAU with ED triage and mechanisms for direct admission to AAU/MAU from GPs, specialists and community services.

Effective use of the MAU/AAU will require close liaison between MAU/AAU staff specialists and other specialties, to ensure that all patients in the Unit are assessed and managed expeditiously – the intention is that all patients in the AAU in the morning should be cleared out of the AAU by 5.00 pm to provide beds for admissions during the evening and night.

MAU/AAU patients will rapidly be transferred to relevant medical specialities home wards within less than 48 hours from presentation.

Effective use of discharge planning services, ambulatory care, community services and the connecting care program to help early discharge and prevent readmission

Establishing MAU/AAU clinics for rapid assessment of patients referred from GP and community sources to prevent admission if possible and to allow early discharge of inpatients with review.

The Connecting Care Program model of care, involving community based CNC chronic care coordinators working with GPs to develop shared care plans, is expected to be strengthened and expanded in the future, with focus on:

- Prompt triage of chronic care patients seen in EDs, MAUs and Ambulatory Care Units to the appropriate service e.g. connecting care, HITH, aged care services, GPs; with Connecting Care staff working more closely with acute facilities especially EDs
- Pathways of care that are very clear, consistent and widely available.
- Enhanced education of staff in RACFs on care of patients with a chronic condition.
- Development of a single point of contact for aged patients and patients with a chronic condition to a centralised service encompassing all aged care services, all community health services, HITH, connecting care, rehabilitation services etc.
- Relocation of facility based rehab programs to community centres to provide better and quicker access for patients with a chronic condition. This could be provided within a one stop shop model e.g. pulmonary and cardiac rehabilitation together with smoking cessation, weight reduction and life style change sessions.
- Close liaison with the SW Medicare Local to ensure integrated primary care occurs, this should be supported by electronic systems to enable GPs and others to access the patient’s medical record post-discharge

In Diabetes and Endocrinology the multidisciplinary Diabetes Centre ambulatory model of care has been a long established and proven management model to successfully keep patients out of hospital. Models of care for the future will build on and enhance this model with a focus on:

- Ensuring Hospital based diabetes services incorporate outreach community roles with hub and spoke models enabling community based services to be established at community health centres and/or integrated primary health care centres
- Increasing liaison with community based practitioners – GPs, community health, connecting care
- Clearer delineation of roles to avoid duplication of services - primary care physician/community services mainly responsible for patients with type 2 diabetes on diet control or adequately controlled on oral anti-hyperglycaemic medications. Primary prevention programs should also take place in the community. Diabetes services in public hospital are important in the management of complicated patients with diabetes who require insulin therapy, patients with type 1 diabetes and those with acute metabolic deterioration requiring hospital admissions
Primary prevention programs run by general practitioners, Medicare Local, community health centres, integrated primary health care centres

Ensure patients have access to complication screening service (either in public or private sector)

Increased / better communication and transfer of medical records between all staff caring for patient (GP, nursing, allied health, specialist)

Establish Urgent Assessment Clinics - to review patients referred urgently from GPs or other specialists for management of acute hyperglycaemia

Establish an integrated Osteoporosis service - with rheumatology, orthopaedics, allied health, nursing, general practice

Enhance and extend Multidisciplinary clinics e.g. Diabetes in pregnancy (with obstetricians, midwives, renal/hypertension service), Diabetes high risk foot clinic (with Infectious diseases, ambulatory care, vascular, orthopaedics; Diabetes /renal /hypertension; Neuroendocrine (with neurosurgery); Thyroid (with nuclear medicine and head and neck surgery); Complication screening; Diabetes pre-admission to prepare poorly controlled patients with diabetes for elective surgery; Aboriginal diabetes/cardiovascular risk

Establish site specifically located services e.g. nuclear medicine/thyroid services at Campbelltown, referral of all inpatients with diabetes at Campbelltown to diabetes service for management

In infectious diseases the current model of care is a hub and spoke model provided by Sydney South West Pathology Service centred on the Microbiology laboratory at Liverpool Hospital. Models of care for the future will maintain Liverpool as the main hub for infectious diseases, microbiology and infection control, inpatient care and specialised outpatient clinics; whilst building services provided at other facilities, aiming to optimise the clinical care of all patients with infection in the LHD. Services will be available at each of the main acute care hospitals of the LHD with an Infection Management and Prevention Team and local ambulatory care and clinic facilities which may extend to multidisciplinary clinics specific to clinical services provided there e.g. orthopaedic infection, haematology infection, transplantation etc. The aim is to ensure:

Infectious Diseases is closely involved in the investigation, treatment and follow-up of all patients with infection through early clinical consultation, microbiology laboratory outreach, antimicrobial stewardship, acute sepsis management, acute referral from the community and multidisciplinary decision making about patients at the bedside

Seamless management of patients with infections by the ID team through the ED, inpatient care, acute ambulatory care, and in the community through hospital-in-the-home and chronic disease management; facilitated through closer collaboration between the ID team, the general practitioner and the community nursing service.

Health care associated infections and complications are prevented through proactive quality improvement processes implemented by a team of Infection Preventionists and supported by epidemiology, data analysis and research.

Antimicrobial use in the LHD is optimised with an educative, decision supporting, restriction and approval system backed up by data.

LHD wide programs such as antimicrobial stewardship, infection prevention and quality improvement, infectious disease epidemiology and data analysis and research remain based at Liverpool. Clinical Governance and support, M and M review, continuing professional development, etc. will be provided centrally at Liverpool for all facility teams.

Clinical care and implementation of programs is at the Facility level supported by a local multi-disciplinary Infectious disease management and prevention team comprising designated Infectious Disease physicians, registrars, specialist nurses (CNC), pharmacists, infection prevention practitioners and administrative staff.
In **rheumatology** the current model of care is that the majority of patients are managed on an ambulatory basis with admissions mainly limited to complex patients e.g. with complications of immunosuppression or acute osteoporotic fractures. Increasing numbers of patients require infusion therapies, currently managed through the ambulatory care service. This model of care will continue with enhancements, focussing particularly on outpatient services:

- Development of urgent care clinics so that patients presenting to EDs or referred from a GP or other health care provider with e.g. acute gout or flares of inflammatory disease, can be seen quickly
- Development of an osteoporosis case finding, investigation and management service led by e.g. a nurse coordinator (See ACI fracture prevention model of care)
- Development of multidisciplinary care clinics for management of patients with obesity, arthritis and other complications of obesity e.g. Diabetes; in particular a comprehensive obesity service is required for SWSLHD.
- Expansion of ambulatory care infusion services – hospital ambulatory care, community centres and at home.
- Extending capability to participate in clinical trials of new therapies, requiring clinic, office and storage space and adequate staffing – medical, nursing, allied health, admin, research
- Expanding clinical services at Campbelltown and Bankstown to meet local demand
- Enhanced outpatient services, particularly for the socio-economic grouping unable to access private care. Currently insufficient private services exist to meet private demand
- Greater networking with GP/ Medicare Local, to support triaging of outpatient requests, optimising the provision of care in the community

In **immunology** the current model of care is predominately as a hospital based service providing inpatient care, consultations to other teams and an outpatient service. Departments are sited at Liverpool and Campbelltown hospitals, with consultative services provided to peripheral hospitals. The future model of care is expected to remain similar to the current model, with enhancements including:

- Continued outpatient service provision at hospital sites due to patient complexity and requirements for cross specialty referral and access to pathology and medical imaging. For immunotherapy and allergen challenges the risk of anaphylaxis requires a hospital setting.
- Increased enrolment of patients in clinical trials networked on a national and international basis to enable data collection on optimal treatment of rare and uncommon conditions often encountered. Centralised online enrolment systems would be beneficial.
- Use of telemedicine and “virtual clinics” to support patients in remote locations with rare immunological diseases. These patients are currently disadvantaged in access to specialty care, exacerbated by the shortage of immunologists across Australia.
- Development of a directory of physician’s interests and subspecialties across Australia to ensure patients with particularly complex diagnostic and management problems or very rare diseases can access the appropriate specialty expertise
- Timely access to records and results from other health services will be increasingly important in maintaining efficiency

In **clinical genetics** the current model of care is an outpatient, consultative service in hospital clinics and at a community health centre (Bowral) and the future model of care is to enhance these services maintaining the outpatient focus:

- Continued outpatient clinical services with hubs at major teaching hospitals and the provision of outreach clinics to smaller metropolitan hospitals and rural health Districts. A hub would be expected based at Campbelltown Hospital by 2021 including a full time genetic counsellor in addition to the existing hubs at Liverpool and RPAH
Greater use of videoconference via telehealth for the provision of counselling services. The IT requirements are changing and should have changed from ISDN (phone) to web based technology.

enhancements to meet the growing need for clinical geneticists with the new molecular technology of exome testing and next generation sequencing, allowing expanded gene testing both through health services and in the public domain e.g. online personalised genetic screening tests, which need interpretation and client counselling along with cascade screening of at-risk family members

**Service Development Directions**

For **general medicine** the critical service development directions for the future include:

- Develop stronger links with tertiary referral centres
- Develop stronger links with universities and increase medical student rotation, including nursing and allied health specialities.
- Further development of acute short stay medicine as a variant of general medicine, with patients either discharged or transferred to “specialty medicine” at 48 hrs.
- Further exploration of alternative care settings to deflect admissions e.g. short stay ED
- Increasing collaboration with ambulatory care services so that they are involved in both management and investigative workup, enhanced use of Hospital in the Home services, expanded use of day hospitals, enhanced use of connecting care program
- Enhancement of general medicine outpatient follow-up to reduce hospital admissions and allow early discharge e.g. acute assessment clinics, rapid discharge clinics
- Increased collaboration with geriatric services including on provision of services to RACFs and with enhanced urology services which are of high prevalence in geriatric populations
- Enhancements of services/workforce to meet increased demands from population growth and ageing; particularly increased junior staff both registrars and residents, to also enable decreased dependence on locums for overnight care
- Undertake a Randomised Controlled Clinical Trial (RCT) to reduce respiratory presentations
- Development of outpatient and community based services to reduce hospital presentations and admissions
- Development of performance management tools, data collection and analysis capabilities to assess programs

In **ambulatory care** the critical service development directions for the future include:

- At most sites, expansion of capacity to meet increasing demand and maintain patient safety
- Closer integration of hospital in the home program with the SW Medicare Local activities, including in data analysis and research as a de facto measure of the harmonious integration of these health jurisdictions and providing venue for undergraduate education and post-graduate professional development across all health disciplines
- Enhancements to senior medical and other workforce to free time for professional development and research activities, case conferences, journal clubs and regular in-services and also to take on more medical students
- Enhancements to nursing workforce availability – endorsed enrolled nurses (EEN), clinical nurse specialists (CNS), clinical nurse educators (CNE)

For **respiratory medicine** the critical service development directions for the future include:

- Providing non-invasive ventilatory support (NIV) and tracheostomy weaning service at respiratory wards, initially via the four respiratory high acuity beds provided in the Liverpool Hospital redevelopment
- Enhance Sleep Investigation services, initially at Liverpool Hospital by increasing from 4 to 6 sleep studies daily requiring an additional 2 inpatient beds, providing daytime multiple sleep latency tests (MSLT) and maintenance of wakefulness tests (MWT), specialised sleep clinics, respiratory failure clinics and multidisciplinary clinics; developing a Sleep and Respiratory Failure service at Bankstown-Lidcombe Hospital; increasing the available sleep investigation resources at Campbelltown to match the excess of sleep breathing disorders seen in the Macarthur community when compared to other areas of NSW
- Provide additional outpatient clinics e.g. Acute Assessment Clinics for early discharge and ED bypass (third corridor), specialty respiratory complex clinics
- Enhance Lung Function Laboratory capabilities, at Liverpool by introducing forced oscillation technique, exhaled nitric oxide, induced sputum analysis, multiple breath nitrogen washout
- Enhance interventional pulmonology services, at Liverpool by supporting lung cancer services for staging and diagnosis with EBUS (endobronchial ultrasound), providing a rigid bronchoscopy service and pleural procedures with bedside ultrasound; development of efficient EBUS and respiratory ultrasound services at Bankstown-Lidcombe Hospital
- Provide capacity at each of Liverpool, Campbelltown and Bankstown-Lidcombe hospitals to provide all of the necessary interventions to diagnose and treat COPD and lung cancer, as these diseases are responsible for the majority of the burden of disease in respiratory medicine
- Expansion of preventive health initiatives e.g. smoking cessation, obesity, vaccination
- Improve the tuberculosis service, at Liverpool by introducing flexible arrangements for demand management during extensive contact screenings and refurbishment of clinic space
- Expansion of the chronic and complex care model to better manage respiratory patients at home and in community centres to reduce hospital presentations, improving coordination with chronic and complex care programs across Sydney; establishing a Chronic and Complex Care Team at Bankstown-Lidcombe hospital, similar to the St George Hospital model
- Enhance staff education and resource the educational program, creating industry and academic collaborations to develop innovative teaching tools for undergraduates and post graduates, ensuring web-based educational resources can be delivered, including live streaming of lectures, increasing the appeal to trainees of SWSLHD placement to improve registrar recruitment; develop a structured system of retraining/up-skilling plus periodic education maintenance, designed to address the education needs of GPs and community healthcare professionals to manage larger numbers of sicker patients outside hospital
- Expanding research and maintaining research infrastructure including computing hardware, software, communications technology; ensuring research funding targets health system goals, and strategies for managing the most burdensome diseases (in terms of morbidity, mortality and finance); supporting clinician researchers (with salary/time components apportioned for research activities and provisional on research outcomes) to undertake research, aligned with specialist research expertise and collaborating across health districts to pool research strengths
- Enhancing Information and communications technology, with upload of reports from diagnostic tests onto electronic patient records (powerchart), Universal electronic medical record, internet access for all clinical staff at point of care, better electronic communications with GPs and all other services

For **neurology/stroke** the critical service development directions for the future include:

- Enhancement to bed base and associated resources at each site
- Expansion of services at Liverpool, Campbelltown, Bankstown – outpatient clinics (including specialist outpatient clinics – multiple sclerosis, Botox, stroke, movement disorder, dementia, epilepsy, neuromuscular); neurophysiology services (inpatient and outpatient); and ambulatory care /PIXI
- Expanded physical capacity at Campbelltown and Bankstown hospitals for neurology and neurophysiology clinics and departments
- Enhance the neuroaudiology service at Liverpool and potentially Bankstown and Campbelltown hospitals
- Enhance the Neurointerventional Radiology service at Liverpool Hospital and development of this service at Campbelltown Hospital – for management of stroke patients
- Establishment of a clinical trials centre for neurology at Liverpool Hospital
- Enhanced access to outpatient or community allied health services with acceptable waiting times – including social work, physiotherapy, occupational therapy, speech therapy, dietetics, clinical psychology, neuropsychology
- Enhancements specific to Campbelltown Hospital – neurophysiology laboratory (Nerve conduction/EMG/EEG), neurology beds and associated workforce, angiography theatre, additional MRI, interventional neuroradiology, neurology research laboratory, introduction of neurosurgery and vascular surgery, increased clinical trials and research, physical infrastructure including lecture theatre, conference rooms, telemedicine, ability to offer outpatient services in the community and in disadvantaged areas, research collaboration with the UWS neuroscientists, enhanced specialty outpatient clinics e.g. for epilepsy, dementia etc.; staff offices, neuropsychological services

For MAU the critical service development directions for the future include:

- Establishment of MAUs/AAUs adjacent to EDs and MAU clinics with adequate physical space and staffing
- Enhanced linkages with ED, GPs, Medicare Local, Ambulatory care, community care, connecting care
- At Liverpool Hospital, the re-establishment of General Medicine as a major specialty, with an emphasis on early assessment and management of stable admitted medical patients - this will require advanced trainees in general medicine – currently the only hospitals in NSW providing this are Royal North Shore Hospital and the Hunter Hospitals
- Development of Peri-operative Medicine in the Hospital to provide safer care for patients with multiple medical co-morbidities admitted under surgical teams - a joint initiative of Aged Care and General Medicine (MAU)
- Taking advantage of opportunities for development of research in general medicine.

For the connecting care program, the critical service development directions for the future include:

- Increased capability to undertake clinical care coordination
- Improved access to allied health staff
- Improved electronic communication with GPs
- Development of a comprehensive HITH service across SWSLHD
- Unified data collection systems with shared access across settings of care

For diabetes and endocrinology, the critical service development directions for the future include:

- At Liverpool Hospital, maintaining the tertiary referral centre, demonstrating leadership and expertise through policy development and clinical guidelines for all medical practitioners in the region, including active roles in national bodies. Maintaining a research focus in gestational diabetes and thyroid disease, with additional staff resources to maintain expanding databases, engage in research and ensure enhanced provision of patient education information
- At Campbelltown Hospital, develop an inpatient diabetes team to better manage critically ill patients; enhance out-patient services through additional clinic space, advanced trainee, transition diabetes educator and dietician to avoid preventable admissions and better prepare elective surgery patients;
increase awareness and management of those at risk of osteoporosis; improve access to nuclear medicine services to enable self-sufficiency in managing thyroid cancer

- At Bankstown-Lidcombe hospital, continuation of the current range of services, including acting as the National Benchmarking Centre for Diabetes Quality Audit Activities for the nation-wide Australian National Diabetes Information Audit and Benchmarking (ANDIAB) Initiative and providing research and teaching initiatives in areas such as high risk foot service multidisciplinary clinics to reduce times to ulcer healing and admissions to hospital; awareness of hypoglycaemia management and rates of inappropriate hypoglycaemic management; providing an insulin pump service for patients; studying the influence that ethnicity has on individuals with diabetes in pregnancy

- At Fairfield Hospital, commence research projects in the areas of gestational diabetes and its complications and enhancements to patient education information; this activity would also build on collaborative study already underway with the GP Academic unit

For infectious diseases, the critical service development directions for the future include:

- Enhance infectious diseases consultative services and outpatient care at all sites, noting the absence of services at Fairfield and Bowral hospitals and limited availability at Bankstown and Campbelltown hospitals
- Establish a SWSLHD-wide Antimicrobial Stewardship Program with computerised decision support and approval system
- Initiate infectious diseases hospital-in-the-home services at Liverpool, Bankstown, Fairfield, Campbelltown and Bowral hospitals.
- Establish infectious diseases acute assessment clinics at Liverpool, Bankstown, Fairfield and Campbelltown hospitals for near admissions, early discharges, acute GP referrals, ID hospital-in-the-home intake
- Provide infectious diseases chronic care clinics at Bankstown, Fairfield, Campbelltown and Bowral Hospitals.
- Enhance links with ambulatory care services and high risk foot clinics
- Establish an LHD Infection Prevention Operational Unit to coordinate and deliver infection prevention and control services to all facilities of the LHD. This Unit will also need epidemiology, data collection and management and quality improvement expertise and resources
- Set up an Infectious Diseases Clinical Research Unit.

For rheumatology, the critical service development directions for the future include:

- Establishing coordinated fracture prevention services.
- Building capacity to participate regularly in clinical trials in order to be able to provide novel therapies for patients with autoimmune diseases
- Developing a coordinated research program that focuses on the clinical case-load and expertise of the Liverpool Hospital department, including further development of the clinical rheumatology database to support case finding and work up of patients on DMARD and bDMARD therapy in trials
- Focusing on a multidisciplinary approach to obesity and osteoarthritis prevention and management

For immunology, the critical service development directions for the future include:

- Enhanced administrative support to improve efficiency in patient flow and provide front-desk capability to address unscheduled drop-in and semi-urgent patient attendances
- Enhanced specialist cover for immunology, immunopathology and on-call requirements, enabling additional clinics and enhanced research capabilities
- Improved access to dietician management of allergy and food chemical sensitivities for patients on complex and restrictive diets
- Enhanced nursing and allied health staffing
- Increased research activity within the Ingham Institute

For **clinical genetics**, the critical service development directions for the future include:

- Consider establishing genetic laboratories at Liverpool Hospital for provision of common molecular testing, possibly with high throughput gene sequencing and to liaise with other genetic laboratories to process gene testing as cost effectively and efficiently as possible. Research projects would develop in conjunction with molecular testing capabilities.
- Developing a clinical genetics hub based at Campbelltown Hospital to provide genetics services to Campbelltown, Camden and Wingecarribee.
- Enhancement to the clinical genetics service at Bankstown Hospital with increased clinics
- Consider resuming genetics clinics at Fairfield Hospital
- Provide specialty genetics clinics for common disorders such as diabetes, hyperlipidaemias and hypertension when the genetic determinants of polygenic diseases are known
- Play a further educational role for medical students at UWS.
- Ensure counsellors are trained to handle the enquiries from private web based gene testing which is in its infancy currently but increasingly available and utilised by couples especially pre-pregnancy.

**Partners in Service Development**

For **general medicine** the partnerships which need to be forged and strengthened to facilitate models of care and service developments in the future include:

- Develop stronger links with tertiary referral centres
- Develop stronger links with universities and increase medical student rotation.
- Closer collaboration with primary care - general practitioners, SW Medicare Local, community health services, Integrated Primary and Community Care Centres - to promote hospital avoidance and early discharge
- Stronger links to private healthcare providers - private hospitals, radiology providers
- Increased use of connecting care program for hospital avoidance
- Enhanced collaboration with Ambulatory Care services for hospital avoidance e.g. Hospital in the Home, connecting care program

For **ambulatory care** the partnerships which need to be forged and strengthened to facilitate models of care and service developments in the future include:

- General Practice and the SW Medicare Local - ongoing dialogue and optimisation of shared care arrangements to improve efficiency, with clearly defined roles and care pathways for escalation and transfer of care.
- Enhanced arrangements for GPs to be engaged in the discharge planning process
- Strengthened links with existing Ministry of Health Structures such as the ACI, CEC, HETI, and BHI
- Defining local models of care and closure of gaps in service delivery across SWSLHD
- Specialist rooms and private nursing agencies – ongoing dialogue also in issues of shared care and good communication flow.
- Awareness of Commonwealth and community resources and projects which can complement care of common patients.
长期以来，我们一直致力于医疗保健服务的持续改进。根据SWSLHD的五年战略规划，共产主义服务、增强服务和信息研究对于神经/中风、肺部、睡眠、老年、慢性病护理、ICU、肺功能实验室、教学、教学、研究、信息和通讯技术等领域的患者护理和专业发展至关重要。我们还将加强与UNSW和UWS的合作，对医学学生进行培训，并与RACP合作，为医学学生提供培训。

此外，我们计划通过多学科睡眠诊所建立神经/中风和睡眠障碍的合作伙伴关系，并通过设施的发展来提高慢性病护理的效率。我们还将建立高危区域，为肺炎及心脏病学设施提供支持。

在肺功能实验室方面，我们计划开发一个软件解决方案，用于肺功能数据的备份和转移，并与ENT、神经学、心理学、呼吸科和心脏病学等学科的专家进行密切合作，以提高患者的护理质量。同时，我们还将加强与UNSW和UWS的合作，对医学学生进行培训，并与RACP合作，为医学学生提供培训。

在过去的一年里，我们在肺功能实验室方面取得了一些进展。我们计划开发一个软件解决方案，用于肺功能数据的备份和转移，并与ENT、神经学、心理学、呼吸科和心脏病学等学科的专家进行密切合作，以提高患者的护理质量。同时，我们还将加强与UNSW和UWS的合作，对医学学生进行培训，并与RACP合作，为医学学生提供培训。

未来，我们将继续致力于加强与UNSW和UWS的合作，对医学学生进行培训，并与RACP合作，为医学学生提供培训。我们还将继续与ENT、神经学、心理学、呼吸科和心脏病学等学科的专家进行密切合作，以提高患者的护理质量。同时，我们还将加强与UNSW和UWS的合作，对医学学生进行培训，并与RACP合作，为医学学生提供培训。
- Increased access to rehabilitation services including development of inpatient rehabilitation services at Liverpool Hospital
- Enhanced access to ambulatory care/PIXI/Hospital in the Home to enable outpatient intravenous therapies – methylprednisone, immunoglobulin
- Rapid access to diagnostic services for inpatients and outpatients - radiology (CT CTA MRI MRA, ultrasound), vascular lab (carotid duplex, venous DVT studies), cardiology (Echo TTE TOE, Holter)
- Timely access to nursing home beds including rapid ACAT assessment
- Adequate home support services - home care, home nursing, EACH
- Benchmark nursing, allied health and administrative staffing inpatients and adequate allied health outpatient clinic availability
- Good interface with connecting care program, community health, GPs and SW Medicare Local.
- Adequate support services for inpatients – porters, interpreters, cleaners etc.
- Adequate Biomedical engineering support
- Access to outpatient or community allied health services with acceptable waiting times – including social work, physiotherapy, occupational therapy, speech therapy, dietetics, clinical psychology, neuropsychology.

