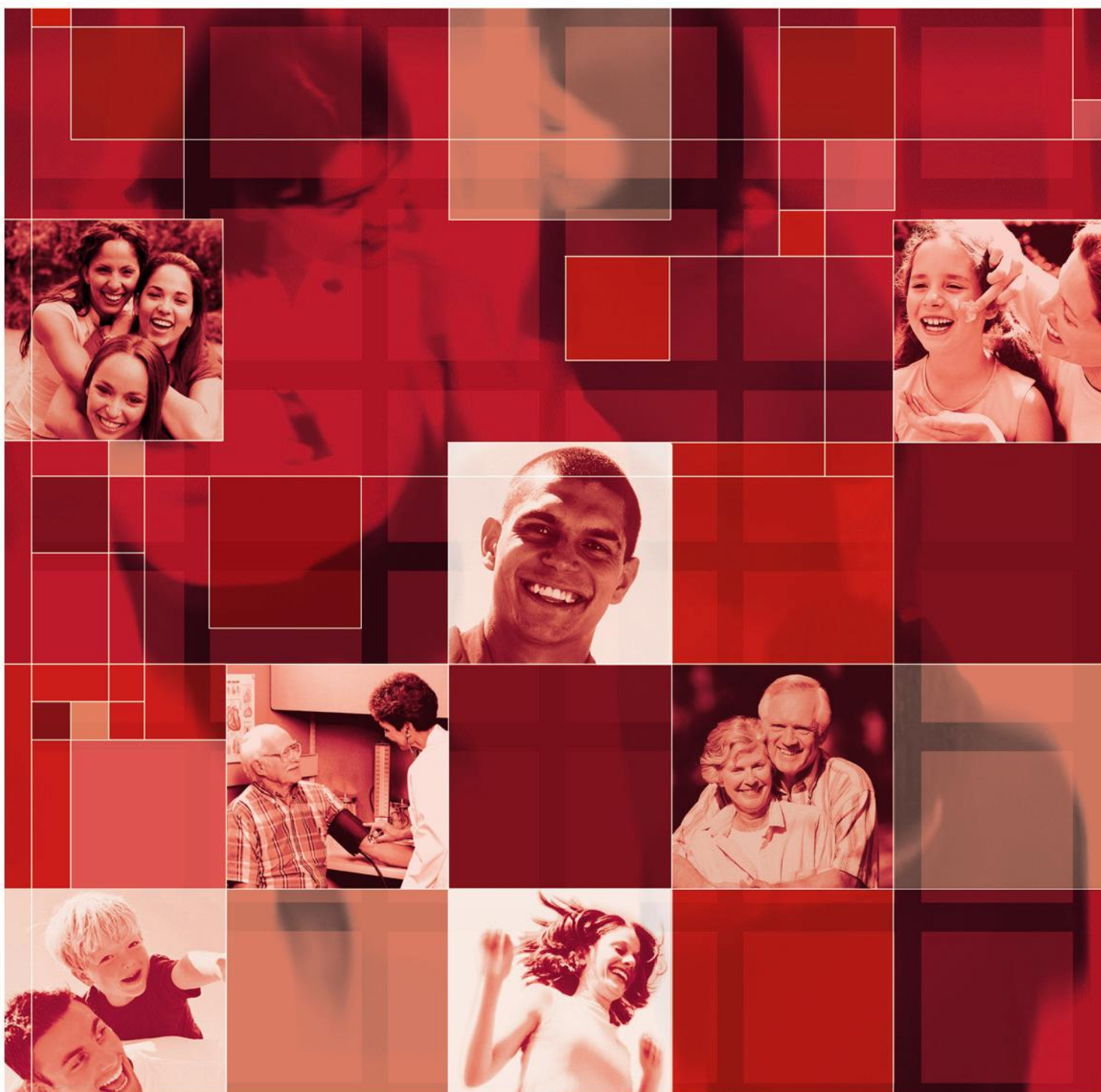


# Critical Care and Emergency Services Plan

October 2006



**Critical Care and Emergency Services Plan 2006-2010**

October 2006

Further copies may be obtained by contacting:  
Via the Hunter New England Health website  
[http://intranet.hne.health.nsw.gov.au/strategic\\_\\_and\\_\\_service\\_planning\\_unit](http://intranet.hne.health.nsw.gov.au/strategic__and__service_planning_unit)

Hunter New England Health  
Planning Unit  
Locked Bag No 1  
New Lambton 2305

Or phoning: Healthlink 1800 063 635

## TABLE OF CONTENTS

<b>1.</b>	<b>EXECUTIVE SUMMARY</b>	<b>4</b>
<b>2.</b>	<b>INTRODUCTION</b>	<b>6</b>
<b>3.</b>	<b>PLAN SCOPE AND PROCESS</b>	<b>7</b>
	3.1 Stakeholder Consultation Strategy and Feedback	8
<b>4.</b>	<b>POLICY ENVIRONMENT</b>	<b>9</b>
	4.1 Statement of Strategic Direction 2006-2010: NSW Health April 2006	9
	4.2 NSW Rural Critical Care Plan	9
	4.3 NSW Rural Health Report	10
	4.4 NSW Health Emergency Department Services Plan – 2001	10
	4.5 NSW Health Intensive Care Service Plan – Adult Services	10
	4.6 Future Planning	10
	4.7 Clinical Network	11
	4.8 Other Policies	12
<b>5.</b>	<b>CURRENT SERVICE PROVISION</b>	<b>13</b>
	5.1 Locations of Services	13
	5.2 Proposed Changes in Role Delineation	13
	5.3 Recent Service Improvements	13
	5.4 Population Projections	15
	5.5 Service Demand Trends	16
<b>6.</b>	<b>STRATEGIC AND SERVICE ISSUES</b>	<b>19</b>
	6.1 Issues Common to all Streams	19
	6.2 Workforce	19
	6.3 Information Technology & Standardised Data Collection	20
	6.4 Professional Development and Education	20
	6.5 Guidelines and Standardisation of Policies and Procedures	20
<b>7.</b>	<b>STREAM ISSUES</b>	<b>21</b>
	7.1 Emergency Service Stream	21
	7.2 Retrieval Service Stream	23
	7.3 Trauma Service Stream	26
	7.4 ICU/HDU Stream	28
<b>8.</b>	<b>ETHNIC AFFAIRS PRIORITY STATEMENT</b>	<b>31</b>
<b>9.</b>	<b>ABORIGINAL HEALTH IMPACT STATEMENT</b>	<b>31</b>
<b>10.</b>	<b>STRATEGIC OBJECTIVES AND STRATEGIC ACTION PLAN</b>	<b>32</b>
<b>11.</b>	<b>APPENDICES</b>	<b>62</b>
	Appendix 1 Core Planning Group	62
	Appendix 2 HNE Stakeholder Survey	63
	Appendix 3 Emergency Department Survey	64
	Appendix 4 Current Workforce	66
	Appendix 5 Related Policies and Other Documents	68
	Appendix 6 Aboriginal Health Impact Statement	69

## 1. EXECUTIVE SUMMARY

Critical care and emergency services are those provided to patients suffering potentially life threatening illness or injury whose treatment is time critical. Although it is acknowledged that the majority of presentations to Emergency Departments are not critical, we have included these services within this brief and the plan is known as the Critical Care and Emergency Services (CCES) Plan.

The Hunter New England (HNE) Critical Care and Emergency Services are in high demand. For example, there were 330,000 presentations (in total) to HNE emergency departments in 2005. These presentations were dealt with in diverse environments ranging from a tertiary referral hospital to a small emergency department with no on-site doctor. John Hunter Hospital (JHH) is the busiest trauma service in NSW and has the greatest proportion of rural trauma admissions. Intensive Care bed occupancy runs at nearly 90 % at the JHH, with other intensive care units also carrying a significant workload. The retrieval services at JHH and Tamworth Base Hospital are in high demand and cover a huge catchment area.

The development of an Area strategic plan for CCES (for both adults and children) was identified as a priority for HNE Health and planning commenced in September 2005. This plan does not include Neonatal Intensive Care Services, which will be included in the Children, Young People and Families Service Plan.

The scope of this plan covers the following service streams: Emergency Departments, Intensive Care and High Dependency Units, Trauma Services and Retrieval Services. Representatives from these services, a member of the Area Executive Team and a Planning Officer formed the core-planning group to oversee the Plan's development. Wide stakeholder consultation also occurred as part of the planning process.

The planning and consultation process identified many issues that impact on the efficiency and effectiveness of the CCES. Over time, the population growth in the Hunter New England catchment area (particularly the southern and coastal areas) is placing additional pressure on the service. Further population growth will require all existing infrastructure to be fully and efficiently utilised, and planning to be undertaken to build capacity across all service streams.

Workforce planning has emerged as the biggest single challenge facing the CCES services and the plan proposes a wide range of initiatives to help address these difficult issues.

Other key issues for all services include the need to improve networking and integration of the four streams across all facilities, development of information technology, standardisation of information systems and data collection; professional development and education; sharing of resources; standardisation of programs offered and further development of guidelines, policies and procedures.

HNE CCES are fragmented in their organisation. The establishment of an area Clinical Network for critical care and emergency services will work across the area to provide coordination, integration and leadership for all critical care and emergency service streams. The function of each clinical stream will be to provide a framework for actioning the roles and responsibilities of the Clinical Network at clinical stream level and may include policy, planning and service development. Much of the detailed work of the Clinical Network will occur at the clinical stream level and will involve clinicians, managers, clinicians from other Clinical Networks, external partners and consumer/community participation.

The plan aims to guide the future of critical care and emergency services by highlighting current and future needs, and proposed strategic directions and initiatives.

The plan proposes:

- Implementing a Clinical Network for critical care and emergency services
- Developing an area workforce plan to attract, train and retain an adequate clinical workforce. Retention and education, and hence optimising the clinical capacity of existing staff, are crucial across the area. The operational issues identified throughout the plan are dependent on provision of an adequate and appropriate workforce
- Expanding CCES capacity to meet increasing demand
- Developing an area capital works plan to highlight and plan for clinical demand in relation to population projections and actual activity
- Improving data collection systems across the area, to better inform the planning process
- Improving information technology services across the area to optimise clinical care
- Exploring and introducing telemedicine and a critical care clinician advice line to facilitate high quality care across the area regardless of clinical location

The Plan proposes an implementation budget to address short-term operational needs, staff development and organisational support.

Other high priority and longer-term objectives have not been fully developed or costed for the Plan and will be further developed over the next five years. Several of these objectives will carry significant costs and rely on additional funding allocations from NSW Health for their implementation. The most costly of these will be in capital and recurrent costs to meet the needs of current and future population. Expansion of critical care and emergency capacity is needed, particularly in the southern and coastal areas.

A pivotal role of the CCES Clinical Network will be to support the development of funding applications to HNE Health and NSW Health for these funds.

## 2. INTRODUCTION

Critical care and emergency services are those provided to patients suffering potentially life threatening illness or injury whose treatment is time critical (NSW Health Rural Critical Care Plan 1998). Emergency Departments provide a high standard of emergency care to those in the community who perceive the need for or are in need of acute or urgent care including hospital admission. Emergency Services are provided in facilities ranging from high-level specialist departments to rooms in small rural and remote hospitals (NSW Health Emergency Department Services Plan, 2001).

HNE Critical Care and Emergency Services (CCES) are in high demand: there were 330,000 presentations to emergency departments across the area in 2005; John Hunter Hospital (JHH) has the busiest trauma service with the greatest proportion of rural trauma admissions in NSW; JHH ICU bed occupancy runs at nearly 90 %; and the John Hunter and Tamworth Hospitals' retrieval services are unable to always provide an immediate response, due to demand for aircraft and staffing that is on an "on call" basis.

As the population grows across the area the demand for critical care and emergency services will also increase. The Area needs to be able to provide equity of access to critical care and emergency services for all residents over a large geographical area.

HNE Health CCES are functionally aligned with former area health service or critical care network boundaries. Before the formation of Hunter New England Health the organisational structures were:

- The Lower Mid North Coast was part of the Mid North Coast Area Health Service and part of the area's critical care network.
- In the New England Area, critical care services were managed by the area critical care committee.
- In the Hunter, critical care services were separated along clinical streams with an area emergency services committee, a John Hunter trauma committee, John Hunter retrieval committee and a critical care committee (mainly looking at intensive care and high dependency issues). These committees generally functioned independently of each other and had little collaboration or interaction.

The development of an Area strategic plan for Critical Care and Emergency Services (for adults and children) was identified as an Area priority and planning commenced in September 2005. Representatives from emergency services, retrieval, trauma, critical care and intensive care/high dependency, a member of the Area Executive Team and a Planning Officer formed the core-planning group, with all members responsible for ensuring wide stakeholder consultation throughout the planning process.

The plan recognises the individual needs of service streams and geographic cluster areas within the wider service needs of the Hunter New England area.

### 3. PLAN SCOPE AND PROCESS

The plan has been developed to facilitate:

- A coordinated approach to the provision of an area CCES (for both adults and children\*)
- Networking between stakeholders involved in the provision of critical care and emergency services
- Appropriate resource allocation and equity of access
- Appropriate utilisation of critical care and emergency services
- A coordinated approach to managing workforce issues

\* Please note that this plan does not include Neonatal Intensive Care Services which are to be included in the Children, Young People and Families Service Plan.

The planning process has involved the following services:

- |   |                                   |
|---|-----------------------------------|
| • Emergency Departments                     | • Critical Care Service           |
| • Intensive Care / High Dependency Services | • Retrieval Service               |
| • The Trauma Service                        | • Ambulance Service of NSW        |
|   | • Patient Flow Unit               |
|   | • John Hunter Children's Hospital |

The methodology used to develop the plan followed the HNE Health Service Planning Framework. Background work was undertaken by a small team, known as the Plan Development Team (PDT), and overseen by the Core Planning Group (refer to Appendix 1 for membership). There has been extensive consultation throughout the development of the plan involving representatives of all service streams and hospitals, onsite visits by the Plan Development Team, internal and external stakeholder consultation at various stages of the planning process, and, review and discussion of draft documents.

### 3.1 Stakeholder Consultation Strategy and Feedback

Internal and external stakeholders were identified and consulted at various stages during the planning process. In addition, two members of the Plan Development Team were members of the Critical Care Health Priority Taskforce and several members of the core planning group participated on other relevant state committees. These members ensured that the plan aligned with relevant state initiatives and frameworks and that the plan also incorporated feedback from other key stakeholders throughout the state. General Practitioner and consumer input was also sought during the planning process. In addition, all members of the core planning group were responsible for liaising with their colleagues and other key stakeholders.

A Communications Officer was assigned to the plan and provided assistance and advice on communication issues. In addition, an Aboriginal Health Worker and a Multicultural Health Worker provided advice to the PDT and appropriate initiatives have been included in the strategic action plan.

The main issues identified by stakeholders related to the need for: an adequate and skilled workforce, improved internal networking and communication, improved equity and resource allocation appropriate to role delineation, improved retrieval and transfer processes and improvements in managing access block.

Three surveys undertaken for the Plan provided valuable information in relation to service provision, information management, staffing profiles, education and equipment requirements, and, workforce issues and strategies. Sixty-four stakeholders responded to a brief written survey in October 2005 identifying issues of concern and suggested strategies (Appendix 2). An extensive survey of all 37 emergency departments (EDs) was completed in December 2005, and a workforce survey in February 2006. Recommendations from the ED and Workforce surveys (Appendices 3 and 4) have been considered in the identification of key issues section and in the development of the strategic action plan.

Internal and external stakeholders consulted during the development of the plan include:

- Aboriginal Health
- Population Health
- Multicultural Health
- Allied Health
- Clinical Support Service Providers
- Tertiary and rural referral hospitals
- District health services
- Community hospitals/rural hospitals and health services
- Consumers
- Newborn Emergency Transport Service (NETS)
- Ambulance Service of NSW
- NSW Institute of Trauma and Injury Management (ITIM)
- Kaleidoscope Executive Advisory Group
- HNE Mental Health
- HNE Area Emergency Services Committee (Southern)
- HNE Area Critical Care Committee
- HNE Disaster Committee
- HNE Area Trauma Committee
- HNE IT
- Workforce Development
- Performance Improvement
- HNE Area Executive Team
- NSW Health Critical Care Health Priority Taskforce

## 4. POLICY ENVIRONMENT

The guiding principles for Critical Care services are well established in NSW Health planning documents (refer to Appendix 5). While a number of these documents are currently under review, advice from the NSW Health Statewide Services Development Branch is that the general policy principles will be retained.

