

Aged Care & Rehabilitation Clinical Stream Service Development Priorities 2014 - 2018

Leading care, healthier communities



Health

South Western Sydney
Local Health District

Table of Contents

Table of Contents 2

Foreword by Clinical Director 3

Introduction..... 4

Vision, mission, values and primary purpose..... 5

Services provided by the Aged Care and Rehabilitation Clinical Stream 6

 Service types / locations11

Demographic and health profile of SWSLHD communities..... 13

Delivering on priority strategic directions in service development 15

 Build capacity to effectively service growing demands for health care15

 Redesign of services bringing them closer to people and their communities15

 Integrated action with primary care providers and regional primary health organisations15

 Partnering with external providers to deliver public health care16

 Enhancing service networks and growing centres of excellence.....16

 Shared access to unified information for all the health care team16

 An integrated focus on primary prevention for patients and communities.....16

 Embedding education and research within service delivery17

Working with facilities on corporate enabling strategies 18

 Providing high quality health services.....18

 Community partnerships.....18

 Seamless networks.....18

 Developing our staff.....19

 Research and innovation.....20

 Enhancing assets and resources.....20

 Supporting business20

 Efficiency and sustainability21

Attachment A Models of care, service development directions and partners 22

Attachment B Projected population of SWSLHD communities 2016 and 2021 27

Attachment C Growth in demand for inpatient care SWSLHD residents to 2016 and 2021..... 28

Foreword by Clinical Director

The Aged Care and Rehabilitation Clinical Stream (AC&R) covers a range of inpatient, outpatient and Community based services. This includes the state-wide Brain Injury Rehabilitation Unit (BIRU) located at Liverpool hospital. The challenges for the service include the growing number of older persons and people with a Disability in South Western Sydney accompanied by the impacts of Activity Based Funding, the National Aged Care Reforms *Living Longer Living Better* and the implementation of the National Disability Insurance Scheme.

As well as challenges there are many opportunities for the AC&R service which include:

- Building on the high quality services we already provide
- Reviewing current models of care and access to service provision
- Exploring further the potentials of shared and integrated Models of Care between specialties
- Increasing the focus on providing patient centred care and promoting the enablement, reablement and wellness approaches
- Critically evaluating and if appropriate expanding in-reach services to Residential Aged Care Facilities
- Continuing to provide responsive assessment and supported discharge services with a view to improving the services further
- Strengthening and expanding partnerships with the non-government sector in the delivery of services
- Expansion of utilisation of IT systems and other technologies

I look forward to working closely with the community, the local health district and hospitals in the district, South West Sydney Medicare Local and all the valuable staff as we implement this plan.

A/Professor Friedbert Kohler
Clinical Director
Aged care and Rehabilitation

Introduction

The health services provided by South Western Sydney Local Health District (SWSLHD) are organized both vertically within an area of geography (hospitals and health centres serving defined population catchments) and horizontally across a service or process (clinical streams). Financial, workforce, activity and performance management is vertically integrated at the facility level. Clinical streams primarily focus on:

- Clinical services planning and the development of clinical networks
- Identifying service gaps and reviewing the appropriateness and configuration of services
- Innovation, research and best practice in models of care
- Maintaining and improving patient access to care
- Flexibility and robustness of clinical systems to respond quickly to changing environments
- Improving consistency and quality of care, safety and clinical governance
- Workforce planning, ensuring the right clinical teams in the right place at the right time
- Strengthening partnerships between facilities within a clinical specialty and between clinical services within a facility

Three strategic planning documents guide the future directions of SWSLHD:

- Strategic and Healthcare Services Plan- *Strategic Priorities in Health Care Delivery to 2021*
- Corporate Plan 2013 – 2017 *Directions to Better Health*
- Summary of Strategic Directions

Together these Plans form the basis of aligning all SWSLHD services to achieving the Vision of **Leading Care, Healthier Communities**. SWSLHD facilities have prepared Operational Plans which outline local corporate strategies and actions. This includes the clinical streams with facility management responsibilities i.e. Mental Health, Oral Health, Community Health, Population Health and Drug Health. These Operational Plans outline how SWSLHD strategic and corporate priorities will be achieved within local vertically integrated facilities.

For those Clinical Streams that have not prepared an Operational Plan a high level *Service Development Priorities* plan outlines the priority actions that will be pursued horizontally in areas of Stream responsibility, to assist in achieving SWSLHD service development and corporate strategies. It outlines high priority actions for the Stream in the eight *Priority Strategic Directions in Service Development* from the Strategic & Healthcare Services Plan and for other core areas of Stream focus from the Corporate Plan i.e. providing high quality health services, community partnerships, developing our staff, supporting business and efficiency and sustainability.