For **MAU** the partnerships which need to be forged and strengthened to facilitate models of care and service developments in the future include:

- Encouragement of direct referral of suitable patients by GPs to the MAU/AAU, rather than to the ED – this is not practicable until there is an AAU adjacent to the ED.
- Improved links with GPs, ambulatory care, community care, connecting care to facilitate earlier discharge.
- Establishment of acute clinics, both to enable same day discharge from the MAU/AAU and to facilitate earlier discharge of General Medicine patients - clinic space adjacent to the AAU would be ideal for this
- Enhance perception of the AAU/MAU as an option for avoiding the ED.
- General Practice – ongoing dialogue and review of their needs; optimised shared care programs to improve efficiency; defined roles as well as care pathways for escalation and transfer of care
- Improved awareness of Commonwealth and community resources and projects which can complement care of common patients.

For the **connecting care** program the partnerships which need to be forged and strengthened to facilitate models of care and service developments in the future include:

- Improved access to rehabilitation programs in a variety of care settings
- Development of a model of community care for COPD and heart failure patients.
- Enhanced integration with primary health care services, including GPs
- Collaborative strategies for smoking cessation and obesity prevention effectively linked across Population Health and primary care in an integrated package
- Collaboration with diabetes services and Diabetes Australia to implement the community diabetes program across SWSLHD
- Increased and more effective engagement with Aboriginal Health services within the SWSLHD and with ACCHS and other Aboriginal organisations providing healthcare
- Access, facilitation and support of available services in NGOs and community groups e.g. exercise programs.

For **diabetes and endocrinology**, the partnerships which need to be forged and strengthened to facilitate models of care and service developments in the future include:
General Practice /SW Medicare Local – a coordinated strategy for disease prevention and management in general practice, especially in relation to diabetes, obesity and metabolic syndromes which is flexibly amenable to lifestyle changes and can be escalated or de-escalated as defined trigger points; raised awareness of osteoporosis among GPs and in the community; regular seminars/teaching sessions for GPs

In-hospital diabetes centres taking an enhanced leadership role in education of all staff, including enhanced links in educational activity with private endocrinologists

Community – enhanced links with community groups for education sessions, e.g. local clubs, ethnic groups, Aboriginal community organisations

For infectious diseases, the partnerships which need to be forged and strengthened to facilitate models of care and service developments in the future include:

- Multi-disciplinary inpatient and outpatient care – closer clinical partnerships between high users of Infectious Disease services such as Haematology/Oncology and surgical services such as orthopaedics; providing benefits in patient care and efficiency/effectiveness
- General practitioners – closer relationships whereby GPs can refer patients early to the ID acute care clinics/ambulatory care/community outreach services and GPs participate more in hospital-in-the-home treatments in partnership with the ID unit and community nursing
- Private Hospitals –SWSLHD infectious diseases services could be provided into private hospitals as community outreach; deficiencies in the availability of ID services in private hospitals may be a barrier to patient access
- RACFs – increasing evidence supports the role of RACFs as reservoirs and sources of multi resistant organisms (MRO) and MRO infections; ID services can play a role in improving antibiotic use, infection control and infection treatment in RACFS, helping divert admission of RACF residents from acute care hospitals – requires the collaboration of RACF clinical staff, GPs and community nurses.
- Community groups – those at increased risk include refugees and migrants, injecting drug users etc. ID could participate in community education campaigns and outreach programs for prevention and early detection e.g. HBV, HCV, and TB etc.
- Research – collaboration with universities and other clinical research groups on clinical infectious diseases research
- Public Health Unit and Communicable diseases Branch Ministry of Health- role in the surveillance and management of established and emerging infectious diseases threats’ with enhanced information exchange and collaboration to optimise outcomes

For rheumatology, the partnerships which need to be forged and strengthened to facilitate models of care and service developments in the future include:

- Maintaining and expanding long established close links to ACI, Arthritis Australia, Arthritis NSW and the College of Nursing, particularly to develop improved models of care and musculoskeletal training for nursing and providing information to the community on models of care, self-management and obesity prevention
- Community based services to help manage disabled patients
- Enhancing links with General Practice and the SW Medicare Local

For immunology, the partnerships which need to be forged and strengthened to facilitate models of care and service developments in the future include:

- Collaboration with other departments in areas such as pharmaco-immunology and neuro-immunology
Maintaining and expanding relationships with patient support groups such as the Lupus Association and Immunodeficiency Diseases Association

Supported residential care for patients with HIV dementia, to address prolonged hospital stays which arise because of lack of appropriate accommodation – currently The Bridge is the single HIV dementia specific unit in Sydney

Collaborative links nationwide for research into individual immune-mediated diseases and immunodeficiency syndromes

Work with the Australasian Society of Clinical Immunology and Allergy to provide patient information on immune mediated diseases in different languages

Ambulatory Care services for rapid access to intravenous infusions

For clinical genetics, the partnerships which need to be forged and strengthened to facilitate models of care and service developments in the future include:

- General Practice - ongoing communication and review of their educational needs regarding genetic conditions and services available; better IT communication; better shared care plans of management
- Continued involvement with Ministry of Health via GSAC for planning of future genetic services for NSW
- Continued interaction with AGSA for genetic support information for patients and families.
- Continued support and interaction with Mothersafe program for information on teratogens in pregnancy
- Increased involvement with providers of personalised private genetic testing through web based sites to ensure their clients receive interpretation and counselling on the results of their testing

Community Health Services

Community Health has developed models of care focussing on four core aims - to provide equitable health and wellbeing outcomes for the people of South Western Sydney; to reduce hospitalisations; to improve quality of life; and to provide care throughout all stages of the life cycle. Community Health is provided from 68 centres across SWSLHD, with 11 major sites, 10 smaller sites and 47 early childhood clinics. The major service components are Child and Family Clinical Services; Specialist Clinical Services; Community Health Nursing; and Corporate and Support Services. Sexual Health Services are managed under the Community Health Stream, with separate information on future models of care, service development directions and partnerships provided for this service.

Models of Care for the future

Expanding demands from population growth and ageing will require community health to enhance health service provision and coordination of care at the interface between primary, secondary and tertiary health care services. Managing hospital demand with limited resources will require community health to provide cost-effective services that manage this demand as well as facilitating equity in health outcomes and quality of life over the whole life cycle. Partnerships with government and non-government agencies, with the Medicare Local as the core major strategic partnership, will become increasingly important to manage the burden that an anticipated increase in mental illness, chronic and complex disease will create. Schematically, the model of care for the future is illustrated as follows.
Community Health Future Model of Care: Looking Towards 2021

The major components of this model of care include:

- Central Access point for managing patient flow – single point of contact (entry) to services with coordinated management of navigation across multiple services
- Standard practice guidelines e.g. consistent patient access guidelines
- Extended hours and flexible service delivery e.g. flexibility in outreaching to vulnerable population groups – Home visiting programmes; paediatric outreach clinics; extended operating hours; use of community health centres on weekends
- Partnerships with key service providers - case management meetings; increased involvement in the planning processes of partner services e.g. Families NSW, Acute facilities and the SW Medicare Local
- Individual management plans e.g. assessment and treatment for individual conditions; Universal Home Visiting and Sustained Home Visiting
- Shared/linked health education and community development.

The Sexual Health Services model of care will aim to reduce the transmission of sexually transmissible infection (STIs) including HIV and Viral Hepatitis and reduce the negative impact of STIs on health status, personal and social wellbeing. In partnership with the Sexual health Promotion Unit, strategies and actions will reflect objectives outlined in the SWSLHD Sexual Health HIV/STI Strategy (2013-2018). A best practice model has been identified consistent with NSW strategies, comprising core elements of:
- **Effective health promotion, prevention and community education - resource development;** awareness raising and social marketing; capacity building, education and support to general practice and other health care providers; collaboration with key stakeholders with an emphasis on community based organisations; STI and HIV education to community groups; community consultation; undertaking research and working in partnership with the Public Health Unit to respond to emerging trends in sexual health

- **Establishing partnerships with GPs and other primary care providers - ensuring support, education and advice provision to maximise the effectiveness of the GP role in sexual health;** GP roles to include provision of clinical services and counselling to the general public and counselling priority populations; encourage GP contribution to health promotion and prevention programs and patient education; initiation of contact tracing

- **Establishing high quality Sexual Health Clinical Services targeting priority populations - high quality clinical services, counselling for priority populations;** including outreach testing, screening and vaccination programs; needle and syringe exchange program; capacity building, education, support to primary care providers; professional education, support and supervision; STI and HIV research; participation in health promotion and prevention; partnerships with communities, GPs, public health; contact tracing; ensuring policies, processes, procedures conform with best practice standards and legal requirements

- **Establishing partnerships with affected populations, clinicians, researchers and other relevant groups - implementing appropriate prevention, health promotion and clinical service models; promoting advocacy; referring for support and care; ensuring appropriate planning, policy and service development**

- **Establishing a strong scientific research and evidence base for service delivery, strategy, policy and planning - epidemiological research; clinical research; intervention and promotion evaluation and assessment; quality improvement and service evaluation; literature reviews; undergraduate, postgraduate and professional development education**

- **Establishing strong partnership with relevant Public Health Units - coordinating STI surveillance and maintaining the national notifiable diseases databases; providing STI Surveillance reports to STI clinics, health promotion, and GPs; investigating and coordinating responses to notifiable disease outbreaks**

- **Incorporating new medical and social media technology - rapid testing and home based testing; drug technology such as Pre/Post Exposure Prophylaxis; social technology such as SMS, websites, social media websites; Electronic Medical Records**

**Service Development Directions**

- **Patient flow management with 24 hour access to clinical advice and referral service for appropriate local care.**

- **A model for integrated referral, intake and coordination where services are required across streams and settings of care e.g. chronic care, child and family, aged care and rehabilitation**

- **Health literacy development for the purpose of hospitalisation prevention e.g. Comdiab education**

- **Building business models for working efficiently in partnerships with other government and non-government organisations**

- **Review the model of community health to ensure that it meets the needs of modern health practice.**

- **Further development of the IPCC model of care, tying aspects of community health practice with general practice and specialist services outreaching from hospitals, with an organisational structure that facilitates multidisciplinary teamwork and linked up service provision – this model has been identified as the service development path for the SWGC, however aspects of the model may be equally suitable for incorporation in existing CHCs or any proposed community infrastructure developments in already settled regions.** There may be potential to trial the IPCC model within an existing CHC, incorporating GP practice and specialist outreach services from hospitals e.g. University clinics
• Strengthened clinical governance arrangements, which includes the governance arrangements for an IPCC model of care to ensure community participation and medical support to guide clinical practice
• Preventative community mental health program development
• Information sharing, internally between various community health groups and externally with partners such as GPs and the hospital.
• Shared community development with NGO and government partners
• Service flexibility so that services are provided at times that make them more accessible to clients
• Medical support especially in regard to governance for community health services
• Enhanced research capabilities and activity

Proposed service development directions in Sexual Health include:

• Community education and health promotion designed to prevent STIs and BBV infections Including HIV, hepatitis B, hepatitis C
• Implementation of localised responses to recommendations and requirements associated with relevant international, national, state and local plans, policies, legislation and procedures
• Provision of targeted services and responses for priority populations including screening, monitoring, contact tracing, surveillance and treatment of STIs
• Education and support of primary health care providers and mainstream healthcare workers to ensure the provision of high quality sexual health care and sexual health promotion
• Development and maintenance of strong partnerships with key providers within the public health sector, with relevant community organisations, affected communities, clinicians, General Practitioners, researchers and other relevant groups and organisations
• Continued development of a strong evidence, research and evaluation basis for sexual health service delivery, strategy, policy and planning. This includes supporting local research and evaluation endeavours.

Partners in Service Development

Service developments in community health will be pursued in close collaboration with a range of service partners, including in the following areas:

• Managing patient flow - working with hospitals, GPs and NGOs
• Shared care models - working with GPs and Medicare Locals
• Increased health literacy and evidence based psychosocial models - working with NGOs, universities, research institutes (e.g. CHETRE)
• Shared community development models - working with NGOs, government agencies, Aboriginal Medical Services, research institutes (e.g. CHETRE)
• Establishing effective business models - working with NGOs
• Flexibility in outreaching to vulnerable populations - working with NGOs via shared locations and resources, South Western Sydney Medicare Local, government agencies (FaHCSIA), schools, Aboriginal Medical Services
• Information sharing both internally and externally - working with GPs, NGOs, government services and internal SWSLHD departments
• Increased involvement in the planning processes of partner services - working with Medicare Locals, NGOs
• Increased medical support and strengthened medical governance - working with GPs, Medicare Locals, VMOs
To address the complex health needs of Sexual Health Service clients a range of key partnerships will be required. These include clinical stream/ network partnerships with - HIV/Immunology, Sexual Health Promotion team, Population Health, Drug Health, Aboriginal Health Services, HARP Unit, Specialist Services Directorate, STIPU, ASHM, Multicultural HIV and Hepatitis Services, ACON, SWOP, Local General Practitioner, and Medicare Local services.

Critical Care

The Critical Care clinical stream provides care within four core medical disciplines and settings – emergency medicine, intensive and high dependency care, anaesthetics and pain services. The identification of future models of care and service development directions is provided under these four areas of activity.

Models of Care for the future

In the emergency departments, the models of care in the future will be characterised by:

- A tripartite networking arrangement, whereby the staff and other resources of the 3 main EDs (Liverpool, Campbelltown and Bankstown hospitals) support the 3 smaller departments (Fairfield, Camden and Bowral hospitals)
- Increasing demand pressures, including that of meeting the NEAT targets will require improved patient flow through the ED, to be supported through full investment in enhancing ED capacity to benchmark levels, with significant enhancement to ward Short Stay capacity.
- ED will continue to provide resuscitation, assessment and procedural interventions to the acute presentations
- The procedural work within the ED will be facilitated by enhancement in procedural room availability, separate to the resuscitation rooms but with the same level of functionality
- Co-location and integration of imaging services with the ED needs to be enhanced
- Significant projected increased demand at Campbelltown Hospital will require increased physical capacity, redesign of operational structures and staffing enhancement to meet needs
- To meet increased demands from population growth (50% of SWGC development will be within Camden LGA), the emergency department at Camden Hospital will need to develop models of care to provide a definitive response to walk-in patients of all ages during all hours of operation, treating a "broad-spectrum" of acute episodic illnesses and injuries, with the ability to perform minor procedures and access to on-site diagnostic services
- The introduction of team based care, addressing implications for the JMO workforce
- Development and/or enhancement of the crossover into specialty specific short stay/assessment units in Paediatrics, Medicine and Surgery

In intensive and high dependency care, the models of care in the future will be characterised by:

- Enhancement of intensive care resources (noting that a new NSW Intensive Care Services Plan – Adult Services is under development by the NSW Ministry Of Health) subject to endorsement through the Critical Care Taskforce (CCT) which advises the NSW Ministry of Health
- Some redistribution of services will be needed to allow guaranteed access to tertiary ICU facilities for tertiary services
- Expansion of some ward based specialty specific high dependency areas e.g. Respiratory Non-Invasive Ventilation Unit; assisting in ICU to ward discharges
- Redevelopment at Bowral Hospital to create a Critical Care “Hub” with HDU and ED. This enhancement would allow for higher acuity admissions to the HDU with ED medical support close by.
In anaesthetics, the models of care in the future will be characterised by:

- Recognition of the increase in out of theatre workload, properly measured and appropriately staffed
- An increase in day only and sedational procedures
- Potential for a different staffing model with increased Staff Specialist appointments reducing complete reliance on VMOs
- Advanced nursing roles in anaesthetics including Nurse Practitioners for minor sedation procedures
- A comprehensive asset enhancement and replacement plan

In pain services, there is recognition that effective pain management is a moral imperative, a professional responsibility and an ethical issue for the community. Models of care in the future will be characterised by:

- Continued implementation of the NSW Government Pain Management Plan introduced in 2012. The Plan aims to improve the delivery of pain services to the community, recognising that chronic pain is a specific disease entity requiring appropriate clinical support
- Further development of acute pain services at all facilities in recognition of increasing demands arising from increased emergency and elective patient activity, increasing number and complexity of surgical procedures and an increase in oncological referrals for acute pain management
- At Liverpool Hospital, enhancement of chronic pain management services to improve the current ten day wait for priority patients (cancer pain, medically urgent cases such as complex regional pain syndrome or herpes zoster, those with uncontrolled pain) and six month waiting time for non-urgent patients. Increasing demand for chronic pain management is also being driven by third party insurers incorporating pain management/procedures into care plans to facilitate return to work
- As pain procedures are safely performed under regional anaesthetic and sedation with the majority under local anaesthetic alone requiring minimal recovery time, they can be appropriately provided in an ambulatory care setting such as PIXI at Liverpool Hospital
- Enhanced interaction with third party insurers such as Workcover to maximise revenue opportunities through negotiation of individualised fee schedules. Third party insurers have identified pain as a significant barrier to injured worker rehabilitation and return to functional work
- Continued collaboration between the Tier 3 Pain Department at Liverpool Hospital and the SWSML to improve education in pain management of both health professionals and the community, to facilitate both direct and electronic consultations, and to accelerate referral to the required level of care.

Service Development Directions

The core service development directions for emergency departments include ensuring:

- All EDs have the physical capacity for the patient load
- All EDs all have access to ESSU and PECC beds/services
- All EDs are represented on the facility Clinical Council and other peak representative bodies
- Enhancements to address the senior staffing shortfall that exists in all the satellite EDs
- Development of a research focus across the District
- Consideration of the development of academic units in Emergency Medicine at Liverpool and Campbellothe hospitals in conjunction with UNSW and UWS, supported by academic chairs
- Further development of an integrated education program for all levels of staff, including consideration of a hub and spoke approach to medical staff education in emergency medicine with Liverpool Hospital as the hub for Registrar education and Campbelltown Hospital as the hub for CMO education
The core service development directions for **intensive and high dependency care** include:

- Enhancing ICU/HDU bed capacity to ensure a manageable 85-90 % occupancy (note that the Ministry of Health’s August 2011 guideline recommends a 75% occupancy rate be used as benchmark for planning purposes) and ability to promptly admit critically ill patients from wards, ED, OT and other metropolitan hospitals, who require ICU management
- Enabling ICU ACCESS nurses continuous presence on the medical ward rounds
- Enhanced ICU research activities
- Providing 24 hour coverage in peripheral units such as at Fairfield and Bowral hospitals

The core service development directions in **anaesthetics** include:

- Moving to a mixed VMO and Staff Specialist appointment model of care
- Enhanced data collection
- Development of a research branch in association with UNSW/UWS and Ingham Medical Research Centre
- Development of an NP/Advanced nursing practice role

The core service development directions in **pain services** include:

- Enhancement of the Liverpool Hospital service to fully provide Tier 3 tertiary level acute and chronic pain services through the PIXI unit in ambulatory care, including equipment and staffing enhancements
- Enhancement to acute pain services provided across all facilities in association with the Departments of Anaesthetics
- Development of multidisciplinary chronic pain services at Bankstown-Lidcombe and Campbelltown hospitals
- Enhanced access for paediatric patients to pain management services
- Enhanced access for drug health clients to pain management services

**Partners in Service Development**

To facilitate the service developments in the **emergency departments**, close partnerships need to be forged and sustained with, in particular:

- Ambulatory Care (Adult and Paediatric)
- Imaging services (needs enhancement, in particular a faster service and access to ultrasound)
- Acute ambulatory clinics
- Community nursing
- General practice
- Rapid access to various inpatient units, particularly ICU/CCU/Cath lab; operating theatres; Acute short stay units (MAU/SAU)

In addition there will need to be maintenance of core partnerships which have developed at individual facilities over time:

- Liverpool Hospital – ESSU; Radiology/Pathology; ICU/Theatres/Cath Lab; After Hours GP Clinic; PECC and D&A; MAU (needs enhancement to reach full potential)
- Campbelltown hospital - Paediatrics/Paediatric Ambulatory Care; MACS; Cardiology
- Fairfield Hospital – Paediatrics; Ambulatory Care; Medicine; GP services
- Bankstown Hospital - Ambulatory Care services (antibiotics, transfusions, cellulitis, PE, DVT etc.), in-patient services, community mental health services; MAU; Rapid Response Team
Some partnerships which need enhancement across SWSLHD to optimise services include:

- Mental Health
- Drug & Alcohol Services
- Community nursing
- Allied health
- Ambulatory care
- Aged Care facilities

To optimise service developments in **intensive and high dependency care**, sustained partnerships will need to be maintained with, in particular:

- The ED for patient flow and Trauma
- Anaesthetics for services outside of theatres and Recovery for patient flow
- Bed managers for patient flow
- Functional MET systems
- Retrieval services
- Private Hospitals (particularly at Bowral)

To optimise service developments in **anaesthetics**, sustained partnerships will need to be maintained with, in particular:

- Procedural centres which may develop outside the acute hospital setting, including potential community based “Eye Centre”(s).
- Other SWSLHD hospitals to support anaesthetic network arrangements
- A range of in-hospital clinical services, particularly Pain Services, Cardiology, Radiology, Nuclear Medicine and Cancer Services

To optimise service developments in **pain management**, sustained partnerships will need to be maintained with, in particular:

- SWSLHD interhospital relationships for seamless access to the Tier 3 pain services at Liverpool Hospital
- Anaesthetic Departments
- Cardiology
- Radiology
- Cancer Services
- Drug Health Services
- Paediatric Services
- SWSML

**Drug Health (shared IDA network across SWSLHD and SLHD to be split 2013-14)**

Drug Health has to date operated under a cross-LHD structure providing a comprehensive range of services including **Opioid Treatment Program (OTP)** at Bankstown-Lidcombe, Campbelltown and Liverpool hospitals; hospital **Consultation and Liaison** services at Bowral, Campbelltown and Liverpool hospitals with extended hours at Liverpool and limited access at Fairfield Hospital and no service at Bankstown-Lidcombe Hospital; **Court Diversion** through the Adult Drug Court operating through the Parramatta Local District Court and
MERIT operating at Liverpool, Fairfield and Campbelltown Local Courts; Harm Minimisation through a primary outlet at Liverpool Hospital and secondaries at Community Health Centres, NGOs and automatic dispensing machines at Camden, Campbelltown, Liverpool and Bowral hospitals.