### 4.1 Statement of Strategic Direction 2006-2010: NSW Health April 2006

The NSW Health vision, goals and strategic directions for the time period covering this plan are outlined in the Statement of Strategic Direction:

Vision	Strategic Directions
<p data-bbox="188 674 710 707">Healthy People – Now and in the Future</p> <p data-bbox="405 741 491 775"><b>Goals</b></p> <ul data-bbox="188 779 730 954" style="list-style-type: none"> <li data-bbox="188 779 544 813">• To Keep people healthy</li> <li data-bbox="188 815 730 880">• To provide the health care that people need</li> <li data-bbox="188 882 651 916">• To delivery high quality services</li> <li data-bbox="188 918 647 952">• To manage health services well</li> </ul>	<ul data-bbox="790 674 1433 1021" style="list-style-type: none"> <li data-bbox="790 674 1347 707">• Make prevention everybody's business</li> <li data-bbox="790 710 1394 775">• Create better experiences for people using the health system</li> <li data-bbox="790 777 1378 842">• Strengthen primary health and continuing care in the community</li> <li data-bbox="790 844 1305 878">• Build regional partnership for health</li> <li data-bbox="790 880 1433 945">• Make smart choices about the costs and benefits of health and health support services</li> <li data-bbox="790 947 1273 981">• Reinvigorate the health workforce</li> <li data-bbox="790 983 1362 1016">• Be ready for new risks and opportunities</li> </ul>

This Plan is consistent with these directions.

### 4.2 NSW Rural Critical Care Plan

The 1993 NSW Rural Critical Care Plan and the 1998 update outline the concept of networking critical care resources. The central concept of the Rural Critical Care plan involved development of rural Critical Care Networks. Networks were to provide a continuum of care from onset of critical illness to rehabilitation. Critical Care Committees, reporting to Area management, were established to advise on the management of rural Critical Care services, and to address specific tasks. These tasks were directed towards achieving:

- Better communication and coordination between Network services
- Designation and resourcing of EDs and hospitals to achieve the appropriate level of Critical Care
- Development and provision of education programs for all staff involved in Critical Care
- Operation of a retrieval service from regional referral hospitals and associated transport protocols
- Monitoring of care
- Development of uniform information systems to measure quality of care and patient outcomes
- Development of clinical guidelines, policies or standards across the Network
- Development and maintenance of strong links between regional hospitals and tertiary centres
- Provision of support mechanisms for clinicians within the Network

HNE Health has two critical care networks covering the former Hunter (including the lower Mid North Coast) and New England Areas.

### **4.3 NSW Rural Health Report**

The 2002 NSW Rural Health Report addresses issues and strategies relevant to planning Critical Care services. A number of the recommendations made in this report were also raised in the Report on the Issues Relating to Rural Critical Care in NSW, 2001 and remain current 5 years on.

The Report reaffirmed the recommendations of previous Critical Care reports that prescribed better networking of Critical Care resources and improved linkages between pre-hospital care, acute hospital care and rehabilitation. Formalising linkages between rural and metropolitan health services is recommended to facilitate referral arrangements, promote education and professional links and foster an attitude of cooperation and responsibility in the referral centres.

The Report recognises the most pressing issues as recruitment and retention of experienced medical, nursing and allied health staff in Critical Care. Key contributing factors include: inability to maintain a critical mass of skilled staff, excessive on call burden for medical staff, limited access to ongoing education, professional development and support; and access to accrued leave entitlements.

Specific issues related to regional ICU staffing and EDs with no on site medical staffing are recognised. The report advocates flexible staffing models such as covering ICU and high dependency areas with medical staff from a range of backgrounds with intensive care experience and extending the roles of RNs in rural and remote EDs.

### **4.4 NSW Health Emergency Department Services Plan – 2001**

This report provides detailed recommendations on ED policy and operations and specifically addresses rural concerns. Of particular relevance to HNE Health are recommendations that EDs should be networked on a hub and spoke model, an Area Director of Emergency Department Services should be appointed and ED operational policies and information systems should be standardised across the Network.

### **4.5 NSW Health Intensive Care Service Plan – Adult Services**

This report provides detailed recommendations on Adult Intensive Care Services, including models of care, quality measures and information technology requirements. Of particular relevance to HNE Health are recommendations that intensive care units should be organised on a network basis and an Area Director of Intensive Care should be appointed. Intensive care services should be concentrated in the base hospitals, and in regional areas, these services should be at NSW role delineation level 5.

### **4.6 Future Planning**

NSW Health is currently reviewing planning and policies for intensive care, emergency services, trauma and retrieval. These policies are expected to outline specific proposals for growth and service developments, but are not due for release until late 2006 or 2007.

Informal NSW Health advice indicates that JHH will be expected to continue its current role in providing adult and children's trauma services. The planning guidelines for ICU and ED bed numbers remain current, with any identified short falls in bed capacity to be met over time as NSW Health resources become available.

## 4.7 Clinical Network

HNE Health is implementing clinical networks across its area. Critical Care and Emergency Services is one of the first five Clinical Networks to be introduced. The purpose of these networks are to build staff capacity and improve service delivery. Clinical Networks provide a formal structure to link groups of health professionals and organisations from primary, secondary and tertiary care to work together in a coordinated manner, unconstrained by existing professional and organisational boundaries to ensure equitable provision of high quality, clinically effective care. Clinical Networks shift the emphasis from separate institutions to a system of integrated care for the consumer.

A Clinical Network for Critical Care and Emergency Services will be established in 2006 incorporating emergency services, intensive care units, high dependency units, trauma and retrieval services. The strategic roles of this Clinical Network will include:

- *Planning* – To lead the development, implementation and monitoring of clinical service plans
- *Resource accountability* – To make recommendations for resource prioritisation and allocation
- *Workforce* – To make recommendations and facilitate activities in relation to the retention, recruitment and succession of staff
- *Advice* – To make recommendations to Area Executive and others as appropriate on service delivery and planning priorities
- *Information* – To facilitate the provision of information for service providers and consumers and their families to support access to appropriate care
- *Professional development* – To enhance peer support and professional training and education for staff
- *Quality* – To promote and use the quality framework (safe, effective, accessible, efficient, appropriateness) in all activities
- *Models of care* – To enhance service delivery through facilitation of consistent coordinated integrated models of care
- *Clinical guidelines and protocols* – To coordinate the development, review and use of appropriate clinical practice guidelines across relevant services
- *Data* – To collect, analyse and evaluate data in relation to service delivery and outcomes
- *Promote* – To facilitate strong relationships across facilities, services, Clinical Networks and external partners to support service delivery

The structure and governance arrangements for the Critical Care and Emergency Services Clinical Network will be determined in the second half of 2006. The Clinical Network is an essential element of this plan and will be tasked with facilitating, implementing and monitoring strategies identified in the plan.

#### **4.8 Other Policies**

The Plan also considered NSW State initiatives listed below:

- NSW State Trauma Plan 2003
- NSW Health Triage in NSW Rural and Remote Emergency Departments With No Onsite Doctors August 2004
- NSW Health Rural Emergency Clinical Guidelines for Adults August 2004
- NSW Health Clinical Services Redesign Program Models of Emergency Care March 2006
- Connecting Critical Care Telemedicine Research Project
- NSW Health Supra-Regional Retrieval Service Model March 2005
- Intensive Care Service Plan-Adult Services NSW Health 2001

A complete list of relevant policies and source documents is listed in Appendix 5.

## **5. CURRENT SERVICE PROVISION**

### **5.1 Locations of Services**

HNE Health has thirty-seven facilities with recognised emergency services. Four facilities provide intensive care or high dependency referral services at or above role delineation 4.

John Hunter Hospital is the only designated major trauma centre for the Hunter New England AHS, while Tamworth Hospital and Manning Rural Referral Hospital provide a regional trauma service.

Retrieval services are based at the John Hunter Hospital and Tamworth Hospital sites.

Table 1 summarises the Area's critical care and emergency services.

### **5.2 Proposed Changes in Role Delineation**

The Area Healthcare Services Plan proposes several increases in role delineation for critical care and emergency services including: Belmont Hospital to increase the ED from level 3 to 4, the Maitland Hospital to increase the ED from level 4 to 5, for Manning Rural Referral Hospital to increase its ED and ICU roles from level 4 to 5 and for Armidale to increase the ED role from level 3 to 4.

Inverell, Gunnedah and Narrabri hospitals also have planned increases in ICU role delineation from a level 2 to 3. The major impact of these changes will be in workforce, and are further discussed in that section.

### **5.3 Recent Service Improvements**

HNE CCES have benefited from recent statewide service investments in ED, ICU and retrieval including:

- Expansion of JHH ICU to 14 beds (Commissioned in 2005)
- Expansion of Tamworth ICU to 7 beds (Commissioned 2005)
- Funding to rebuild and expand the Manning Rural Referral Hospital ED to 22 beds (due for commissioning in 2008)
- Funding to expand retrieval services at JHH
- Funding to support retrieval services at Tamworth
- Funding to introduce an ambulance response team at JHH ED 2006
- Funding to enhance ICU/HDU services at Armidale

**Table 1: HNE Health Critical Care and Emergency Services by Hospital**

Hospital	EMERGENCY DEPARTMENT			ICU / HDU					TRAUMA
	ED Role Delineation	ED Attd (04-05)	Current ED Beds	ICU/ HDU Role Delineation	ICU activity (2005)		Current ICU/HDU Beds (refer to table 8 for more detailed and current data)		Trauma Level
					Adm	Avg bed days	ICU	HDU	
<b>Tertiary Referral</b>									
John Hunter #	6	55,000	33	6	1323	4,509	14	4	Major
NMMH	5	25,000	14	5			5	1	Non DP4
<b>Rural Referral</b>									
Tamworth #	5	39,000	23	5	498	1,814	7	4	Rural
Maitland	4 →5	32,000	13	3 →4	1,201	2,664		4	DP4
Manning	4 →5	24,000	12	4 → 5	442	1,585		4	Rural
Armidale	3 →4	14,000	8	3 →4				4	DP4
<b>District</b>									
Belmont	3 →4	18,300	12	2→3					Non DP4
Cessnock	3	15,750	8	3					DP4
Singleton	3	9,243	3	3					DP4
Kurri Kurri	2	7,385	3	2					Non DP4
Muswellbrook	3	6,600	3	3					DP4
Scott Memorial	2	4,000	4	2					DP4
Gloucester	2	2,400	2	2					Non DP4
Moree	3	10,000	3	3					DP4
Inverell	3	7,500	3	2→3					DP4
Gunnedah	3	6,399	3	2→3					DP4
Narrabri	3	4,179	2	2→3					DP4
Glen Innes	2	4,000	2	2					DP4
Manilla	2	4,900	2	-					DP4
Quirindi	2	2,645	3	2					DP4
<b>Community Hospitals/Multi Purpose Services</b>									
Tomaree	2	8,000	3						Non DP4
Dungog	2	1,672	3						Non DP4
Merriwa	2	1,000	1						Non DP4
Wilson Memorial	1	860	1						Non DP4
Denman	1	800	2						Non DP4
Buladelah	1	2,800	2						Non DP4
Tenterfield	2	2,000	2						DP4
Barraba	2	6,000	3						DP4
Walcha	2	2,900	2						DP4
Guyra	2	2,500	2						DP4
Wee Waa	2	1,589	2						DP4
Werris Creek	1	264	1						Non DP4
Boggabri	2	350	2						DP4
Warialda	2	1,400	2						DP4
Bingara	2	1,200	2						DP4
Emmaville	1	804	2						DP4
Tingha	1	250	1						Non DP4

Note:

- indicates service undergoing or looking to undergo a change in role delineation
- # Indicates Retrieval services
- NA = Not available
- ICU Admissions only counted for Levels 4, 5 and 6
- DP4=Designated Protocol 4 Trauma Service

## 5.4 Population Projections

The Department of Infrastructure, Planning and Natural Resources (DIPNR) project an increase of 9.8% in the population of the Hunter New England area from 2001–2021. The population will grow from 814, 800 persons in 2001 to 895, 080 persons in 2021.

Over the period of this plan, growth in the Hunter New England area is projected to increase by 2.3% overall, however, growth is predominantly in the lower and coastal regions. The Greater Hunter, Lower Hunter and Lower Mid North Coast populations will increase by 2.9%, 3.9% and 3.8% respectively.

**Table 2: HNE Area Population 2006-2016**

Geographic Cluster	Population								% Aboriginal 2004
	Number 2006	Number 2011	Number 2016	% growth 2006-2011	% 65+ yrs 2006	% 65+ yrs 2011	% ≤14 yrs 2006	% ≤14 yrs 2011	
Greater Newcastle	402,580	414,060	424,390	2.9	10.69	12.1	12.6	11.6	22
Lower Hunter	140,020	145,600	150,970	3.9	12.6	14.4	21.8	20.2	15
Lower Mid North Coast	85,930	89,230	92,610	3.8	22.6	24.8	18.3	16.6	12
Mehi	30,130	29,540	29,040	-1.9	11.4	12.9	22.9	21	19
McIntyre	20,710	20,180	19,950	-2.5	8.06	8.8	9.5	8.8	0.4
Peel	73,090	73,990	74,920	1.23	15.8	17.6	21.1	16.7	18.6
Tablelands	50,870	50,670	50,600	-0.39	15	17	10.5	9.5	7
Upper Hunter	34,340	33,690	33,100	-1.89	13.7	15.9	21.7	20.4	6
<b>HNE TOTALS</b>	<b>837,670</b>	<b>856,870</b>	<b>875,580</b>	<b>2.3</b>	<b>13</b>	<b>14.7</b>	<b>16</b>	<b>14.5</b>	

Ref: DIPNR Dec 2004

The areas of Port Stephens, Maitland and Great Lakes have the highest projected growth.

**Table 3: Highest Projected Population Changes 2001-2021**

SLA (Statistical Local Area)	Growth % (n)
Great Lakes	37.8 (12,240)
Port Stephens	30.5 (18,010)
Maitland	25 (14,170)

The population reduction in the rural areas should have little impact on critical care demand and therefore provides little opportunity for an internal redistribution of resources. Reductions in the number of persons are likely to be offset by increased demand from an ageing population.

The most significant population effect will be in the Area's southern catchment where an additional 20,000 persons are expected in the next 5 years and 40,000 persons over the next 10 years.

## 5.5 Service Demand Trends

Service demand trends are difficult to predict and are hampered by the lack of consistent area wide data. Currently only emergency departments in the southern part of the area and larger rural centres collect and report on common key performance indicators. Presently there are no data collection systems for ICU/HDU, trauma or retrieval services.

In planning future services the best predictors of demand currently available are population and inpatient activity projections. It is reasonable to assume that growth in demand for critical care and emergency services will generally follow increases in these projections.

### Inpatient Activity Projections

The aIM-modeling tool (2005) reports on projected changes to acute inpatient activity from 2003/04. By 2011/12, it is projected that demand for inpatient services will increase by 10% or 13,000 separations across HNE Health facilities. The greatest increases in activity are predicted to occur within the southern hospital networks with separations at Greater Newcastle Hospitals and at Manning Base Hospital predicted to increase by 13%. Maitland Hospital activity is projected to increase by 11%, while the Lower Hunter cluster of Kurri Kurri, Singleton, Cessnock and Dungog will increase by 14%.

The largest increase in separations will occur for the older age groups. Paediatric (0-15 year old) admissions are projected to decrease by 4%, the 6-69 age group to increase by 5% and the seventy years and over group to increase by 21%.

### Emergency Demand Trends

The larger hospitals have had substantial growth in ED presentations over the past few years.

Table 4 shows growth of up to 11% (in some departments) over a two-year period. This is a statewide trend and suggests that HNE Health will continue to experience increasing ED presentations during the next 5 years.