The Strategic and Healthcare Services Plan outlined for each Clinical Stream in the timeframe to 2021, models of care for the future, service development directions and partners in service development. These are included at Attachment A, providing the framework for development of these Service Development Priorities.

Vision, mission, values and primary purpose

The Aged Care and Rehabilitation Clinical Stream is committed to achieving the **SWSLHD Vision** of

Leading care, healthier communities

It is also committed to the **SWSLHD Mission** which 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.

Staff in the Clinical Stream uphold the **core values** of

- Collaboration
- Openness
- Respect
- Empowerment

The primary purpose of the Aged Care and Rehabilitation Clinical Stream is to promote equitable access to health services for older persons, persons with a disability and their carers.

As part of a broader agenda the Aged Care and Rehabilitation Clinical Stream also advocates for individuals with disability and their carers to:

- Improve access to buildings, events and facilities
- Provide access to information
- Accommodate the specific needs of people with a disability
- Support the employment of people with a disability
- Encourage and create opportunities for people with a disability to access the full range of services and activities available in the community

Services provided by the Aged Care and Rehabilitation Clinical Stream

The AC&R service is complex from both a service design and delivery perspective, with funding and guidance for the delivery of programs coming from multiple sources at an Australian and State government level, as well as direct from the District and through other partnership arrangements. Core services have been categorised as inpatient, non-inpatient and community.

Inpatient

Within the SWSLHD, inpatient Geriatric and Rehabilitation Units are provided at Bankstown/Lidcombe, Liverpool, Fairfield, Braeside and Camden Hospitals. Liverpool, Campbelltown and Bowral Hospitals also have Aged Care CNCs in the in-patient setting. In 2013 Liverpool Hospital commenced the in-patient Rapid Response Rehabilitation team RRRT.

Geriatric Consultations

A geriatric medical consultation service is provided at Bankstown, Bowral, Campbelltown, Camden, Fairfield and Liverpool hospitals to assist other service in providing high quality services for aged care patients or accept patients under the care of the geriatricians.

Rehabilitation Consultations

A rehabilitation consultation service is provided at Bankstown, Campbelltown, Fairfield and Liverpool service to assist in the management of human function in patients under the care of the primary admitting team and to support transfer of appropriate patient to one of the subacute facilities where this is the best option for ongoing treatment.

Shared Care models

Specialised orthogeriatric consultations and services are provided at Bankstown, Fairfield and Liverpool hospital.

Brain Injury Rehabilitation

A state-wide service provided at Liverpool Hospital for people with a traumatic brain injury. The service offers community programs to assist patients with transitioning back to the community. This service is also offers limited respite services for carers of people with a brain injury.

Rehabilitation for Individuals following a lower limb amputation

A comprehensive service for patients who have an amputation of the lower limb is offered in a coordinated service in three sites: at Bankstown, at Camden and across Liverpool/Braeside.

Non-Inpatient and Community Services

A range of community and non-inpatient services are required for AC&RS clients, including community and hospital based prevention, early intervention, support and maintenance services. The following core community and non-inpatient services are required to provide for the growing demand from AC&R clients:

- Aged Care Services in Emergency Teams (ASET)
- Aged Care Emergency Service ACE (Liverpool Hospital)
- Connecting Care Geriatrician (Bankstown Hospital)
- Dementia/Delirium Clinical Nurses Consultants (in-patient and community)
- Outpatient Clinics – Geriatric and Rehabilitation

- Aged Care Assessment Teams (ACAT)
- Specialist Aged Care and Specialist Aged Care and Rehabilitation Teams
- Macarthur Physical Disabilities Team
- Liverpool/Fairfield Home Care Packages Program
- Transitional Aged Care Program (TACP)
- Centre Based Day Care (CBDC)
- Dementia Advisory Service (DAS)
- Respite and Support Services
- ComPacks is managed by the AC&R clinical stream in conjunction with the SWSLHD.
- Triple I (HUB) This service is managed by Community Health in conjunction with Aged Care and Rehabilitation and other clinical streams

Aged care services in the Emergency Department (ASET)

SWSLHD operates ASET to respond to the unique needs of older people in Emergency Departments (EDs). In the SWSLHD the ASET have improved ED responsiveness to older clients and diverted admissions. The model of this service is varied across the LHD. Bankstown Hospital has a medical ASET model. Liverpool and Campbelltown Hospitals have ASET Teams that are headed by a CNC. Fairfield Hospital has one CNC while Bowral Hospital does not offer this service. The Aged Care CNC at Bowral Hospital covers the Emergency Department.