Other important services include Counselling from community health settings at Tahmoor, Rosemeadow, Narellan, Ingleburn, Wollondilly, Bankstown, Cabramatta, Fairfield and Liverpool; Perinatal and Family Drug Health services (Campbelltown, Liverpool, Fairfield and Bowral); Dual Diagnosis at Liverpool and Fairfield; the Aboriginal Maternal & Infant Health Strategy (AMIHS) at Macarthur; Fairfield Enhanced Care Team (FECT) shared care OTP with Community GP's and Pharmacies; and Inpatient Detoxification at Fairfield

Models of Care for the future

The model of care for the future will build on existing services to provide an integrated drug health service offering:

- Continuum of care between the community and hospital settings.
- Enhanced proximity to key clinical partners
- Increased treatment options for patients and families
- Coordinated case management
- Improved responsiveness to complex patient and service demands within hospital, in Drug Health and in community environments
- Enhanced access to and sustainability of workforce

Service Development Directions

Proposed service development directions in Drug Health include:

- Enhanced hospital Consultation and Liaison services, with extended hours at Campbelltown and Liverpool hospitals
- Provision of admitting rights to Drug Health Service specialists at Liverpool, Fairfield, Bankstown and Campbelltown Hospitals - either with nominated acute beds or admission in available beds
- Enhanced services addressing Perinatal and comorbidity issues
- Co-location of Drug Health Services including OTP clinics within hospitals to facilitate integrated care
- Expansion of partnerships – toxicology, pain management, gastro, MHS, Maternity
- Workforce Development
- Teaching & research - defined career opportunities with junior, middle and senior medical, nursing and allied health positions
- Conjoint medical appointments with UWS and UNSW
- Less reliance on project funding with increased permanent funding and access to ABF funding models
- Expanded ambulatory detoxification in a model of shared care with GPs
- Establishment of tobacco cessation services across all facilities
- Primary health care clinic at Campbelltown and expansion of secondary NSP

Partners in Service Development

To address the complex health needs of Drug Health patients a range of key partnerships is required. These include facility based services such as Emergency Departments, Maternity Services, Gastroenterology, Respiratory and general wards. In addition, clinical stream/network partnerships with Mental Health, Community Health, Child Protection and Population Health form a basis of common objectives for shared patient populations. Broader still, a range of government and non-government agencies provide a platform
for shared case management activity facilitating housing, social and welfare support. Partnerships in this regard include Justice Health, Probation and Parole, Housing, CentreLink, NSW Police, Legal Aid, attorney General’s and a range of drug and alcohol NGOs.

Gastroenterology and Liver

The Gastroenterology & Liver Stream encompasses gastroenterology, hepatology, general surgery, upper GI and colorectal surgery, stomal therapy and complex wound management. It also covers general surgical emergencies, including trauma; with all trauma patients initially admitted under the care of a general surgeon. To optimise efficiency, the stream is undertaking a review and audit of its current practice through working parties of senior clinicians critically examining the processes underpinning current models of care.

Models of Care for the future

The models of care for the future will refine current practice, aimed at maximizing efficiency and strategically planning for both the increase in demand and the complexity of services. This will require strengthening of clinical partnerships with certain departments e.g. cancer, radiology, Infectious Diseases, interventional radiology.

Service developments will proceed within an integrated framework across SWSLHD which will include the development of tertiary referral services with research, teaching and training capacity.

Following optimisation of efficiency through the current review process, there will still be a need to make strategic investments in staff, equipment and infrastructure e.g. efficiency dividends from deploying digital operating rooms, which can yield up to a 30% decrease for complex laparoscopic cases.

Models of care in the future will be characterised by strengthened networking arrangements within all disciplines, including development of (and strengthening of existing services):

- A Viral Hepatitis Treatment Service and Hepatocellular cancer service as centres of excellence, with a robust multidisciplinary clinical service, interaction with MDT and significant research activity and leadership
- An Inflammatory Bowel Disease (IBD) Centre of Excellence with multidisciplinary service and strong research focus.
- Centres of Excellence for pelvic surgical oncology, bariatric services, oesophageal surgery, hepatic surgery, gastric surgery, pancreatic surgery and complex colorectal surgery
- A Medicare Local electronic interface i.e. primary care access to Cerner
- Primary health care centre(s) to provide screening/diagnostic endoscopy services
- Ambulatory care models to expand into community based centres with consideration given to the inclusion of a Nurse Practitioner model
- Shared care arrangements with GPs and maternity Services to improve management of women with hepatitis during pregnancy
- Discharge planning and coordination of care transition from acute services to network with community services via MDTs
- CALD specific health literacy and patent information resources, along with staff education
- Nurse-led models of care e.g. nurse practitioners

Service Development Directions

Over the next decade a number of service developments will influence patient care and hospital stay, with priority service developments including:

- Ensuring sufficient access to Gastro and Liver services through enhanced use of home wards
Integration of translational research into personalized patient care for malignancies with increased collaboration within MDTC across all sites, including the increased use of teleconferencing for these MDTC

- Proteomics/Comprehensive data bases
- Ensuring residents of south west Sydney can access digital and robotic surgery
- Establishing a National Centre for Excellence in surgical and endoscopic training
- Academic development of gastroenterology, upper gastrointestinal and colorectal surgery across SWSLHD
- Enhancement to outpatient continence services
- Use of day only facilities for surgical procedures which have traditionally been undertaken in hospitals i.e. cholecystectomy, breast surgery, hernia repair, ophthalmology and many other procedures
- Increased treatment capacity of Hepatitis services at Liverpool to develop new therapies, and develop multidisciplinary hepatitis services at Campbelltown, Bankstown-Lidcombe and Fairfield Hospitals
- Develop a Liver Cancer Service at Liverpool
- Advances in technology e.g. evidence based consideration of Natural Orifice Translumenal Endoscopic Surgery (NOTES)
- Interaction between sophisticated imaging techniques and endoscopy and surgery
- Stand-alone endoscopy units
- Surgical Ambulatory Care Units for procedures that can be safely performed as Day Only cases

**Partners in Service Development**

Service developments in the gastroenterology and liver stream will be pursued in close collaboration with a range of service partners, including in the following areas:

- Public and Private partnerships
- Priority groups e.g. Aboriginal Outreach Services
- CALD groups
- Medicare Local opportunities
- Consumer participation groups
- Closer links with General Practice, enhancing the ability to deliver educational programs to GPs in relation to service delivery in the acute setting. This will include early discharge programs for patients leaving the Gastroenterology and Liver Service and should also apply to community nursing services.

**Laboratory Services**

Currently, laboratory services in SWSLHD are provided through a centralised Tertiary Pathology service at Liverpool Hospital, with sector labs at Bankstown, Bowral, Campbelltown and Fairfield providing the immediate acute diagnostic services. Liverpool, Bankstown and Campbelltown run 24/7 services for Blood Bank, Chemistry and Haematology. Microbiology provides an 18/7 service at Liverpool and Anatomical Pathology provides a 10/5 also at Liverpool. There is a comprehensive courier service to ensure that specimens are delivered to the centralised laboratory in a timely manner. All laboratories are NATA accredited.

It is important to consider the pathology component of laboratory services as a medical consultative service, a clinical service where demands are determined by requests from other clinical services. Pathology has a major role to play in:
• Diagnosis - it is estimated that pathology results are involved in approximately 70% of diagnostic decisions. The number of occasions of this use is predominantly determined by patient population, particularly the inpatient numbers

• Monitoring of disease

• Monitoring of treatment

While both the second and third uses are affected by patient numbers there has been a growth of both classes of use out of proportion to patient numbers in recent years. Patterns of medical practice are considered to be a major determinant.

Models of Care for the future

It is expected that laboratory services will maintain the current service model, as it provides a very cost effective service without compromising patient care. This intention is predicated on the normal travel times for the courier service being maintained. Growing demands for pathology are expected as the ageing population is disproportionally affected by degenerative cardiovascular and cerebrovascular disease, including the effects of diabetes. The impact on pathology demand is likely to be manageable.

Cancer is likely to be a major driver of pathology demand in the next 10 years, irrespective of any change in incidence, arising from the increasing sophistication of diagnosis, much of which will be labour intensive in anatomical pathology. Cancer diagnostic demands are also likely to require a major expansion in technology of immunohistochemistry and somatic genetics. While much of this may be automated there will be a major demand for acquisition of new skills which will have to be anticipated before actual demand occurs.

Service Development Directions

The service development direction for Laboratory Services focuses on developing capability and capacity to meet reasonably expected requirements over the coming decade. Experience has shown that growth in utilisation of pathology is endemic and sustained and this trend is expected to continue, in line with national and international experience.

Demand growth has been offset by major improvements in productivity which should also continue, however the balance between growth and productivity may be different. Changed technology particularly automation with robotics is already well advanced in chemical pathology and haematology, however considerable scope for growth in automation is now emerging in microbiology and will be fully developed in the next 10 years. On the other hand, Anatomical Pathology is likely to remain highly labour intensive.

Realising the scope for further automation for all aspects of laboratory service provision will be critical to maintaining present service levels without significantly increasing staffing levels.

In cytology, service development is required to address limiting factors in the provision of an optimal cytological service to diagnostic and procedural clinics in all facilities and particularly at Bankstown-Lidcombe and Campbelltown hospitals. This issue will need to be addressed as this service moves to an increased networked platform. In addition, service development is required to optimise the use of frozen section in major oncology surgery performed outside of Liverpool Hospital, to mitigate significant theatre inefficiencies which arise. Improved staffing or networking of pathologists to hospitals undertaking this surgery may need to be considered.

In the short term Laboratory Services has adequate infrastructure to immediate requirements. However, within the next 12 months it will be necessary to enhance the collection service to adequately meet needs, particularly at Liverpool Hospital but also elsewhere. The demands for diagnosis and management of cancer
will be a major medium-term requirement which will have to be met. At current growth rates, increased laboratory space will be required within the next five years.

It will be important that as plans for first-line clinical services mature, a formal component of the planning process identify the likely impact on pathology at least into “high”, “medium” or “low” together with any highly specific requirements which become apparent e.g. the acquisition of molecular diagnostics.

**Partners in Service Development**

As indicated above, Laboratory Services will continue to have a close partnership with front-line clinical services which are the demand generators in pathology. It is also important to recognise that from mid 2012, laboratory services in SWSLHD have been managed under a State-wide service, NSW Health Pathology.

**Medical Imaging**

**Models of Care for the future**

- Provide a networked imaging service to permit scheduled transfers of patients in a timely manner from all facilities
- Meet clinically relevant waiting times for the provision of imaging services for inpatients and outpatients
- Strengthen, enhance and staff appropriately ED based radiology services e.g. in X ray, CT and ultrasound
- Provide a real-time consultant reporting model which includes after-hours access; requiring a major re-map and redesign of clinical service delivery models and work practices, supported by staff enhancements. Alternatively, service provision via off-site teleradiology from consultant’s home, but there are currently major limitations for a frontline service such as reliability, capacity of home PC network and logistics of report generation
- Establish an Imaging hub reporting model across SWSLHD based on sub-specialisation and/or body region; to replace the current facility and modality based reporting model, particularly for increasingly complex CT and MRI. This service delivery model will improve redundancy, back-up in difficult cases and peer review process, and improve the overall efficiency of service delivery. This will also match the increasingly stringent accreditation and re-credentialing requirements by professional colleges and Medicare authorities.
- The imaging hub model can provide redundancy and cover for smaller hospitals such as Fairfield which can struggle to attract suitable radiologists, and a platform for peer review
- Establish a Registrar network across SWSLHD
- Explore networking opportunities: e.g. paediatric, MRI, ultrasound and breast imaging; enabling sharing of expertise, protocols, economy of scale in procurement, and the medical and technical workforce
- For interventional radiology, provide comprehensive facilities at Liverpool, Campbelltown and Bankstown hospitals, with shared medical workforce.
- Foster and strengthen a Translational approach (from bench to bedside) to provide clinical care and conduct research. Medical imaging plays a crucial role in “Personalised Medicine” and theranostics i.e. finding the right target for the right patient, and not purely based on epidemiology data.

**Service Development Directions**

- Enhance IT infrastructure, including a functional PACS and RIS platform, with a universal work list to support a LHD-wide imaging hub reporting model, and registrar network in SWSLHD.
- Consolidate an ED based radiology service delivery model, with real-time reporting after-hours
- Enhancement of interventional radiology services at Bankstown and Campbelltown hospitals.
Maintain and enhance the provision of interventional neuroradiology located at Liverpool as part of the state-wide service.

As part of the Campbelltown Hospital redevelopment, provide an on-site Nuclear medicine and PET service

Realign medical imaging services to match surgical redesign and service developments across SWSLHD

Provide a molecular imaging based research and theranostics approach for treatment delivery i.e. linking diagnostics and therapy; an increasing focus of research directions within the Cancer Services stream and the Ingham Institute of Applied Medical Research. This will require close collaboration with the Medical imaging clinical stream, investment in infrastructure, workforce planning to meet demand and establishment of a sustainable funding model

**Partners in Service Development**

Service developments in imaging will need to proceed in close collaboration with a range of service partners, including in the following areas:

- In funding and performance monitoring with Governmental authorities e.g. in refining the ABF funding model to apply to outpatient services; addressing competitive impacts; enhancing asset management planning (it is considered that there is a lack of accurate data and no robust costing model in Medical Imaging at state-wide level); addressing access and turnaround time (TAT) to imaging services which are crucial to meeting NEAT targets (note that from July 2013 imaging TAT indicators are to be included in LHD performance management frameworks and that SWSLHD has been engaged as a test site in the state-wide Cerner Data source pilot program to extract Medical Imaging performance parameters)

- In establishment of appropriate business processes e.g. asset management plans, networking, workforce planning, accountability (note the NSW Ministry of Health is reviewing business modelling for capital investment required for rapidly evolving medical imaging), exploring public-private-partnership models

- With GPs and community members in IT connectivity; web and social media communication; engagement with the community for support, advocacy for more resources and in fund raising

- In strategies to conduct high quality research, properly resourced and with academic chair leadership in radiology/nuclear medicine; addressing competing clinical, academic and research demands from different clinical streams and academic institutions; with defined mechanisms in place to ensure that the benefits/ research output feed back to the imaging service

- In strategic planning for major growth areas in imaging-guided therapy planning and therapeutics: cancer theranostics, cardiac disease, neurosciences and Alzheimer’s disease.

- in external collaboration with universities, government bodies (e.g. CI, ANSTO) and vendors as a reference site and part of world-wide knowledge sharing network

**Mental Health (shared IDA network across SWSLHD and SLHD to be split 2013-14)**

Mental Health services currently operate through four streams – Infant Child and Adolescent Mental Health Services (ICAMHS); Youth; Adult and Specialised Mental Health Services for Older People (SMHSOP), providing inpatient services at Bankstown-Lidcombe, Bowral; Braeside, Campbelltown and Liverpool hospitals; with specialist community (ambulatory) services based at Bankstown, Bowral, Carramar (Fairfield), Liverpool, Campbelltown and Tahmoor.

**Models of Care for the future**

- Enhanced infrastructure across the spectrum – adequate community teams to provide assertive community care; inpatient resources to cover issues across the life span with step down care options and capacity to sustain those living with mental illness in the community
A collaborative care model between ED, Toxicology, Drug Health & Mental Health to manage acute intoxication & behavioural disturbance
Enhanced partnerships with GP primary care, private sector and NGO providers

Service Development Directions

Enhanced community teams, especially assertive community care teams (HiH)
Inpatient facilities that have adequate capacity to manage peak demands for care
Collaborative Teams, Services & facilities to manage the behaviourally intoxicated
Consolidate partnerships with Universities to develop necessary workforce
Demonstrate efficacy of outcomes via research.

Infrastructure developments to sustain this model of care and service development direction include:

At Bankstown-Lidcombe hospital, a new 6 bed PECC and modest enhancement to the acute inpatient unit
At Campbelltown hospital a major expansion of 70 additional beds - 20 older person beds; 30 non acute adult; and 20 acute adult comprising 10 high dependency & 10 Intensive Care (PICU)
At Liverpool Hospital an additional 24 sub-acute beds to operate from first half of 2013 (funding secured), supplemented by an additional 20 older person & 10 adolescent beds
Development of real time access to EMR for mobile staff with capacity to enter updated clinical information remotely
Increased workforce to deliver assertive community care & staff inpatient expansion.

Partners in Service Development

Service developments in Mental Health for the South West will be facilitated by enhancing relationships with a range of service partners, including in the following areas:

Consolidate Consumer & Carer networks
Enhance physical health care in community with GPs
Develop work & housing options for consumers in partnership with NGOs
Addressing holistically the overall health needs of people with mental health problems across SWSLHD
Explore opportunities to partner with the non-government sector to provide sub-acute services

Oral Health (shared IDA network across SWSLHD and SLHD to be split 2013-14)

To date the Oral Health clinical stream has operated as a shared network under an IDA with Sydney LHD, working to deliver high quality, affordable and well-managed dental services through the Sydney Dental Hospital (SDH) and community-based oral health clinics in the South West at Bankstown, Bowral, Fairfield, Ingleburn, Liverpool, Narellan, Rosemeadow, Tahmoor and Yagoona.

Models of Care for the future

The Oral Health model of care for the South west is predicated on reaching a balance between:

Providing timely emergency and acute care to the eligible population based on equity of access all sites, aligned with the NSW Priority Oral Health Program (POHP)
Assessing general treatment need and clinically prioritising and offering care through treatment waiting list codes A to E
Ensuring quality, productivity and efficiency in care provision

| 260 |
Progressively investing in the “Population Oral Health Approach” through capacity building of other health professionals; partnership with other health providers; and engaging community participation in planning and consultative processes

This model is supported by:

- An LHD-wide clinical stream model with its own clinical and corporate governance
- A PolyClinic approach in community oral health (COH)
- LHD-wide access for appointments and patient flow to improve equity of access - Demand Management Strategy
- Optimal use of Oral Health Fee For Service Scheme (OHFFSS) and overtime for staff
- Creation of Hubs of Excellence for Specialists/Registrars/Students rotation
- Good corporate and financial management

The LHD-wide clinical stream model:

- Provides a framework for integration of resources creating stronger network of COH Clinics and specialty services and allows equitable access for care across the LHD supported by the unique SSWOHS Demand Management Strategy targeting high demand
- Student Placements in COH Clinics
- District-wide Digital Radiology and ability for specialist advice whilst patient is in the chair
- Strategic capital growth in areas of high need

Service Development Directions

- Ensuring quality, productivity and efficiency in care provision through use of clinical audits (the Squad); clinical indicators including monitoring unplanned returns for restorations, endodontics, extractions and dentures; internal and external benchmarking; benchmarking treatment appointments with a minimum of 11 appointments per day of 40min duration in every clinic and SMS reminders; broader options of care – maintenance of skills; support for continuing education courses, attendance at SSW clinical forums and the Specialist Mentor programme
- Proving the evidence base through appropriate research - Active Research Committee; 2 major Randomised Controlled Trials (RCT) on Early Childhood Caries (USyd and NSW Ministry of Health) and Oral Health during Pregnancy (UWS); active register of research; annual Research Showcase; and an active Oral Health Promotion (OHP) register
- Professional Development of staff through a Learning and Development Committee; Annual Clinical Forum; Specialist Mentor Programme; Distinguished Lecturer Visits; representation at local and International Conferences and Research Presentations; Registration review and log; MDAAC Appointment processes; Clinical Audits; and UTas Master in Clinical Management
- Creation of Hubs of Excellence at Liverpool Hospital with 20 Chairs and a focus on Oral Surgery and Oral Medicine; at Campbelltown Hospital with 20 Chairs and a focus on Paediatric Dentistry; and Bankstown-Lidcombe Hospital with 12 Chairs and a focus on Preventive & Minimal Intervention Dentistry (MID)

Partners in Service Development

Service developments in Oral Health for the South West will be facilitated by development and strengthening of relationships with a range of service partners, including in the following areas:

- South West Sydney Medicare Local
- Universities and other educational institutions
Other LHDs in relation to patient flow
- Specialist Services at SDH and Westmead Centre for Oral Health
- Medical and Nursing streams
- Aboriginal Community Controlled Health Services (ACCHS) and other Aboriginal healthcare services
- Australian Dental Association (ADA), Royal Australian College of Dental Surgeons (RACDS), Dental and Oral Health Therapists Association (DOHTA) and Public Health Association of Australia (PHAA)
- State and Federal Government agencies
- Health Workforce Australia (HWA)
- Centre for Oral Health Strategy (COHS) NSW Ministry of Health

Paediatrics and Neonatology

Projections indicate that the paediatric population (0-19 years) in the South West will grow at the fastest rate of any LHD in NSW, particularly those aged 0-14 years and predominately in the growth corridor of Camden, Liverpool, Campbeltown and Wollondilly. Already paediatric emergency department presentations at SWSLHD hospitals are running at around 60% of that experienced by the Sydney Children’s hospitals network. Future models of care and service development directions will reflect the expected significant growth in demand.

Models of Care for the future

The future model of care in paediatrics and neonatology for SWSLHD will involve an integrated health care system by a multidisciplinary team of clinicians, where care is coordinated around the child and their family and located as close to the home environment as possible. Core characteristics of this model include:

- Establishment and expansion of ambulatory care services at each facility to maximise hospital avoidance and emergency department avoidance
- Provision of healthcare services for children as close to the home as possible, optimised by enhanced outreach capacity
- Placing the child and their family at the centre of the care plan, with their participation and active involvement in the management of the child’s case plan
- Defining a clear role delineation for each facility and protocols for rapid transfer to other facilities for definitive care where the child’s care needs are outside the facility’s capabilities
- Ensuring the size of paediatric units are sufficiently large for cost efficiency and for development and maintenance of clinical expertise
- Further development of subspecialty services, in conjunction with state wide service programs and networking with Sydney Children’s Hospitals Network to maximise access to expertise and resources
- A focus on timely access to evidence based services.