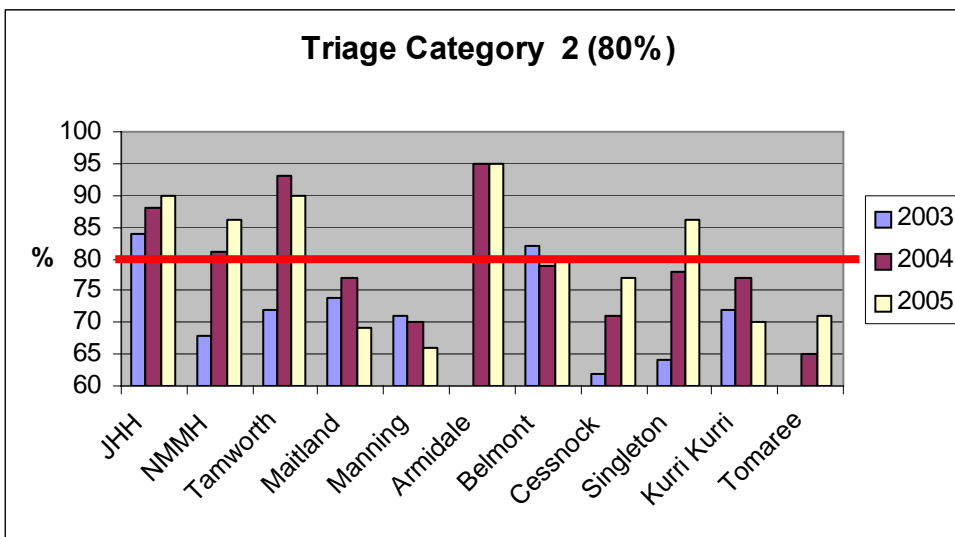
**Table 4: Growth in the Major HNE Emergency Departments 2003 - 2005**

Hospital	2003	2004	2005	% Increase 2003 - 2005
John Hunter	48967	50736	54318	11%
NMMH	24006	23577	25213	5%
Tamworth	35,811	38,293	39400	10%
Maitland	29574	30747	32810	11%
Manning	20571	20115	21450	5%
Armidale	-	12849	12514	-3%
Belmont	17174	17822	19580	14%
Cessnock	14919	14791	15749	6%
Singleton	8392	8310	9264	10%
Kurri Kurri	7651	7498	7386	-3%
Tomaree	-	7428	7962	7%
Dungog	1900	1544	1672	-12%

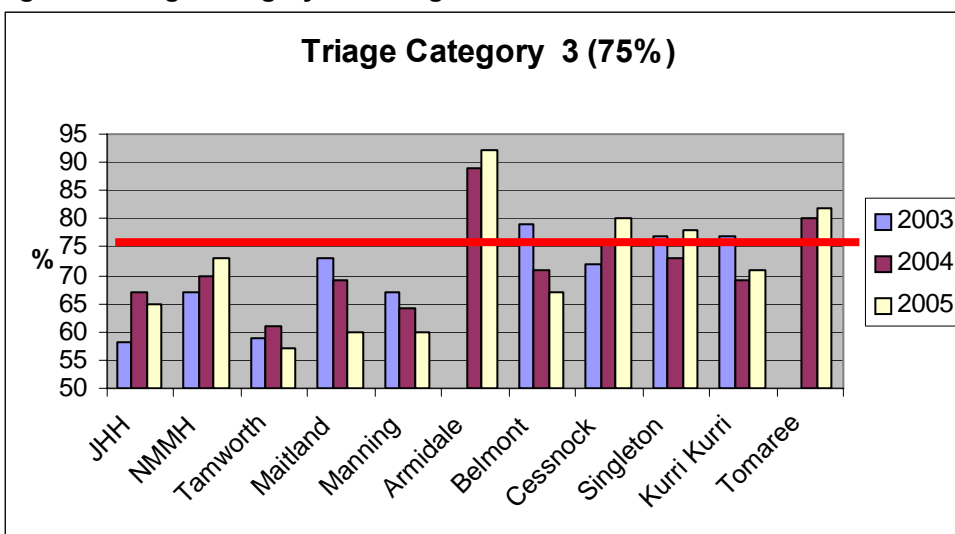
Triage waiting time performance for category two patients demonstrate a mixed performance across HNE Health facilities. Over the past three years there has been marked improvement in meeting targets for category 2 patients at JHH, NMMH, Tamworth and Singleton Hospitals, but decreases in performance at Maitland Hospital and Manning Rural Referral Hospital. Most EDs are not meeting Category 3 targets and the larger EDs are not meeting Category 3 or Category 4 targets.

The following figures (1-3) show triage waiting time performance trends for HNE Health EDs that are experiencing significant growth. Benchmark levels are indicated by the horizontal percentage line. The figures indicate the pressures these EDs face in meeting benchmark-waiting times. Of particular note is the gradual decline of performance at Maitland Hospital and Manning Rural Referral Hospital where growth demand has exceeded service growth.

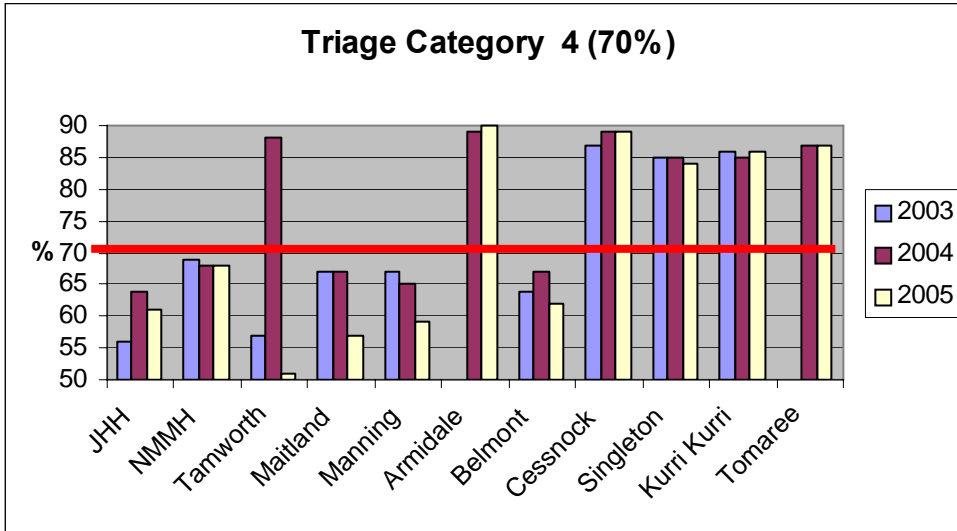
**Figure 1: Triage Category 2 Waiting Time Performance 2003-05**



**Figure 2: Triage Category 3 Waiting Time Performance 2003-05**



**Figure 3: Triage Category 4 Waiting Time Performance 2003-05**



## 6. STRATEGIC AND SERVICE ISSUES

### 6.1 Issues Common to all Streams

The four CCES streams face common issues that need to be addressed on an Area wide basis.

These issues include, but are not limited to:

- The need to improve integration and networking of streams across all facilities
- Workforce recruitment and retention
- Information technology standardisation of systems used and data collected
- Access to professional development and education, sharing of resources and standardisation of programs offered
- Standardisation of guidelines, policies and procedures

### 6.2 Workforce

The greatest challenge for CCES streams is the ability to attract, train and retain an adequate clinical workforce. The operational issues identified throughout this plan are dependent on the availability of an appropriately skilled workforce to manage the clinical demands and with capacity for service development. Steps to address this issue are priority areas of the plan.

Stakeholder feedback identified the following to be the key workforce issues for HNE Health critical care and emergency services:

1. Ability to recruit and retain staff, (at all levels of seniority in nursing, allied health and medicine) particularly in more rural areas. Recruitment problems are evidenced by reduced service availability, increased waiting times, reliance on locums, reduced access to leave entitlements and staff/client dissatisfaction
2. Limited resource infrastructure and planning capability resulting in reduced ability to access and utilise IT, conduct research, apply for study leave and manage increasing activity within existing resources
3. Limited and restrictive scope of career support structures and industrial awards impacting on the ability to attract staff, provide opportunities for career advancement and to offer flexible working conditions
4. Limited opportunities for education, peer support and clinical rotation resulting in workforce capability not fully aligned to service needs, inadequate orientation and reduced interest in working for the HNE CCES (particularly at district and community hospitals)

Workforce risks are rated a “B” (using the HNE Corporate Risk Matrix) representing a significant operational risk for HNE Health.

Many strategies identified in the plan are directed towards creating a safer and more supporting environment within the CCES that will help develop, retain and recruit the required workforce. The plan recognises that major extensions of activity and workforce numbers are dependent on additional government funding and initiatives.

This plan proposes specific additional positions to assist with training and skills development, improved data collection, coordination, and resources to develop business cases and funding applications for Area and State consideration. Further work is needed to determine future workforce requirements. Details of the current workforce are included in Appendix 4.

### **6.3 Information Technology & Standardised Data Collection**

Stakeholder consultations consistently identified the need to improve the levels of information technology available to critical care and emergency services. These range from low cost local solutions such as the availability of hands free and cordless phones to Area wide initiatives to improve the consistency and availability of basic critical care utilisation data to support datasets to inform quality evaluation and improvement.

### **6.4 Professional Development and Education**

Professional development is closely related to the workforce issues noted above. It is essential that the Area develops and implement strategies to make the best use of the staffing resources that will be available. This will be a major role for the Clinical Network.

### **6.5 Guidelines and Standardisation of Policies and Procedures**

There is a fine balance to be reached in promoting guidelines and standardisation of practice in an Area as diverse as HNE Health. Guidelines and standardisation help promote best practice and reduce errors in care, but if poorly implemented can be difficult to support, unduly restrictive (particularly for experienced rural practitioners) and have high administrative overheads. This plan advances a range of strategies to further develop and implement guidelines and promote standardisation of policy and procedures throughout the Area. Again, this will be a major role for the Clinical Network.

## 7. STREAM ISSUES

### 7.1 Emergency Service Stream

The ED is the primary entry point for critically ill or injured patients to the health system. Emergency departments work within the guidelines of the Australian College of Emergency Medicine (P06, 2001) and the Department of Health, which dictate waiting times for patients who present to the department based on the clinical severity of their condition and how long they should wait for an inpatient bed if one is required (access block). Emergency departments within HNE are committed to meeting these benchmarks and to utilising the NSW Health Models of Emergency Care Toolkit (2006) to assist with patient flow.

Thirty-seven facilities provide an emergency service to the HNE community and are described as being a tertiary referral, rural referral, and district or community hospital. It is important to note that, apart from Belmont, there are no onsite doctors at any of the district or community hospitals.

Population projections indicate that Newcastle, Maitland and Manning (Greater Taree LGA) will be subject to the greatest potential increases in presentations. These hospitals are already having difficulty in meeting NSW Health ED waiting time performance targets.

Managing increased future demand is the primary strategic issue for EDs. The NSW Health Emergency Models of Care (2006) seeks to meet increasing demand by improving patient flow. These options need to be fully explored in all departments, especially those with capacity restraints that do not allow for future physical expansion such as the John Hunter Hospital. However, it is clear that a number of HNE Health ED departments, including Maitland and Manning lack adequate bed capacity to deal appropriately with current demand, and these pressures are likely to grow in the future.

NSW Health 2005 recommends 1 ED bed for every 1460 ED presentations. Based on these figures there is a significant current shortfall in beds at the JHH, Maitland and Manning Hospitals. JHH expanded its ED in 2003 and a redevelopment is underway for Manning ED to increase capacity from 9 to 22 beds by August 2008, however, no expansion plans exist for Maitland or elsewhere in the Newcastle area.

A detailed survey of all HNE emergency departments was conducted in December 2005. Survey questions related to bed allocation, information technology, data collection, current workforce, access to education and equipment. The complete survey results including a comprehensive workforce profile are included in Appendix 5.

Key recommendations arising from the consultation are summarised in Table 5 and included in the Strategic Action plan.

- Development of the ED workforce
- The need for more detailed planning for infrastructure and capital works including a review of future bed numbers. The priority areas for increasing ED capacity are Maitland and Manning. Maitland should be seen as a priority for new ED beds in future capital works. Initiatives that will assist JHH dealing with an increasing ED load such as the introduction of an Emergency Medical Unit (EMU) are also given a high priority.
- IT/Data requirements including the introduction of ED iPims across all Area EDs and the introduction of a critical care advice line

**Table 5: Emergency Department Stream Recommendations**

<b>Capital Works/Bed Numbers</b>	<b>Status</b>
Larger refurbished departments at Maitland, Manning, Singleton and Mater Hospitals	Plans for Manning and Mater underway, Maitland and Singleton waiting
Emergency Medical Unit (EMU) at JHH	Needs to be implemented
Move Muswellbrook and Gloucester Emergency Departments to ground floor	Needs to be implemented
<b>Information Technology</b>	
Introduction of a critical care advice line	Needs to be implemented
PACS available at all sites ED role delineation level 4 and above	Needs to be implemented
Ensure CAP, iPMS & Pathology (15 sites are without)	Planned to be available by end 2008
Improved access to Medical Records after hours for all sites	Needs to be implemented
Video Conferencing available to all sites (15 sites are without)	Pending the outcome of the NSW Health Connecting Critical Care project
Point of care pathology in all sites without pathology labs on site, with associated QA and maintenance support (19 sites are without)	No plans for rollout
Development of HNE ED specific website (for ED specific guidelines)	Will be done as part of the CN
Facsimiles in all EDs	Needs to be implemented
At least one (1) hands-free, speaker telephone in all EDs	Needs to be implemented
Tamworth & Manning require an ABG analyser in the ED	Needs to be implemented
<b>Data Management</b>	
ED iPMS implemented for all sites	Planned for completion 2008
ED iPMS Coordinator available to provide monthly audits of data for all sites	Needs to be implemented
Improved clerical support for all sites to allow improved real time data entry for nursing staff after hours & at weekends	Needs to be implemented
Access to adequate numbers of PCs in the ED for data entry	Needs to be implemented
Data system for tracking or highlighting potential public health issues	To be referred to IT
Electronic medical records and discharge summaries / communication to GPs	To be referred to IT
Improved / useful patient ALERT system on ED iPMS – aggressive, dangerous or infectious patients	To be referred to IT
<b>Nursing Workforce</b>	
1: 1 Nursing care for allocated trauma / resuscitation beds in Level 4-6 facilities	Needs to be implemented
Designated Triage Nurse, CIN (Clinical Initiatives Nurse) and/or REAT (Rapid Emergency Assessment Team) for all facilities, Level 4 & above	Needs to be implemented (as indicated by Models of Care implementation)
Adopt reasonable workload tool for all EDs	When developed and released by NSW Health
<b>Medical Workforce</b>	
Central recruitment of middle grade and senior medical staff with administrative support to achieve this	Needs to be implemented
Dedicated ED Medical Director (FACEM) for Manning	Needs to be implemented
Improved after hours Staff Specialist coverage at JHH, Tamworth, Manning, Maitland, NMMH, Belmont, & Armidale	Needs to be implemented
Review medical coverage at rural sites with high activity such as Cessnock District Hospital and Tomaree Community Hospital	Needs to be implemented
<b>Allied Health Workforce</b>	
The recognition of allied health staff as an essential, effective partner in the multidisciplinary approach to care provision with the ED	Needs to be implemented
Allied Health inclusion in funding / resource allocations to emergency services	Needs to be implemented
Recruitment and retention of experienced staff to work in this challenging and intense area of work	Needs to be implemented

## 7.2 Retrieval Service Stream

Medical retrieval services play a major role in delivering equity of access for critically ill and injured patients to critical care services. An effective retrieval system enables high level critical care services to be available to all areas of the health service.

The medical retrieval requirements of patients within the area are met by a number of distinct retrieval services, which are coordinated by the Sydney based NSW Aeromedical and Medical Retrieval Service.

The retrieval service entities are:

- 1) HNE Southern Retrieval Service (JHH)
- 2) Tamworth Base Hospital Retrieval Service
- 3) Associated NETS retrieval service – based at JHH Neonatal Intensive Care Unit
- 4) Aeromedical and Medical Retrieval Service: Sydney based
- 5) NETS: Sydney based
- 6) Lismore retrieval service (this service is occasionally tasked for patients in the most northern section of HNE Area Health service)

The medical retrieval services based in Sydney and Lismore are called on when the local HNE retrieval services are unable to provide the service required.

HNE Health provides retrieval services at JHH and Tamworth consistent with the NSW Health Supra-Regional Retrieval Service Model 2005. The NSW Health model outlines areas of activity, service, and operational and funding structure for regional retrieval services.

Both services have negotiated service agreements and received enhancements from NSW Health for retrieval based on this model. However it must be noted that neither of these agreements are sufficient to provide the range of services that the model outlines and should be viewed as the first step towards future enhancements with the long term aim of meeting all requirements of the model.

Retrieval service principles and the funding agreements currently in place are outlined on the following page, while Table 6 details current year activity.

**Table 6: Retrieval Activity 2006 (Jan to April)**

<b>Mode</b>	JHH (139 missions)	Tamworth (36 Missions)
Road	75	6
Fixed wing	0	1
Helicopter	64	29
Combination	0	0

<b>Calls taken by service</b>	JHH	Tamworth
Medical advice only	18	NA
Weren't required MRU tasked	25	NA
Able but due to logistics referred to MRU	9	NA
Unable team already deployed	16	NA

## **NSW Health Super Regional Retrieval Service Principles**

1. Regional retrieval services are statewide resources
2. Regional retrieval services will routinely operate beyond traditional Area Health Service boundaries
3. There is a single tasking authority which is the NSW Medical Retrieval Unit
4. Regional clinical autonomy is maintained
5. Funding for all aspects of the retrieval service is held centrally by the ASNSW Medical Retrieval Unit
6. Funding and Performance Agreements will exist between the central fund holder (ASNSW), NSW Health and the Supra-Regional Retrieval Service covering all aspects of service provision
7. Operationally, the retrieval service will be independent of other hospital or AHS roles
8. The retrieval service will have both prehospital and interhospital capacity
9. The service will be available 24 hours a day
10. The decision as to whether the medical crew will be permanently onsite (available for immediate departure) or available onsite within prescribed response criteria will be determined by issues including available funding, local staffing and workload requirements
11. The service will be available to respond by road, helicopter and fixed wing as required
12. The service can be provided by an Area Health Service, hospital or independent provider
13. All aspects of the service including funding will recognise that a retrieval team consists of a doctor/paramedic or doctor/nurse team

## **HNE Southern Sector Adult and Paediatric Retrieval Service**

### Service Agreement Provision 2005/06

- Maximum 500 retrievals per year
- 10 hours/day on site medical officer and retrieval nurse, 14 hours /day offsite on call medical and nursing staff
- Combined medical and nursing team for secondary retrievals
- Combined medical and paramedic team for primary response (NB: this has yet to commence)
- Predominantly medical registrar staffing
- Provide adult and paediatric (non neonate) medical retrieval capability
- Provide predominate service to HNE Area health service, but tasked by NSW Aeromedical and Medical Retrieval Service to Areas outside HNE if required (this traditionally is to Central Coast and Mid North Coast regions)

## **HNE Northern Sector Retrieval Service**

### Service Agreement Provision 2005/06

- Equipment upgrade
- Equipment – consumables, RMR
- 1.05 FTE retrieval RN
- Funding of retrieval nurse and doctor on-call and call-back costs
- Education and other administration

The main issues identified for HNE Health retrieval services are:

### **Workforce**

Recruitment of sufficiently trained registrars is a difficult and ongoing problem. As there is a limited pool of appropriately trained staff, the amount of on call required from staff creates significant recruitment and retention issues. The current funding agreements provide insufficient funding for dedicated retrieval staff requiring staff to be on call for retrieval and critical care backup services. This situation is further compounded by staff specialist award conditions that do not attract staff specialists from assisting with after hours retrieval work. A key goal of the service is to achieve a full retrieval roster for John Hunter Hospital.