Aged care emergency CNC

The aim of this service is to offer acute and sub-acute care for residents of aged care facilities who would normally present to the Liverpool Hospital ED. The Residential Aged Care Facilities (RACF) may be the most appropriate setting to receive care and ACE intervention prevents unnecessary transfers to Hospital. The ACE service provides telephone advice and support to staff RACFs and will facilitate progress through the Emergency Department, when this is clinically appropriate. Support is provided to the following RACFs:

- Frank Whiddon Masonic Nursing Home
- St Sergius Aged Care Facility
- Elizabeth Drive Nursing Home
- Scalabrini Village Aged Care Facility, Austral
- Scalabrini Village Aged Care Facility, Chipping Norton
- Ruby Manor Aged Care Services

Connecting Care Geriatrician/Clinical Nurse Consultant

The Connecting Care Geriatrician provides a comprehensive geriatric service to elderly people within residential aged care facilities and the Connecting Care Clinical Nurse Consultant provides intensive care coordination to people with chronic disease, either directly or through the supervision of other health care professionals. Research has shown that some treatment for older people is best delivered in an environment familiar to them. Services are provided at:

- Bankstown/Greenacre Nursing Home
- Bass Hill Nursing Home

- Weroona Nursing Home
- Bupa Nursing Home Bankstown
- Chester Hill Residential Aged Care Facility

Dementia/delirium Clinical Nurse Consultants (in-patient and community)

Provide comprehensive assessment of patients/clients in an attempt to achieve timely diagnosis, appropriate case management, timely referral and provision of support services to reduce the risk of a crisis and carer stress and with the aim of enabling a client to remain in the community for longer. Liaise with the client's GP or medical specialist in relation to the client's symptoms, behaviours and medications. This service provides clinical advice, consultation, education and support for in-patient staff, families, carers, GPs, practice nurses, residential aged care facilities, community nursing and other community based services.

Outpatient clinics – Geriatric and Rehabilitation

Outpatient clinics are available to varying degrees across SWSLHDAHS, subject to resource availability. As hospital avoidance strategies and post-acute care services become more widely available, there will be an increased demand for outpatient clinic services, of both a generalist and specialist nature. Outpatient geriatric and rehabilitation clinics are established at All SWSLHD hospitals with the exception of Campbelltown and Fairfield Hospitals.

- Geriatric: Bankstown, Liverpool, Camden and Bowral Hospitals
- Psychogeriatric: Bankstown, Braeside and limited services at Bowral and Camden Hospitals
- Memory/Dementia: Bankstown, Bowral, Camden and Liverpool
- Rehabilitation: Bankstown, Bowral, Braeside, Camden and Liverpool Hospitals
- Amputee: Bankstown, Camden and Liverpool Hospitals
- Prosthetic: Camden and Liverpool Hospitals
- Spasticity: Braeside, Camden and Liverpool Hospital
- Spina Bifida: Camden Hospital
- Upper Limb: Camden Hospital
- Motor Neurone Disease Liverpool Hospital
- Occupational Therapy Housing NSW: Liverpool Hospital
- Gait and Balance Clinic at Bankstown Hospital
- Younger Onset Dementia Professorial Clinic at Bankstown

Aged Care Assessment Team (ACAT)

ACAT are funded by the Australian Government Department of Social Services under the Aged Care Assessment Program. The primary role of ACAT is to assess people to determine their eligibility for packaged care and subsidised residential aged care services. As the population ages and disability becomes increasing prevalent, demand for this service is increasing, in both the community and inpatient setting. In July 2014, the 4 SWSLHD ACAT amalgamated to become the SWSLHD ACAT This enables any member of the SWSLHD ACAT team to assess and delegate patients throughout the whole LHD improving flexibility to respond better to demand.

Specialist Aged Care Team SpACT /Specialist Aged Care & Rehabilitation Team SpACRT

Outpatient and home based therapy services provide alternatives to inpatient care, using a comprehensive, integrated and multidisciplinary model. These services provide opportunities to avoid hospital admissions and to provide post-acute and subacute care, in order to improve functioning and independence. Selected clients who cannot access facility based services or where their home environment significantly contributes to their level of function benefit most from the delivery of targeted therapy services in the home. This service operates with joint SWSLHD and Home and Community Care (HACC) funding.

Macarthur Physical Disabilities Team

The Physical Disabilities Service is a team of allied health professionals providing primarily a comprehensive, integrated and multidisciplinary home based service for clients under the age of 65 years with a chronic physical disability, of greater than 3 months. The service consists of assessment, information, support, aids, exercise programs and equipment, to promote and maintain as much as possible the client's physical function, safety and independence. The service is available to clients with progressive conditions effecting physical function. The service is funded under the Home and Community Care HACC Program.

Transitional aged care program

The Transitional Aged Care Program (TACP) is jointly funded by the Australian Government Department of Social Services and NSW Ministry of Health. The service provides a package of services to patients who have completed an episode of acute or sub acute care within a hospital setting, who upon discharge require case management and a combination of "low intensity" therapy, nursing and in-home support (such as domestic assistance and meals) to improve their physical, cognitive or psycho-social functioning in order to maximise their level of independence and/or optimal activity and participation levels. The program is goal orientated and time limited (maximum of 12 weeks). The service currently offers 99 community packages. In partnership with Uniting Care Ageing, the service offers 13 TACP beds at the Uniting Care Residential Aged Care Facility located in Meredith St Bankstown.