Service Development Directions

- Explore the feasibility of a paediatric centre for surgery within SWSLHD with the suggested site being Campbeltown Hospital, with complex cases being transferred to Sydney Children’s Hospital, Randwick and/or The Children’s Hospital, Westmead.
- In the interim, ensure that there is provision of infrastructure and resources required for paediatric surgery at all acute hospitals
- Development of paediatric assessment units and ambulatory care services at Liverpool and Bankstown hospitals.
- Enhance affiliations with the University of Western Sydney and University of New South Wales and develop a Clinical Academic Position in Paediatrics across SWSLHD
- Improve recruitment and retention of staff, in particular nurses in paediatrics and neonatology and allied health clinicians with specialised paediatric skills in their discipline
- Develop website and social media portals that focus on paediatrics and neonatology services
- Increase Adolescent Mental Health Inpatient beds within SWSLHD
- Establish an ED and Children’s Ward psychiatry consultative service for adolescent mental health
- Enhancements to optimise a comprehensive child protection service for the LHD.
- Expansion of paediatric subspecialty outpatient services, networking with the Sydney Children’s Hospital Network
- Expansion of neonatal intensive care beds at Liverpool Hospital in line with the increasing paediatric patient catchments
- Development of a high observation bed capacity for paediatrics at Liverpool, Campbelltown and Bankstown-Lidcombe hospitals
- Expansion of therapy and developmental assessment services to meet current and emerging demand.
- Development of a tertiary education program for paediatric nursing
- Establishment of a Tertiary Complex Cases Clinic to enable a multidisciplinary approach to management of Mental Health in intellectual disability
- Develop a transition service to support movement of older children and young adults into adult services from 16 years of age e.g. for those with chronic surgical problems, congenital malformations and chronic care issues

**Partners in Service Development**

The priority areas where close liaison with partners is required to implement models of care and service developments include:

- Enhanced integration with services provided by Community Health e.g. for developmental disability, refugees, children out of home, child protection, early childhood etc.
- Development of health facilities closely linked with universities to ensure capacity to expand as a tertiary facility i.e. Campbelltown Hospital affiliation with University of Western Sydney.
- Enhancement of IT infrastructure with ISD to ensure data collection is optimised to take advantage of opportunities under activity based funding.
- Strengthen the relationship with New South Wales Child Health Networks, in particular Greater Eastern and Southern Child Health Network and the Western Child Health Network to enhance service improvement projects and initiatives
- Develop a relationship with the **NSW Kids and Families** entity and the associated Board to ensure the needs of the South West are included in their strategic planning for the future of paediatric services in New South Wales
- Establishing a paediatric education program with the South Western Sydney Medicare Local

**Population Health (shared IDA network across SWSLHD and SLHD to be split 2013-14)**

Population Health has a range of operational units, managed under an umbrella directorate which also focuses on issues of equity and healthy urban development. The operational units are the Health Promotion Service (HPS); Public Health Unit (PHU); Centre for Research, Evidence Management and Surveillance (REMS); HIV and Related Programs (HARP); Multicultural HIV and Hepatitis Service (MHAHS); NSW Refugee Health Service...
(RHS); and the Centre for Health Equity Training, Research and Evaluation (CHETRE). Models of care and service development directions are provided both overall for the directorate as a whole and for individual operational units.

**Models of Care for the future**

In general, Population Health aims to increasingly work with local councils, other state government and non-government agencies and Medicare Locals. This reflects the Population Health tenet that working in partnership with the community and with other organisations within and beyond the health sector is essential for achieving population health goals. For the operational units the future focus of models of care is seen as:

- **HARP Unit** – ensuring future facility planning for SWSLHD incorporates provision for the Needle & Syringe Program (NSP), via Automatic Dispensing Machines, Internal Dispensing Chutes or over-the-counter dispensing; and sharps waste disposal bins

- **Refugee Health Service** – the model of nurse-led health assessments will gradually expand across Sydney and the rest of NSW. There may be a need for increased specialised refugee clinics to meet the health needs identified by the nurse assessments, in collaboration with local GPs. There will be expansion of health promotion programs tailored to meet the needs of refugee and other CALD communities.

- **Health Promotion Service** – maintaining a service model with sufficient critical mass to implement large scale interventions and services across large geographic area - with presence in key locations to enable links with local organisations and communities for delivery of programs. These sites will need to be located around population densities in the SWSLHD and take into account the operational role of the Health Promotion Service

- **CHETRE** – further expansion of international research collaborations to test ‘home-grown’ population health research; growing a strategic program of work (i.e. research, policy, program and service delivery) with regional partners focussed on health equity

- **Public Health Unit** – focussing on more strategic use of website and web services as a means of communication with professional groups and communities; better use of new technologies to facilitate contact tracing; better partnership working with local councils

**Service Development Directions**

Population Health has a *Strategic Directions* document to end of 2012. It is expected that service development directions for the future will build on those currently in place and being implemented. There are four overarching objectives:

1. Make prevention everybody’s business
2. Build regional partnerships for health
3. Build a sustainable population health workforce
4. Be ready for new risks and opportunities

For prevention, a prime development direction is to increase the adoption of healthy lifestyles and the development of healthy environments through: increasing the budget share allocated to prevention and early intervention; developing evidence-based programs to address issues such as socio-economic disadvantage, healthy lifestyles, healthy ageing, healthy environments and the needs of vulnerable population groups; expand health promotion programs addressing smoking, obesity, healthy eating and drinking, food security, physical activity and falls prevention; implement the Healthy Children Initiative to address childhood obesity; create strategic links with clinical services in developing, implementing and evaluating evidence-based primary and secondary prevention initiatives; enhance capacity to influence healthy urban design and work with planning agencies to develop healthy urban environments; and participate in community renewal activities across SWSLHD.
The prevention focus will also aim to reduce health disadvantage through: tailoring programs to the needs of disadvantaged communities; focussing activities on reduction of health inequity; increasing illness prevention activities and services; maintaining programs to support the increased uptake of immunisation; partnership work with prevention and clinical services to reduce the spread of sexually transmissible infections and blood borne viruses such as HIV, Hepatitis B and Hepatitis C; and enhancing programs addressing communicable disease control and environmental health.

In building **regional partnerships** for health the prime direction will be in enhanced participation in forums to build the capacity of the region to respond to current and anticipated health issues through: active participation in urban planning processes; partnership work with primary health care providers, local government, other government agencies and Non-Government Organisations to protect and promote the health of the local population; and participation in local government planning processes.

To build a sustainable population health **workforce**, the aim is to ensure people want to work in and can build a career in Population Health through: ensuring the workforce is matched to the needs of the community; providing all staff with a comprehensive orientation program; delivering in-house workforce development programs within SWSLHD workforce development frameworks; promoting occupational health and safety; and providing a supportive environment to develop population health advocates.

To ensure readiness for **risks and opportunities**, the aim will be to build the capacity and reputation of SWSLHD as an innovator in population health research and information management, through: increasing the output of Population Health research activities; and producing health and epidemiological profiles and reports on population health issues.

A focus on opportunities in response to changes in the operating environment of SWSLHD will be encouraged through: participation in Health Impact Assessment projects; comprehensive preparedness for disasters and pandemics; and monitoring changes in major health issues.

**Partners in Service Development**

Partnership work is at the core of population health activities. In the future the operational units of Population Health will focus on strengthening partnerships in particular areas:

- The Population Health **Directorate** will actively participate in urban planning processes by working in partnership with primary health care providers, local government, other government agencies and Non-Government Organisations to protect and promote the health of the local population
- The **Refugee Health Service** will focus on immunisation clinics in partnership with Public Health Units and Community Health; refugee youth health interventions in partnership with the Department of Education, communities and LHDs; and undertake ongoing liaison with and up-skilling of GPs
- **CHETRE** will collaborate in research, training and policy development with Medicare Locals
- **REMS** will aim for closer links with Medicare Locals; develop regional partnerships so as to be able to impact on policies and practices of partners; and explore opportunities to conduct interventional research with partners to establish an evidence base for activities
- The **Health Promotion Service** will focus on closing the gap in aboriginal life expectancy, promoting healthy populations and building and maintaining healthy environments. Health promotion initiatives will be underpinned by fostering strong and enduring partnerships with clinical health services, external government and non-government agencies, Medicare Locals, residents, community groups, universities and research bodies; and building the evidence through strengthening health promotion research and evaluation
- **HARP** will establish relationships with Medicare Locals to enhance prevention, treatment and care in the areas of HIV hepatitis C and sexually transmitted diseases, and develop new partnerships with NGOs to provide needle and syringe distribution options.

**Surgical Specialties**

This clinical stream provides care across a wide range of predominately surgical disciplines including neurosurgery, orthopaedics, plastics, hands, trauma, ophthalmology and ENT.

**Models of Care for the future**

- Provide an increased range and complexity of plastics surgery at Bankstown
- Enhance training and education for plastics registrars, nurses and JMO’s/ medical students
- Provide a fully comprehensive onco-plastic breast service across SWSLHD, including specialist in hospital nursing for support & early post-operative discharge, improved coordination between GPs & discharge nurses for early post op discharge and community nursing support,
- Improved integrated model of care between specialties such as plastics and oncology
- Increased day surgery procedures and greater utilisation of community nursing/GP’s to facilitate early discharge initiatives.
- Increased networking between hospitals
- Post operative outcome data collection for elective and emergency patients
- Consider role for expert workforce such as Nurse Practitioners
- Identify and develop models for a comprehensive stand-alone Eye Centre providing clinical and consultation space, within either a hospital or community setting or in public/private partnership
- Identify and develop models for hand surgery to ensure timely acute care interventional procedures and hand therapy (occupational therapy and physiotherapy)
- Becoming a training centre for hand surgeons with accreditation from Australian Hand Surgery Association
- All models designed around evidence based best practice
- Strong research and education focus
- Rostering practices based on 24/7 hospital

**Service Development Directions**

- Bankstown Plastics accredited for registrar training
- Development of research proposals
- Increased teaching for medical and nursing staff
- Increase day only and day of surgery procedures
- Improved discharge and follow up procedures including improved access to post op outpatient clinics
- Greater networking for services across facilities
- Expansion to acute and sub-acute theatre sessions
- Development of departmental data bases to record/report quality of care data for accreditation/ benchmarking / patient focused service development
- Comprehensive Asset register and equipment replacement/enhancement plan for each service at each site
- Provision of hand surgery at Fairfield Hospital
- Development of Fellowship positions in key specialties
- Flexible employment practices
Partners in Service Development

- Potential for increased use of private care providers such as hand physios
- Community education sessions on common topics/presentations like skin cancers
- Greater integration of GPs and community nurses to support early discharge initiatives
- Improved dental service
- Support and education for GP’s on services available and post discharge care
- Seek “preferred provider” status with Workcover and insurance companies
- Consider public/private or privately referred non-inpatient models of care and funding
- Involvement in corporate funded research trials
- Collaboration with emergency departments to improve initial emergency care for specialties such as hands

Women’s Health

It is projected that demand for Women’s Health Services will grow steadily into the future. The projected population growth and high birth rates underpinning growing demands for maternity services and ageing of populations will also impact on demand for gynaecology service needs. In particular, the main localities for growing demand in women’s health services will be in Bankstown, Camden and Liverpool.

Models of Care for the future

Antenatal service

A range of models of care will need to be available in Women’s Health to reflect clinical needs, safety factors and woman’s choice, and reflect the complexity of care required. Across SWSLHD the aim is to provide safe, responsive and integrated models of care. This will be achieved through collaboration with key stakeholders in service models that offer women:

- Community based models of care for women with low risk pregnancies e.g. shared care with general practitioners, outpatient clinics
- Expansion of models of care that provide women with continuity of carer i.e. Midwifery-led models of care
- Obstetric-led models of care for women with high risk factors
- New collaborative Shared Care models between midwives and general practitioners for women without risks

The overall approach to these models should emphasise safety and advocate towards normal birth where possible. The models will aim to ensure continuity of care for the woman whilst reducing the traditional fragmented approach to care. This will include clear criteria for assessing risk and selection of the appropriate pathway of care and model according to risk factors.

Intrapartum service

Collaborative practices will aim to enhance the quality of care provided to the woman and her family by utilising a variety of skilled professional groups including obstetricians, midwives, allied health, neonatologists and general practitioners to improve birthing plans that emphasise the normality of pregnancy and birth, where possible. The multidisciplinary team with clear delineation of role will work together to ensure an improved health outcome for women and children presenting to maternity services within SWSLHD.

There will be a move towards low risk women being managed in the community rather than at an acute facility. The management of moderate to high risk pregnancies will be provided by obstetric teams.
Postnatal service

Expansion of the Midwifery Support Program home visiting services across SWSLHD will help facilitate the early transition back into the community following birth, which will be a necessary strategy to respond to demands on services as the population grows.

Developing healthier babies initiatives are also a priority and a focus on increasing the low percentage of women breastfeeding their babies across SWSLHD. The focus will be on providing more lactation support and developing a culture of acceptability of breastfeeding in the community, particularly young women.

Facility models of care

In particular future planning will need to consider the following models of care for each facility:

- **Bowral and District Hospital** – The models of care for this facility will focus on a combination of midwifery led models of care and shared care models with an emphasis on GP/midwifery led care managing women and children with low risk pregnancies. This is a key initiative for Bowral and across Wingecarribee due to the difficulties in recruiting obstetric personnel to the region. This model will be reliant on the continuing partnership with Campbelltown Hospital for transfer of moderate to high risk obstetric women for ongoing management and care, with antenatal and postnatal care provided at Bowral.

- **Campbelltown Hospital** – to offer a range of models of maternity care including midwifery and obstetrics. It also reflects the enhanced networking with Bowral and District Hospital with outreach community antenatal clinics for moderate to high risk women. There is a need for increased participation in GP shared care programs; an improved model of care for Aboriginal women; and expanded Midwifery Group Practice models to deliver innovative services to meet the needs of local women. Opportunities to upgrade the maternity service to a role delineation level 5 will be explored, along with the establishment of a four bedded birthing centre.

- **Camden Hospital** – The model of care will continue to extend outreach antenatal care programs and work in collaboration with birthing and postnatal services at Campbelltown Hospital with early discharge into the community.

- **Liverpool Hospital** – The model of care will focus on expanding tertiary services e.g. the Fetal Medicine Unit. In addition, there will be a focus on continuity of care for women by expansion and development of midwifery led models of care, GP shared care program, and community based antenatal models of care; as well as improved models of care for Aboriginal and other vulnerable populations including for women with mental health and drug health issues.

- **Fairfield Hospital** – the model of care will continue to maintain the facility as a low to moderate risk obstetric facility with expansion in the GP shared care program; midwifery clinics; and community outreach antenatal services. There will be further enhancement of the affiliation with Liverpool Hospital to support women with higher obstetric needs from the Fairfield LGA.

- **Bankstown-Lidcombe Hospital** – the focus will be on increased participation in the GP shared care program and establishing a community based antenatal outreach service. Opportunities will be explored to develop a birth centre or increase birthing rooms to assist with the policy towards normal birth and implementation of Midwifery Group Practice to provide women with another option of care. Moreover, an upgrade of the maternity service to a role delineation level 5 will be explored. This may be indicated due to the presence of a high level of supporting services from medical subspecialties, ICU, anaesthetics and radiology; that would be helpful to meet maternity needs in general and rising complexity and risk factors reflecting particular needs of the growing population in the area i.e. diabetes, renal, hypertension and genetics issues.
Service Development Directions

Priorities for service development in the Women’s Health clinical stream to facilitate the implementation of enhanced models of care include:

- Developing collaborative models of care that emphasise a woman centred approach that increases choice and moves towards increasing normal births and reducing caesarean operations
- Matching services to clinical needs and staff numbers to services including one to one midwifery care in labour for first time mothers and women who are attempting a vaginal birth after a previous caesarean operation
- Improve triaging of woman on the correct pathway according to risk i.e. low risk encouraged towards midwifery models or GP shared care options in community settings
- Establishing integrated service networking for outlying hospitals i.e. Bowral/Campbelltown and Fairfield/Liverpool/Bankstown.
- Improve access to antenatal care in a timely manner, this is a priority at each facility
- Improve access to community outreach service options to assist women in the transition from hospital to community care i.e. Midwifery Support Programs, improved transitioning of care from midwives to the child and family health nurses
- Improve breastfeeding initiatives and rates within SWSLHD
- Reflect current evidence based practice
- Attract an appropriate number and mix of health care professionals with the necessary knowledge and skills and experience for the clinical stream
- Responsive gynaecological services to meet increased demand from a growing population of older women
- To deal with the impact of rise in diabetes, hypertension and obesity issues on pregnancy, birth and newborns in a collaborative manner with other teams
- Expand day only and outpatient services for gynaecological procedures

Partners in Service Development

Partnerships that will need to be forged and strengthened to enable the models of care and service developments to be successfully implemented in the Women’s Health clinical stream include:

- Develop relationships with the SWS Medicare Local
- Partnerships with key universities i.e. University of Western Sydney, UNSW;
- Closer relationships with other important clinical streams and services including Aboriginal Health, Mental Health, Drug Health, paediatrics, medicine and with CALD populations
- Improved community outreach options of care at NGO or community centres
A19. Healthcare facilities – current profile and service development directions to 2021

The following summarises the current profile and service development directions to 2021 for each facility in the District. The constraints on existing infrastructure at a number of sites will have implications for service location and management arrangements. In addition, changing policy and new models of care and service delivery will effect where and how services are provided and who provides them. Services traditionally operated on a hospital site may be located elsewhere in the community and/or may be developed in partnership with other organisations.

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Bankstown-Lidcombe Hospital

Providing mainly for NSW communities of:

<table>
<thead>
<tr>
<th>LGA</th>
<th>% Hospital Beddays from LGA</th>
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<tr>
<td>Campbelltown</td>
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Profile of Bankstown-Lidcombe Hospital in 2012

Bankstown-Lidcombe Hospital is a principal referral group A1B hospital with tertiary affiliations to the University of NSW, University of Sydney and University of Western Sydney. It provides a wide range of general medical and surgical services and some sub-specialty services to a local Bankstown/Canterbury community mainly at role delineation level 5.

Located:
- In the suburb of Bankstown
- In the LGA of Bankstown
- In the State electorate of Bankstown
- In the Federal electorate of Blaxland

Providing clinical services in:
- Emergency Medicine
- Cardiology
- Surgical sub-specialties including general, ENT, colorectal, peripheral neurosurgery, ophthalmology, orthopaedics, plastics, upper gastrointestinal pancreatic and biliary, vascular, breast and urology
- Medical sub-specialties including general medicine, endocrinology, gastroenterology, infectious diseases, neurology, neurophysiology, renal medicine, respiratory and rheumatology
- Cancer therapy including medical & surgical oncology, chemotherapy and haematology
- Intensive Care Unit/High Dependency Unit (ICU/HDU)
- Maternity, gynaecology, special care nursery and paediatrics
- Mental Health
- Drug Health
- Rehabilitation and Aged Care
- Imaging – interventional, CT, MRI, nuclear medicine, ultrasound and general radiography.

Activity and Bed Base – 2011-12 & projected 2021-22

Using the MoH endorsed projection methodologies and assuming the clinical profile and flow patterns of patients are maintained into the future, the following table shows activity in 2010-11 and 2021-22 projected, with the bed capacity required to service that demand at benchmark occupancy levels, compared to the average bed availability over 2011-12. These “supply” projections take no account of changed patient flow patterns expected from the introduction of new services at a facility. These impacts are identified in Clinical Services Plans and Business Cases prepared for individual facilities and service development proposals. Where provision of a new service has a net impact of attracting patients who previously received care outside SWSLHD, additional capacity will be required to meet the increased demand.
Service Development Directions for Bankstown-Lidcombe Hospital to 2021

**Allied Health** - provide extended hour social work and physiotherapy services for emergency and specific inpatient caseloads 7 days per week

**Aged Care and Rehabilitation** - develop Day Hospital capacity and expertise as a tertiary referral centre for the District and Telemedicine referral centre for NSW with expertise in younger onset dementia and falls

**Cancer** - redevelop and expand cancer services to include haematology and cancer genetics, expanded chemotherapy, surgical resection work and improved access to radiotherapy for Bankstown residents (note new and expanded radiotherapy services are identified in the Statewide Service Plan); enhance breast surgery services including a dedicated breast care nurse, mammography, breast assessment clinic and breast coil for MRI machine; provide outpatient dermatology services; and develop a palliative care inpatient service
Cardiovascular - increase cardiology beds; monitor access to satellite renal dialysis; enhance and expand the diabetes service to manage increasingly complex patients and incorporate pre-admission screening programs for elective surgery patients; establish an Interventional Endovascular Unit incorporating cardiac catheterisation and enabling expansion of vascular surgery (e.g. advanced peripheral interventions; carotid, renal and mesenteric stenting) with interventional radiology available 24/7; and provide out of hours pulmonary and cardiac rehabilitation programs

Complex care and Internal Medicine - expand rheumatology services including urgent care clinics, ambulatory care infusion services and outpatient clinics; expand respiratory services with development of a Sleep and Respiratory Failure service, Chronic and Complex Care team and expanded capacity to diagnose and treat COPD and lung cancer, EBUS and respiratory ultrasound; increase interventional pulmonology, with interventional bronchoscopy, endobronchial ultrasound and pleural ultrasound; develop respiratory home ward(s) to manage higher dependency patients with respiratory failure requiring subacute non-invasive nasal ventilation and enabling transfer from ICU; expand neurology services including inpatient capacity, thrombolysis service and development of a neuroaudiology service; develop a combined immunology/HIV service; and expand ambulatory care/clinic capacity in clinical genetics, infectious diseases, neurology and neurophysiology

Critical Care - expand ED services and physical capacity; provide ESSU and PECC services; establish a Medical Assessment Unit/ Acute Assessment Unit (MAU/ AAU) adjacent to ED with associated clinics; and enhance intensive care resources (State planning) and HDU

Drug Health - expand physical capacity to enable hospital consultation and liaison; perinatal drug health services; counselling and to provide more effective opioid treatment services; provide for the Needle & Syringe Program (NSP) via Automatic Dispensing Machines or over-the counter dispensing through the community health centre, and installation of sharps disposal bins.

Gastroenterology and Liver - establish home wards with a high acuity pod for HDU step down patients; establish a stand-alone or virtual stand alone endoscopy service with expanded capacity and quarantined patient flow, potentially an HVSS model with separate delineation of patient flow; develop Centres of Excellence in Inflammatory Bowel Disease and in Upper GIT (in sub-specialties of pancreatic surgery, oesophageal surgery including thoracic lung work, gastric surgery and complex biliary surgery); enhance the Bankstown Facility for Investigation of Ano-rectal and Functional Bowel Disorders; continue to provide a full range of colorectal procedures including complex laparoscopic surgery; develop specialist multidisciplinary services for viral hepatitis; explore development of a National Centre for Excellence in Training for Gastroenterology and Liver

Laboratory - enhance on-site pathology e.g. frozen section and tumour banking

Medical Imaging - enhance imaging service integration and availability in ED; enhance ultrasound services

Mental Health - enhance capacity, including facilities for people who are behaviourally intoxicated

Oral Health - an Oral Health Hub of Excellence focusing on preventive and minimal intervention dentistry

Paediatric - expand and develop high observation bed capacity, paediatric assessment and ambulatory care

Research - expand capacity to undertake research, including clinical trials

Surgical Specialties - enhance peri-operative medicine for people with multiple medical co-morbidities admitted under surgical teams; develop a High Volume Short Stay (HVSS) surgical centre, including ophthalmology, less complex head and neck e.g. thyroid, plastic and colorectal surgery; enhance orthopaedic surgery service to Training Programme Status with a rotating Registrar; enhance tracheostomy services through appointment of an ENT surgeon with head and neck training; maintain a plastic and reconstructive service, with an enhanced training network and a rotating Registrar; and explore options for most ophthalmology procedures to be moved from operating theatres to a procedural room environment

Women’s Health - enhance antenatal services for complex patients, with low risk patients monitored through GP shared care programs and outreach; enhance fetal ultrasound; commence an Early Pregnancy Assessment
Service (EPAS) to address risk of miscarriage; implement Towards Normal Birth policies with recruitment of fully qualified midwives; investigate birthing centre development and upgrading of maternity services for women with complications during pregnancy; expand the SCN; and explore potential for gynaecology procedures in outpatient areas rather than in operating theatres e.g. large loop excision of the transformation zone (LLETZ) surgery
Bowral and District Hospital

Profile of Bowral and District Hospital in 2012

Bowral and District Hospital is a District group C1 hospital, providing services for the local community at mainly role delineation level 3.