### **Retrieval Transport**

Availability of aero-medical and road based transport systems for retrieval service requires long-term consideration. Existing rotary wing aircraft (ie helicopters) are heavily utilised by a number of services (eg Medical, Ambulance, Police and Fire Brigade) and are tasked for a variety of missions, with the result that they may not be locally available when required. In addition, there is limited availability of aircraft with night flying capabilities. The benefits of rotary wing aircraft is that they are versatile in landing environments, greatly enhance response times, and deliver crew and equipment directly to the scene or hospital. The alternative to rotary wing aircraft is fixed wing aircraft (ie NSW Air Ambulance and RFDS planes). However, this is also problematic due to access and availability. Fixed wing aircraft require runways and this necessitates co-ordination with the NSW Air Ambulance to deliver the crews to the scene or hospital, and then to transport crew and patient back to the aircraft. This adds considerably to response times and as they are heavily utilised as a statewide resource, they are often unavailable for urgent retrievals. This necessitates the use of rotary wing aircraft to undertake lengthy retrieval missions, thus potentially making them unavailable for extended periods. Although the retrieval services based at JHH also use hospital ambulance vehicles for some inter-hospital retrievals, they are increasingly unavailable, and therefore the service is also heavily reliant on the NSW Air Ambulance for road transportation.

### **Funding**

The retrieval service will continue to seek enhancement of State funding to meet the super regional service model.

### **Prehospital Response**

Prehospital response protocols and training can be improved through:

- Training of staff in trauma resuscitation and stabilisation
- Improved coordination and cooperation with paramedic ambulance staff
- Increased focus on quality assurance

### **Activation**

Retrieval activation systems within the Hunter New England area can be improved with a single access phone contact and improved documentation of calls through voice recording and dedicated retrieval medical consultants.

### 7.3 Trauma Service Stream

Injuries are the leading cause of death and serious disability in all people aged 1-44 years. About 100,000 people in NSW each year require admission to hospital for an injury. Nine out of ten people can be safely treated in their local hospital. One out of ten patients will have a life threatening injury (serious trauma) requiring rapid transport to a specialist trauma centre.

Based on the NSW ITIM minimum trauma dataset (NSW Rural Profile 2002-04), John Hunter Hospital is the busiest trauma centre in NSW, while the Hunter Region has the greatest proportion of rural trauma admissions in NSW (at 22%), followed by the Mid North Coast region (at 18%). Tamworth Hospital is one of the three busiest hospitals for severe trauma in rural NSW, with 51 admissions during 2002-2004.

The provision of trauma services across the state is currently under review and a draft options paper for trauma is currently being circulated for comment. This document looks to determine the direction and shape of trauma services across the state in the future and will have a direct impact on the role of the Trauma service at JHH. Table 7 outlines the requirements of a Trauma service and progress towards its implementation.

Key Issues for the Trauma service include:

- HNE Health trauma data collection fails to comply with the NSW Minimum Trauma Dataset
- Additional trauma nurses are required to meet the clinical, educational and research roles of a “regional and rural” trauma hospital.
- Additional trauma staff are required in the regional trauma centres (Tamworth, Manning and Armidale)

Key Recommendations for this plan are to:

1. Employ trauma CNCs at Tamworth and Manning (with support provided to Armidale)
2. Improve data management to ensure compliance with data collection requirements
3. Develop a trauma network across HNEAHS – to enable collaboration and enhancement of clinical, research and educational opportunities
4. Provide area wide trauma education and training for GPs and rural nurses
5. Increase primary health involvement with key stakeholders in developing sustainable prevention programmes – e.g. with the RTA, police, media, John Hunter Children’s Hospital, Kidsafe and sporting associations such as horse riding, cycling, off road motorized vehicle

**Table 7: Requirements of a HNE Trauma Service**

<b>Trauma Service Recommendations</b>	<b>Status</b>
<b>Pre-hospital</b>	
Uniform early major trauma service notification	Protocol 4 in place*
Adherence to destination protocol	Protocol 4 in place*
Radio communication with pre-hospital personnel	New Initiative
<b>Emergency Department</b>	
Up to date diagnostics to ED	New Initiative
Availability of lead gowns for all members of the trauma team	New Initiative
Adequate staffing of the trauma bay (1 to 1 nursing is an essential requirement)	In place at JHH only
All staff need to be trained in EMST, TNCC and paed resuscitation	Partially implemented
Each bed should have a portable monitor with level 6 monitoring	Partially implemented
Trauma resuscitation beds with portable XR capability	Partially implemented
<b>Surgical Specialties</b>	
Dedicated Trauma ward with trauma nurses and trauma physiotherapists	New Initiative
On-Call Trauma surgeon at JHH for area consultations and transfers	New Initiative
Separate Trauma Surgery Roster	New Initiative
Trauma adult outpatient clinic for patient follow up	New Initiative
Trauma surgery fellowship program	New Initiative
Trauma rotation as a part of the Surgical Registrar rotation	New Initiative
Reconstructive Plastic Surgical service	New Initiative
Trauma rostering for surgical registrars (especially after hours)	New Initiative
<b>Imaging</b>	
Up to date diagnostics to ED	New Initiative
24/7 interventional radiologist coverage for trauma	New Initiative
Real-time consultant reporting on trauma imaging	New Initiative
<b>Operating Room</b>	
Three dedicated trauma theatres with 24 hour availability (for general, ortho, neuro, spinal, paediatric, cardiothoracic, hand, vascular, max-facs and surgical traumas)	New Initiative
Dedicated surgical trauma training (DSTC, DNPTC) for operating theatre staff	New Initiative
<b>Rehabilitation Services</b>	
Dedicated trauma physiotherapists	New Initiative
Major trauma rehabilitation facility with aquatherapy	New Initiative

\*Protocol 4 of the NSW Ambulance Service (from NSW Health 2005, PD2005\_266 Early Notification of Severe Trauma in Rural New South Wales)

## 7.4 ICU/HDU Stream

Table 8 outlines the number of beds currently available in the Hunter New England area.

**Table 8: Role Delineation and Number and Level of Current ICU/HDU Beds in the HNE Area**

Site	Level 3	Level 4	Level 5	Level 6	Total
<b>Tertiary referral</b>					
JHH (adult)	4			12	16
JHH (paed)				2	2
Calvary Mater	1		5		6
<b>Rural referral</b>					
Tamworth	4		7		11
Maitland	4				4
Manning	2	2			4
Armidale	4				4
<b>Total adult</b>	<b>19</b>	<b>2</b>	<b>12</b>	<b>12</b>	<b>45 adult</b>
<b>Total paed</b>				<b>2</b>	<b>2 paed</b>
<b>Private Hospitals</b>					
Newcastle Private	2	2			4 adult
Lake Macquarie	1	1			2 adult
<b>Total</b>	<b>3</b>	<b>3</b>			

The NSW Intensive Care Plan – Adult (2001) recommends 8.8 intensive care beds per 100,000. NSW Health has recently advised that:

- The formula should be applied to the adult population 15 years and above and
- Existing level 3/4 HDU beds and private beds should be included when calculating ICU/HDU bed capacity

(NB: this formula is currently under review by DOH).

This means that currently in HNE Health we have:

- 24 adult ICU beds (levels 5 and 6)
- 2 adult HDU beds (level 4)
- 19 adult HDU beds (level 3)

The 6 beds in the private sector brings the total available adult ICU/HDU beds in the Hunter New England area to 51 beds.

When the DOH formula is applied to assess ICU/HDU bed requirements, the area is currently short of 8 adult beds. Over the next ten years the projected population increase will further increase the number of beds required. Current capacity and future requirements are summarised in Table 9. A review is also being undertaken to assess paediatric ICU/HDU support requirements.

**Table 9: Number of Beds Currently Available and Number of Additional Beds Required (2006-2016)**

Year	Number of Beds Required	Number Available	Additional Beds Required
2006	59	51	<b>8</b>
2011	62		<b>11</b>
2016	64		<b>13</b>

**Key:** All estimates are based on adult population only

ICU bed numbers have been gradually increased over the last few years with an additional 2 beds at Tamworth (July 2005) and 2 beds at JHH (Aug 2005). Further investment in ICU/HDU beds is required to ensure HNE Health has ICU/HDU services that meet the needs of our population.

Location of these beds across the area should be based on clinical need/ability, population projections and role delineation. JHH, as the only tertiary ICU in the area, will remain the core referral centre and largest unit, although its capacity for growth is limited due to physical constraints.

HNE Health need to fully utilise ICU and HDU bed capacity in existing units, primarily through recruitment of appropriately skilled clinicians to support the level of services required. Given the known difficulties of recruiting in this area, recruiting and training initiatives should begin well in advance of the actual beds being opened.

The Paediatric Intensive Care Advisory Group (2006) has recommended that there should be 1.3 paediatric ICU beds per 100,000 children serviced. JHH acts as the tertiary referral source for HNE and the Northern Child Health Network and is the appropriate location for a paediatric ICU. There are 290,730 children aged from 0-14 in the John Hunter Children's Hospital catchment indicating a requirement for **4** paediatric ICU/HDU beds.

Key recommendations for ICU/ HDU services development

- Open sufficient adult and paediatric ICU/HDU beds to achieve appropriate levels
- Increase HDU beds in the Greater Newcastle area
- Upgrade Maitland from level 3 to 4 and appoint a medical director
- Implement strategies recommended by the Connecting Critical Care Telemedicine Research Project

## Critical Care and Emergency Service Triangles

The following Service Triangles represent the major components of the Critical Care and Emergency Service for the Hunter New England area. The two triangles represent current and future levels of service provision.

The table below defines service level classifications and features:

**Table 10: Service Triangle Definitions: Level, Definitions and Features**

No	Level*	Definition	Features
1	<b>Universal-</b> in all areas	Access to critical care and emergency services Able to provide initial assessment and management	<ul style="list-style-type: none"> <li>- Targeted at the whole population</li> <li>- Involves primary prevention and promotion of healthy lifestyle</li> <li>- Services will include assessment, initial management, stabilisation, referral/transfer</li> </ul>
2	<b>Basic-</b> in local areas	Critical care and emergency services for people with disease/condition who require basic medical intervention or investigations	<ul style="list-style-type: none"> <li>- Targeted at people with the disease/condition who are at mild to moderate risk of the disease progressing and requiring hospitalisation</li> <li>- Services will also include diagnosis, clinical management, referral and care coordination</li> </ul>
3	<b>Specialist-</b> in regional centres	Critical care and emergency specialist services for people with disease/condition who require acute inpatient care and specialised interventions	<ul style="list-style-type: none"> <li>- Targeted at people with the disease/condition who need specialist multidisciplinary in patient care</li> </ul>
4	<b>Complex</b> -at limited sites	Critical Care and Emergency Services for people with disease/condition who require complex specialist in-patient care that can only be provided at limited site(s)	<ul style="list-style-type: none"> <li>- Targeted at critically ill patients requiring complex specialist in patient care</li> <li>- Highest cost per intervention</li> <li>- Services provided require very specialised skills, equipment and infrastructure that are only located at limited locations/sites</li> </ul>

\*

*If a service is provided at one level it is then automatically available in the level / levels above*

## **8. ETHNIC AFFAIRS PRIORITY STATEMENT**

“In the development of the Hunter New England Health Critical Care and Emergency Services Plan, the health needs and interests of people from culturally and linguistically diverse groups have been considered. HNE Health is committed to delivering services that best meet their needs and there are specific strategies included in the Strategic Action Plan demonstrating that commitment.”

## **9. ABORIGINAL HEALTH IMPACT STATEMENT**

“The health needs and interests of Aboriginal people have been considered, and where relevant, incorporated and appropriately addressed in the development of the Critical Care and Emergency Services Plan”.

See Appendix 6 for the completed Aboriginal Health Impact checklist.

## 10. STRATEGIC OBJECTIVES AND STRATEGIC ACTION PLAN

The following pages present the Critical Care and Emergency Services Strategic Objectives and Strategic Action Plan. The plan details the strategic initiatives that will be implemented to ensure we achieve our Strategic Objectives.

### **CRITICAL CARE AND EMERGENCY SERVICES STRATEGIC OBJECTIVES**

Our Vision, Purpose, Key Focus Areas and Strategic Objectives are presented as a one-page summary.

Our Key Focus Areas are those areas that we consider are critical to achieving our Vision. For each Key Focus Area, Strategic Objectives are identified to ensure that Critical Care and Emergency Services remains focussed on the most important issues and needs.

### **CRITICAL CARE AND EMERGENCY SERVICES STRATEGIC ACTION PLAN**

Our Strategic Action Plan identifies performance measure/s for each of the key objectives and presents the strategic initiatives (the actions, activities or projects) that we will implement over the next five years to improve our performance, reach our targets and achieve our key objectives.

Each Objective is risk-rated using the HNE Health Risk Matrix, which is based on the NSW Health Severity Assessment Code (SAC). In rating the strategic objectives the consequences and likelihood of not achieving an objective and the impact on service provision and outcomes for the community were considered. The risk ratings identified for each strategic objective signify the priority placed on achieving each objective and where we want to be as an organisation in relation to the objective in five years time.

**CRITICAL CARE AND EMERGENCY SERVICES**

**VISION:** Healthier communities: Excellence in healthcare  
**PURPOSE:** Working with our communities to deliver quality health services

**Focus Area: Communities and Patients**

To achieve our vision, the key outcomes we must deliver are:

- ❖ Informed and involved communities
- ❖ Improved health and wellbeing through health promotion and disease prevention
- ❖ Equity of access to timely and appropriate services
- ❖ Patient centred care, quality health service experience

**Focus Area: External Partners**

To deliver the required community outcomes, we need to excel in:

- ❖ Collaboration with external partners, through effective communication and liaison

**Focus Area: Internal Networking and Processes**

To deliver the required community outcomes, we need to excel in:

- ❖ Effective communication between patients, their carers and the healthcare team
- ❖ Effective integration of the critical care and emergency services network across all facilities
- ❖ Safe and evidence based healthcare

**Focus Area: Resource Accountability**

To deliver the required community outcomes, we need to excel in:

- ❖ Prioritisation, allocation and effective management of resources and assets to best meet the health needs of people requiring critical care and emergency services

**Focus Area: Our People, Culture and Capability**

(Employees and Contracted)

To achieve the desired community outcomes and sustain our ability to change and improve, we need to excel in:

- ❖ Attracting and retaining high quality staff
- ❖ Developing competence, capability, individual accountability and performance
- ❖ Ensuring a safe working environment
- ❖ Demonstrating innovative healthcare

**OUR VALUES**

TEAMWORK

HONESTY

RESPECT

ETHICS

EXCELLENCE

CARING

COURAGE

COMMITMENT

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Communities and Patients</b>						
<b>OBJECTIVE:</b>	To achieve our vision, a key outcome we must deliver is: <b>Informed and involved communities</b>					<b>Risk Rating</b>	
						Current	Target
						<b>K</b>	<b>L</b>
<b>DESTINATION STATEMENT:</b>	<i>People in our communities have knowledge of the role and function of our critical care and emergency services and use appropriately</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	♦ <b>Funding 1,2,3</b>	* <b>Priority L, M, H</b>
Percent appropriate committees with consumer representation	100%	Annual	<b>All streams</b> <ul style="list-style-type: none"> <li>Develop and implement a promotional strategy (in consultation with the HNE Communications Unit) to inform the community about the role of Critical Care and Emergency Service (CCES), including: <ul style="list-style-type: none"> <li>- When to come to an emergency department</li> <li>- Utilising weeks such as “Australian Organ Donor Awareness Week” and “Spinal Injury Awareness Week” to raise awareness and increase fund raising opportunities</li> </ul> </li> <li>Develop strategies to increase participation by consumers on relevant committees</li> <li>Develop strategies to increase community awareness (and registration) about issues such as tissue and organ donation</li> </ul>	All Directors/Clinical Network  All Directors/ Clinical Network All Directors / Clinical Network	Feb 2009  Apr 2009 Mar 2009	1  1 1	