Liverpool/Fairfield home care level 2 package

This program is funded by the Australian Government Department of Social Services. This service provides low level care to clients with complex needs in their own home.

A Home Care Package may include assistance with any of the following services: Individualised care planning, personal care, domestic assistance, meal preparation, shopping, arranging Webster packs, medication monitoring, accompaniment to medical and other appointments.

Centre based day care

This service is funded under the Home and Community Care HACC and the National Respite for Carers Programs NRCP. The CBDC Program provides a mix of frail aged and multicultural services in Bankstown, Liverpool, Fairfield and Macarthur. These services are designed for elderly people and younger people with disabilities in the community who are socially isolated. These services also provide respite for carers. Day centres provide transport, meals and a diversional therapy program to encourage social interaction and the maintenance of skills. Aboriginal specific day centres are located at Minto, Hoxton Park Community Health Centre and Fairfield. In reach chronic care services are provided to the Aboriginal CBDC via the Hub at Miller and the Tharawal and Gandangarra medical

services. Dementia Specific day centres operating from Monday to Saturday are offered via Aimee's Place, Fairfield and Broughton House, Camden.

Dementia advisory service

Dementia Advisory Services (DAS) are funded under the Home and Community Care HACC Program and have a key role in supporting people with dementia and their carers through direct support and education. Dementia education is offered via the Dementia Cafe's and other educational forums often in partnership with Alzheimers Australia.

Respite Services

These services are funded under the Home and Community Care HACC and the National Respite for Carers Programs NRCP. These services include in and out of home respite for carers and the Macarthur In Home Support Service. The latter service provides monitoring for people with dementia who live alone or spend considerable time alone. The service assists with medication, meal monitoring and encourages small group outings for isolated people.

COMPACKS

Compacks is a supported discharge program designed for patients being discharged from a participating public hospital in NSW. It caters for all patients including patients being discharged from Emergency Departments, Medical Assessment Units, Day Surgery and other short stay units. The service is suitable for patients who require immediate access to case management and a combination of community services to remain safely at home.

Triple I (HUB)

The Triple I (Hub) Intake, Information and Intervention is the central entry point for people wanting to make a referral to community based AC&R, community nursing, connecting care, ComPacks and other community based services. The catchment areas for the Triple I (Hub) are the local government areas of Bankstown, Liverpool, Fairfield, Campbelltown, Camden and the Wollondilly and Wingecarribee Shires. This model has been demonstrated to improve access to the range of services, and the quality and consistency of referral information collected, reduce inappropriate referrals, and enhance service effectiveness and efficiency. The Hub is managed and run by Community Health.

Service types / locations

Specialty or Service	Service Type	Facility								
		Bankstown	Braeside	Bowral	C'town	Camden	Fairfield	Liverpool	CHC	Other (list)
Aged Care & Rehabilitation Service	Acute Aged Care Unit	X						X		
	In-patient Rehabilitation Unit	X	X			X	X			
	Brain Injury							X		
	In-patient Geriatric Consultations	X	X (consultation service available if required)	X	X	X	X	X		
	In-patient Rehabilitation Consultations	X	X	X	X	X	X	X		
	ASET	X			X		X	X		
	ACE							X		
	Dementia/Delirium CNC	X		X	X	X	X	X	X	
	Connecting Care Geriatrician/CNC	X								
	Outpatient Clinics									
	Geriatric	X		X		X		X		
	Psychogeriatric	X	X	X		X				
	Memory/Dementia	X		X		X		X		
	Rehabilitation	X	X	X		X		X		
	Amputee	X				X		X		
	Prosthetic	X				X		X		
Spasticity		X				X	X			

Aged Care and Rehabilitation Clinical Stream Service Development Statement 2014 - 2018

Specialty or Service	Service Type	Facility								
		Bankstown	Braeside	Bowral	C'town	Camden	Fairfield	Liverpool	CHC	Other (list)
	Spina Bifida					X				
	Upper Limb					X				
	Younger onset of dementia	X								
	MND							X		
	Gait and Balance Clinic	X								
	ACAT	X	X	X	X	X	X	X	X	
	SpACT/SpACRT	X	X (rehab outpatients and day hospital)	X	Service available at Camden	X	Service available through Braeside	X		
	PDS					X				
	TACP	X	X	X	X	X	X	X		Private Hospitals
	Home Care Package Level 2						Service available through Liverpool	X		
	CBDC	X			Service available at Camden	X	Service available through Liverpool	X	X	
	DAS	X			X	X	X	X		
	Respite Services	X			Service available at Camden	X	X	X	X	
	ComPacks	X		X	X	X	X	X		
	Triple I(HUB)	X	X	X	X	X	X	X	X	X

Demographic and health profile of SWSLHD communities

Comprehensive demographic and health status profiles of SWSLHD communities are available at <http://www.swslhd.nsw.gov.au/planning/>. The population of SWSLHD is expected to grow significantly over the period covered by the *Service Development Priorities* plan, with Attachment B outlining the projected population by LGA and age category in 2011, 2016 and 2021.