Located:
- In the suburb of Bowral
- In the LGA of Wingecarribee
- In the State electorate of Goulburn
- In the federal electorate of Throsby

Providing clinical services in:
- Emergency Medicine
- General Medicine including Stroke, Cardiac and Aged care
- General Surgery
- Orthopaedic Surgery
- Obstetrics
- Gynaecology
- Paediatrics
  - Paediatrics outreach
- High Dependency Unit (HDU)
- Ophthalmology
- Anaesthetics
  - Pre admission
- Allied Health
- Drug Health
- Imaging
- Cardiac assessment and rehabilitation
- Mental Health
- Day therapy unit
- Satellite Renal service (single chair)

Activity and Bed Base – 2011-12 & projected 2021-22

Using the MoH endorsed projection methodologies and assuming the clinical profile and flow patterns of patients are maintained into the future, the following table shows activity in 2010-11 and 2021-22 projected, with the bed capacity required to service that demand at benchmark occupancy levels, compared to the average bed availability over 2011-12. These “supply” projections take no account of changed patient flow patterns expected from the introduction of new services at a facility. These impacts are identified in Clinical

<table>
<thead>
<tr>
<th>LGA</th>
<th>% Hospital Beddays from LGA</th>
<th>% LGA Beddays to Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wingecarribee</td>
<td>76.82%</td>
<td>58.09%</td>
</tr>
<tr>
<td>Wollondilly</td>
<td>16.26%</td>
<td>12.01%</td>
</tr>
<tr>
<td>Goulburn Mulwaree</td>
<td>1.51%</td>
<td>0.81%</td>
</tr>
<tr>
<td>Shoalhaven</td>
<td>0.97%</td>
<td>0.19%</td>
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<tr>
<td>Campbelltown</td>
<td>0.30%</td>
<td>0.05%</td>
</tr>
<tr>
<td>Upper Lachlan Shire</td>
<td>0.21%</td>
<td>0.46%</td>
</tr>
<tr>
<td>Camden</td>
<td>0.20%</td>
<td>0.11%</td>
</tr>
</tbody>
</table>
Services Plans and Business Cases prepared for individual facilities and service development proposals. Where provision of a new service has a net impact of attracting patients who previously received care outside SWSLHD, additional capacity will be required to meet the increased demand.

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric Acute</td>
<td>Day Only</td>
<td>145</td>
<td>145</td>
<td>0</td>
<td>208</td>
<td>208</td>
<td>1</td>
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<tr>
<td></td>
<td>Overnight</td>
<td>8</td>
<td>543</td>
<td>1,295</td>
<td>5</td>
<td>544</td>
<td>1,226</td>
<td>4</td>
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<td>Total</td>
<td></td>
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<td>1,440</td>
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<td>752</td>
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<tr>
<td></td>
<td>Overnight</td>
<td>42</td>
<td>2,725</td>
<td>12,533</td>
<td>40</td>
<td>3,668</td>
<td>20,940</td>
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<td>4,762</td>
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<td>6,155</td>
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<td>56</td>
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<tr>
<td></td>
<td>Overnight</td>
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<tr>
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<td>Total</td>
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<td>6,068</td>
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<td>59</td>
<td>7,725</td>
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Additional Acute projected 2011-22

<table>
<thead>
<tr>
<th>Additional Sub-acute project 2011-22</th>
<th>23</th>
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</table>

Additional Sub-acute projected 2011-22

<table>
<thead>
<tr>
<th>Total Acute and Sub-acute</th>
<th>66</th>
<th>6,112</th>
<th>18,239</th>
<th>60</th>
<th>7,922</th>
<th>30,593</th>
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Additional Acute and Sub-acute projected 2011-22

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<tr>
<th>Mental Health</th>
<th>DO &amp; Overnight</th>
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<tr>
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<tr>
<td></td>
<td>Baby care cots</td>
<td>2</td>
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<td></td>
<td>3</td>
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<td></td>
<td>Bassinets</td>
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<td></td>
<td>13</td>
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</tr>
<tr>
<td></td>
<td>Delivery</td>
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<tr>
<td>Total Beds</td>
<td>94</td>
<td>87</td>
<td></td>
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</table>

Additional Total Beds projected 2011-22

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy</td>
<td>42</td>
</tr>
</tbody>
</table>

1 FlowINFO V11.2
2 aiM2010 and SIAM2010
3 Aged 0-15
4 Birthing, antenatal and postnatal beds
5 Projected at 80% MHCCP
6 NICU (Liverpool Hospital only) and SCN
7 Not currently included in bed counts - access to chairs at Southern Highlands Private Hospital

**Service Development Directions for Bowral and District Hospital to 2021**

Significantly upgrade the hospital’s physical fabric, notwithstanding on-going upgrades recently achieved such as refurbishment of the Children’s Ward. In addition, take advantage of opportunities to improve and enhance relationships with the co-located and expanding private hospital and increase participation in research.

**Allied Health** - provide extended hour social work and physiotherapy services for emergency and specific inpatient caseloads 7 days per week

**Aged Care and Rehabilitation** - enhance geriatric, rehabilitation and stroke services, including expansion of multidisciplinary day hospital/outpatient/home based therapy service and establishment of a nurse specialist led stroke thrombolysis service
Cancer - develop a Cancer Care Centre providing haematology and cancer genetics, in conjunction with private hospital services, and ultimately a Wellness Centre to enhance survivorship.

Cardiovascular - enhance cardiology services through development of a Cardiology on call roster; and continue on site renal dialysis for self-dialysing, ambulatory patients in a stable medical condition.

Complex Care and Internal Medicine - develop peri-operative medicine for people with multiple medical co-morbidities admitted under surgical teams; expand medical inpatient and ambulatory care capacity and service provision in chronic care, including ambulatory infusion services; and establish an Infectious Diseases Service, including consultation, Hospital in the Home and chronic care clinics.

Critical Care - expand ED services and physical capacity; establish a Medical Assessment Unit/Acute Assessment Unit (MAU/AAU) adjacent to ED, including associated MAU/AAU clinics; and create a Critical Care “Hub” to allow for higher acuity admissions to the HDU with ED medical support close by 24/7.

Drug Health - continue provision of hospital consult liaison and counselling and provide for the Needle & Syringe Program (NSP) via Automatic Dispensing Machines or over-the-counter dispensing and sharps disposal bins.

Laboratory - Investigate expansion of Pathology to meet demand and changing service models.

Medical Imaging - Investigate expansion of Imaging to meet demand and changing service models.

Paediatrics and Neonatology - explore feasibility of providing paediatric ENT services; and expand medical inpatient and ambulatory medical capacity.

Surgical Specialties - increase surgical short stay capacity and consider need for modest expansion of operating theatre capacity; and expanded orthopaedic surgery provision; and explore options for ENT and urology service development for local public patients in partnership with the private hospital.

Women’s Health - deliver a midwifery led / GP led shared care service for women with low risk pregnancies (and their babies), with transfer to Campbelltown Hospital for moderate and high risk obstetrics care; and continue antenatal and post natal care at Bowral.
Braeside Hospital

Providing mainly for NSW communities of:

<table>
<thead>
<tr>
<th>LGA</th>
<th>% Hospital Beddays from LGA</th>
<th>% LGA Beddays to Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairfield</td>
<td>46.14%</td>
<td>6.78%</td>
</tr>
<tr>
<td>Liverpool</td>
<td>34.76%</td>
<td>5.73%</td>
</tr>
<tr>
<td>Bankstown</td>
<td>6.12%</td>
<td>0.84%</td>
</tr>
<tr>
<td>Campbelltown</td>
<td>5.44%</td>
<td>0.94%</td>
</tr>
<tr>
<td>Holroyd</td>
<td>1.72%</td>
<td>0.22%</td>
</tr>
<tr>
<td>Parramatta</td>
<td>0.81%</td>
<td>0.14%</td>
</tr>
<tr>
<td>Marrickville</td>
<td>0.78%</td>
<td>0.26%</td>
</tr>
</tbody>
</table>

Profile of Braeside Hospital in 2012

Braeside Hospital is an Affiliated Health Organisation (Public Hospital) listed under the 3rd Schedule of the Health Services Act as part of HammondCare Health and Hospitals. It is a 72-bed public hospital that provides inpatient, outpatient and community services. Braeside offers specialised health and community services for the residents of south western Sydney include rehabilitation, palliative care and older persons’ mental health.

Located:
- In the suburb of Fairfield
- In the LGA of Fairfield
- In the State electorate of Smithfield
- In the Federal electorate of McMahon

Providing clinical services in:
- Palliative Care - inpatient, outpatient, day hospital, telephone advice and community assessments
- Rehabilitation - inpatient, outpatient and day hospital
- Specialist Mental Health Services for Older People (with a focus on dementia) - inpatient and outpatient (note the current classification of these beds is sub-acute and not mental health)

Activity and Bed Base – 2011-12 & projected 2021-22

Using the MoH endorsed projection methodologies and assuming the clinical profile and flow patterns of patients are maintained into the future, the following table shows activity in 2010-11 and 2021-22 projected, with the bed capacity required to service that demand at benchmark occupancy levels, compared to the average bed availability over 2011-12. These “supply” projections take no account of changed patient flow patterns expected from the introduction of new services at a facility. These impacts are identified in Clinical Services Plans and Business Cases prepared for individual facilities and service development proposals. Where provision of a new service has a net impact of attracting patients who previously received care outside SWSLHD, additional capacity will be required to meet the increased demand.
## Service Development Directions for Braeside Hospital to 2021

Develop an integrated strategy with Fairfield Hospital to expand sub-acute capacity across the two campuses, with Braeside maintaining its significant role in rehabilitation, psychogeriatric (older person’s mental health) and palliative care. In addition, undertake infrastructure development to improve current environment and potentially deliver new services.

**Cancer** - Maintain evolution of palliative care inpatient activity with a focus on shorter stay admissions, including day only, for resolution of issues such as in symptom alleviation/control and crisis management; consolidate and expand the palliative care day hospital and outpatients clinic; and enhance bereavement services.

**Mental Health** - expand the psychogeriatric (older person’s mental health) community outreach program.

### Patient Category

<table>
<thead>
<tr>
<th>Patient Category</th>
<th>Bed Category</th>
<th>2010-11</th>
<th>2021-22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric Acute</td>
<td>Day Only</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Overnight</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adult Acute exc. Maternity</td>
<td>Day Only</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Overnight</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Maternity Acute</td>
<td>Day Only</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Overnight</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
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</tr>
<tr>
<td>All Acute</td>
<td>Total</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

### Additional Acute projected 2011-22

- **All ages Sub acute**
  - Day Only: 1,570
  - Overnight: 72
  - Total: 2,389
- **Total Acute and Sub-acute**: 72

### Other

- **Emergency Renal Dialysis Baby care cots**
- **Bassinets Delivery**

<table>
<thead>
<tr>
<th>Bed Category</th>
<th>Av. Avail. Beds 2011-12</th>
<th>2010-11</th>
<th>2021-22</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sepe Beds</td>
<td>Beddays</td>
<td>Notional Beds</td>
</tr>
<tr>
<td>Paediatric Acute</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adult Acute exc. Maternity</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Maternity Acute</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All Acute</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
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</table>

### Service Development Directions for Braeside Hospital to 2021

- **Cancer** - Maintain evolution of palliative care inpatient activity with a focus on shorter stay admissions, including day only, for resolution of issues such as in symptom alleviation/control and crisis management; consolidate and expand the palliative care day hospital and outpatients clinic; and enhance bereavement services.

- **Mental Health** - expand the psychogeriatric (older person’s mental health) community outreach program.

### Table Note

1. FLOWINFO V11.2
2. aM2010 and SiAM2010
3. Aged 0-15
4. Birthing, antenatal and postnatal beds
5. Projected at 80% MHCCP
6. NICU (Liverpool Hospital only) and SCN
7. Not currently included in bed counts
Camden Hospital

Profile of Camden Hospital in 2012

Camden Hospital is (for peer grouping purposes only) a District Group C1 hospital administered under a joint management structure with Campbelltown Hospital, providing acute services at mainly role delineation level 3. It also has a significant role in providing sub-acute palliative care and rehabilitation for South West residents. Karitane also operates a service from Camden Hospital.

Located:
- In the suburb of Camden
- In the LGA of Camden
- In the State electorate of Camden
- In the Federal electorate of Macarthur

Providing clinical services in:
- Emergency Department (on ambulance bypass networked with Campbelltown)
- General Medicine and sub-specialty medicine on consultation
- Palliative Care
- Rehabilitation
- Medical Transit Unit
- Karitane
- University Medical Clinics Camden & Campbelltown
- Midwifery Group Practice antenatal clinics
- Allied Health Services

Activity and Bed Base – 2011-12 & projected 2021-22

Using the MoH endorsed projection methodologies and assuming the clinical profile and flow patterns of patients are maintained into the future, the following table shows activity in 2010-11 and 2021-22 projected, with the bed capacity required to service that demand at benchmark occupancy levels, compared to the average bed availability over 2011-12. These “supply” projections take no account of changed patient flow patterns expected from the introduction of new services at a facility. These impacts are identified in Clinical Services Plans and Business Cases prepared for individual facilities and service development proposals. Where provision of a new service has a net impact of attracting patients who previously received care outside SWSLHD, additional capacity will be required to meet the increased demand.
Service Development Directions for Camden Hospital to 2021

Further enhance and integrate clinical networks with Campbelltown Hospital and expand interest in and physical capacity to undertake research, including clinical trials.

Aged Care and Rehabilitation - increase sub-acute inpatient capacity in geriatric care, transitional care and rehabilitation; and expand outpatient and day hospital services

Cancer - increase sub-acute inpatient and outpatient/day hospital capacity in palliative care

Complex Care and Internal Medicine - increase ambulatory care services for people with chronic needs, including through University medical clinics, and including ambulatory infusion services. Further develop multidisciplinary care clinics for patients with obesity, arthritis and other complications of obesity e.g. diabetes; establish a leadership role to develop a comprehensive networked multidisciplinary metabolism and obesity service across SWSLHD; and provide the comprehensive multidisciplinary ambulatory assessment and
management component of a Centre of Excellence in Bariatric Surgery to be established in Macarthur, with surgical care provided at Campbelltown Hospital

**Critical Care** – maintain emergency medicine presence at current role delineation level, with capability to care for walk-in patients, access to on-site diagnostic services and continuation of ambulance bypass to Campbelltown Hospital

**Drug Health** - provide for the Needle & Syringe Program (NSP) via Automatic Dispensing Machines and sharps disposal bins

**Women’s Health** - enhance antenatal and postnatal services for local mothers through continuing support of the Midwifery Group Practice ambulatory services, GP shared care and access to on-site Karitane mothercraft
**Campbelltown Hospital**

Providing mainly for NSW communities of:

<table>
<thead>
<tr>
<th>LGA</th>
<th>% Hospital Beddays from LGA</th>
<th>% LGA Beddays to Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campbelltown</td>
<td>62.56%</td>
<td>54.86%</td>
</tr>
<tr>
<td>Camden</td>
<td>17.32%</td>
<td>53.56%</td>
</tr>
<tr>
<td>Wollondilly</td>
<td>9.05%</td>
<td>36.98%</td>
</tr>
<tr>
<td>Liverpool</td>
<td>2.77%</td>
<td>2.32%</td>
</tr>
<tr>
<td>Wingecarribee</td>
<td>2.28%</td>
<td>9.55%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>1.36%</td>
<td>1.01%</td>
</tr>
<tr>
<td>Bankstown</td>
<td>0.53%</td>
<td>0.37%</td>
</tr>
</tbody>
</table>

**Profile of Campbelltown Hospital in 2011**

**Campbelltown Hospital** is a major metropolitan group B1 hospital, operating under a common executive management structure and with networked services with Camden Hospital, providing a range of services at mainly role delineation level 4. It is a teaching campus for the University of Western Sydney Medical School.

A major redevelopment of the hospital is approved to provide for the immediate acute care needs of the Macarthur area and to establish some of the building blocks for Campbelltown Hospital to function as a Principal Referral Hospital, with tertiary teaching level services by 2020. The redevelopment will provide:

- Expanded Emergency Department
- Additional acute and sub-acute inpatient beds
- Expanded pathology
- Establishment of birthing suites
- Expanded outpatients (adult and paediatric) and ambulatory care areas
- New cardiac catheterisation labs/ interventional suites with multi-capability equipment
- 24-hour MRI and CT
- Expanded pathology

Located:

- In the suburb of Campbelltown
- In the LGA of Campbelltown
- In the State electorate of Wollondilly

Providing clinical services in:

- Emergency Medicine
- Cardiac Diagnostic Service
- Surgical sub-specialties including general, ENT, ophthalmology, orthopaedics, breast and urology;
- Medical care within a general medicine model with sub-speciality care on consultation including endocrinology, gastroenterology, neurology, immunology, aged care, renal medicine, respiratory, oncology, cardiology and rheumatology
- Inpatient paediatric medical and surgical care
- Adult and Paediatric Ambulatory Care Services
- Cancer therapy including radiation oncology, chemotherapy and haematology
- Intensive Care Unit/High Dependency Unit (ICU/HDU)
- Women’s Services including antenatal, birthing, postnatal, Feto-Maternal Assessment Unit and Early Pregnancy Assessment Unit
- Mental Health
- Drug Health
- Rehabilitation and Aged Care
• Imaging – MRI, CT, ultrasound and general radiography
• Allied Health Services.

**Activity and Bed Base – 2011-12 & projected 2021-22**

Using the MoH endorsed projection methodologies and assuming the clinical profile and flow patterns of patients are maintained into the future, the following table shows activity in 2010-11 and 2021-22 projected, with the bed capacity required to service that demand at benchmark occupancy levels, compared to the average bed availability over 2011-12. These “supply” projections take no account of changed patient flow patterns expected from the introduction of new services at a facility. These impacts are identified in Clinical Services Plans and Business Cases prepared for individual facilities and service development proposals. Where provision of a new service has a net impact of attracting patients who previously received care outside SWSLHD, additional capacity will be required to meet the increased demand.

<table>
<thead>
<tr>
<th>Patient Category</th>
<th>Bed Category</th>
<th>Av. Avail. Beds 2011-12</th>
<th>2010-11</th>
<th>Notional Beds</th>
<th>2021-22</th>
<th>Notional Beds</th>
</tr>
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<tbody>
<tr>
<td>Paediatric Acute</td>
<td>Day Only</td>
<td>739</td>
<td>739</td>
<td>2</td>
<td>802</td>
<td>802</td>
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<td></td>
<td>Overnight</td>
<td>3,569</td>
<td>8,052</td>
<td>29</td>
<td>5,058</td>
<td>10,111</td>
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<td>Total</td>
<td>29</td>
<td>4,308</td>
<td>32</td>
<td>5,860</td>
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<tr>
<td>Adult Acute exc. Maternity</td>
<td>Day Only</td>
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<td>5,794</td>
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<td>5,226</td>
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<td></td>
<td>Overnight</td>
<td>196</td>
<td>63,988</td>
<td>206</td>
<td>16,475</td>
<td>95,061</td>
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<td>Total</td>
<td>215</td>
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<tr>
<td>Maternity Acute</td>
<td>Day Only</td>
<td>266</td>
<td>266</td>
<td>1</td>
<td>342</td>
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<tr>
<td></td>
<td>Overnight</td>
<td>30</td>
<td>10,019</td>
<td>37</td>
<td>4,085</td>
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<tr>
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<td>Total</td>
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<td>3,580</td>
<td>37</td>
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<tr>
<td>All Acute</td>
<td>Total</td>
<td>274</td>
<td>25,198</td>
<td>295</td>
<td>31,988</td>
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**Additional Acute projected 2011-22**

<table>
<thead>
<tr>
<th>Patient Category</th>
<th>Bed Category</th>
<th>Av. Avail. Beds 2011-12</th>
<th>2010-11</th>
<th>Notional Beds</th>
<th>2021-22</th>
<th>Notional Beds</th>
</tr>
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<tr>
<td>All ages Subacute</td>
<td>Day Only</td>
<td>36</td>
<td>36</td>
<td>0</td>
<td>201</td>
<td>201</td>
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<tr>
<td></td>
<td>Overnight</td>
<td>105</td>
<td>581</td>
<td>2</td>
<td>342</td>
<td>4,091</td>
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<td>Total</td>
<td>0</td>
<td>141</td>
<td>2</td>
<td>543</td>
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**Additional Sub-acute projected 2011-22**

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<th>Av. Avail. Beds 2011-12</th>
<th>2010-11</th>
<th>Notional Beds</th>
<th>2021-22</th>
<th>Notional Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>DO &amp; Overnight</td>
<td>66</td>
<td>1,471</td>
<td>23,111</td>
<td>74</td>
<td>151</td>
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<tr>
<td>Other</td>
<td>Emergency</td>
<td>32</td>
<td>32</td>
<td>56</td>
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<tr>
<td></td>
<td>Renal Dialysis</td>
<td>7</td>
<td>7</td>
<td>30</td>
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<tr>
<td></td>
<td>Baby care cots</td>
<td>16</td>
<td>16</td>
<td>22</td>
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</tr>
<tr>
<td></td>
<td>Bassinets</td>
<td>38</td>
<td>38</td>
<td>48</td>
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<tr>
<td></td>
<td>Delivery</td>
<td>8</td>
<td></td>
<td>12</td>
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<tr>
<td></td>
<td>Total Beds</td>
<td>441</td>
<td>464</td>
<td>739</td>
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</tr>
</tbody>
</table>

**Additional Total Beds projected 2011-22**

<table>
<thead>
<tr>
<th>Patient Category</th>
<th>Bed Category</th>
<th>Av. Avail. Beds 2011-12</th>
<th>2010-11</th>
<th>Notional Beds</th>
<th>2021-22</th>
<th>Notional Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy</td>
<td></td>
<td>8</td>
<td></td>
<td>28</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 FLOWINFO V11.2
2 alM2010 and SIAM2010
3 Aged 0-15
4 Includes 7 Hospital in the Home Beds in 2011-12 count
5 Includes 20 Hospital in the Home beds in 2011-12 count
6 Birthing, antenatal and postnatal beds
7 Projected at 80% MHCCP (includes 15 bed comorbid detox unit co-managed with Drug Health)
8 NICU (Liverpool Hospital only) and SCN
9 Not currently included in bed counts
Service Development Directions for Campbelltown Hospital to 2021