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding  
\* Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Communities and Patients</b>						
<b>OBJECTIVE:</b>	To achieve our vision, a key outcome we must deliver is: <b>Improved health and wellbeing through health promotion and disease prevention</b>					<b>Risk Rating</b>	
						Current <b>D</b>	Target <b>H</b>
<b>DESTINATION STATEMENT:</b>	<i>People in our communities are healthier and have fewer injuries and health risks</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding 1,2,3</b>	<b>★ Priority L, M, H</b>
Percent staff trained in health promotion and disease prevention	100%	Annual	<b>All streams</b> <ul style="list-style-type: none"> <li>Collaborate with Aboriginal Health staff to develop culturally appropriate education programs</li> <li>Improve access to culturally appropriate educational materials (especially at sites with a high Aboriginal population)</li> <li>Develop a plan for risk reduction strategies in all streams, based on a review of top DRGs and top 10 ED presentations</li> </ul>	All Directors	Feb 2008	2	
Injury and poisoning death rate (per 100,000)	<20/100,000 pa	Annual		All Directors	June 2008	2	
Area trauma death rate * excludes hanging, poisoning, drowning	<150 pa*	Annual		All Directors	Mar 2008	1	
			<b>Emergency Services:</b> <ul style="list-style-type: none"> <li>Train staff to provide opportunistic health promotion and disease prevention (eg opportunistic smoking intervention by ED staff)</li> <li>Increase staff awareness on particular risk factors of local community (eg in areas of high Aboriginal population with increased risk factors for cardiovascular disease, diabetes, trauma injury, renal disease and acute respiratory illness)</li> <li>Improve staff assessment of those at risk of falls</li> <li>Implement child protection screening tool for use in all EDs (currently in development)</li> </ul>	ED Dir(s)/ Clinical Network	Oct 2008	2	
				ED Dir(s)/ Clinical Network	June 2008	1	
				ED Dir(s)/ Clinical Network	July 2008	2	
				ED Dir(s)/ Clinical Network	Sept 2009	2	

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Communities and Patients</b>						
<b>OBJECTIVE:</b>	To achieve our vision, a key outcome we must deliver is: <b>Improved health and wellbeing through health promotion and disease prevention</b> <i>continued</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding 1,2,3</b>	<b>* Priority L, M, H</b>
<i>Continued</i>			<b>Emergency Services (cont):</b> <ul style="list-style-type: none"> <li>• Develop and standardise advice information sheets to provide to patients and carers e.g. paediatric guidelines, TASC</li> <li>• Continue to provide patients and families with health promotion and disease prevention information and advice sheets and ensure that CALD clients have the same access to information (eg by using interpreters and translated material)</li> <li>• Improve compliance with identification of Aboriginality on ED presentation</li> <li>• Increase utilisation of Aboriginal Liaison Officers by Aboriginal people in EDs</li> </ul>	ED Dir(s)/ Clinical Network	Dec 2006	1	
				ED Dir(s)/ Clinical Network	Dec 2006	1	
				ED Dir(s)/ Clinical Network	Sept 2008	1	
				ED Dir(s)/ Clinical Network	Sept 2008	1	
			<b>Trauma:</b> <ul style="list-style-type: none"> <li>• Collaborate with Population Health, Communications Unit and other relevant units of HNE (eg Kaleidoscope, John Hunter Children's Hospital, Aboriginal Health, Mental Health Multicultural Health, kid safe) to develop/implement media awareness campaigns (such as child injury prevention, trauma prevention) in relation to CCES</li> </ul>	Dir Trauma	Oct 2008	2	

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

\* Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Communities and Patients</b>												
<b>OBJECTIVE:</b>	To achieve our vision, a key outcome we must deliver is: <b>Equity of access to timely and appropriate services</b>						<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"><b>Risk Rating</b></td> </tr> <tr> <td style="text-align: center;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Current</td> <td style="width: 50%; text-align: center;">Target</td> </tr> <tr> <td style="text-align: center; background-color: red; color: white;">D</td> <td style="text-align: center; background-color: orange; color: white;">H</td> </tr> </table> </td> </tr> </table>	<b>Risk Rating</b>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Current</td> <td style="width: 50%; text-align: center;">Target</td> </tr> <tr> <td style="text-align: center; background-color: red; color: white;">D</td> <td style="text-align: center; background-color: orange; color: white;">H</td> </tr> </table>	Current	Target	D	H
<b>Risk Rating</b>													
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Current</td> <td style="width: 50%; text-align: center;">Target</td> </tr> <tr> <td style="text-align: center; background-color: red; color: white;">D</td> <td style="text-align: center; background-color: orange; color: white;">H</td> </tr> </table>	Current	Target	D	H									
Current	Target												
D	H												
<b>DESTINATION STATEMENT:</b>	<i>Within our Area, people with a clinical need have access to critical care services that meet their needs with in a reasonable timeframe</i>												
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding</b>	<b>★ Priority L, M, H</b>						
% Staff who are accredited in advanced clinical practice	10%	Annual	<b>All streams</b> <ul style="list-style-type: none"> <li>Increase nos. of clinicians with accredited advanced clinical practice skills by appointment of education support positions such as DEMA and NEs</li> <li>Implement appropriate medical, nursing and allied health staff levels and skill mix as per workforce plan (when developed)</li> </ul>	GMs	Nov 2011	2	H						
				GMs	Dec 2008	3							
% ED Triage 2 time treatment commences (within 10 mins)	80%	Monthly	<b>Emergency Services:</b> <ul style="list-style-type: none"> <li>Provide appropriate physical environment to assess and treat patients (arrival, reception, assessment and treatment), particularly at Maitland and Manning</li> <li>Develop processes to fast track patient registration</li> <li>Support appropriate use of emergency services by promoting the use of:                             <ul style="list-style-type: none"> <li>- Direct admissions to wards</li> <li>- Community Services eg CAPAC</li> <li>- Chronic and complex care case managers</li> <li>- After hours GP services</li> <li>- Advice lines (Kids Kare, GPAAH)</li> </ul> </li> <li>Pilot provision of rapid access to specialist clinics for EDs and GPs at JHH</li> </ul>	Dir(s) ED/GMs	Nov 2010	3 (capital works)	L						
% ED Triage 3 time treatment commences (within 30 mins)	75%	Monthly		Dir(s) ED	May 2009	2							
% ED Triage 4 time treatment commences (within 60 mins)	70%	Monthly		Dir(s) ED/Clinical Network/Dir Ops Acute and Community networks	Nov 2008	2							
% Not admitted within 8 hours (Access Block)	20%	Monthly		Dir(s) ED/Clinical Network	Nov 2008	1							

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

FOCUS AREA:		Communities and Patients						
OBJECTIVE:		To achieve our vision, a key outcome we must deliver is: <b>Equity of access to timely and appropriate services</b> <i>continued</i>						
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding	★ Priority L, M, H	
Average time to triage	10min	Monthly	<b>Emergency Services (cont):</b> <ul style="list-style-type: none"> <li>Implement and evaluate Ambulance Release Team (ART) at JHH</li> <li>Implement and evaluate ASNSW matrix and arrivals board for all EDs (in GN and Lower Hunter)</li> </ul>	Dir ED JHHN	Aug 2007	1		
Ambulance off loaded within 30 mins	85%	Monthly		Amb Liaison Committee	Dec 2006	1		
Number appropriate patients not able to be admitted to a HNE Adult ICU/HDU	Nil	Monthly	<b>Intensive Care:</b> <ul style="list-style-type: none"> <li>Develop funding submissions to attain recommended numbers of adult ICU/HDU beds as per revised ICU/HDU plan (due 2006), and liaise with SSDB to secure funding</li> <li>Develop paediatric specific ICU/HDU (at JHH) as per PICAG Report, 2006</li> <li>Maintain Level 4 HDU at Maitland and appoint a medical director</li> <li>Allocate additional resources according to role delineation, demand and population projections</li> <li>Develop an area wide escalation process to increase bed accessibility (including out of area transfers)</li> <li>Develop a process to ensure quarantined access (ie guaranteed access to ICU beds) is available to support surgical services</li> <li>Develop an area plan for HDU location and capacity</li> <li>Develop a plan to minimise exit block for all ICU/HDUs</li> </ul>	Dir(s) ICU/ Clinical Network	June 2007	1	H	
Number of appropriate patients not able to be admitted to a HNE Paed ICU/HDU	Nil	Monthly		Dir(s) ICU/ Clinical Network	June 2011	2		
Number ICU Transfers out of HNE for care	Nil	Monthly		Dir(s) ICU/ Clinical Network	May 2008	3		
Number elective operations cancelled due to no ICU/HDU beds	Nil	Monthly		Dir(s) ICU/ Clinical Network	Aug 2009	1		
% Patient not transferred from ICU (ICU Exit block >4hrs)	Nil	Monthly		Dir(s) ICU/ Clinical Network	Aug 2008	2		
# Activation of ICU default matrix implemented	Nil	Monthly		SM's	Oct 2008	1		
				Dir(s) ICU/ Clinical Network	June 2009	1		
			ICU Dirs	July 2009	1			

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Communities and Patients</b>						
<b>OBJECTIVE:</b>	To achieve our vision, a key outcome we must deliver is: <b>Equity of access to timely and appropriate services</b> <i>continued</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding</b>	<b>* Priority L, M, H</b>
Head CT for head injury (GCS < 13) within 2 hours of injury	75%	Monthly	<b>Trauma:</b> • Review time to head CT for head injuries	Dir Trauma	Nov 2006	1	
Response time: Secondary mission (within retrieval guidelines):	100%	6 monthly	<b>Retrieval:</b> • Coordinate retrieval services within HNE and the state as per the super regional retrieval plan • Align with AMRS communication strategies for all retrieval referrals and support • Develop strategies to manage increase in demand for retrieval services	Dir(s) Retrieval/ Clinical Network	Sept 2007	1	
Response time: Primary mission (within retrieval guidelines)	100%	6 monthly		Dir(s) Retrieval/ Clinical Network	Oct 2007	2	
				Dir(s) Retrieval/ Clinical Network	June 2009	2	

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding  
 \* Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Communities and Patients</b>												
<b>OBJECTIVE:</b>	To achieve our vision, a key outcome we must deliver is: <b>Patient centred care, quality health services experience</b>						<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td colspan="2" style="text-align: center;"><b>Risk Rating</b></td> </tr> <tr> <td style="text-align: center;">Current</td> <td style="text-align: center;">Target</td> </tr> <tr> <td style="text-align: center; background-color: orange;">K</td> <td style="text-align: center; background-color: orange;">L</td> </tr> </table>	<b>Risk Rating</b>		Current	Target	K	L
<b>Risk Rating</b>													
Current	Target												
K	L												
DESTINATION STATEMENT:	<i>People who come into contact with us are confident that we consistently deliver safe, effective, appropriate services</i>												
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding</b>	<b>★ Priority L, M, H</b>						
Patient satisfaction score	80%	Bi-annual	<b>All streams</b> <ul style="list-style-type: none"> <li>Plan and implement customer service, cultural awareness/ sensitivity, conflict resolution and communication training for all CCES staff</li> <li>Collaborate with Aboriginal Liaison Officers to provide culturally appropriate information (includes posters, pamphlets, fact sheets, survey forms)</li> <li>Collaborate with Multicultural Liaison Officers to provide culturally appropriate information (includes posters, pamphlets, fact sheets, survey forms)</li> <li>Monitor complaints from IIMS provided to Aboriginal Liaison Officers and collaborate on appropriate initiatives to minimise same</li> <li>Monitor complaints from IIMS provided to Multicultural Liaison Officers and collaborate on appropriate initiatives to minimise same</li> <li>Develop, implement and evaluate a CCES Family/Carer Feedback Form</li> </ul>	GMs	Apr 2011	2							
Percent initiatives implemented as a result of complaints process	90%	Quarterly		Dir(s) of CCES	Mar 2011	2							
				Dir(s) of CCES	Mar 2009	2							
				Dir(s) of CCES	Nov 2006	1							
				Dir(s) of CCES	Nov 2006	1							
				Dir(s) of CCES	June 2008	1							

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

FOCUS AREA:		Communities and Patients					
OBJECTIVE:		To achieve our vision, a key outcome we must deliver is: <b>Patient centred care, quality health services experience</b> <i>continued</i>					
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	◆ Funding	* Priority L, M, H
<i>Continued</i>			<b>Emergency Services:</b> <ul style="list-style-type: none"> <li>• Audit ED signage (both external and internal on all sites) and prioritise recommendations</li> <li>• Review the physical environment of EDs in line with standards relating to                             <ul style="list-style-type: none"> <li>- Children</li> <li>- Mental Health</li> <li>- Aged Care</li> <li>- Dementia</li> <li>- Physically impaired</li> <li>- Aboriginal and Torres Strait Islanders and CALD</li> <li>- Aggressive patients and carers</li> </ul> </li> <li>• Ensure that input is provided by above groups when reviews/upgrades occur</li> </ul>	Dir(s) ED/ Clinical Network	Mar 2011	1	
				Dir(s) ED Clinical Network /GM's	May 2011	1	
				Dir(s) ED Clinical Network /GM's	May 2011	1	
			<b>Intensive Care:</b> <ul style="list-style-type: none"> <li>• Develop a plan for appropriate and sufficient parent/carer and family accommodation</li> <li>• Develop improved links with other services such as paed, rehab</li> </ul>	Dir(s) ICU/GM's	Feb 2010	1	
				Dir(s) ICU/ Clinical Network	Aug 2008	1	

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

\* Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>External Partners</b>						
<b>OBJECTIVE:</b>	To deliver the required community outcomes, we need to excel in: <b>Collaboration with external partners through effective communication and liaison</b>						<b>Risk Rating</b> Current    Target <b>Q            R</b>
<b>DESTINATION STATEMENT:</b>	<i>Our partnerships deliver benefits to people across Hunter New England through shared goals, clearly agreed responsibilities and effective outcomes</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding</b>	<b>★ Priority L, M, H</b>
Percent initiatives implemented from external service agreements	75%	Annual	<b>All streams</b> <ul style="list-style-type: none"> <li>ASNSW to develop a staff survey that includes appropriate questions relating to CCES</li> <li>Improve accessibility to ongoing education provided by CCES for ASNSW officers (eg via ASNSW intranet and CCES website)</li> <li>Participate as a Member and support appropriate committees (eg Intensive Care Taskforce, State Organ Liaison Group, PICAG, SSDB, Retrieval)</li> <li>Develop and continue with partnerships to improve clinical care (eg. SAFTE) and other joint training or planning initiatives eg. GPs Divisions</li> <li>Liaise with and review service agreements with other Area Health Services regarding transfer of patients</li> <li>Enhance links with education providers to ensure CCES are consulted on the development of undergraduate and postgraduate courses</li> <li>Liaise with Aboriginal Community Controlled Health Service providers (refer to the HNE Aboriginal Health Partnership Agreement 2005 and Two Ways Together: the NSW Aboriginal Affairs Plan 2003-12) to enhance effective partnerships</li> </ul>	Clinical Network	Sept 2008	1	
Percent appropriate State and collaborative committees with a HNE representative	100%	Annual		Clinical Network	Apr 2010	1	
GP Satisfaction score	70%	Annual		Clinical Network	July 2011	1	
				Clinical Network	July 2011	2	
				Clinical Network	Oct 2011	1	
				Clinical Network	Mar 2011	1	
				Clinical Network/GMs	May 2007	2	

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

FOCUS AREA:	<b>External Partners</b>						
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: <b>Collaboration with external partners through effective communication and liaison</b> <i>continued</i>						
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	♦ Funding	* Priority L, M, H
<i>Continued</i>			<b>All streams (cont)</b> <ul style="list-style-type: none"> <li>• Facilitate membership (and support) for GPs/VMOs to participate on relevant committees</li> <li>• Collaborate with and provide access (for GPs and VMOs who provide CCES care) to ongoing educational opportunities</li> <li>• Collaborate with GPs to include appropriate CCES questions within GP satisfaction survey</li> </ul>	Clinical Network	Dec 2008	3	L
				Clinical Network	Dec 2008	2	
				Clinical Network	Dec 2009	1	
			<b>Emergency Services:</b> <ul style="list-style-type: none"> <li>• Undertake a review of ASNSW inter-hospital transport agreement</li> <li>• Collaborate with ASNSW to standardise pre-hospital notification to all HNE EDs</li> <li>• Explore ways of providing rural emergency medicine training eg by collaborating with GPET medical educators or by developing a business case for the appointment of a coordinator</li> <li>• Collaborate with GPAAH &amp; Divs of GPs to ensure adequate access of ED patients to after hours care</li> </ul>	Dir(s) ED/ Dir(s) Ops Acute & PC	Nov 2009	1	
				Dir(s) ED/ Dir(s) Ops Acute & PC	Nov 2008	1	
				Dir(s) ED	May 2010	2	
				Dir(s) ED	May 2007	1	
			<b>Retrieval:</b> <ul style="list-style-type: none"> <li>• Participate in developing/reviewing the Aero-Medical and Medical Retrieval Service (AMRS) agreement</li> <li>• Develop effective communication and liaison with Helicopter operators, Ambulance Service NSW (ASNSW) and AMRS</li> <li>• Ensure HNE retrieval services are represented on Statewide Retrieval Services Committee</li> <li>• Improve tasking coordination of the SRS helicopter</li> </ul>	Dir(s) Retrieval	Nov 2006	1	
				Dir(s) Retrieval	Nov 2006	1	
				Dir(s) Retrieval	Nov 2006	1	
				Dir(s) Retrieval	Nov 2007	1	