Aspects of the demographic and health status profile and projected growth of SWSLHD communities of particular importance for the Aged care and Rehabilitation Clinical Stream include:

Demographic trends to 2021 Strategic and HealthCare Services Plan

Demographic change will significantly increase demands for healthcare by 2021.

The projected population in South Western Sydney is expected to grow from 875,384 in 2011 to 960,000 people by 2016, 1.06 million by 2021 and up to 1.4 million in 2036. Demographic change will significantly increase demands for healthcare over the decade to 2021.

An **overall** increase in population of **20%** is projected, with more rapid growth of older age cohorts that place proportionately more demand on healthcare services i.e. **50%** increase for those aged **70-84** years and **48%** increase for those aged **85+** years. The majority of the District's growth will be in **Camden** (33%) and **Liverpool** (26%).

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 NonacutePatient [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:

With population growth, demands on the clinical stream are expected to grow significantly. This will include demands for the provision of care as hospital inpatients, outpatients and care provided in the community. Attachment C illustrates the projected growth in demand from SWSLHD residents for inpatient hospital care by Service Related Group, a combination of DRGs that align with clinical specialties. Aspects of projected demand of particular importance for the Clinical Stream include:

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 with or without community support packages for as long as possible. 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 standalone 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 as it decreases the pool of general physicians to assist in taking care of the medical needs of the aged. 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. 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.

Delivering on priority strategic directions in service development

The SWSLHD Strategic and Healthcare Services Plan- *Strategic Priorities in Health Care Delivery to 2021* identified eight priority strategic directions to underpin service development, enhancing the way health care is delivered and organizations partner for better health in local communities. The following identifies priority areas where the Clinical Stream will contribute to delivering on the eight strategic directions.

Build capacity to effectively service growing demands for health care

- Reappraisal of priority projects in the Asset Strategic Plan focussing on non-asset strategies and alternative service models, hospital avoidance strategies and private not for profit sector involvement in responding to demand growth
- Providing additional, enhanced and new clinical services of greater sophistication and complexity at all hospitals, with role delineation uplift across clinical networks
- Developing with partner education agencies, more comprehensive educational services for all employees with flexible technology assisted learning using modern state of the art facilities
- Enhanced attention to patient-centred care, meeting National patient safety, quality and performance indicators and implementing initiatives from the CEC and ACI
- Creating systems to plan, implement and evaluate new models of care and emerging technology, with reengineering and disinvestment in current inefficient or ineffective models

Redesign of services bringing them closer to people and their communities

- Reviewing the range of services, models of care and service delivery mechanisms of Community Health Services, identifying opportunities for community benefit from program provision in partnership with the profit or not for profit sector
- Establishing Regional Integrated Primary and Community Care centres at Oran Park and Leppington, so that residents can access locally a seamless and integrated continuum of services across prevention, primary care and ambulatory specialist care
- Exploring the potential to consolidate the existing matrix of Community Health provision into larger centres providing a greater range of services more efficiently, matched specifically to local health needs and readily accessible by local communities
- Establishing a rolling program for the increased migration of acute ambulatory care and day stay hospital services to community health centres, enhancing local access for communities and mitigating demand at congested hospital sites

Integrated action with primary care providers and regional primary health organisations

- Ensuring an integrated preventative health strategy is working involving all settings of care, providers of care, tiers and agencies of government and is embedded in community action
- Collaborating to improve access to care providers in the community aiming for extended hours availability across primary care, community health services and specialist outreach services
- Establishing an integrated clinical governance framework with links between Clinical Councils
- Moving towards shared ownership of a core set of indicators to measure the impact of integrated action to improve patient and community health outcomes

- Developing a shared Consumer and Community Framework with SWSLHD community participation networks increasingly engaged in primary care issues

Partnering with external providers to deliver public health care

- Work with Affiliated Health Organisations to increase capacity in sub-acute care Exploring Public Private Partnership (PPP) opportunities e.g. for diagnostic and interventional laboratories within public hospitals; medical specialist centres in the community; providing public care in high demand specialties in the private sector; privately referred ambulatory care
- Strengthening partnerships with Ministry of Health (MoH) Pillars and academic institutions
- Increasing partnerships