Campbelltown Hospital is classified as a Major Metropolitan Hospital. The intention is to establish it as Principal Referral Hospital by 2020, involving expansion of overall capacity (beds and services) required for tertiary teaching hospital status, particularly availability of the four pillars of service provision: on-site Magnetic Resonance Imaging (MRI); 24 hour availability of CT scanning; 24 hour availability of core pathology services, especially blood banking; and interventional angiography. Identified service development directions include:

**Aged care and Rehabilitation** – enhance acute services including orthogeriatrics; develop inpatient services, including a secure unit for patients with behavioural and psychological symptoms of dementia, and outpatient and day hospital capacity (with slower stream sub-acute rehabilitation to be provided at Camden Hospital)

**Allied Health** - provide extended hour social work and physiotherapy services for emergency and specific inpatient caseloads 7 days/week

**Cancer** - enhance capacity of the Macarthur Cancer Therapy Centre in medical oncology, chemotherapy and in the longer term radiotherapy (State planning) linked to enhanced surgical activity for high prevalence cancers such as lung, colorectal, breast and urological; establish a Wellness centre to enhance survivorship; develop haematology and cancer genetics; upgrade radiation oncology machinery e.g. linear accelerator replacements; maintain a fixed site breast screen service in Campbelltown (currently Browne Street) and mobile services for local communities e.g. Tharawal AMS; and develop inpatient and outpatient palliative care services linked to Camden Hospital

**Cardiovascular** - expand physical capacity and services for inpatient and outpatient cardiology; enhance renal medicine and dialysis capacity (with an in-centre and expanded satellite service); develop endovascular (interventional radiology, cardiac catheterisation and vascular surgery) services ensuring interventional radiology is available 24/7; enhance availability of invasive cardiology including electrophysiology; and provide out of hours pulmonary, cardiac and metabolic rehabilitation programs

**Complex Care and Internal Medicine** - expand ambulatory care and outpatient capacity, including ED bypass options; develop an inpatient diabetes team and multidisciplinary clinics for people with high risk, complication screening, Aboriginal people, and pre-admission and urgent assessment clinics; enhance infectious diseases services including consultation, acute assessment and chronic care clinics and hospital in the home; expand immunology services including paediatric allergy testing/food challenges and ambulatory care services for rapid access to intravenous infusions; develop a clinical genetics hub; enhance respiratory services including Lung Function Laboratory capabilities, capacity to manage COPD and lung cancer and delivery of non-invasive respiratory ventilation; enhance sleep disorder services including expanded sleep study capacity and additional testing services in daytime sleep latency and maintenance of wakefulness, with associated clinics; enhance interventional pulmonology services including supporting lung cancer services for staging and diagnosis with EBUS (endobronchial ultrasound), providing interventional bronchoscopy and pleural procedures with bedside ultrasound; develop urgent care clinics and ambulatory infusion capacity in rheumatology and an integrated osteoporosis service with rheumatology, orthopaedics, allied health, nursing, and general practice; enhance and strengthen dermatology services; expand physical capacity for neurology and neurophysiology services including inpatient beds, neurophysiology/electrophysiology laboratory, clinics and research and the neuroaudiology service, and develop capabilities to manage complex patients; provide additional therapies for stroke including intravenous thrombolysis and neurointerventional radiology available 24/7 (State planning)

**Critical Care** - expand ED services and physical capacity including paediatric spaces; enhance the ED capacity to provide ESSU and maintain PECC services; establish assessment units adjacent to ED with associated clinics, with capability to provide the model of care identified for Medical Assessment Units (MAU), Acute Assessment Units (AAU) and Surgical Assessment Units (SAU); expand ICU (State planning) and HDU and establish cardiac
step-down beds and respiratory high acuity beds (Respiratory Non-Invasive Ventilation Unit); enhance pain management services

**Drug Health** - expand drug health capacity with enhanced consultation and liaison services (with extended hours), tobacco cessation; ambulatory detoxification supported by GP shared care establishment of a primary health care clinic; co-locate the Drug Health Service including the OTP clinic within the hospital and align with other services and expand secondary NSP; investigate options for a multidisciplinary drug health/mental health co-morbid detoxification unit.

**Gastroenterology and Liver** - develop a Centre of Excellence in Upper GIT sub-specialties of bariatric surgery, complex biliary surgery and benign oesophageal surgery; develop specialist multidisciplinary services for viral hepatitis; maintain and enhance the GI Motility Clinic; o and establish home wards with a high acuity pod for HDU step down patients

**Laboratory Services** - enhance on-site anatomical pathology, particularly cytology and frozen section to support surgical service expansion

**Medical Imaging** - enhance imaging integration with and availability in ED; and enhance services including MRI scanner, with enhanced access to nuclear medicine / PET services

**Mental Health** - enhance inpatient capacity including intensive care, high dependency, older people, acute and non-acute, and include facilities to manage people who are behaviourally intoxicated; expand paediatric and adolescent mental health services; establish a tertiary complex cases clinic to support multidisciplinary management of mental health in intellectual disability

**Oral Health** - establish an Oral Health Hub with a focus on Paediatric Dentistry

**Paediatrics and Neonatology** - develop a regional paediatric service with medical and surgical capability including paediatric oncology, providing a SWSLHD hub for elective paediatric surgery (with dedicated theatre, imaging and associated HDU); and paediatric mental health, day therapy and development assessment services

**Teaching and Research** - expand physical capacity to undertake research, including clinical trials, and deliver expanded education functions including development of the clinical school/education centre.

**Surgical Specialties** - develop peri-operative medicine for people with multiple medical co-morbidities admitted under surgical teams; expand theatre numbers and develop a High Volume Short Stay (HVSS) surgical centre with appropriate protocols to enhance short stay and day stay surgery, with additional endoscopic room capacity to develop models for stand-alone or virtual stand-alone endoscopy patient flow; enhance surgical services including spinal and other peripheral neurosurgery, head and neck surgery, elective paediatric surgery, ophthalmology, dental surgery, bariatric surgery, uncomplicated plastic and hand surgery, urology and thoracic surgery (in the medium term) and joint replacement surgery (in the longer term); and provide greater access to digital and robotic surgery and to new surgical technology evidenced as efficacious

**Womens Health** - expand birthing services, including networking with Bowral and District Hospital, midwifery and shared care models and new models for Aboriginal women; potentially develop higher level services; expand the Special Care Nursery; develop a foetal maternal sub unit which includes reproductive imaging; explore options for some gynaecology procedures to be conducted in outpatient areas rather than in operating theatres e.g. large loop excision of the transformation zone (LLETZ)
Carrington Centennial Care

Profile of Carrington Centennial Care in 2012

Carrington Centennial Care is an Affiliated Health Organisation (Public Hospital) listed under the 3rd Schedule of the Health Services Act and a leading Aged Care organisation in the Macarthur region of south Western Sydney. It is operated by Carrington Centennial Care Ltd in close collaboration with SWSLHD and provides residential aged care and community based services for people who are frail aged and people with a disability.

Located:
- In the suburb of Werombi
- In the LGA of Camden
- In the State electorate of Camden
- In the Federal Electorate of Macarthur

Carrington Centennial Care provides a range of care services in different settings
- Permanent Residential Aged Care - High Care and Low Care
- Residential Respite Care - High Care and Low Care
- Community Based Care - High Care - Extended Aged Care at Home
- Community Based Care - Low Care - Community Aged Care Packages
- Community Based Care - Domestic Assistance and Personal Care
- Retirement Living in self care units.

Activity and Bed Base – 2011-12 & projected 2021-22

Carrington Centennial Care provides residential and community based aged care services, which do not come within the definition of inpatient care measured by MoH data bases or within scope of endorsed projection methodologies. There is no State wide accepted methodology for projecting forward residential and community based aged care services.

Service Development Directions for Carrington Centennial Care to 2021

Maintain excellence in the provision of aged and disability care in both the residential and community setting and become a Centre of Excellence in palliative care and dementia care for residential and community based aged care aged clients. In addition, expand residential aged care services to the growing ageing population in South Western Sydney. Progress transition of public licences to the non-government sector consistent with the service development directions identified in the NSW Health Review of Public Nursing Homes.
Community Health Services

Profile of Community Health Services in 2012

Community Health provides a range of community-based prevention, early intervention, assessment, acute/post-acute treatment, health maintenance and continuing care services designed to improve or maintain the health and wellbeing of individuals and communities.

Services are provided from community health centres, early childhood health centres and other community health facilities, and in preschools, schools, homes and workplaces.

Providing clinical services in:
- Child and Family Health assessments and interventions for children 0-18 years and their families; child and family health nursing; child health school health, vision screening and health promotion; audiometry; occupational therapy; speech pathology; physiotherapy; social work; psychology; orthoptics; medical and child protection
- Specialist areas including multicultural health; sexual health; women’s health; sexual assault; HIV/AIDS; nutrition; community development; and youth health
- Community health nursing including post acute care, general nursing, and palliative care nursing.

Other clinical services which provide care in community settings include oral health, drug health, mental health, aged care and rehabilitation, respiratory and cardiovascular.

The main Community Health centres are located at Bankstown, Bowral, Cabramatta, Campbelltown, Carramar, Hoxton Park, Ingleburn, Liverpool, Miller, Moorebank, Narellan, Prairiewood, Rosemeadow and Tahmoor. In total, there are more than 60 venues including early childhood, youth health and other centres across SWSLHD used for the delivery of community health services.

Activity and Bed Base – 2011-12 & projected 2021-22

Community Health does not provide inpatient services. Activity is recorded as equivalent Non Admitted Patient Occasions of Service (NAPOOS), which takes account of group sessions and non face-to face contacts. Total equivalent NAPOOS for SWSLHD community health services fell from 327,750 in 2009-10 to 306,361 in 2010-11. There is no State wide accepted methodology for projecting forward community health activity.

Service Development Directions for Community Health Services to 2021

Community Health Services will enhance the linkage and interaction with general practice and the South Western Sydney Medicare Local across all models of care; and will explore an integrated primary and
community care service model within existing CHC(s) to trial and embed innovative practice prior to the development of RIPCCCs in the SWGC. In addition, opportunities will be explored for providing services such as palliative care, women’s health, immunisation clinics, chronic disease programs, primary prevention initiatives, rehabilitation, aged care, mental health, allied health, day procedures and infusion therapies in multiple settings (e.g. community health centres, GP clinics, community centres and patient’s homes) through closer partnerships with GP’s and other service providers. This will require a review of existing models of care to ensure that they meet the needs of modern health practice.

Greater service flexibility will be pursued e.g. extended hours into evenings and weekends, flexible models of delivery such as outreach, and new and innovative models of care, services and facilities in areas of housing development, significant population growth or emerging health risks.

To support these directions, a Community Health Infrastructure Renewal Strategy will be developed to match infrastructure requirements to: emerging models such as IPPCCs; potential outreach of ambulatory hospital services; fibre optic enabled practice and to changed and evolving population growth patterns. In addition:

**Post acute and chronic care nursing** - clarify the role of community health in post-acute care service provision, particularly in relation to increasing rates of day surgery; expand Primary Health Nurse services to meet the needs of ageing communities; and enhance capabilities to provide community nursing support for cancer patients, including blood-taking, symptom control etc.

**Early Years and School Aged Children** - continued movement towards Targeted Sustained Home Visiting across SWSLHD; and further expand Health Promoting Schools and other school outreach programs

**Community Development and Partnerships** - expand community development activities; work with other agencies to deliver “whole of government” responses to community needs; and build partnerships in innovative multidisciplinary primary health care to improve health outcomes for marginalised and at risk populations e.g. homeless young people
**Fairfield Hospital**

Providing mainly for NSW communities of:

<table>
<thead>
<tr>
<th>LGA</th>
<th>% Hospital Beddays from LGA</th>
<th>% LGA Beddays to Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairfield</td>
<td>71.27%</td>
<td>28.17%</td>
</tr>
<tr>
<td>Liverpool</td>
<td>14.24%</td>
<td>6.32%</td>
</tr>
<tr>
<td>Campbelltown</td>
<td>3.39%</td>
<td>1.58%</td>
</tr>
<tr>
<td>Holroyd</td>
<td>2.32%</td>
<td>1.58%</td>
</tr>
<tr>
<td>Bankstown</td>
<td>2.31%</td>
<td>0.86%</td>
</tr>
<tr>
<td>Camden</td>
<td>0.78%</td>
<td>1.28%</td>
</tr>
<tr>
<td>Blacktown</td>
<td>0.74%</td>
<td>0.20%</td>
</tr>
</tbody>
</table>

**Profile of Fairfield Hospital in 2012**

Fairfield Hospital is a Major Metropolitan Group B1 hospital, providing services mainly at role delineation levels 3 and 4. The Whitlam Joint Replacement Centre is sited here providing elective orthopaedic services for Liverpool-Fairfield and Macarthur communities.

Located:

- In the suburb of Prairiewood
- In the LGA of Fairfield
- In the State electorate of Smithfield
- In the Federal electorate of McMahon

Providing clinical services in:

- Emergency Medicine
- Cardiology
- Surgical sub-specialties including general, orthopaedics (provided in the Whitlam Joint Replacement Centre), gynaecology and breast
- Medical sub-specialties including general medicine, neurology and renal with other sub-specialties on consultation
- High Dependency Unit (HDU)
- Maternity, Special Care Nursery and paediatrics
- Ambulatory Care Unit
- Aged care and Rehabilitation
- Dental
- Drug Health
- Imaging – CT, ultrasound and general radiography.

**Activity and Bed Base – 2011-12 & projected 2021-22**

Using the MoH endorsed projection methodologies and assuming the clinical profile and flow patterns of patients are maintained into the future, the following table shows activity in 2010-11 and 2021-22 projected, with the bed capacity required to service that demand at benchmark occupancy levels, compared to the average bed availability over 2011-12. These “supply” projections take no account of changed patient flow patterns expected from the introduction of new services at a facility. These impacts are identified in Clinical Services Plans and Business Cases prepared for individual facilities and service development proposals. Where provision of a new service has a net impact of attracting patients who previously received care outside SWSLHD, additional capacity will be required to meet the increased demand.
Service Development Directions for Fairfield Hospital to 2021

- **Aged Care and Rehabilitation** - develop acute geriatrics services in association with sub-acute and rehabilitation services
- **Allied Health** - provide extended hour social work and physiotherapy services for emergency and specific inpatient caseloads 7 days per week
- **Cancer** - increase capacity to provide palliative care; and establish a fixed BreastScreen NSW service in Fairfield LGA, including investigation of Fairfield Hospital as a potential site
- **Cardiovascular** - consolidate and expand the satellite renal dialysis subject to demand; enhance non-invasive cardiology and cardiac rehabilitation services; and develop a HDU Cardiology on-call roster
- **Complex Care and Internal Medicine** - provide 24 hour medical coverage; enhance the capacity to care for stroke patients; consider viability of resuming genetics clinics; establish an Infectious Diseases Service, including consultation, hospital in the home and acute assessment and chronic care clinics; and expand ambulatory care capacity including infusion services
- **Critical Care** - expand ED services and physical capacity including paediatric spaces; and establish a Medical Assessment Unit/ Acute Assessment Unit (MAU/ AAU) adjacent to ED with associated clinics

---

1. FLOWINFO V11.2
2. aIM2010 and SiAM2010
3. Aged 0-15
4. Birthing, antenatal and postnatal beds
5. Projected at 80% MHCCP
6. NICU (Liverpool Hospital only) and SCN
7. Not currently included in bed counts
- **Drug Health** - enhance consultation and liaison and ambulatory detoxification supported by GP shared care; provision of counselling as well as the Needle & Syringe Program (NSP) via Automatic Dispensing Machines and sharps disposal bins

- **Gastroenterology and Liver** - increase use of endoscopic diagnostic investigation including bronchoscopy and gastroscopy; develop specialist multidisciplinary services for viral hepatitis; and establish a stand-alone or virtual stand-alone endoscopic procedures unit to enable diversion of some endoscopic procedures e.g. check cystoscopies from the operating theatres

- **Laboratory** - assess requirements for expansion to meet demand and changing service models

- **Medical Imaging** - enhance service integration with and availability in ED; and assess requirements for expansion to meet demand and changing service models

- **Oral Health** - investigate feasibility for oral surgery (to relieve Liverpool Hospital waiting lists) for low risk day patients, potentially in the community oral health clinic

- **Paediatrics and Neonatology** - enhance paediatric short stay capacity

- **Research** - expand physical capacity to undertake research, including clinical trials.

- **Surgical Specialties** - enhance peri-operative medicine for people with multiple medical co-morbidities admitted under surgical teams; enhance surgical capacity in the short term via full 5 day week operation of the 4th operating theatre; assess options for urology service development including access to theatres for minor, mainly day only and uncomplicated procedures; enhance general surgery capacity using emerging surgical technology with evidenced efficacy for minor colorectal (including endoscopy), laparoscopic cholecystectomies, hernia repairs (to relieve waiting lists at Liverpool Hospital) and other day and short stay procedures; establish a hand surgery unit to provide the less complicated follow-up surgery after initial trauma assessment and care at Liverpool Hospital and short stay, low risk elective procedures e.g. carpal tunnel, trigger finger, Dupytren’s contracture and ganglions; expand elective orthopaedic surgery provision, including joint replacement (subject to available beds) and additional minor procedures, supported by enhancement of the Fairfield Orthopaedic Hip and Knee Service (FOHKS) and patient education and medical management whilst on the waiting list; expand the role in post-surgical rehabilitation for older patients with orthopaedic trauma; and continued expansion of the Whitlam Research Centre focusing on surgical outcomes and patient satisfaction following orthopaedic surgery, with roll-out of the post operative joint replacement outcome registry

- **Women’s Health** - Maintain maternity networks with Liverpool Hospital, ensuring Fairfield mothers can access midwifery models of care and general practice shared care in a timely manner
Karitane

Providing mainly for NSW communities of:

<table>
<thead>
<tr>
<th>LGA</th>
<th>% Hospital Beddays from LGA</th>
<th>% LGA Beddays to Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campbelltown</td>
<td>10.89%</td>
<td>0.34%</td>
</tr>
<tr>
<td>Bankstown</td>
<td>8.36%</td>
<td>0.21%</td>
</tr>
<tr>
<td>Liverpool</td>
<td>7.62%</td>
<td>0.23%</td>
</tr>
<tr>
<td>Camden</td>
<td>7.10%</td>
<td>0.79%</td>
</tr>
<tr>
<td>Sutherland Shire</td>
<td>6.45%</td>
<td>0.19%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>5.83%</td>
<td>0.16%</td>
</tr>
<tr>
<td>Randwick</td>
<td>4.91%</td>
<td>0.15%</td>
</tr>
</tbody>
</table>

Profile of Karitane in 2012

Karitane is an Affiliated Health Organisation (Public Hospital) listed under the 3rd Schedule of the Health Services Act. It provides support, guidance and information to families experiencing parenting difficulties. The Residential Family Care Unit is a tertiary state-wide referral centre located at Carramar and Camden Hospital. Other services provided for South West Sydney include a Family Care Cottage at Liverpool, Jade House day stay facility for women with severe pre and post natal depression, volunteer family home visiting and a State-wide Careline. There are 22 residential beds (11 mother and 11 baby beds) at Carramar and 16 residential beds (8 mother and 8 baby beds) at Camden Hospital. There is also a Family Care Cottage at Randwick covering South East Sydney.

Located:
- In the suburb of Carramar
- In the LGA of Fairfield
- In the State electorate of Fairfield
- In the Federal electorate of Blaxland

Providing clinical services in:
- Parenting skills
- Parent craft
- Pre and Post Natal Depression
- Child and Family Health Nursing
- Paediatrics
- Psychiatry
- Psychology and Social Work.

Activity and Bed Base – 2011-12 & projected 2021-22

Karitane provides residential care services that are recorded as admitted patients within the Ministry of Health’s data collections. In 2010-11 there were 1,320 separations recorded of mothers and babies, with 4,463 bed days at an average length of stay of 3.38 days. Karitane is not included within the scope of the aIM2010 or Siam2010 projection methodologies, hence there is no State endorsed methodology for projecting the demand for mothercraft beds.

Service Development Directions for Karitane to 2021

Continue services through the recently redeveloped Carramar campus, including the purpose built day stay unit for women with perinatal mood disorders and post natal depression and education and research facility; provide residential care, day stay, home visiting and 24-hour care line to support families experiencing parenting difficulties; expand services in toddler early intervention assessments and behaviour therapies; and provide education to health professionals and the community.
**Liverpool Hospital**

Providing mainly for NSW communities of:

<table>
<thead>
<tr>
<th>LGA</th>
<th>% Hospital Beddays from LGA</th>
<th>% LGA Beddays to Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liverpool</td>
<td>37.61%</td>
<td>68.42%</td>
</tr>
<tr>
<td>Fairfield</td>
<td>28.49%</td>
<td>46.18%</td>
</tr>
<tr>
<td>Campbelltown</td>
<td>12.96%</td>
<td>24.73%</td>
</tr>
<tr>
<td>Bankstown</td>
<td>7.15%</td>
<td>10.86%</td>
</tr>
<tr>
<td>Camden</td>
<td>2.54%</td>
<td>17.08%</td>
</tr>
<tr>
<td>Wollondilly</td>
<td>1.91%</td>
<td>16.97%</td>
</tr>
<tr>
<td>Canterbury</td>
<td>1.24%</td>
<td>2.60%</td>
</tr>
</tbody>
</table>

**Profile of Liverpool Hospital in 2012**

Liverpool Hospital is a principal referral group A1a hospital with tertiary affiliations to the University of NSW and University of Western Sydney. It provides referral and district acute services to the Liverpool catchment and higher level tertiary care for South Western Sydney residents at mainly role delineation level 6, critical care for rural retrieval catchments and a supra regional catchment in brain injury. The hospital has undergone a major redevelopment in recent years, with most works scheduled for completion in 2012 (Phase 1). Further redevelopment is proposed to cater for demand to 2021 and beyond (Phases 2 and 3).