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

\* Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	Internal Networking and processes						
<b>OBJECTIVE:</b>	To deliver the required community outcomes, we need to excel in: <b>Effective communication between patients, their carers and the healthcare team</b>					<b>Risk Rating</b>	
						Current	Target
						<b>D</b>	<b>H</b>
<b>DESTINATION STATEMENT:</b>	We have communication systems that ensure that information is effectively shared between health care providers, the patient and their carer(s)						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding</b>	<b>★ Priority L, M, H</b>
Percent initiatives implemented in agreed timeframe	75%	Annual	<b>All streams</b> <ul style="list-style-type: none"> <li>• Develop, support and implement a plan for appropriate allied health coverage at all sites (business case for enhancement of allied health services in the emergency departments of Belmont, Maitland, Manning and Tamworth hospitals, Feb. 2006)</li> </ul>	Dir Allied Health/ All Directors	July 2007	2	
Patient satisfaction re: communication	80%	Biannual	<ul style="list-style-type: none"> <li>• Develop and coordinate a critical care and emergency services website to include:                             <ul style="list-style-type: none"> <li>- Education programs</li> <li>- Patient discharge summaries</li> <li>- Primary and Fellowship training resources</li> <li>- Guidelines</li> <li>- Patient management plans</li> <li>- Learning packages</li> <li>- Discussion group</li> <li>- Patient advice/information sheets</li> <li>- OH &amp; S info</li> <li>- Links to other sites</li> </ul> </li> </ul>	Clinical Network	July 2007	2	
			<ul style="list-style-type: none"> <li>• Ensure frontline staff attend Cultural Respect training program</li> </ul>	Clinical Network	Dec 2008	2	
			<ul style="list-style-type: none"> <li>• Utilise ALOs to improve communication with the health care team and Aboriginal patients/families</li> </ul>	Clinical Network	Nov 2007	1	
			<ul style="list-style-type: none"> <li>• Ensure collaboration/liaison with mental health team to facilitate early identification and intervention for mental health patients</li> </ul>	CCES/ Mental Health Directors	Feb 2009	1	
			<ul style="list-style-type: none"> <li>• Provide interpreters when needed or requested</li> </ul>	CCES Dir(s)	Ongoing	1	

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding ★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	Internal Networking and processes						
<b>OBJECTIVE:</b>	To deliver the required community outcomes, we need to excel in: <b>Effective communication between patients, their carers and the healthcare team</b> <i>continued</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding</b>	<b>* Priority L, M, H</b>
			<b>Retrieval:</b> <ul style="list-style-type: none"> <li>Develop and implement a process where all retrieval phone conversations are recorded (with computer based conferencing and recording features) for quality assurance purposes</li> </ul>	Dir(s) Retrieval	Aug 2008	3	H
			<b>Intensive Care</b> <ul style="list-style-type: none"> <li>Consider implementation of a Clinical Information System for all tertiary Intensive Care Units, in line with NSW Health Policy</li> </ul>	Dir(s) ICU	Oct 2009	2	

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

\* Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Internal Networking and processes</b>						
<b>OBJECTIVE:</b>	To deliver the required community outcomes, we need to excel in: <b>Effective integration of the critical care and emergency services network across all facilities</b>						<b>Risk Rating</b> Current    Target <span style="background-color: orange; padding: 2px;">K</span> <span style="background-color: yellow; padding: 2px;">R</span>
<b>DESTINATION STATEMENT:</b>	<i>Critical care and emergency services staff work together to deliver coordinated, consistent high quality healthcare</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>♦ Funding</b>	<b>* Priority L, M, H</b>
Percent initiatives implemented from clinical service plan within timeframe	60%	Annual	<b>All streams</b> <ul style="list-style-type: none"> <li>Implement the critical care and emergency services (CCES) clinical network across all facilities</li> <li>Develop individual streams for ICU, ED, Retrieval, and Trauma</li> <li>Ensure all streams take responsibility for effective service delivery across all sites</li> </ul>	Clinical Network	Nov 2006	3	H
Number of guidelines / models of care developed, implemented and evaluated	20	Annual		<ul style="list-style-type: none"> <li>Standardise CCES policies, procedures, guidelines and pathways (as appropriate)</li> <li>Ensure appropriate representation on area committees eg PFU, Children &amp; Young People, Mental Health, Aged Care, Retrieval, Trauma and Critical Care</li> <li>Ensure appropriate input (including multidisciplinary input and consultation with key stakeholders) into clinical guidelines, policies, procedures and management plans</li> <li>Develop a capability table that outlines clinical capability and capacity of CCES, in line with transfer of care project</li> </ul>	Dir(s) / Clinical Network	Nov 2006	3
			<b>Emergency Services:</b> <ul style="list-style-type: none"> <li>Develop and implement guidelines for transfer of patients to and from EDs, in collaboration with the Patient Flow Unit</li> <li>Collaborate with Maggie transfer of care project team to ensure only patients who require emergency care come to ED</li> <li>Develop, implement and evaluate area guidelines and procedures for the management of patients when there is no doctor on site or available</li> </ul>	All Directors/ Clinical Network	Dec 2006	1	
				Clinical Network	June 2010	1	
				Clinical Network	Aug 2011	1	
				Clinical Network	Sept 2011	1	
				Clinical Network	Oct 2008	1	
				Dir(s) ED/ Clinical Network/PFU	Aug 2007	1	
				Dir(s) ED/ Clinical Network	Sept 2007	1	
				Dir(s) ED/ Clinical Network	June 2010	2	

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding    \* Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	Internal Networking and processes						
<b>OBJECTIVE:</b>	To deliver the required community outcomes, we need to excel in: <b>Effective integration of the critical care and emergency services network across all facilities</b> <i>continued</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding</b>	<b>★ Priority L, M, H</b>
<i>Continued</i>			<b>Trauma:</b> <ul style="list-style-type: none"> <li>• Develop/ implement an adult trauma outpatient clinic (at JHH) for patient follow up</li> <li>• Ensure all rural trauma hospitals have trauma/emergency team activations developed</li> <li>• Develop a Traumatology Model of Care</li> </ul>	Dir Trauma  Dir Trauma/CN  Dir Trauma	May 2009  Oct 2009  Sept 2011	1  1  2	
			<b>Retrieval:</b> <ul style="list-style-type: none"> <li>• Formalise communication with HNE Retrieval Services, PFU and Coronary Care Transport</li> </ul>	Dir(s) Retrieval	Mar 2007	1	

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Internal Networking and processes</b>										
<b>OBJECTIVE:</b>	To deliver the required community outcomes, we need to excel in: <b>Safe and evidence based healthcare</b>						<b>Risk Rating</b> <table style="margin: auto; border-collapse: collapse;"> <tr> <td style="padding: 2px 10px;">Current</td> <td style="padding: 2px 10px;">Target</td> </tr> <tr> <td style="background-color: red; color: white; text-align: center; padding: 2px 10px;">D</td> <td style="background-color: yellow; text-align: center; padding: 2px 10px;">N</td> </tr> </table>	Current	Target	D	N
Current	Target										
D	N										
<b>DESTINATION STATEMENT:</b>	<i>We ensure our care is based on best practice and minimises harm</i>										
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>♦ Funding</b>	<b>★ Priority L, M, H</b>				
Number cardiac arrest/MET calls for NFR patients	Nil	Monthly	<b>All streams</b> <ul style="list-style-type: none"> <li>Ensure morbidity and mortality is formally reviewed (either at Morbidity and Mortality meetings or as an agenda item at other relevant meetings) by all services on all sites</li> <li>Develop supporting plan for disaster management</li> <li>Review and evaluate Medical Emergency Team (MET) services across HNE</li> <li>Pilot Medical Emergency Criteria in District and Community hospitals (with no on-site Doctor)</li> </ul>	Clinical Network	Feb 2011	1					
				Clinical Network	Apr 2007	1					
				Dir(s) ICU/ Clinical Network /GMs	Oct 2009	1					
				Dir(s) ICU/ Clinical Network /GMs	Oct 2009	2					
Time to Thrombolysis (ED) within 30mins	100%	Monthly	<b>Emergency Services:</b> <ul style="list-style-type: none"> <li>Ensure appropriate transport of critically injured and unwell patients to definitive care is provided (Right patient, Right time, Right hospital)</li> <li>Provide ongoing support structure for NICS and CEC initiatives such as TASC and mental health collaborative</li> <li>Support the implementation of Models of Emergency Care (NSW Health Emergency Care Taskforce)</li> <li>Develop and implement standardised guidelines, clinical protocols and education packages for top 10 adult and paediatric presentations area wide</li> <li>Improve patient ALERT system on iPIMS (eg aggressive, dangerous or infectious, Interpreter required)</li> <li>Improve access to Medical Records after hours for all sites</li> </ul>	Dir(s) ED/ Clinical Network	Dec 2007	2					
Time to PTCA (ED) within 2 hrs	100%	Monthly		Dir(s) ED/ Clinical Network	July 2010	1					
Time to Analgesia (ED) within 30 mins	100%	Monthly		Dir(s) ED/ Clinical Network	Aug 2010	1					
				Dir(s) ED/ Clinical Network	Dec 2008	2					
				Dir(s) ED/ Clinical Network /Dir IT	Dec 2007	1					
				Dir(s) ED/ Clinical Network	Aug 2010	2					

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>		<b>Internal Networking and processes</b>					
<b>OBJECTIVE:</b>		To deliver the required community outcomes, we need to excel in: <b>Safe and evidence based healthcare</b> <i>continued</i>					
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding</b>	<b>★ Priority L, M, H</b>
Fracture fixation (in general) within 24 hours from injury	>90%	Annual	<b>Trauma:</b> <ul style="list-style-type: none"> <li>Develop a business case in relation to trauma data collection requirements in regional centres</li> <li>Implement recommendations from Trauma Verification site visit</li> <li>Implement guidelines for management of patients with Post Traumatic Amnesia (PTA)</li> </ul>	Dir Trauma	Aug 2008	1	
Major trauma wounds washout in OT within 4 hours	>90%	Annual		Dir Trauma	Nov 2008	1	
% Appropriate patients with PTA assessment conducted	>90%	Annual		Dir Trauma	Apr 2008	2	
Unplanned admissions to ICU (from ED 24 hrs)	Nil	Monthly	<b>Intensive Care:</b> <ul style="list-style-type: none"> <li>Develop a business case for an ICU Liaison Nurse</li> </ul>	Dir(s) ICU	Apr 2008	2	
Unplanned readmission to ICU within 48hrs of discharge	Nil	Monthly					

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Resource Accountability</b>						
<b>OBJECTIVE:</b>	To deliver the required community outcomes, we need to excel in: <b>Prioritisation, allocation and effective management of resources and assets to best meet the health needs of people requiring critical care and emergency services</b>					<b>Risk Rating</b>	
						Current <b>D</b>	Target <b>L</b>
<b>DESTINATION STATEMENT:</b>	<i>Staff and communities are confident that resources are allocated to meet identified health needs and resources support effective health service delivery</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding</b>	<b>★ Priority L, M, H</b>
Net cost of service percent variance	TBD	Monthly	<b>All streams</b> <ul style="list-style-type: none"> <li>• Review all CCES budgets to identify underlying causes that may impact on budget overrun</li> <li>• Develop and implement a stream specific asset management plan for both the northern and southern regions</li> <li>• Develop revenue and savings targets and agreements for expenditure</li> <li>• Review and make recommendations for the prescribing and use of medicines, ordering of pathology and imaging services</li> <li>• Ensure that relevant streams participate in budget development and resource allocation (includes support services/allied health)</li> <li>• Allocate resources based on population (include seasonal fluctuation and projected growth) and acuity</li> </ul>	Clinical Network /GMs	Dec 2006	2	
				Clinical Network	Aug 2009	2	
				GMs	Aug 2009	1	
				Clinical Network	Aug 2009	1	
				Clinical Network /GMs	Sept 2009	1	
				Clinical Network	July 2007	1	
Percent growth in revenue	TBD	Monthly	<ul style="list-style-type: none"> <li>• Maximise revenue raising opportunities</li> </ul>	Dir(s) / Clinical Network	Nov 2009	2	

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

FOCUS AREA:	Resource Accountability						
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: <b>Prioritisation, allocation and effective management of resources and assets to best meet the health needs of people requiring critical care and emergency services</b> <i>continued</i>						
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	♦ Funding	★ Priority L, M, H
Percent identified IT requests implemented	TBD	6 Monthly	<b>Emergency Services:</b> <ul style="list-style-type: none"> <li>• Review budget arrangements for Level 4 and above EDs and explore benefits of having a separate budget</li> <li>• Ensure that EDs (Level 3 and below) participate in budget development and resource allocation within the hospital</li> <li>• Develop an IT strategy, (including infrastructure) to identify areas of need for implementation/updating of hardware, software and IT systems to include:                             <ul style="list-style-type: none"> <li>- CAP (for all EDs)</li> <li>- PACS (for all level 4 and above EDs)</li> <li>- Electronic medical records and discharge summaries</li> <li>- Data system for tracking/highlighting potential public health issues (eg influenza outbreaks)</li> </ul> </li> </ul>	Dir(s) ED/ Clinical Network	July 2010	1	
			<ul style="list-style-type: none"> <li>• Optimise access across the Area to:                             <ul style="list-style-type: none"> <li>- Telemedicine facility rollout (in line with NSW Health Connecting Critical Care Project)</li> <li>- Facsimiles/photocopiers in all EDs</li> <li>- At least one (1) hands-free telephone in all EDs</li> <li>- Adequate numbers of clinical computers</li> </ul> </li> <li>• Liaise with HNE Path Services to optimise services for:                             <ul style="list-style-type: none"> <li>- POCT at all sites (that is appropriately supported in regard to QA and maintenance)</li> <li>- Electronic pathology results available at all sites</li> <li>- ABG analyser in ED at Tamworth &amp; Manning</li> </ul> </li> </ul>	Dir(s) ED/ Clinical Network/ General Mans	Dec 2009	2	
				Dir(s) ED/ Clinical Network /IT Services	Oct 2007	2	
				Dir(s) ED/ Clinical Network /Path Services General Mans	Dec 2009	3	H

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

FOCUS AREA:	Resource Accountability						
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: <b>Prioritisation, allocation and effective management of resources and assets to best meet the health needs of people requiring critical care and emergency services</b> <i>continued</i>						
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	♦ Funding	★ Priority L, M, H
<i>Continued</i>			<b>Emergency Services (cont):</b> <ul style="list-style-type: none"> <li>Implement iPIMS with ED module for all sites</li> <li>Review and make recommendations in regards to data analysis capabilities across HNE</li> <li>Undertake a needs analysis of all sites for improved clerical support (especially A/H &amp; weekends)</li> </ul>	Dir(s) ED/ Clinical Network	Nov 2008	2	
Number retrievals by non HNE retrieval services	TBD	Monthly	<b>Retrieval:</b> <ul style="list-style-type: none"> <li>Source dedicated retrieval funding for capital equipment and recurrent funding for dedicated retrieval workforce as per NSW Health super regional plan</li> </ul>	Dir(s) Retrieval	May 2011	2	
Number of retrieval missions	TBD	Monthly					
Length of stay (top 10 DRGs)		6 Monthly	<b>Intensive Care:</b> <ul style="list-style-type: none"> <li>Review budget arrangements for Level 4 and above ICU s and explore benefits of having separate budget</li> <li>Ensure that ICUs (Level 3 and below) participate in budget development and resource allocation within the hospital</li> <li>Implement area wide ICU database</li> </ul>	Dir(s) ICU/ Clinical Network	July 2010	1	
Admission rates (top 10 DRGs)-adult		6 Monthly		Dir(s) ICU/ Clinical Network	July 2010	1	
Admission rates (top 10 DRGs)-paediatrics		6 Monthly		Dir(s) ICU	Nov 2008	3	H

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Our people, culture and capability</b>										
<b>OBJECTIVE:</b>	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in: <b>Attracting and retaining high quality staff</b>						<b>Risk Rating</b> <table style="margin: auto; border-collapse: collapse;"> <tr> <td style="padding: 2px 10px;">Current</td> <td style="padding: 2px 10px;">Target</td> </tr> <tr> <td style="text-align: center; background-color: red; color: white; font-weight: bold;">C</td> <td style="text-align: center; background-color: orange; color: black; font-weight: bold;">H</td> </tr> </table>	Current	Target	C	H
Current	Target										
C	H										
<b>DESTINATION STATEMENT:</b>	<i>We have the right people with the right skills, in the right place, at the right time</i>										
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>♦ Funding</b>	<b>* Priority L, M, H</b>				
Staff turnover rate	TBD	Quarterly	<b>All streams</b> <ul style="list-style-type: none"> <li>Develop a CCES Workforce Plan for each stream to identify and manage gaps across all levels of a multidisciplinary workforce (includes Nurse Practitioners, CN staffing requirements, locums), as well as professional development initiatives</li> <li>Develop a CCES network rotation plan for medical, allied health and nursing staff                             <ul style="list-style-type: none"> <li>- Consider accommodation and transport requirements</li> <li>- Source funding from HNE Rural Nurses Exchange Program</li> </ul> </li> <li>Support and encourage clinical staff to take allocated leave</li> <li>Develop strategies to back fill staff, especially in rural facilities</li> <li>Develop a plan for succession planning and staff development</li> </ul>	Clinical Network /Area Dir Workforce	Sept 2007	3	H				
Staff satisfaction score	TBD	2 yearly									
Percent staff with excess leave	TBD	Monthly									
Vacancy rate clinical positions (medical, nursing, allied health)	TBD	Quarterly		Clinical Network /Area Dir Workforce	June 2008	2					
Percent shifts filled by Locums	TBD	Quarterly		All Directors	Feb 2011	2					
			Clinical Network / Area Dir Workforce	June 2007	2						
			Clinical Network / Area Dir Workforce	June 2007	2						