Enhancing service networks and growing centres of excellence

- Increasing the role delineation (sophistication and complexity of care) in a number of specialties at Campbelltown Hospital
- Role of Braeside as an expert in the delivery of inpatient, outpatient and community rehabilitation services

Shared access to unified information for all the health care team

- Prioritising IT developments to provide all health professionals in the care team with access to the hospital eMR from remote locations e.g. general practice
- Developing a SWSLHD Enterprise Data Integration Model converting de-identified clinical data from multiple sources into reporting modules to support corporate decision making
- Expanding teleconferencing, telehealth, web based technologies, fibreoptic initiatives and social media to improve connectivity of all the health care team, including patients and carers
- Supporting research and education through eMR modules and firewall traversal to Universities
- Exploring web and social media portals for the community and service providers to access a unified service directory and resources in health information, education and health literacy

An integrated focus on primary prevention for patients and communities

- Closing the Gap in Aboriginal communities, in partnership with Aboriginal Land Councils and health organisations, with a focus on overweight and obesity and smoking related harm
- Reducing the burden of preventable chronic disease through programs addressing smoking, obesity, healthy eating and drinking, food security, physical activity and falls prevention
- Reducing health inequity through primary prevention and multilateral community renewal programs in areas of locational disadvantage and ensuring services address health equity
- Working with planning agencies to develop healthy urban environments promoting safety, social interaction and cohesion, connectivity, active transport and healthy food

Embedding education and research within service delivery

- Creating a stronger research and teaching culture emphasising leadership, recognition of research achievement and retention of high quality academic clinicians
- Ensuring curriculum and workforce development provides quality teaching and learning
- Encouraging collaborative research that focuses on national, state and local priorities
- Growing research capacity through expanded enrolment in post graduate research courses and building clinical trial capability, including governance and support structures
- Increasing the community's willingness to participate in research and clinical teaching programs

Working with facilities on corporate enabling strategies

The SWSLHD Corporate Plan 2013 – 2017 *Directions to Better Health* identified eight areas of corporate action where organizational values and vision can be included in the day to day operation of health services. The corporate areas of action are underpinned by the eight priority strategic directions identified in the SWSLHD Strategic and Healthcare Services Plan. Implementation of the corporate actions is primarily the responsibility of facilities and the way this will be achieved is outlined in each facility's Operational Plan.

The Aged Care and Rehabilitation clinical stream will work with facilities on corporate actions which have close alignment to the areas of focus of the Streams. The earlier identification of priority areas where the Clinical Stream will contribute to delivering on the eight strategic directions also identifies the Stream's contribution to three corporate action areas – seamless networks; research and innovation; and enhancing assets and resources. Clinical Streams will also contribute to delivering on the remaining five corporate areas of action – providing high quality health services; community partnerships; developing our staff; supporting business; and efficiency and sustainability. The following identifies priority areas where the Clinical Stream will contribute to delivering on these five areas of corporate action.

Providing high quality health services

- Meeting National Patient Safety and Quality Standards
- Patient care challenge
- Embedding ethics into all aspects of health service operations
- Creating healthy environments
- Strong clinical governance framework

Community partnerships

- Implementing the SWSLHD Community Participation Framework
- Including community and agency consultation at all levels of strategic and service planning
- Adopting new approaches to engaging multicultural communities
- Expanding and supporting the volunteer workforce
- Increasing community participation in research projects
- Building partnerships with Aboriginal medical services.
- Implementing the SWSLHD Media and Communication Strategy
- Using new technology e.g. social media to reach more people with health information and education
- Improving health literacy and building community capacity to engage in health affirming action

Seamless networks

- Participating in NSW and Regional Coordination Management Forums
- Contributing to NSW Government community renewal strategies
- Working with agencies and communities on the social determinants of health

- Contributing to Local Council and Interagency planning, coordination and implementation forums
- Partnering with the South Western Sydney Medicare Local on integrated care strategies such as care pathways
- Developing a framework and models for collaborative work with external agencies and services
- Developing further integrated networks of care
- Developing an equity framework for engagement of high needs populations
- Establishing a framework for development of centres of excellence
- Developing collaborative service models integrating prevention, primary, secondary and tertiary care.
- Implementing strategies to support patient handover and transfer of care that are patient and carer centred
- Developing web based information on service availability, entry criteria and referral mechanisms
- Improving the availability of health related transport for disadvantaged and rural communities
- Establishing a framework for all services to review models of care for Aboriginal patients
- Implementing chronic disease programs for Aboriginal people to reduce avoidable hospitalisations
- Implementing a SWSLHD Disability and Carers Action Plan
- Enhancing access to health care for rural fringe and isolated areas