Located:
- In the suburb of Liverpool
- In the LGA of Liverpool
- In the State electorate of Liverpool
- In the Federal electorate of Hughes

Providing clinical services in:
- **Emergency Medicine** - Liverpool Hospital is a major trauma centre
- **Cardiology**
- Surgical sub-specialties including cardiothoracic, general, ENT, colorectal, neurosurgery, ophthalmology, orthopaedics, plastics, oral and maxillofacial, upper gastrointestinal, vascular, gynaecology, urology, head and neck, hand and paediatrics
- Medical sub-specialties including, endocrinology, gastroenterology, HIV/AIDS, dermatology, immunology, microbiology and infectious diseases, neurology, renal, aged care, pain management, respiratory, clinical genetics and rheumatology
- Cancer therapy including medical and surgical oncology, chemotherapy, haematology and radiation oncology
- Obstetrics, newborn care, neonatology and paediatrics
- Intensive Care Unit/High Dependency Unit (ICU/HDU) and Neonatal Intensive Care (NICU)
- Anaesthetic Services
- Ambulatory Care Unit
- Mental Health
- Drug Health
- Rehabilitation including the Brain Injury Rehabilitation Unit
- Palliative Care
- Imaging – interventional, PET, MRI, CT, nuclear medicine, general radiography, PACS/RIS technology
- South Western Area Pathology Service (SWAPS)
- The Clinical Skills Centre (commences operations in 2012)

Also located at Liverpool Hospital campus:
- Ingham Institute for Applied Medical Research, including the Ingham Linear MRI research bunker
- State Office of Preventative Health
Activity and Bed Base – 2011-12 & projected 2021-22

Using the MoH endorsed projection methodologies and assuming the clinical profile and flow patterns of patients are maintained into the future, the following table shows activity in 2010-11 and 2021-22 projected, with the average bed capacity required to service that demand at benchmark occupancy levels, compared to the average bed availability over 2011-12. These “supply” projections take no account of changed patient flow patterns expected from the introduction of new services at a facility. These impacts are identified in Clinical Services Plans and Business Cases prepared for individual facilities and service development proposals. Where provision of a new service has a net impact of attracting patients who previously received care outside SWSLHD, additional capacity will be required to meet the increased demand.

<table>
<thead>
<tr>
<th>Patient Category</th>
<th>Bed Category</th>
<th>Av. Avail. Beds 2011-12</th>
<th>2010-11(^1)</th>
<th>2021-22(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric Acute</td>
<td>Day Only</td>
<td>671</td>
<td>843</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Overnight</td>
<td>2,289</td>
<td>5,340</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>2,960</td>
<td>6,183</td>
<td>22</td>
</tr>
<tr>
<td>Adult Acute exc. Maternity</td>
<td>Day Only</td>
<td>7,766</td>
<td>11,169</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Overnight</td>
<td>24,232</td>
<td>27,983</td>
<td>603</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>25,998</td>
<td>39,152</td>
<td>640</td>
</tr>
<tr>
<td>Maternity Acute</td>
<td>Day Only</td>
<td>1,594</td>
<td>1,905</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Overnight</td>
<td>3,867</td>
<td>4,278</td>
<td>51</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>3,461</td>
<td>6,183</td>
<td>58</td>
</tr>
<tr>
<td>All Acute</td>
<td>Total</td>
<td>547</td>
<td>220,346</td>
<td>720</td>
</tr>
</tbody>
</table>

Additional Acute projected 2011-22

173

Additional Sub-acute projected 2011-22

19

Total Acute and Sub-acute

571

Additional Acute and Sub-acute projected 2011-22

192

Mental Health\(^3\)

Emergency | 50 | 50 | 55
Renal Dialysis | 37 | 37 | 48
Baby care cots\(^4\) | 32 | 32 | 46
Bassinet | 30 | 30 | 35
Delivery | 9 | 9 | 13

Total Beds

798

Additional Total Beds projected 2011-22

273

Chemotherapy\(^7\)

14

111

Service Development Directions for Liverpool Hospital to 2021

By the end of the Stage 2 Phase 1 redevelopment, Liverpool Hospital will have: increased inpatient capacity in critical care (ICU and HDU), cancer services, cardiovascular services, renal medicine, gastro and liver and mental health; increased day only ambulatory care capability; improved facilities for interventional cardiology,
cardiac catheterisation and endoscopy; additional renal dialysis and chemotherapy chairs; additional operating theatres and radiotherapy bunkers; a Specialist Endoscopy Unit (SEU); and improved research and education facilities.

Stage 2 Phases 2 & 3 Liverpool Hospital redevelopment implementation will ensure current services remain at tertiary role levels, and day and overnight acute, sub and non-acute (including mental health) bed capacity will be expanded to the 1,000+ beds/spaces identified in the Liverpool Hospital Phase 2 Development Business Case. Identified service development directions to 2021 are:

**Aged care and Rehabilitation** - expand acute and sub-acute geriatric beds and psychogeriatrics, with specialised capacity to manage dementia/delirium, delivered in an Aged Care precinct with associated Day Hospital; develop acute and sub-acute inpatient rehabilitation; and expand the brain injury service

**Allied Health** - provide extended hour social work and physiotherapy services for emergency and specific inpatient caseloads 7 days per week; and enhance paediatric allied health workforce and physical capabilities

**Cancer** - Expand Cancer Therapy Centre with additional inpatient beds and services in haematology, medical oncology, a melanoma clinic, a Wellness Centre to enhance cancer survivorship and expanded chemotherapy and radiation oncology; develop a Centre of Excellence in Hepatology and Hepatocellular cancer; develop a complex pelvic malignancy surgical unit (gynaecology, urological cancer and colorectal cancer) with associated services; explore development of a Breast Cancer Assessment Unit (including imaging, assessment and support for breast surgery undertaken at local hospitals, and specialist nursing support); develop a prostate brachytherapy service, and an Allogeneic Bone Marrow Transplant service (as per the NSW Blood and Marrow Transplantation Plan); and expand inpatient palliative care and education in palliative care

**Cardiovascular** - develop a Centre of Excellence for Cardiology and Renal Services, including a Cardiology Academic Chair; expand provision of cardiothoracic surgery and increase the cardiology bed base; maintain the tertiary referral centre role for diabetes and endocrinology; expand in-centre renal dialysis and enhance the interventional component of the renal service; expand interventional imaging, acute primary angioplasty and non-invasive cardiology, ensuring interventional radiology is available 24/7; and provide out of hours rehabilitation programs (for people with cardiac, pulmonary and metabolic conditions)

**Complex Care and Internal Medicine** – grow General Medicine as a major specialty with a pivotal role in acute assessment; enhance respiratory services including Lung Function Laboratory capabilities, capacity to manage COPD and tuberculosis and deliver non-invasive respiratory ventilation; enhance sleep disorder services (with expanded sleep study capacity and additional testing for daytime sleep latency and maintenance of wakefulness and associated clinics); enhance interventional pulmonology services (with support for lung cancer services for staging and diagnosis with EBUS (endobronchial ultrasound), rigid bronchoscopy service and pleural procedures with bedside ultrasound); establish a District Infection Prevention Operational unit, expand the infectious disease hub to strengthen prevention initiatives and maintain links with the microbiology laboratory with inpatient, acute and chronic clinics and specialised services to other streams supported by research; investigate establishment of clinical genetics laboratory for common molecular testing and research with clinics for common disorders as new methods and technology emerge; expand rheumatology and immunology inpatient and clinic services to support greater patient complexity (including accessing to support and emergency services for allergy testing, ED bypass urgent care clinics and rapid access to intravenous infusions; develop an osteoporosis case finding, investigation and management service (as per the ACI fracture prevention model of care), with outreach capabilities; develop a comprehensive, multidisciplinary care for people with obesity (including management for arthritis, diabetes and other complications); enhance dermatology services; expand the neurology inpatient, outpatient, neuroaudiology and neurophysiology services and provide additional therapies for stroke including intravenous thrombolysis and neurointerventional radiology 24/7 (State planning)

**Critical Care** - expand trauma capacity to meet local needs and potentially wider catchments; expand ED services and physical capacity with imaging service availability in ED; provide additional ESSU and PECC
services; establish a Medical Assessment Unit/Acute Assessment Unit (MAU/AAU) including clinics, adjacent to ED; and expand ICU and HDU (supported by cardiac step-down beds and respiratory high acuity beds)

**Drug Health** - Continue provision of enhanced consultation and liaison services with extended hours, tobacco cessation; ambulatory detoxification supported by GP shared care; co-locate the Drug Health Service including the OTP clinic, counselling and court diversion programs within the hospital and align with other services; establish an integrated toxicology service and expand secondary NSP.

**Gastroenterology and Liver** - Fully commission the Stage 2 Phase 1 Special Endoscopy Unit (SEU) as a stand-alone unit utilising specialised equipment e.g. EUS, EBUS, improving timeliness, efficiency and cost of care; establish home wards with a high acuity pod for HDU step down patients; expand capacity for high level viral hepatitis therapy services; develop a centre of excellence in liver cancer; and develop a Centre of Excellence in Upper GIT sub-specialties of hepatic, gastric surgery and complex biliary surgery

**Laboratory Services** - expand physical capacity and invest in new technology to meet increasing demand

**Medical Imaging** - extend imaging support via MRI (including planning MRI scanner), CT, PET, ultrasound, nuclear medicine; and investigate establishing a GMP compliant cyclotron and radiopharmaceutical production facility for molecular imaging and delivery of a translational research approach, particularly in oncology, cardiac disease, neurosciences and Alzheimer’s disease

**Mental Health** - deliver additional mental health inpatient, ambulatory care and 24-hour receiving capacity, with inpatient services for older people, adolescents and people who are behaviourally intoxicated

**Oral Health** - Create a Hub of Excellence, focusing on Oral Surgery and Oral Medicine

**Paediatrics and Neonatology** - Develop paediatric assessment units and expand ambulatory and outpatient care in liaison with the Sydney Children’s Hospital Network; and maintain an emergency paediatric surgery role

**Surgical Specialties** - enhance peri-operative medicine for people with multiple medical co-morbidities admitted under surgical teams; expand operating theatre availability to support additional major and complex surgery workloads including emergency and urgent general surgery, jaw and facial trauma surgery, emergency and trauma orthopaedic surgery, caesarean section surgery, complex hand trauma, vascular surgery, cardiothoracic surgery, cancer resection, neurosurgery, head and neck surgery including endocrine, upper GIT surgery including hepatic, breast microvascular reconstruction surgery, urology particularly complex malignancies; establish a Surgical Ambulatory Care Unit (SACU) to initially provide under local anaesthetic some theatre surgeries e.g. estimated that 20% of head and neck surgery could be provided in SACU, noting provision of services requiring regional block anaesthesia within SACU is under clinical review and that some pain, dermatology, plastic surgery and ophthalmology services could also be provided in SACU; and provide greater access to digital and robotic surgery and emerging evidence-based technology

**Women’s Health** - provide a tertiary maternity service and develop a birth centre, with expanded antenatal care; enhance NICU and SCN capacity; develop a District-wide infertility service; explore options for some gynaecology procedures to occur in outpatients rather than in operating theatres i.e. large loop excision of the transformation zone (LEEP)

**Research and Teaching** - enhance research through a multifaceted research facility with links to the Ingham Institute of Applied Medical Research; and enhance clinical school capacity (reflecting the presence of two university medical schools) with overnight and long term accommodation for medical officers and students

**Patient/relative accommodation** - Enhance accommodation for patients undergoing continuing care not requiring inpatient supervision, or travelling long distances and for the relatives of patients under care
South West Sydney Scarba Service

Profile of Scarba in 2012

The Benevolent Society operates South West Sydney Scarba Service, together with similar services in Eastern and Central Sydney. These services are Affiliated Health Organisations (AHOs) listed under Schedule Three of the Health Services Act 1997. Scarba is a moderate to high risk, outreach child protection service offering multidisciplinary support to individuals and families through in-centre, home based and outreach programs. The South West Sydney Scarba Service is located at Ingleburn and provides outreach services in the Liverpool LGA and the northern half of the Campbelltown LGA (Glenfield, Ingleburn, Macquarie Fields and Minto).

Located:
- In the suburb of Ingleburn - servicing Campbelltown and Liverpool LGAs
- In the State electorate of Macquarie Fields
- In the Federal electorate of Werriwa

Providing clinical services in:
- Family based therapeutic outreach
- Strength and needs assessments
- Assessments of risk and safety within the child protection environment
- Change-oriented therapeutic services to families whose children are at risk of removal from their families by statutory authorities
- Provide recommendations for statutory action to protect children
- Case planning and management of families
- Long term service delivery to create habitual change in complex families with chronic problems
- Individual counselling
- Family building and family activities
- Budgeting support and information
- Referrals for key services
- Advocacy
- Home visiting
- Supported playgroup and outreach play programs
- Developmental assessments
- Early childhood nursing
- Occupational therapy
- Speech pathology
- Homework and school holiday groups
**Activity and Bed Base – 2011-12 & projected 2021-22**

Scarba does not provide inpatient services. Activity is recorded as equivalent Non Admitted Patient Occasions of Service (NAPOOS), which takes account of group sessions and non face-to-face contacts. Total equivalent NAPOOS for Scarba fell from 2,824 in 20010-11 to 1,966 in 2011-12. There is no State wide accepted methodology for projecting forward the community health type activity provided by Scarba. Aspects for consideration in projection of demand would include:

- Due to the complexity of needs experienced by participating families, there is a propensity for service recipients to require long term access to Scarba’s services
- Scarba has built excellent relationships with the local Community Service Centres who refer to the service. There is a constant demand for services, which is projected to continue in the future
- Scarba holds regular induction and information sessions for internal and external stakeholders to ensure that referrers are kept up to date with current services. Referrers are informed when Scarba has vacancies
- There is no waiting list for Scarba, as families are in immediate need of support, with referrers asked to source alternative support services if there is no capacity. Referrers complete a written referral form, in consultation with the Scarba Team Leader, with referrals allocated within one week of being accepted, and will be followed by a Case planning meeting with the referrer and relevant agencies
- At present 60% clients are in the Liverpool LGA, and 40% are in the Campbelltown LGA, however these percentages fluctuate. The large anticipated population growth in the next 5–10 years may result in an increased demand for the Scarba service

**Service Development Directions for South West Sydney Scarba to 2021**

The recent creation of the Affiliated Health Organisation Agreement (including key performance indicators and reporting mechanisms) will support monitoring of practice and client contact to reflect targets. Stronger links will be made with local Health services and Family and Community Services, to ensure the best possible service to families. There will be increased integration of therapeutic behavioural services, ensuring that families have access to a full range of internal services; and there will be full implementation of the evidence informed Resilience Practice Framework in work with clients.
NSW Service for the Treatment and Rehabilitation of Trauma and Torture Survivors

Profile of STARTTS in 2012

STARTTS is an Affiliated Health Organisation (Public Hospital) listed under the 3rd Schedule of the Health Services Act. It provides a state-wide service which helps refugees recover from their experiences and build a new life in Australia. These services may be provided directly or through the delivery of support and education to other professionals to enable them to better work with refugees and survivors of trauma and torture.

The head office is located at Carramar, with branch offices in Auburn, Liverpool, Blacktown, Coffs Harbour, Wagga Wagga and Newcastle. Outreach counselling services are also provided at various locations throughout Sydney and in some regional areas.

Head office located:
- In the suburb of Carramar
- In the LGA of Fairfield
- In the State electorate of Fairfield
- In the Federal electorate of Blaxland

Providing clinical and support services in:
- Counselling
- Group therapy
- Group activities and outings
- Camps for children and young people
- Physiotherapy
- Psychiatry
- Acupuncture
- Early Intervention Programs for people arriving in the previous 12 months
- Legal advice
- English classes.

Demands on STARTTS – current & projected 2021-22

STARTTS does not provide inpatient services. Activity is recorded as equivalent Non Admitted Patient Occasions of Service (NAPOOS), which takes account of group sessions and non face-to face contacts. Total equivalent NAPOOS for increased from 14,974 OOS in 2010/11 to 15,124 OOS in 2011/12. In addition, there was an increase in group participants in the same period from 1,508 to 1,989.

There is no State wide accepted methodology for projecting forward community based activity provided by STARTTS. Aspects for consideration in projection of demand would include:

- Growth in Community Detention and Villawood Immigration Detention Centre demand
- Increasing numbers of community based asylum seekers who have complex needs and require additional support but are often unable to access government funded assistance
- Release of bridging visa holders from Immigration Detention (500 nationally per month in 2012 and 2013)
- Increased demand associated with the implications of the increase in Refugee and Special Humanitarian Program places from 13,500 nationally in 2012 to 20,000 nationally in 2013 and beyond). This will result in an estimated 40 - 50% growth in demand.

Service Development Directions for STARTTS to 2021

Recent changes announced to the Australian Government Refugee and Special Humanitarian Program are expected to have far reaching implications for the services provided by STARTTS over the next ten years. While many of these changes are yet to be confirmed in detail, the main elements are outlined below:

- Re-initiation of offshore processing (Nauru and Manus Island)
- Cessation of split family arrangements (Special Humanitarian Program)
- Increase in the overall refugee program

To respond to the increase in demand and government policy changes, STARTTS will improve physical infrastructure and facilities via refurbishment and expansion of the Auburn Office (2013) and development of outreach services in Southern NSW (Griffith and Albury). In addition:

Direct Client and Clinical Services – expand using online and computer based assessment tools to enhance service accessibility; expand neurofeedback and biofeedback clinics at Carramar, Auburn and Blacktown; expand existing child counselling clinic at Carramar and through outreach; further develop counselling services for aged and ageing refugees; and expand availability of outreach counselling services via additional capacity at Coffs Harbour, Lismore, Armidale, Wagga Wagga, Griffith and Albury; and develop new outreach services into Tamworth, Orange and Bathurst.

School-aged Children - increase counselling and groupwork support programs to school aged children in school and alternative settings through expanded schools projects from 2013 including use of capoeira and other groupwork methods.

Community development - strengthen community development through expansion of the Families in Cultural Transition program (to support recently arrivals in Australia to understand local culture and systems) into rural and regional areas; and by re-initiation of metropolitan based legal support project from 2013 at Liverpool, offering legal advice for issues unrelated to migration.

Workforce capacity - increase the number of training programs delivered and the number of participants undertaking training to improve their response to refugees and people with a refugee like background.
Integrated Primary and Community Care Services

Profile of Integrated Primary and Community Care Centres (IPCCCs) in 2012

There are currently no IPCCs in South Western Sydney, however extensive planning has been undertaken in the past few years to identify appropriate models and services to establish them in the South West Growth Centre, supported by hospital based services at Campbelltown, Camden and Liverpool. This planning was undertaken collaboratively between the former Sydney South West GP Link and the LHD.

The proposed model to support delivery of appropriate health services to 2021 revolves around the development of three tiers of service, based on a SWGC catchment of 300,000 people. These tiers are as follows:

**Team General Practice (Tier 1) - servicing a catchment population of 4-5,000 people**

Approximately 70 TGP are required:
- Expected minimum services include various configurations of general practice supported by practice nursing.

**Primary Care Clinics (Tier 2) - servicing a catchment population of 15 - 18,000 people**

Approximately 18 PCCs are required:
- Expected minimum services include group general practice, practice nursing, additional on-site and visiting services
- On-site options might include private dental, private diagnostic imaging and private pharmacy
- Visiting service options might include early childhood health, medical specialist clinics and community nursing.

**Regional Integrated Primary and Community Care Centres (RIPCC) (Tier 3) - servicing a catchment population of 75 - 100,000 people**

Proposed RIPCCs include the major centre at Leppington, and other centres at Oran Park and eventually the western portion of SWGC as that develops (potentially at Bringelly). Discussions are proceeding on site identification:
- Expected minimum services might include group general practice, practice nursing, multidisciplinary specialist clinics, medical procedural care/day surgery, chronic care, aged care, child, youth and family services, mental health and drug health
Additional options might include diagnostic imaging, pharmacy, satellite dialysis, day therapy cannulation, satellite radiotherapy bunker(s), oral health, sexual health and training and education

**Activity and Bed Base – 2011-12 & projected 2021-22**

These centres are yet to be established. The majority of service provision will be non-admitted primary and community care services and ambulatory clinic services outreaching from hospitals, recorded as NAPOOS. RIPCCs could also potentially provide day admitted services such as day surgery, day hospital and ambulatory infusions including chemotherapy, renal dialysis and satellite radiotherapy. Demand for clinical services provided on an ambulatory or day basis is growing rapidly across the District. At present, additional demand from the first stage releases of the SWGC is being managed at existing facilities in close proximity to new developments.

As the population continues to grow, additional demand will require the provision of a broader range and higher volume of local services. The exact nature and extent of demand is yet to be determined and will be the subject of further detailed planning over the next decade and beyond. Indicative service profiles and space requirements have been identified for the RIPCCs based on Australasian Health facility Guidelines (AusHFG). Service directions and proposals have been structured flexibly to respond to changing community needs.

Service performance and quality evaluation and research will be built into all new models of care developed to support the delivery of IPCC. The results of this will inform continuous improvement and evolution of the models delivered.