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Our people, culture and capability</b>						
<b>OBJECTIVE:</b>	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in: <b>Attracting and retaining high quality staff <i>continued</i></b>						
Measure:	Target	Reporting Timeframe	Strategic Initiatives/Actions	Responsibility	Time frame	♦ Funding	* Priority L, M, H
<i>Continued</i>			<b>Emergency Services:</b> <ul style="list-style-type: none"> <li>• Develop a business case for a dedicated ED Medical Director for Manning</li> <li>• Gain ACEM Accreditation for level 4 and above facilities</li>   <li>• Support the development of workforce strategies to ensure adequate FACEM cover at JHH, Belmont, Maitland, Mater, Tamworth and Manning EDs</li> <li>• Review medical coverage at all sites and make appropriate recommendations to AET</li> </ul>	Dir(s) ED/ Clinical Network  Dir(s) ED/ Clinical Network  Dir(s) ED/ Clinical Network /Area Dir Workforce  Dir(s) ED/Clinical Network	Feb 2011  Oct 2011  Nov 2008  Apr 2007	2  2  2  2	
			<b>Trauma:</b> <ul style="list-style-type: none"> <li>• Review the feasibility of establishing a JHH adult trauma ward</li> </ul>	Dir Trauma	Oct 2008	1	
			<b>Intensive Care</b> <ul style="list-style-type: none"> <li>• Develop and maintain new technologies in ICU to attract and retain trainee clinical staff</li> </ul>	Dir ICU	Oct 2008	1	

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

\* Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Our people, culture and capability</b>						
<b>OBJECTIVE:</b>	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in: <b>Developing competence, capability, individual accountability and performance</b>					<b>Risk Rating</b> Current    Target <b>K</b> <b>R</b>	
<b>DESTINATION STATEMENT:</b>	<i>Our staff develop their skills, accept responsibility for their decisions and actions, and are supported to optimise their performance</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>♦ Funding</b>	<b>* Priority L, M, H</b>
Percent staff with post graduate qualifications		Annual	<b>All streams</b> <ul style="list-style-type: none"> <li>• Identify core courses (to be provided within facility budgets) for appropriate staff to attend eg Grad Cert Retrieval Science/ICU/ED, Helicopter Safety Training, EMST, ELS, APLS, TNCC, ACLS, FAST, ALS, FLEC, ENEC, DSTC and DNPTC</li> </ul>	Clinical Network/GMs	June 2007	1	
Percent staff accredited in advanced clinical roles		Annual	<ul style="list-style-type: none"> <li>• Develop local training plan for critical care and emergency services</li> <li>• Plan to provide staff education on disaster management</li> <li>• Lobby for increase in funding for post graduate nursing positions</li> <li>• Liaise with CNCs across all specialties to provide an area service</li> <li>• Encourage staff to attend Aboriginal Cultural Respect Training</li> <li>• Develop standardised clinical position descriptions and proforma</li> <li>• Develop professional core competencies by stream for all staff who work in CCES</li> <li>• Develop framework for assessment of core competencies</li> <li>• Develop and implement multidisciplinary mobile scenario based training (high fidelity simulation training centre)</li> <li>• Develop a business case for an Area nurse educator position (1 FTE) for CCES network</li> <li>• Provide staff with access to appropriate clinical support, professional development and up to date technology</li> </ul>	Clinical Network Area Dir Dis Mng Clinical Network All CNCs All Dir Clinical Network /Area Workforce Clinical Network /Area Workforce All Directors/ Clinical Network Clinical Network All Dir All Dir	June 2010 May 2009 Aug 2008 Nov 2007 Oct 2008 Mar 2010 June 2010 June 2009 Dec 2007 July 2010 Dec 2007	2 2 2 1 1 2 2 1 3 2 2	H

♦ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

\* Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Our people, culture and capability</b>						
<b>OBJECTIVE:</b>	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in: <b>Developing competence, capability, individual accountability and performance</b> <i>continued</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding</b>	<b>★ Priority L, M, H</b>
			<ul style="list-style-type: none"> <li>Provide staff with adequate release and relief for ongoing education and training</li> <li>Implement clinical supervision workshops eg teaching on the run</li> <li>Ensure staff specialists undertake adequate TESL per year</li> </ul>	Clinical Network Clinical Network Clinical Network	Dec 2007 Nov 2009 Sept 2007	2 2 1	
Percent staff with a current performance plan	80%	Annual	<b>Emergency Services:</b>				
			<ul style="list-style-type: none"> <li>Develop a business case for 1 FTE CNE positions for level 4 and above EDs</li> </ul>	Dir(s) ED/ Clinical Network	Apr 2007	2	
			<ul style="list-style-type: none"> <li>Coordinate workforce planning and funding for supervision and control of Interns throughout the HNE emergency stream</li> </ul>	Man MSR & P Dir(s) ED/ Clinical Network /JMO units	July 2009	2	
			<ul style="list-style-type: none"> <li>Support the development of Advanced Clinical Nursing roles in all level EDs</li> </ul>	Dir(s) ED/ Clinical Network	Aug 2008	2	
			<ul style="list-style-type: none"> <li>Develop strategies for “teaching on the run” modules in all EDs</li> </ul>	All Dirs/ Clinical Network	July 2008	1	
			<ul style="list-style-type: none"> <li>Develop and implement correct staffing ratios for all EDs               <ul style="list-style-type: none"> <li>Ensure one-to-one nursing care for allocated trauma / resuscitation beds in all Level 4-6 facilities</li> </ul> </li> </ul>	Dir(s) ED/ Clinical Network	Sept 2007	2	
<ul style="list-style-type: none"> <li>Ensure provision of a designated CIN and/or REAT for all Level 4 facilities &amp; above</li> </ul>	Dir(s) ED/ Clinical Network	June 2007	3	M			

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Our people, culture and capability</b>						
<b>OBJECTIVE:</b>	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in: <b>Developing competence, capability, individual accountability and performance</b> <i>continued</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding</b>	<b>★ Priority L, M, H</b>
<i>Continued</i>			<b>Trauma:</b> <ul style="list-style-type: none"> <li>• Ensure all clinical staff working in trauma undertake training in EMST, TNCC and paediatric resuscitation</li> <li>• Develop and implement a surgical registrars trauma rotation program</li> <li>• Deliver and evaluate an Area wide trauma education program for all clinical staff</li> <li>• Identify key staff to provide education and support to identified trauma staff, including the role of trauma team leader</li> </ul>	Dir Trauma	Oct 2008	2	
			<b>Retrieval:</b> <ul style="list-style-type: none"> <li>• Develop and assess core competencies for staff who work in retrieval environment</li> </ul>	Dir(s) Retrieval	Sept 2009	2	
			<b>Intensive Care:</b> <ul style="list-style-type: none"> <li>• Support the development of Advanced Clinical Nursing roles in all Level 5 and 6 ICUs</li> </ul>	Dir ICU	May 2009	2	

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Our people, culture and capability</b>							
<b>OBJECTIVE:</b>	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in: <b>Ensuring a safe and healthy working environment</b>						<b>Risk Rating</b> Current    Target	
						<b>K</b>	<b>L</b>	
<b>DESTINATION STATEMENT:</b>	<i>We actively maintain a safe workplace</i>							
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding</b>	<b>★ Priority L, M, H</b>	
Number hours over time	TBD	Monthly	<b>All streams</b> <ul style="list-style-type: none"> <li>Ensure appropriate representation at area disaster planning meetings</li> <li>Liaise with staff health to develop strategies for all staff to be immunised</li> <li>Monitor and evaluate sick leave and workers compensation data</li> <li>Review the implementation of flexible work practice such as 10 hr shifts, job sharing etc</li> </ul>	Clinical Network	Dec 2007	1		
Lost Time Injury Frequency Rate	Nil	Monthly		<ul style="list-style-type: none"> <li>Liaise with staff health to develop strategies for all staff to be immunised</li> </ul>	All Dir	Feb 2007	1	
Severity rate – number days lost per million hours worked	TBD	Monthly		<ul style="list-style-type: none"> <li>Monitor and evaluate sick leave and workers compensation data</li> </ul>	All Dir	Oct 2007	1	
Staff immunisation rate	80% (Cat A)	6 Monthly		<ul style="list-style-type: none"> <li>Review the implementation of flexible work practice such as 10 hr shifts, job sharing etc</li> </ul>	Clinical Network	June 2007	1	
Sick leave rate	TBD	Monthly	<ul style="list-style-type: none"> <li>Develop and implement (by stream) an appropriate RMR strategy</li> <li>Plan for the appropriate implementation of communicable disease preparedness across the CCES</li> </ul>	Clinical Network	Oct 2007	1		
			<ul style="list-style-type: none"> <li>Plan for the appropriate implementation of communicable disease preparedness across the CCES</li> </ul>	Clinical Network	Mar 2008	2		
			<b>Emergency Services:</b> <ul style="list-style-type: none"> <li>Support the provision of personal security alarms for all staff as per Australian Standards 4485 and NSW Health policy</li> <li>Develop and implement recommendations and strategies to provide 24 hour coverage and adequate and timely response by trained security staff on all sites</li> <li>Develop and implement strategies for hospital and emergency department lock down</li> </ul>	GMs/Dir(s) ED/ Clinical Network	June 2007	2		
			<ul style="list-style-type: none"> <li>Develop and implement recommendations and strategies to provide 24 hour coverage and adequate and timely response by trained security staff on all sites</li> </ul>	Dir(s) ED/ Clinical Network	July 2007	2		
			<ul style="list-style-type: none"> <li>Develop and implement strategies for hospital and emergency department lock down</li> </ul>	Dir(s) ED/ Clinical Network	July 2007	2		
			<ul style="list-style-type: none"> <li>Provide budgetary support for the provision of orientation and compulsory inservice on safety/security for all staff</li> </ul>	Dir(s) ED/ Clinical Network	Oct 2007	2		
			<ul style="list-style-type: none"> <li>Develop strategies and implement site specific orientation packages for all staff including casuals, locums and agency staff</li> </ul>	Dir(s) ED/ Clinical Network	Apr 2007	2		

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding ★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Our people, culture and capability</b>						
<b>OBJECTIVE:</b>	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in: <b>Ensuring a safe and healthy working environment</b> <i>continued</i>						
<b>DESTINATION STATEMENT:</b>	<i>We actively maintain a safe workplace</i>						
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding</b>	<b>★ Priority L, M, H</b>
<i>Continued</i>			<b>Emergency Services (cont):</b> <ul style="list-style-type: none"> <li>• Develop and implement (according to role delineation) standard guidelines for minimum equipment levels for emergency departments</li> <li>• Adopt reasonable nursing workload tool (when finalised) for all EDs</li> </ul>	Dir(s) ED/ Clinical Network	June 2008	2	
			<b>Intensive Care:</b> <ul style="list-style-type: none"> <li>• Implement a reasonable nursing workload tool for ICU/HDU (currently in development)</li> </ul>	Dir(s) ICU/Nurse Managers	Apr 2009	2	

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

## CRITICAL CARE AND EMERGENCY SERVICES

<b>FOCUS AREA:</b>	<b>Our people, culture and capability</b>												
<b>OBJECTIVE:</b>	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in: <b>Demonstrating innovative healthcare</b>						<table border="1" style="float: right; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;"><b>Risk Rating</b></td> </tr> <tr> <td style="text-align: center;">Current</td> <td style="text-align: center;">Target</td> </tr> <tr> <td style="text-align: center; background-color: yellow;">N</td> <td style="text-align: center; background-color: yellow;">N</td> </tr> </table>	<b>Risk Rating</b>		Current	Target	N	N
<b>Risk Rating</b>													
Current	Target												
N	N												
<b>DESTINATION STATEMENT:</b>	<i>We are recognised nationally and internationally for innovation in clinical, organisational and support services</i>												
<b>Measure:</b>	<b>Target</b>	<b>Reporting Timeframe</b>	<b>Strategic Initiatives/Actions</b>	<b>Responsibility</b>	<b>Time frame</b>	<b>◆ Funding</b>	<b>★ Priority L, M, H</b>						
Number critical care and emergency services research projects completed within timeframe		Annual	<b>All streams</b> <ul style="list-style-type: none"> <li>Encourage and support staff to apply for research and funding grants, as well as provide small grants for the development of research proposals</li> </ul>	Clinical Network	June 2007	2							
Number external awards of recognition achieved		Annual		<ul style="list-style-type: none"> <li>Encourage and support staff to undertake and publish research articles in peer reviewed journals</li> <li>Develop a business case for a multidisciplinary research personnel</li> <li>Support the roll out of the Clinical Applications Portal (CAP)</li> <li>Participate in the pilot and roll out of HealthLINK</li> <li>Explore innovative interpersonal communication technology options</li> <li>Explore and implement an area CCES advice/consultation line (for clinical staff)</li> <li>Develop a business case for advanced clinical roles (eg NP)</li> </ul>	All Directors	June 2007	2	L					
				Clinical Network	Apr 2008	3							
				Clinical Network	Dec 2007	2							
				All Directors	Nov 2009	2							
				Clinical Network	Mar 2010	2							
				Clinical Network	Mar 2008	3	H						
				Dir(s), Clinical Network	Mar 2010	2							
			<b>Intensive Care:</b> <ul style="list-style-type: none"> <li>Develop a business case for a dedicated research personnel for tertiary ICU</li> </ul>	Dir(s) ICU/ Clinical Network	Feb 2008	2							

◆ Funding: 1 = Can be implemented without funding, 2 = Can be implemented using existing resources, 3 = Requires funding

★ Priority: L = Low, M = Medium, H = High

### Abbreviations

ABG	Arterial Blood Gas
ACCCN	Australian College of Critical Care Nursing
ACEM	Australian College of Emergency Medicine
ACLS	Advanced Cardiac Life Support
ALO	Aboriginal Liaison Officer
AMRS	Aeromedical and medical retrieval service (formally Medical Retrieval Unit)
ALS	Advanced Life Support
APLS	Advanced Paediatric Life Support
ART	Ambulance Release Team
ASNSW	Ambulance Service NSW
ATS	Australasian Triage Score
CALD	Culturally and Linguistically Diverse
CAP	Clinical Applications Portal
CAPAC	Community and Post Acute Care
CCES	Critical Care and Emergency Services
CCHS	Community Controlled Health Service
CEC	Clinical Excellence Commission
CIN	Clinical Initiatives Nurse
CNE	Clinical Nurse Educator
CN	Clinical Network
DEMT	Division of Emergency Medicine Trainer
DSTC	Definitive Surgical Trauma Course
DNPTC	Definitive Perioperative Nursing Trauma Course
EAP	Employee Assistance Program
ED	Emergency Department
ELS	Emergency Life Support
EMST	Early Management of Severe Trauma
ENEC	Enrolled Nurse Emergency Care
FAST	Focussed Abdominal Sonography in Trauma
FLEC	First Line Emergency Care
GM	General Manager/Facility Manager
GPAAH	GP Access After Hours
HNE	Hunter New England
HSAs	Health Security Assistants
ICIG	Intensive Care Implementation Group
iPMS	Information Patient Management System
KEAG	Kaleidoscope Executive Advisory Group
MET	Medical Emergency Team
NICS	National Institute of Clinical Studies
PACS	Picture Archiving and Communication System
PFU	Patient Flow Unit
PICAG	Paediatric Intensive Care Advisory Group
POCT	Point of Care Testing
PTA	Post traumatic amnesia
REAT	Rapid Emergency Assessment Team
SAFTE	Sub Acute Fast Track Elderly
SSDB	Statewide Services Development Branch
TASC	Towards A Safer Culture
TESL	Training, Education, Study Leave
TNCC	Trauma Nursing Care Course
TRRH	Tamworth Rural Referral Hospital

## **11. APPENDICES**

### **Appendix 1 Core Planning Group**

#### **Critical Care and Emergency Services Core Planning Group**

Michael di Rienzo: Executive Sponsor, Director of Operations- Acute Networks

Todd McEwan: Plan Leader, ICU/Anaesthetics Representative

Marianne Gaul/Phil Way: Plan Leaders, Rural Critical Care Representatives

Leanne Egan: Plan Leader, Emergency Department Representative

Louise Evans: Planning Officer, Population Health, Planning and Performance Unit

Zsolt Balogh: Director of Trauma, John Hunter Hospital

Mr Sandy Brown: Senior Radiographer, John Hunter Hospital

Katrina Ellem and Tracey Muscat, Mater Misericordiae Hospital Representatives

David Gleadhill: Director of Emergency Medicine, The Maitland Hospital

Dan Connor and Chris Somerville: Manning Hospital Representatives

Ken Havill: Acting Director Intensive Care Services, John Hunter Hospital

David White: Nurse Manager Critical Care and Retrieval Tamworth Base Hospital

Steve McPherson: Operations Manager, Ambulance Service of NSW

Jane O'Brien: Area Critical Care Coordinator (Southern), John Hunter Hospital

David Rhodes: Area Director Allied Health

Martin Rowley: Area Critical Care Advisor (Southern)