Developing our staff

- Providing models of education that foster inter and intra-disciplinary teamwork
- Developing systems and processes to identify the skill mix for new models of care and managing job redesign
- Implementing leadership programs in collaboration with the NSW Health Education and Training Institute
- Strengthening succession planning by linking performance management to training and mentoring programs
- Working with other agencies to expand educational opportunities and build a professional workforce
- Developing and using workforce information to inform decision making, planning and benchmarking Ensuring performance management aligns with service goals and priorities
- Supporting career and study pathways through recognised training programs
- Increasing workplace flexibility and addressing workload management
- Promoting career opportunities locally including school based traineeships
- Implementing recommendations of the SWSLHD Improving Support for Staff who are Carers
- Working with educational agencies to grow clinical placement capacity

Research and innovation

- Implementing the SWSLHD Research Strategy 2012-2021
- Improving workforce capability to undertake research Incorporating a research component into new service developments
- Aligning new research with District and NSW priorities
- Developing new collaborations with the University sector
- Increasing academic and clinical academic positions in AC&R in SWSLHD facilities
- Strengthening the application of evidence in new models of service delivery
- Developing research infrastructure including facilities, videoconferencing, clinical skills laboratories and funding
- Building the research interest and skills of nursing, allied health, and community health staff and managers
- Implementing local approaches for using staff talents and sharing innovation and excellence
- Developing a program to acknowledge, celebrate and showcase the work of individuals and teams
- Developing a framework to assess, plan for, implement and evaluate new models of care, innovations in practice and emerging health technology
- Increasing participation in quality and innovation award programs »» Implementing clinical redesign programs in priority areas
- Collaborating with universities to promote exchange of ideas through overseas travel and hosting of international experts
- Working with the MoH and Pillars to ensure NSW priorities and new programs are responsive to local needs and are equitably allocated

Enhancing assets and resources

- Regular review of models of care for accordance with best practice
- Undertaking business planning with non government and the private sector on new ways to deliver services

Supporting business

- Providing a single point of contact for patients and the community to access service information and coordination
- Participating in national and state wide technology developments
- Developing a framework for cascading of District priorities and directions to facility, stream and service plans
- Ensuring facility, stream and service plans link to the KPIs in the SWSLHD Annual Strategic Priorities and Performance Agreement
- Developing business planning capacity to identify the benefits, risks and financial implications of new proposals and service development directions

Efficiency and sustainability

- Enhancing capability, understanding and responsiveness to Activity Based Funding (ABF)
- Maximising ABF funding, achieving clinical coding targets and contributing to State wide costing processes
- Strengthening of procurement capabilities and active participation in MoH contract management initiatives
- Reviewing efficiency and effectiveness of services, identifying strategies for reengineering and disinvestment
- Expanding availability of sub-acute beds to increase efficiency of acute bed utilisation

Attachment A Models of care, service development directions and partners

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 Compacts 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 coordination 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 system

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 Rehabilitation 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

Attachment B Projected population of SWSLHD communities 2016 and 2021

Population projections	SWSLHD			Bankstown		
	2011	2016	2021	2011	2016	2021
0 - 4 yrs	63,172	73,317	80,383	14,291	15,979	16,546
5 - 14 yrs	125,198	133,606	149,714	26,276	27,861	30,526
15 - 44 yrs	371,889	400,104	428,701	79,512	81,425	84,949
45 - 69 yrs	246,607	274,788	298,218	51,713	55,762	59,348
70 - 84 yrs	57,062	68,380	87,866	15,071	15,663	18,409
85+ yrs	11,835	15,942	19,065	3,988	4,834	4,971
All ages	875,763	966,137	1,063,947	190,851	201,523	214,749

Population projections	Camden			Campbelltown		
	2011	2016	2021	2011	2016	2021
0 - 4 yrs	4,678	6,110	8,585	11,118	13,499	15,095
5 - 14 yrs	9,326	12,974	15,932	21,558	22,983	26,739
15 - 44 yrs	25,499	38,139	47,235	65,809	71,687	77,402
45 - 69 yrs	15,115	21,298	27,282	44,008	47,798	50,674
70 - 84 yrs	3,045	4,685	7,030	7,307	10,037	14,549
85+ yrs	776	1,204	1,614	1,373	1,830	2,310
All ages	58,439	84,409	107,680	151,173	167,834	186,768

Population projections	Fairfield			Liverpool		
	2011	2016	2021	2011	2016	2021
0 - 4 yrs	12,736	14,680	15,085	14,407	17,017	18,882
5 - 14 yrs	26,337	26,318	28,653	28,611	30,359	34,330
15 - 44 yrs	84,114	84,237	86,146	84,603	92,302	100,482
45 - 69 yrs	56,978	61,545	64,396	49,085	56,654	63,815
70 - 84 yrs	13,826	15,627	19,228	9,809	12,367	16,091
85+ yrs	2,488	3,527	4,367	1,573	2,512	3,353
All ages	196,479	205,933	217,875	188,088	211,212	236,953