**Service Development Directions for IPCCs to 2021**

Services identified as being suitable for delivery in an RIPCC include:

- Infusion therapy, including chemotherapy
- Radiotherapy (contingent on state-wide planning)
- Satellite dialysis
- Cancer survivorship centres
- Screening/diagnostic endoscopy
- Ambulatory care - minor procedures, intravenous infusion
- Specialist nursing support - cardiac, respiratory, diabetes
- Community health services - community nursing, women's health, child and family
- Oral Health
- Mental health
- Aged Care
- Rehabilitation
- Drug Health
- Research
- Education.
# Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>The capacity or potential to obtain a service or benefit. Access incorporates notions of geographical access, cultural access, service appropriateness and affordability.</td>
</tr>
<tr>
<td>Activity</td>
<td>Refers to the work done by health services measured as hospital inpatient separations and outpatient occasions of service.</td>
</tr>
<tr>
<td>Acute</td>
<td>Acute care is where the principal clinical intent is to do one or more of the following: manage labour (obstetric); cure illness or treat injury; perform surgery; relieve symptoms of illness or injury (excluding palliative care); reduce the severity of an illness or injury; protect against exacerbation and/or complications of an illness and/or injury; and perform diagnostic or therapeutic procedures.</td>
</tr>
<tr>
<td>Admissions</td>
<td>The administrative process by which a hospital records the commencement of an episode of care, whether it be same day or overnight. Admissions can be planned or unplanned or via the emergency department.</td>
</tr>
<tr>
<td>aIM2010</td>
<td>The Acute Inpatient Modelling (aIM2010) program is a PC-based interactive program that enables health planners to review acute inpatient projections to the year 2021/22. The base projections can be revised to take into account anticipated local changes in health delivery, including changes in population, relative utilisation (RU), average length of stay (ALOS) and referral patterns to hospitals.</td>
</tr>
<tr>
<td>All-Cause Mortality Rate</td>
<td>The rate at which a population in any particular region is dying, counting every cause of death.</td>
</tr>
<tr>
<td>Ambulatory Care</td>
<td>The delivery of health services in a variety of settings including outpatient departments, short stay/day only beds, specialists’ rooms and the patient’s home.</td>
</tr>
<tr>
<td>Available Beds and Bed Days</td>
<td>A bed or treatment chair (e.g. dialysis, endoscopy, chemotherapy), which is immediately available to be used for treatment of admitted patients in a hospital, that is, resources with services and staff and is located in a suitable place for care. Available beddays are the assessed number of beddays, which were available for inpatient care during the year. Same day inpatients are recorded as one inpatient bed day.</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>The average (or mean) length of stay for a group of patients, less leave days.</td>
</tr>
<tr>
<td>Bed Capacity</td>
<td>Refers to the ability to meet current and forecasted demand.</td>
</tr>
<tr>
<td>Bed Occupancy Rate</td>
<td>The percentage of available beds which have been occupied over the last year. The bed occupancy rate is a measure of the intensity of the use of hospital resources by inpatients. It is calculated as occupied beddays – Unqualified babies beddays/Available beddays x 100.</td>
</tr>
<tr>
<td>Benchmark</td>
<td>A process of comparison of like processes, outputs or outcomes.</td>
</tr>
<tr>
<td>Best Practice</td>
<td>The care which will lead to the maximum benefit for an individual or a population.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Capacity Building</td>
<td>Improving the ability of an organisation to meet needs e.g. through enhanced buildings and equipment, services, resources and staff; technology; skills, knowledge and capability to take opportunities; leadership; learning and education; awareness, confidence, motivation and empowerment; and enabling policies and systems.</td>
</tr>
<tr>
<td>Capital</td>
<td>Assets including buildings, equipment and land.</td>
</tr>
<tr>
<td>Clinical Governance</td>
<td>The process by which the health system is accountable for continuously improving the quality of services and safeguarding high standards of care.</td>
</tr>
<tr>
<td>Clinician</td>
<td>Allied Health, Nursing and Medical personnel.</td>
</tr>
<tr>
<td>Community</td>
<td>A group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings.</td>
</tr>
<tr>
<td>Community Participation</td>
<td>The process of involving community members in decision making about their own health care, health service planning, policy development, setting priorities and addressing quality issues in the delivery of health services</td>
</tr>
<tr>
<td>Consultation</td>
<td>The ways used to gain community input or feedback around a specific issue or topic. These are usually one-off or short term.</td>
</tr>
<tr>
<td>Consumer</td>
<td>A person who uses or has used a health service.</td>
</tr>
<tr>
<td>Corporate Governance</td>
<td>The system and structure by which the Local Health District is directed and controlled.</td>
</tr>
<tr>
<td>Demand</td>
<td>Refers to the requirement for health services from the community. This demand may be met locally, or outside of the Area.</td>
</tr>
<tr>
<td>Diagnosis Related Group</td>
<td>A group of inpatient codes that consumes similar hospital resources. An inpatient code describes the diagnosis assigned to the patient for the admission.</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>The benefit achieved as a result of a service, intervention or process.</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Best value for money and making the best use of limited resources.</td>
</tr>
<tr>
<td>Episode of Care</td>
<td>A phase of treatment during which the patient receives a particular type of care (e.g. acute, rehabilitation etc.). When that type of care is concluded the episode of care is ended and the patient either undergoes a type change separation to a different type of care or a formal separation and leaves the hospital.</td>
</tr>
<tr>
<td>Equity</td>
<td>Equal opportunity for access to services for equal or similar need.</td>
</tr>
<tr>
<td>Evidence-Based Health Care</td>
<td>An approach to health care that requires the explicit, judicious and conscientious incorporation of the results of research in decision-making at all levels including individual patient care, public policy, planning and resource allocation.</td>
</tr>
<tr>
<td>Health Literacy</td>
<td>The capacity of an individual to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which are health-enhancing.</td>
</tr>
<tr>
<td>Humanitarian Entrants</td>
<td>Persons who migrate permanently to Australia having received refugee status overseas.</td>
</tr>
<tr>
<td>Incidence</td>
<td>The rate of occurrence of a health problem/disease within a community.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Inflows</td>
<td>People who are not residents of a Local Health District who receive care with local SWLHD Hospitals.</td>
</tr>
<tr>
<td>Inpatient</td>
<td>A patient admitted to a hospital or health service facility.</td>
</tr>
<tr>
<td>Intake</td>
<td>The process by which referrals for health services are received by the Local Health District.</td>
</tr>
<tr>
<td>Macarthur</td>
<td>Camden, Campbelltown and Wollondilly Local Government Areas.</td>
</tr>
<tr>
<td>Morbidity</td>
<td>Refers to illness episodes. Morbidity data is data on illness/health problems in a community/group. In Australia this usually refers to data on hospital separations and health centre usage.</td>
</tr>
<tr>
<td>Morbidity Rate</td>
<td>The sickness rate, that is, the number of people who are sick compared with the total number of people.</td>
</tr>
<tr>
<td>Mortality</td>
<td>Refers to death. Mortality data is data on the numbers and causes of death, collected in each state.</td>
</tr>
<tr>
<td>Mortality Rate</td>
<td>The death rate, that is, the number of people who die of a certain disease compared with the total number of people.</td>
</tr>
<tr>
<td>Natural Flow</td>
<td>Movement of a District’s residents across a Health District border that occurs usually because a hospital or service in the neighbouring area is more easily accessed.</td>
</tr>
<tr>
<td>Non-Admitted Patient Occasions of Service</td>
<td>The number of occasions on which health care services are delivered to non-inpatients. An occasion of service may be an examination, consultation, diagnostic test, treatment or other service provided to the patient in each functional unit of the health service. Services may be provided to an individual or group. A group occasion of service would typically show the number of participants in the group.</td>
</tr>
<tr>
<td>Occupancy</td>
<td>The percentage of a hospital’s beds filled at a specific time, or in a specific period.</td>
</tr>
<tr>
<td>Outflow</td>
<td>People resident of a Health District who receive hospital services outside of their Health District of residence.</td>
</tr>
<tr>
<td>Patient</td>
<td>A person in contact with the healthy system seeking attention for a health condition.</td>
</tr>
<tr>
<td>Patient Acuity</td>
<td>Refers to the severity of a patient’s illness.</td>
</tr>
<tr>
<td>Patient Flow</td>
<td>The movement of a patient through the hospital system.</td>
</tr>
<tr>
<td>Population Health</td>
<td>Population health refers to rates and other measures of health in a specified population that, in turn, represent the end-result of primary prevention, early intervention and rehabilitation provided through the organised efforts of a health care system.</td>
</tr>
<tr>
<td>Population Health Services</td>
<td>An agreed suite of programs and strategies designed to improve population health status, reduce inequalities between population groups and address gaps in services for groups with special needs.</td>
</tr>
<tr>
<td>Potential Years of Life</td>
<td>Number of potential years of life lost due to premature death.</td>
</tr>
<tr>
<td>Premature Death</td>
<td>Dying before the age of 75 years.</td>
</tr>
<tr>
<td>Primary Care</td>
<td>The first point of access for the community to health services.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Primary Care Provider</strong></td>
<td>Includes general practitioners, hospital emergency departments, community and allied health services, community pharmacists and non-government organisations.</td>
</tr>
<tr>
<td><strong>Protective Factor</strong></td>
<td>Characteristics, variables or circumstances which, if present for a given individual or population, will modify, ameliorate, or alter risk factors and make it less likely that this individual or population will develop health problems.</td>
</tr>
<tr>
<td><strong>Residential Aged Care</strong></td>
<td>A low care (hostel), high care (nursing home) or similar, for the aged.</td>
</tr>
<tr>
<td><strong>Risk factors</strong></td>
<td>Characteristics, variables or hazards that, if present for a given individual or population, make it more likely that this individual or population will develop health problems. Risk factors include biological, psychological, social, economic and environmental factors.</td>
</tr>
<tr>
<td><strong>Role Delineation</strong></td>
<td>A process which determines the support services, staff profile, minimum safety standards and other requirements to ensure that clinical services are provided safely and appropriately. The roles range from 1 (lowest level) to 6 (highest level and most comprehensive service).</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td>The extent to which potential risks are avoided and inadvertent harm is minimised in care delivery processes.</td>
</tr>
<tr>
<td><strong>Same Day Separation</strong></td>
<td>A same day separation results when an inpatient is admitted and separated on the same calendar day. It includes inpatients who are transferred to another hospital and those who have died.</td>
</tr>
<tr>
<td><strong>Self-sufficiency</strong></td>
<td>Local residents treated locally i.e. the number of local residents treated within SWSLHD as a proportion of all residents demand. This is usually expressed as a percentage.</td>
</tr>
<tr>
<td><strong>Separations</strong></td>
<td>A separation is a death, transfer or discharge of a patient from or in a hospital.</td>
</tr>
<tr>
<td><strong>Social Determinants of Health</strong></td>
<td>The economic and social conditions that influence individual and group differences in health status, including the social environment, physical environment, health services, and structural and societal factors e.g. early years' experiences, education, economic status, employment, housing, transport, access to care, access to resources and the built environment.</td>
</tr>
<tr>
<td><strong>Supply</strong></td>
<td>Refers to the total hospital activity provided to both District residents and people from outside of the District.</td>
</tr>
<tr>
<td><strong>Tertiary</strong></td>
<td>Refers to medical and related services that consume large inputs of health resources, usually on patients with high complexity.</td>
</tr>
<tr>
<td><strong>Triage</strong></td>
<td>A method of ranking sick of injured people according to the severity of their sickness or injury in order to ensure that medical and nursing staff facilities are used most effectively.</td>
</tr>
</tbody>
</table>
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAU</td>
<td>Acute Assessment Unit</td>
</tr>
<tr>
<td>ABF</td>
<td>Activity Based Funding</td>
</tr>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACAR</td>
<td>Aged Care and Rehabilitation</td>
</tr>
<tr>
<td>ACAT</td>
<td>Aged Care Assessment Teams</td>
</tr>
<tr>
<td>ACEM</td>
<td>Australasian College for Emergency Medicine</td>
</tr>
<tr>
<td>AcI</td>
<td>Agency for Clinical Innovation</td>
</tr>
<tr>
<td>ACON</td>
<td>AIDS Council of NSW</td>
</tr>
<tr>
<td>ADHC</td>
<td>Ageing, Disability and Home Care</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>aIM</td>
<td>Acute Inpatient Modelling</td>
</tr>
<tr>
<td>AHSP</td>
<td>Area Healthcare Services Plan</td>
</tr>
<tr>
<td>ALOS</td>
<td>Average Length of Stay</td>
</tr>
<tr>
<td>APPI</td>
<td>Activity Projections Plus Interventions</td>
</tr>
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<td>ASET</td>
<td>Agedcare Services Emergency Teams</td>
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<td>ASHM</td>
<td>Australasian Society for HIV Medicine</td>
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<tr>
<td>ASP</td>
<td>Asset Strategic Plan</td>
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<tr>
<td>ASQGHC</td>
<td>Australian Safety and Quality Goals for Health Care</td>
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<td>AWSF</td>
<td>Aboriginal Workforce Strategic Framework (NSW Health)</td>
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<tr>
<td>BDHMS</td>
<td>Bowral and District Hospital Masterplan Strategy</td>
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<tr>
<td>BES</td>
<td>Biomedical Engineering Service</td>
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<tr>
<td>BHI</td>
<td>Bureau of Health Information</td>
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<td>BIRU</td>
<td>Brain Injury Rehabilitation Unit</td>
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<td>BLHCSDP</td>
<td>Bankstown-Lidcombe Hospital Clinical Services Development Plan (2012)</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<tr>
<td>BMT</td>
<td>Blood and Marrow Transplantation</td>
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<td>BOLB</td>
<td>Buy, Own, Lease Back (PPP)</td>
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<tr>
<td>BOO</td>
<td>Build, Own, Operate (PPP)</td>
</tr>
<tr>
<td>BOOT</td>
<td>Build, Own, Operate, Transfer (PPP)</td>
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<tr>
<td>BOT</td>
<td>Build, Operate, Transfer (PPP)</td>
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<td>BYOD</td>
<td>Bring Your Own Device</td>
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<td>CAAH</td>
<td>NSW Centre for the Advancement of Adolescent Health</td>
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<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
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<tr>
<td>CAPD</td>
<td>Continuous Ambulatory Peritoneal Dialysis</td>
</tr>
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<td>CBD</td>
<td>Central Business District</td>
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<tr>
<td>CCC</td>
<td>Consumer and Community Council</td>
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<td>CCF</td>
<td>Chronic Cardiac Failure</td>
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<td>CCORE</td>
<td>Collaboration for Cancer Outcomes Research and Evaluation</td>
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<td>CCU</td>
<td>Coronary Care Unit</td>
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<tr>
<td>CEC</td>
<td>Clinical Excellence Commission</td>
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<td>CHC</td>
<td>Community Health Centre</td>
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<td>CHETRE</td>
<td>Centre for Health Equity Training and Research</td>
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<td>CISP</td>
<td>Capital Investment Strategic Plan (MoH)</td>
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<td>CIT</td>
<td>Community Integration Team (Justice Health)</td>
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<td>CLIN</td>
<td>Clinical Libraries &amp; Information Network</td>
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<td>Clinical Nurse Consultant</td>
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<td>CNS</td>
<td>Clinical Nurse Specialists</td>
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<td>CNSP</td>
<td>Care Navigation Support Program (Justice Health)</td>
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<td>COAG</td>
<td>Council of Australian Governments</td>
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<td>ComPacks</td>
<td>Community Packages</td>
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<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td>CPAP</td>
<td>Continuous Positive Airway Pressure</td>
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<td>CPG</td>
<td>Clinical Planning Group</td>
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<td>CQC</td>
<td>Clinical and Quality Council</td>
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<td>CRGH</td>
<td>Concord Repatriation General Hospital</td>
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<td>CSP</td>
<td>Clinical Service Plan</td>
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<td>CSPM</td>
<td>Clinical Services Plan for Macarthur (to 2021)</td>
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<td>CT</td>
<td>Computer Tomography</td>
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<td>DAS</td>
<td>Dementia Advisory Service</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>DBFO</td>
<td>Design, Build, Finance and Operate (PPP)</td>
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<tr>
<td>DH</td>
<td>Drug Health</td>
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<tr>
<td>DPI</td>
<td>Department of Planning and Infrastructure</td>
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<tr>
<td>DRG</td>
<td>Diagnosis Related Group</td>
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<td>EBUS</td>
<td>Endobronchial Ultrasound</td>
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<tr>
<td>ECC</td>
<td>Early Childhood Clinic</td>
</tr>
<tr>
<td>ECG</td>
<td>Electro Cardiograph</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>EEG</td>
<td>Electroencephalogram</td>
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<td>ELP</td>
<td>Equipment Lending Pool</td>
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<tr>
<td>eMR</td>
<td>Electronic Medical Record</td>
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<td>EMU</td>
<td>Emergency Medical Unit</td>
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<td>ENT</td>
<td>Ear Nose and Throat</td>
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<td>EPAS</td>
<td>Early Pregnancy Assessment Service</td>
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<td>EPS</td>
<td>Electrophysiology</td>
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<td>ERCP</td>
<td>Endoscopic Retrograde Cholangiopancreatography</td>
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<td>ESRG</td>
<td>Enhanced Service Related Groups</td>
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<td>ESSU</td>
<td>Emergency Short Stay Unit</td>
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<td>EUS</td>
<td>Endoscopic Ultrasound</td>
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<td>FOHKS</td>
<td>Fairfield Orthopaedic Hip and Knee Service</td>
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<tr>
<td>FRACP</td>
<td>Fellow of the Royal Australian College of Physicians</td>
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<td>FTE</td>
<td>Full Time Equivalent</td>
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<td>Geriatric Evaluation and Maintenance</td>
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<td>GIT</td>
<td>Gastro Intestinal Tract</td>
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<td>GMTT</td>
<td>Greater Metropolitan Transition Taskforce</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>HACC</td>
<td>Home and Community Care</td>
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<tr>
<td>HbA1C</td>
<td>Glycosylated haemoglobin</td>
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<td>HBV</td>
<td>Hepatitis B Virus</td>
</tr>
<tr>
<td>HCV</td>
<td>Hepatitis C Virus</td>
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<td>HDU</td>
<td>High Dependency Unit</td>
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<td>HEO</td>
<td>Health Education Officer</td>
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<td>HETI</td>
<td>Health Education and Training Institute</td>
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<td>HIE</td>
<td>Health Information Exchange</td>
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<td>HITH</td>
<td>Hospital in the Home</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HLS</td>
<td>Health Language Services</td>
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<td>HNSW</td>
<td>Housing New South Wales</td>
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<td>Health Services Building</td>
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<td>HSFAC</td>
<td>Health Service Functional Area Coordinator</td>
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<td>Health Support Services</td>
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<td>HVSS</td>
<td>High Volume Short Stay (surgery)</td>
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<td>Health Workforce Australia</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
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<tr>
<td>ID</td>
<td>Infectious Disease</td>
</tr>
<tr>
<td>IDA</td>
<td>Inter District Agreement</td>
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<td>IDER</td>
<td>Infectious Diseases Emergency Response group</td>
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<td>IHPA</td>
<td>Independent Hospital Pricing Authority</td>
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<td>IIAMR</td>
<td>Ingham Institute of Applied Medical Research</td>
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<tr>
<td>ILP</td>
<td>Indicative Layout Plan</td>
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<td>IPCC</td>
<td>Integrated Primary and Community Care</td>
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<tr>
<td>IPCCC</td>
<td>Integrated Primary and Community Care Centre</td>
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<tr>
<td>IM&amp;TD</td>
<td>Information Management and Technology Division</td>
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<td>IRSD</td>
<td>Index of Relative Socio-economic Disadvantage</td>
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<td>IT</td>
<td>Information Technology</td>
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<td>IV</td>
<td>Intravenous</td>
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<td>JMO</td>
<td>Junior Medical Officer</td>
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<tr>
<td>LCG</td>
<td>Lead Clinician Group</td>
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<tr>
<td>LCSP</td>
<td>Liverpool Hospital Clinical Services Plan</td>
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<tr>
<td>LGA</td>
<td>Local Government Area</td>
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<tr>
<td>LHD</td>
<td>Local Health District</td>
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<tr>
<td>LINAC</td>
<td>Linear Accelerator</td>
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<tr>
<td>LOS</td>
<td>Length of Stay</td>
</tr>
<tr>
<td>LOTE</td>
<td>Language other than English</td>
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<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>LLETZ</td>
<td>Large Loop Excision of the Transformation Zone (gynaecological surgery)</td>
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<td>MAA</td>
<td>Motor Accidents Authority</td>
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<td>Medical Assessment Unit</td>
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<td>MDT</td>
<td>Multi Disciplinary Team</td>
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<td>MET</td>
<td>Medical Emergency Team</td>
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<td>MH</td>
<td>Mental Health</td>
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<tr>
<td>MH-CCP</td>
<td>Mental Health - Clinical Care and Prevention model</td>
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<td>MID</td>
<td>Minimal Intervention Dentistry</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health (NSW)</td>
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<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
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<td>NAP</td>
<td>Non-Admitted Patient</td>
</tr>
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<td>NAPOOS</td>
<td>Non-Admitted Patient Occasions of Service</td>
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<td>NAATI</td>
<td>National Accreditation Authority for Translators and Interpreters</td>
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<td>NBN</td>
<td>National Broadband Network</td>
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<td>NDS</td>
<td>National Disability Strategy</td>
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<td>National Diabetes Services Scheme</td>
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<td>National Emergency Access Target</td>
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<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>National Health Performance Authority</td>
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<td>NICU</td>
<td>Neonatal Intensive Care Unit</td>
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<td>NoF</td>
<td>Neck of Femur</td>
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<td>NOTES</td>
<td>Natural Orifice Transluminal Endoscopic Surgery</td>
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<td>National Partnership (Agreement)</td>
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<td>NRT</td>
<td>Nicotine Replacement Therapy</td>
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<td>NSP</td>
<td>Needle &amp; Syringe Program</td>
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<td>NSW</td>
<td>New South Wales</td>
</tr>
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<td>OTP</td>
<td>Opioid Treatment Program</td>
</tr>
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<td>PACS</td>
<td>Picture Archive Communication System</td>
</tr>
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<td>PADP</td>
<td>Program of Appliances for Disabled People</td>
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<td>PANOC</td>
<td>Physical Abuse and Neglect of Children</td>
</tr>
<tr>
<td>PCYC</td>
<td>Police Citizens Youth Club</td>
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<tr>
<td>PEACH</td>
<td>Palliative Care Extended Aged Care at Home</td>
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<td>PECC</td>
<td>Psychiatric Emergency Care Centre</td>
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<td>PET</td>
<td>Positron Emission Tomography</td>
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<td>PHIDU</td>
<td>Primary Health Care Research and Information Service</td>
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<td>Primary Health Nurse</td>
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<td>PIRS</td>
<td>Performance Information Reporting System</td>
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<td>POC</td>
<td>Point of Care</td>
</tr>
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<td>PoW</td>
<td>Prince of Wales Hospital</td>
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<td>PPP</td>
<td>Private Public Partnership</td>
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<td>PRNIP</td>
<td>Privately Referred Non Inpatient</td>
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<td>PSA</td>
<td>Prostate-Specific Antigen</td>
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<td>RACF</td>
<td>Residential Aged Care Facility</td>
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<td>RCMG</td>
<td>Regional Coordination Management Group</td>
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<td>RDF</td>
<td>Resource Distribution Formula</td>
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<td>RIPCCC</td>
<td>Regional Integrated Primary and Community Care Centre</td>
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<td>RMO</td>
<td>Resident Medical Officer</td>
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<td>RNSH</td>
<td>Royal North Shore Hospital</td>
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<td>RPAH</td>
<td>Royal Prince Alfred Hospital</td>
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<tr>
<td>RTO</td>
<td>Registered Training Organisation</td>
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<td>SACU</td>
<td>Surgical Ambulatory Care Unit (Liverpool Hospital)</td>
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<tr>
<td>SARA</td>
<td>Surgical Acute Rapid Assessment Unit</td>
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<td>Sudden Acute Respiratory Syndrome</td>
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<td>SAU</td>
<td>Surgical Assessment Unit</td>
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<td>SCN</td>
<td>Special Care Nursery</td>
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<td>SDS</td>
<td>Strategic Directions Statement</td>
</tr>
<tr>
<td>SEIFA</td>
<td>Socio-Economic Indexes for Areas</td>
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<td>SESLHD</td>
<td>South Eastern Sydney Local Health District</td>
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<td>SEU</td>
<td>Specialist Endoscopy Unit (Liverpool Hospital)</td>
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<td>SIS</td>
<td>State Infrastructure Strategy</td>
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<td>Acronym</td>
<td>Description</td>
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<tr>
<td>SLHD</td>
<td>Sydney Local Health District</td>
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<td>SMHSOP</td>
<td>Specialist Mental Health Service for Older People</td>
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<tr>
<td>SRG</td>
<td>Service Related Group</td>
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<tr>
<td>STARTTS</td>
<td>NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors</td>
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<tr>
<td>STI</td>
<td>Sexually Transmissable Infection</td>
</tr>
<tr>
<td>STIPU</td>
<td>NSW Sexually Transmissable Infections Programs Unit</td>
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<td>SSWAHS</td>
<td>Sydney South West Area Health Service</td>
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<td>SWGC</td>
<td>South West Growth Centre</td>
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<tr>
<td>SWOP</td>
<td>Sex Workers Outreach Project</td>
</tr>
<tr>
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<td>Technical and Further Education</td>
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<td>Transurethral Prostatectomy</td>
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<td>VMO</td>
<td>Visiting Medical Officer</td>
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<td>Voice Over Internet Protocol</td>
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<td>WA</td>
<td>Western Australia</td>
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