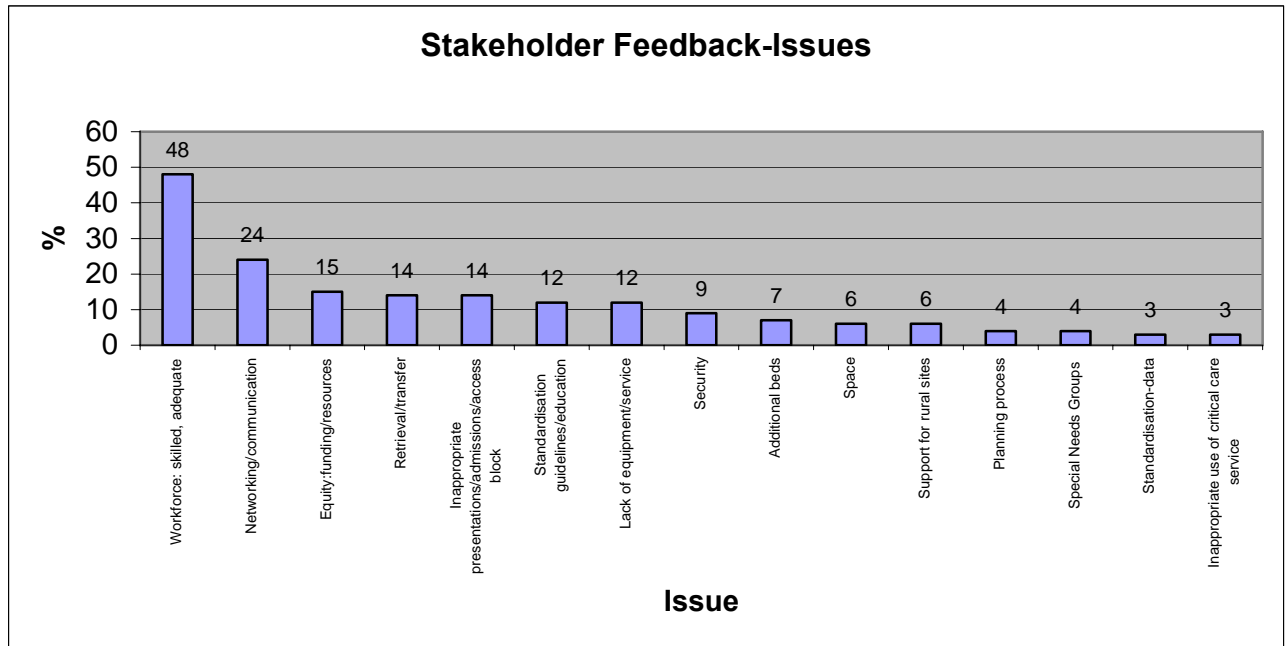
Carolyn Hullick: ED Director, John Hunter Hospital

Verity Treeve: ED NUM Tamworth Base Hospital

## Appendix 2 HNE Stakeholder Survey

### Stakeholder Feedback Report

We received completed surveys from 64 of our internal and external stakeholders. Issues identified for critical care and emergency services (in order of priority) are indicated in Figure 1.



**Figure 1:** Issues Identified by Stakeholders

Stakeholders also provided feedback about strategies in relation to key issues. Some strategies would require a large amount of resources and time and may not be achievable within the scope of this plan. Suggested strategies included:

- Central coordination of locum provision
- Standardisation of job descriptions
- Provision of relocation expenses
- Area approach to education
- Formalise existing networks
- Develop a critical care and emergency services website
- Area wide approach to purchasing equipment
- Use of telemedicine
- Develop referral guidelines to the service
- Additional after hours GP services
- Use of community media eg regarding inappropriate ED presentations

### Appendix 3 Emergency Department Survey

As part of the stakeholder consultation process, all HNE Emergency Departments (37) were invited to participate in a survey to gain information about key issues and recommendations. Survey participants provided valuable information in relation to IT, data collection and workforce requirements, as well as capital works developments/improvements. The nineteen emergency departments (51%) that provided feedback (see Table 1) have been categorised as either a:

1. Major Centre
2. Southern Centre
3. Northern Centre

**Table 1: Emergency Departments Providing Feedback**

Major	Southern	Northern
Belmont	Muswellbrook	Glen Innes
Manning	Kurri Kurri	Manilla
Maitland	Tomaree	Barraba
Mater	Singleton	Narrabri
Tamworth	Cessnock	Gunnedah
John Hunter		Inverell
		Moree
		Armidale

Feedback has been collated and group into the following categories:

1. Capital works/refurbishments
2. IT
3. Data collection
4. Workforce

#### Feedback from Major Centres

1. John Hunter – require Emergency Medical Unit (EMU) which is attached to ED & managed by ED Physicians/Nurses
2. Mater - needs larger refurbished department
3. Maitland – need adequate staffing and increased bed capacity to cope with increase in population growth
4. Manning – need adequate staffing with refurbished department / increased bed capacity in line with population growth predictions

#### Feedback from Southern Centres

1. Tomaree – need increased bed capacity to cope with population growth
2. Singleton – needs refurbished ED
3. Muswellbrook - move ED to ground level
4. Gloucester - move ED to ground level

#### IT Recommendations-all centres

1. PACS available at all level > 3 sites - (12 sites without)
2. CAP available at all level > 3 sites - (15 sites without)
3. Improved access to Medical Records after hours for all sites
4. Video Conferencing available to all sites – (15 sites without)
5. Istat machines in all sites without pathology on site - (19 sites without)
6. Tamworth & Manning – require ABG analyser in ED
7. Development of HNE ED specific website (containing ED specific guidelines)
8. Facsimilies in all EDs and at least one (1) hands-free telephone in all ED's

**ED Data Collection Recommendations-all centres**

1. Recommend iPMS implemented for all northern sites
2. Recommend iPMS coordinator available to provide audits of data each month for all sites
3. Improved clerical support for all sites to allow improved real time data entry for nursing staff after hours & weekends
4. Improved patient ALERT system on iPMS – aggressive, dangerous or infectious patients
5. Access to adequate number of PC's in the ED for data entry
6. Data system for tracking or highlighting potential public health issues.
7. Electronic medical records and discharge summaries / communication to GP's

**Nursing Workforce Recommendations-all centres**

1. Designated Triage Nurse, CIN and/or REAT for all Level 4 facilities & above
2. 1: 1 Nursing care for allocated trauma / resuscitation beds in Level 4-6 facility
3. Adopt reasonable workload tool for all ED's
4. Improved allocated funding for ED Nursing positions
5. Nursing recruitment with an aging workforce – average nurses age 40-50 years
6. Increased nurses staffing Tamworth to cover allocated 23 beds in unit

**Medical Workforce Recommendations-all centres**

1. Central recruitment of middle grade and senior medical staff with administrative support to achieve this
2. Dedicated ED Medical Director (FACEM) for Tamworth & Manning
3. Improved after hours Staff Specialists coverage – JHH, Tamworth, Manning, Maitland, Mater, Belmont, & Armidale
4. 16 hours 7 days a week staff specialist coverage at JHH
5. CMO Coverage at Cessnock
6. CMO coverage at Tomaree to cover seasonal fluctuations

**Appendix 4 Current Workforce**

<b>Stream/Location</b>	<b>Category</b>	<b>Permanent FTE</b>	<b>Current Active Recruitment</b>
<b>Trauma</b>	Trauma Director (Medical, Area Position 0.5 clinical, 0.5 administrative)	1	Clinical Fellow
	Paediatric Trauma Director (Area Position)	0.2	
	CNCs (2 are based at JHH)	3	
	Admin	1	
<b>Retrieval-JHH</b>	10 hours/day on site medical and nursing staff  14 hours/day offsite on call medical and nursing staff		
<b>Retrieval-Tamworth</b>	RN	0	1.5
<b>ICU/HDU -JHH</b>	Nursing	95.77	
	Registrar/RMO	9	
	Fellow	3	
	Staff Specialist	5.2	
-Tamworth	Nursing	50.5	6.5
	Staff Specialist	1.4	1.0
-Mater	Nursing	23.8	2.0
	Staff Specialist	2.5	
	CMO + SRMO	5.2	
-Maitland	RN	11	
	CNS	3	
	NUM	1	
	Physicians	4	
	REG	4	
	RMO	4	
-Armidale	Nursing	12.6	
-Belmont	Nursing	10.9	

**Current Workforce (cont)**

<b>Stream/Location</b>	<b>Category</b>	<b>Permanent FTE</b>	<b>Current Active Recruitment</b>
<b>Emergency - JHH</b>	Nursing	72.9	
	Registrar/SRMO	19.8	
	RMO	6	
	Interns	8	
	Staff Specialist	7.75	
<b>-Tamworth</b>	Nursing	27	
	FACEMs	3.6	2.0
	Registrars	3	
	CMOs	0.35	
	RMOs	8	
	Interns	4	
	Clerks	4.8	
<b>-Mater</b>	Nursing (RN)	11.37	3.8
	EN	3.47	
	CNS	5.21	
	NUM	1	
	Registrars	6.89	
	FACEMs	3	1 Director
	Interns	3	
	CMO	3	5
	RMO	5	
	Clerical ED PSA	2	
	Admin Officer	1.6	
	Clinical Coordinator	0.63	
	Data Manager	0.63	
	Technical Assistant	1.71	
	EDAC	2	
	Mental Health	1.47	
<b>-Maitland</b>	Nursing	23.9	
	FACEMs	2.75	
	Registrars	1	
	CMO	11.2	
	RMO	2	
<b>-Armidale</b>	Nursing	11	
<b>-Belmont</b>	Nursing	17.2	
	FACEMs	1	
	CMO	11.4	
<b>Allied Health ICU/ HDU/CCU - JHH</b>		4.5	
<b>- Tamworth</b>		1.5	
<b>- Mater</b>		0.8	
<b>- Maitland</b>		0.3	
	Unable to give accurate figures at other sites due to blended workforce		
<b>District and Community Services</b>	Unable to give accurate figures due to blended workforce		

## **Appendix 5 Related Policies and Other Documents**

- NSW Health Rural Critical Care Plan 1998
- NSW Health Metropolitan Critical Care Plan 1996
- NSW Health Emergency Department Services Plan 2001
- NSW Health Intensive Care Service Plan – Adult Services 2001
- NSW State Trauma Plan 2003
- NSW Minimum Trauma Data Set 2002-2004
- NSW Health NSW Rural Health Plan September 2002
- NSW Health NSW Rural Health Report September 2002
- NSW ITIM Trauma Minimum Data Set Report NSW Rural Profile 2002-2004
- NSW Health Report of the Greater Metropolitan Services Implementation Group June 2001
- NSW Health Policy Directive (PD2005\_266): The Early Notification of Severe Trauma in Rural NSW
- NSW Health Policy Directive (PD2005\_473): Helicopter transport of patients – Procedures to be Followed
- NSW Health Guide to the Role Delineation of Health Services, 2002
- NSW Health Rural Companion Guide to the Role Delineation of Health Services, 2004
- NSW Health NSW Severe Burns Injury Service-Burns Transfer Guidelines, 2004
- NSW Health Triage in NSW Rural and Remote Emergency Departments With No Onsite Doctors August 2004
- NSW Health Rural Emergency Clinical Guidelines for Adults August 2004
- Strategic Directions for Health 2000-2005, NSW Health 2000
- NSW Health Clinical Services Redesign Program Models of Emergency Care March 2006
- Report of the Greater Metropolitan Services Implementation Group, June 2001
- The Critical Care Nurse Workforce in Australia 2001-2011, Australian Health Workforce Advisory Committee Report 2002.1, Dec 2002
- HAHS Emergency Services Plan 2004-2007
- HAHS Intensive Care/High Dependency Care Plan 2002-2006
- Mid North Coast Emergency/Critical Care Services Plan (draft) 2004-2009
- NEAHS Critical Care Plan (draft) 2003-2005
- HNEAHS Trauma Care Plan 2005-2010
- HNE Sustainable Access Plan February 2005
- HNE Draft Service Planning Process March 2006
- HNE Draft Workforce Development Framework for Clinical Service Plans October 2005
- NSW Health Supra-Regional Retrieval Service Model March 2005

## Appendix 6 Aboriginal Health Impact Statement

Have all items of the checklist been reviewed and answered?

Yes          No

Will this policy, program or strategy significantly affect the health\* of Aboriginal people?

Yes           No

Is this policy, program or strategy likely to lead to a change in the nature or level of resources or health services available for Aboriginal Health?

Yes          No

If so, specify:

Strategies have been included to: increase liaison with Aboriginal Community Controlled Health Service providers to enhance effective partnerships, and to improve services provided (especially in Emergency Departments)

### Statement

“The health needs and interests of Aboriginal people have been considered, and where relevant, incorporated and appropriately addressed in the development of the Critical Care and Emergency Services Plan”

Head of Unit Name: Michael Di Rienzo

Unit Name: Director of Operations - Acute Networks

### Development of the Policy, Program or Strategy

1. Has there been appropriate representation of Aboriginal stakeholders in the development of the policy, program or strategy?

Yes          No          N/A

2. Have Aboriginal stakeholders been involved from the early stages of policy, program or strategy development?

Yes          No          N/A

Please provide a brief description

The Planning Officer met with the nominated Aboriginal health worker in Tamworth in late 2005. The meeting allowed for the development of a process for facilitating appropriate feedback and consultation on plan development. Prior to this meeting in Tamworth, the Planning Unit Director and Planning Officer met with the Area Director of Aboriginal Health, to discuss how to appropriately and effectively consult on plan development

*\* For Aboriginal people, health is defined as not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community.*

3. Have consultation/negotiation processes occurred with Aboriginal stakeholders:

√ Yes                      No                      N/A

4. Have these processes been effective?

√ Yes                      No                      N/A

Explain

Regular communication has occurred, allowing for sharing of information and the development of an effective working relationship. Appropriate strategies have been identified and included in the strategic action plan. The Planning Officer has travelled three times to Tamworth to meet with Aboriginal Health Workers (from HNE Health and Aboriginal Community Controlled Health Services) and has also made use of existing meeting schedules for this interaction to occur.

5. Have links been made with relevant existing mainstream and/or Aboriginal-specific policies, programs and/or strategies?

√ Yes                      No                      N/A

Explain

The plan highlights the need to strengthen links with Aboriginal Liaison Officers and to seek advice from Aboriginal stakeholders regarding improvements and/or developments for new departments (eg Emergency Departments). In addition, strategies relating to compliance with identification of Aboriginality and increased collaboration with Aboriginal Community Controlled Health Services have been included in the plan.

6. Has the policy, program or strategy been endorsed by the NSW Aboriginal Health Partnership/Local Aboriginal Health Partnership where required?

Yes                      No                      √ N/A

Contents of the Policy, Program or Strategy

7. Does the policy, program or strategy clearly identify the effects it will have on Aboriginal health outcomes and health services?

Yes                      √ No                      N/A

Comments

No specific measures have been identified in relation to aboriginal health outcomes, but the plan clearly defines the need to increase identification of Aboriginal people, utilise existing Aboriginal services and review service provision in line with Aboriginal needs or requests. As this plan is a “living” document, measures and initiatives may be amended to gain more specific data in relation to access, service utilisation and health outcomes. Also specific measures for Aboriginal health outcomes will be included in the area Aboriginal Health Plan.

8. Have these effects been adequately addressed in the policy, program or strategy?

Yes                      √ No                      N/A

As above

9. Are the identified effects on Aboriginal health outcomes and health services sufficiently different for Aboriginal people (compared to the general population) to warrant the development of a separate policy, program or strategy?

√ Yes                      No                      N/A

An area Aboriginal Health plan is to be developed in 2006. In addition, planning processes ensure that there is appropriate input in all plans (in relation to the health needs of Aboriginal people).

Implementation and Evaluation of the Policy, Program or Strategy

10. Will implementation of the policy, program or strategy be support by an adequate allocation of resources specifically for its Aboriginal health aspects?

√ Yes                      No                      N/A

Any initiatives in the Critical Care and Emergency Services Plan that require additional funds will be prioritised, costed and provided to the Area Executive Team for consideration. This same process will also occur for the area Aboriginal Health Plan.

11. Will the policy, program or strategy be implemented in partnership with Aboriginal stakeholders?

√ Yes                      No                      N/A

Ongoing consultation and collaboration will occur, to ensure effective implementation and improved services for Aboriginal people

12. Does an evaluation plan exist for this policy, program or strategy?

√ Yes                      No                      N/A

Via the balanced scorecard reporting process which will be monitored by the Clinical Network

13. Has it been developed in conjunction with Aboriginal stakeholders?

Yes                      √ No                      N/A

During the life of this strategic plan, there are specific initiatives that will include Aboriginal stakeholder involvement in evaluation of the implemented action. Therefore, Aboriginal stakeholder involvement in evaluation will occur during the life of the plan, but has not occurred in the initial stage of planning. However, Aboriginal stakeholders will be involved from the outset in the evaluation of the area Aboriginal Health Plan.