Population projections	Wingecarribee			Wollondilly		
	2011	2016	2021	2011	2016	2021
0 - 4 yrs	2,696	2,482	2,510	3,246	3,551	3,680
5 - 14 yrs	6,171	5,997	5,864	6,919	7,114	7,669
15 - 44 yrs	14,361	14,211	13,966	17,991	18,103	18,522
45 - 69 yrs	16,229	16,928	16,997	13,479	14,803	15,706
70 - 84 yrs	5,490	6,690	8,123	2,514	3,311	4,436
85+ yrs	1,179	1,433	1,675	458	603	776
All ages	46,126	47,741	49,134	44,607	47,485	50,789

Source: NSW Department Planning and Infrastructure, New South Wales State and Local Government Area Population Projections: 2014 Final

Attachment C Growth in demand for inpatient care SWSLHD residents to 2016 and 2021**Projected separations of SWSLHD residents at all hospitals by Service Related Group**

Service Related Group	2010-11	2016-17	% Δ to 10-11	2021-22	% Δ to 10-11
Acute Care					
11 Cardiology	10,655	11,897	11.66%	13,769	29.23%
12 Interventional Cardiology	4,346	5,219	20.09%	6,176	42.11%
13 Dermatology	783	820	4.70%	915	16.89%
14 Endocrinology	1,154	1,376	19.27%	1,586	37.43%
15 Gastroenterology	18,573	21,836	17.57%	25,079	35.03%
16 Diagnostic GI Endoscopy	14,184	16,345	15.24%	19,089	34.58%
17 Haematology	1,645	1,958	19.02%	2,199	33.66%
18 Immunology and Infections	2,067	2,252	8.96%	2,537	22.73%
19 Oncology	1,573	2,155	37.02%	2,565	63.04%
20 Chemotherapy	2,396	3,200	33.55%	4,021	67.80%
21 Neurology	6,695	7,536	12.57%	8,634	28.97%
22 Renal Medicine	2,383	2,666	11.87%	3,201	34.34%
23 Renal Dialysis	42,543	53,799	26.46%	64,444	51.48%
24 Respiratory Medicine	12,471	13,878	11.28%	15,769	26.45%
25 Rheumatology	1,032	1,368	32.57%	1,587	53.81%
26 Pain Management	1,380	1,362	-1.27%	1,559	12.98%
27 Non Subspecialty Medicine	10,686	12,256	14.69%	14,257	33.41%
41 Breast Surgery	1,615	1,833	13.47%	2,047	26.77%
42 Cardiothoracic Surgery	936	981	4.76%	1,094	16.89%
43 Colorectal Surgery	4,585	5,209	13.60%	5,823	27.00%
44 Upper GIT Surgery	4,486	4,862	8.39%	5,433	21.11%
46 Neurosurgery	4,129	4,617	11.82%	5,299	28.35%
47 Dentistry	3,098	3,607	16.45%	4,150	33.94%
48 ENT & Head and Neck	8,485	9,511	12.10%	10,676	25.82%
49 Orthopaedics	18,859	21,466	13.82%	24,743	31.20%
50 Ophthalmology	9,314	12,210	31.10%	15,496	66.37%
51 Plastic and Reconstructive Surgery	5,446	6,101	12.02%	7,023	28.95%
52 Urology	9,662	11,015	14.00%	12,665	31.08%
53 Vascular Surgery	2,669	2,781	4.20%	3,245	21.59%
54 Non Subspecialty Surgery	14,553	15,876	9.09%	17,819	22.44%
61 Transplantation	56	49	-12.73%	53	-4.86%
62 Extensive Burns	52	68	31.06%	75	44.15%
63 Tracheostomy	342	444	29.71%	519	51.81%
71 Gynaecology	10,690	11,634	8.83%	12,771	19.47%
72 Obstetrics	17,434	19,566	12.23%	21,132	21.21%
73 Qualified Neonate	2,739	2,981	8.83%	3,342	22.01%
74 Unqualified Neonate	10,623	12,145	14.33%	13,300	25.20%
75 Perinatology	617	578	-6.33%	657	6.47%
81 Drug and Alcohol	1,828	1,975	8.04%	2,126	16.31%
99 Unallocated	413	413	0.00%	413	0.00%
Total Acute all Hospitals	267,197	309,846	15.96%	357,288	33.72%
Sub and Non Acute Care					
84 Rehabilitation	12,153	17,395	43.14%	22,580	85.80%
85 Psychogeriatric Care	142	133	-6.46%	160	13.00%
86 Palliative Care	1,477	1,835	24.26%	2,095	41.87%
87 Maintenance	583	888	52.35%	1,106	89.77%
Total Sub and Non Acute all Hospitals	14,355	20,252	41.08%	25,943	80.72%
Grand Total all Hospitals	281,552	330,097	17.24%	383,231	36.11%



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